## Revision History

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Section 1: Introduction

Overview

The Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual is provided to each managed care entity (MCE) contracting with the State to administer services to Hoosier Healthwise and Healthy Indiana Plan (HIP) members enrolled in the respective plans. This manual provides an overview of each MCE’s role in the two programs and the interactions and interfaces among the MCEs, the State, and other contractors.

This manual is organized into the following sections:

- **Introduction** outlines the Indiana Health Coverage Programs (IHCP), including the Hoosier Healthwise and HIP program objectives and components, and MCE enrollment.

- **Program Administration** includes information about eligibility requirements for an MCE, the MCE’s expected role in the Hoosier Healthwise and HIP programs and staffing requirements.

- **Healthy Indiana Plan Billing and Collections** describes the HIP payment program and the expectations for program administration. In addition, the steps for Personal Wellness and Responsibility (POWER) Account reconciliation at redetermination are provided.

- **Covered Services** describes the services that are covered and excluded from the various programs under the managed care umbrella, which includes Hoosier Healthwise and HIP. Information is also included about in-network versus out-of-network services and self-referral services. The pharmacy benefit is included to provide a thorough understanding of the managed care entity’s (MCE’s) responsibilities.

- **Member Services** details the regulations and general program expectations relating to member education and enrollment, member helpline, grievance, and member-provider communication information for Hoosier Healthwise and HIP.

- **Member Enrollment** describes each benefit package and the related aid categories, the categories of IHCP members who are placed in Hoosier Healthwise, how the eligibility is determined for Hoosier Healthwise and HIP, eligibility verification, disenrollment of members from the two programs, and the data exchange processes required for each of these events. In addition, the Member Enrollment section provides expanded benefit information for the Children’s Health Insurance Program (CHIP) established by the Balanced Budget Act of 1997, specifics about Presumptive Eligibility (PE), and Notification of Pregnancy (NOP).

- **Redetermination** describes how eligibility is renewed, the redetermination intervals required for the different programs, provisional eligibility, appeals, and changing MCEs. This section describes the assistance that MCEs can provide to their members.

- **Provider Enrollment and Network Development** describes the requirements and processes with respect to eligible MCEs and providers, network development, enrollment processes, disenrollment processes, and reporting requirements. This section provides details about the MCE’s requirements for enrollment, education, and practice standards for network providers that render services to Hoosier Healthwise and HIP members.

- **Quality Improvement and Utilization Management** is a critical aspect of managed care and expectations, incentive programs, compliance, monitoring, and reporting for Hoosier Healthwise and HIP.

- **Information Systems** describes the functionality required and the data sharing and reporting requirements of the MCEs in reference to encounter data, third-party liability (TPL), and general financial reporting, including for HIP POWER Accounts.
• Performance Reporting describes submission of performance data to the State.

In addition to these sections, Appendixes A through M provide information about extracts, forms, POWER Account reconciliation, and so forth.

**Hoosier Healthwise**

Since its inception in 1994, Hoosier Healthwise has expanded from a Medicaid managed care program to an all-inclusive plan of benefits serving various populations eligible for the IHCP. Hoosier Healthwise is a risk-based managed care program covering children and pregnant women. Indiana offers Hoosier Healthwise members comprehensive benefits depending on the aid category in the following three benefit packages:

• Package A – Full coverage for children and pregnant woman.
• Package C – Preventive, primary, and acute care services for some children under 19 years old.
• Package P – Presumptive eligibility for pregnant women.

See Member Enrollment for details of each benefit package and the related aid categories.

This manual documents policies and procedures applied to the Hoosier Healthwise component of the IHCP specific to MCEs and their roles in the program. General IHCP policies and information provided in the IHCP Provider Reference Modules or elsewhere are referenced and not duplicated in this manual.

Throughout this manual, the member may also be referred to as an enrollee (and may be referred to as recipient by other social service agencies). The following outlines the definitions for enrollee and potential enrollee, as defined in the federal regulations. For the purpose of this manual, enrollees are in the Hoosier Healthwise or the HIP programs:

• Enrollee is a Medicaid member who is currently enrolled in an MCE.
• Potential enrollee is a Medicaid member who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCE.

The healthcare industry, and managed care in particular, is constantly changing to meet the demands of its patients, providers, and payers. Hoosier Healthwise is subject to many of these changes. Hoosier Healthwise is a fluid program striving to meet the needs of its many constituents. The State provides many forums – formal and informal – to address the concerns of Hoosier Healthwise participants and refine policies to reflect the input received. The State Care Programs team documents the finalized policies and incorporates changes into updates of this manual.

**Healthy Indiana Plan**

Indiana offers HIP members a comprehensive benefit package through a deductible health plan paired with a personal healthcare account called a POWER Account. This health plan is subject to a $2,500 deductible and includes first-dollar coverage for ACA-required preventive services. The preventive services benefit is designed to help eliminate barriers to obtaining preventive care.

In 2015, HIP was changed to provide healthcare coverage to all non-disabled low-income adults between the ages of 19 and 64 with household income at or below 138% federal poverty level (FPL). This change included the transition to HIP of many members who were previously enrolled in Hoosier Healthwise. This transition to HIP promoted better health outcomes for individuals, but also reduced churn between the programs, created administrative efficiencies, and provided a seamless experience.
for the members. In addition, the POWER Account changed from $1,100 deductible to a $2,500 deductible while still including first-dollar coverage for preventive services. The annual and lifetime caps were also removed from the plan.

HIP was also updated to create distinct benefit packages: HIP Plus, HIP Basic, HIP State Plan Plus, and HIP State Plan Basic.

**HIP Plus (MA RP):** HIP Plus is available for all members enrolled in HIP who choose to make their POWER Account contribution. Individuals in HIP Plus make a POWER Account contribution and do not have copayments for services. They have a copayment for nonemergent use of the emergency room (ER). Individuals over 133% FPL, which does not include the 5% cost share, who do not make their POWER Account contribution are terminated from HIP and face a 25% penalty of any funds due to them and a six-month program lockout unless they meet one of the lockout exemptions discussed in Healthy Indiana Plan Billing and Collections.

**HIP Basic (MA RB):** HIP Basic is the default option for members with income at or below 133% FPL, which does not include the cost who does not take into account the 5% cost share, who fail to make a POWER Account contribution. HIP Basic requires the member to make copayments at the point of service for services received from a provider, with the exception of preventive services. Individuals enrolled in HIP Basic are allowed to reenroll in HIP Plus upon their annual redetermination if they choose to begin paying their POWER Account contributions.

**HIP State Plan Plus (MA SP):** Individuals enrolled in State Plan benefits have access to the greater benefit package available under the state plan. Those in State Plan Plus have the same cost sharing requirements as HIP Plus, they must make a POWER Account contribution, and they do not have copayments for services.

**HIP State Plan Basic (MA SB):** Individuals enrolled in State Plan benefits have access to the greater benefit package available under the state plan. Those in State Plan Basic have the same cost sharing requirements as HIP Basic and they have the same copayments for services.

All HIP members have a POWER Account. The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and is funded with State and member contributions. Employers and other third parties (for example, nonprofit organizations and family members) may also contribute some or all of the member’s POWER Account contribution. Members use POWER Account funds to meet the $2,500 deductible. POWER Accounts are funded with post-tax dollars and are not considered HSAs or other health spending accounts (for example, Flexible Spending Accounts, Health Reimbursement Accounts, and so forth) under federal law. POWER Accounts are not subject to regulation under the U.S. Tax Code as such.

HIP members are not fully eligible, or enrolled as members, until the earlier of (i) payment of their first POWER Account contributions, (ii) payment of a “Fast Track” $10 prepayment (PPAC) or, (iii) for individuals at or below 100% FPL, the expiration of the 60 day payment period. HIP-accepted members who are still in the initial 60 day payment period who have not yet paid their first POWER Account contributions are referred to as “conditionally eligible.”

Section 1931 parents and caretakers will continue to be eligible for Medicaid State Plan benefits, but are deemed eligible for HIP State Plan benefits. Individuals enrolled in State Plan benefits are subject to the same cost-sharing components as HIP Plus or HIP Basic through a POWER Account contribution or copayments. In addition to this group, low-income 19- and 20-year-old dependents are also afforded the opportunity to receive State Plan benefits.

A new group of individuals will also be eligible for State Plan benefits if they are deemed to be medically frail. The medically frail determination is based on 42 CFR §440.315(f). These individuals will be determined medically frail through the claims and pharmacy data or self-report. The claims
data is applied by the MCEs through Milliman underwriting guidelines to determine whether they are medically frail. Additional information regarding the medically frail determination can be found in POWER Account Reconciliation.

**Managed Care Entity Orientation**

When the MCEs contract with the State, the State schedules orientation sessions with the MCEs to review policy and technical procedures necessary to the contract administration. This includes interfaces with the State and its contractors before and after implementation of any contract. The MCEs identify individuals to participate in the initial and/or ongoing orientation sessions. Individuals participating would generally be from the following functional areas:

- Provider network development and enrollment, including primary medical providers (PMPs).
- Technical and systems support.
- Medical policy.
- Member services and enrollment.
- Member financial obligations for premium payment programs.
- Quality assurance and utilization review.

The State designates members from its staff and contractor representatives to work with the MCE on implementation issues. During orientation, the State and its Hoosier Healthwise and HIP contractors provide the MCE with a broad range of materials.

The fiscal agent provides the following:

- Claim resolution edits and audits documents are made available, via File Exchange posting to the MCEs twice a year, in January and July.
- **IHCP explanation of benefits (EOBs) codes.**
- **IHCP Provider Reference Modules**, which are available on the Provider Reference Materials page at indianamedicaid.com.
- Schedules for financial cycles for capitation payments.
- Schedules for generation of all other information to and from the MCEs.
- IHCP provider update bulletins and banner pages for the current year (available at indianamedicaid.com).
- Electronic file layouts and requirements for data exchanges, including provider extract files, POWER Account reconciliation file layout, and third-party liability files, which are available on the MCO Question and Answer page at indianamedicaid.com. The password is mcoquestion).
- User ID and password for access to electronic files, including Health Insurance Portability and Accountability Act (HIPAA)-compliant member enrollment rosters and capitation payments. Additional information about other electronic files and claims processing is provided in Information Systems.
- Companion guides for the 5010 HIPAA-compliant 834 Benefit Enrollment Transactions, 820 Capitation and POWER Payment Transactions, 835 Remittance Advice Transactions, 837 Professional and Encounter Claims Transactions, and 837 Institutional Claims and Encounter Transactions. The guides for upgrading to 5010 HIPAA-compliant transactions are also available on the Electronic Data Interchange (EDI) page at indianamedicaid.com. This section contains structure and transaction specifications. The IHCP Companion Guide Overview and the IHCP Notes provide IHCP information. See the revision history document for specific updates. Providers...
and EDI vendors developing software for electronic data interchange may need to view multiple guides.

- MCE enrollment information, forms, and procedures, which are available on the MCO Question and Answer page at indianamedicaid.com. The password is mcoquestion.
- PMP enrollment and disenrollment procedures.
- Member MCE auto-assignment process for Hoosier Healthwise and HIP, and information regarding the Hoosier Healthwise open enrollment process.
- Monthly MCE Technical Meeting format and procedure for submission of agenda items.

The State or its designee provides the following:

- Orientation meeting schedule.
- Resource-based relative value scale (RBRVS) and other relevant fee schedules.
- Diagnosis-related group (DRG) information and base rates.
- Telephone numbers for the State, enrollment broker, and fiscal agent contacts.
- Annual IHCP report and other program summary reports.
- Program meeting schedules.
- Readiness review criteria.
- Quarterly and ad-hoc reporting requirements and schedule.

The enrollment broker provides the following materials:

- Hoosier Healthwise and HIP member materials.
- Enrollment broker script for member education and enrollment process.
- In-service training opportunities.

The State arranges orientation sessions for each newly contracted MCE. Orientation sessions are not automatically conducted for each contract renewal for an incumbent MCE. At the time of a contract renewal, an incumbent MCE can request the orientation session to accommodate changes in networks or other transitions for which the MCE believes an orientation session would be beneficial. The MCE must make this special request in writing to the State and ask whether it wishes to participate in the entire session or in a limited session to review specified topics.
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Overview

Managed care entities must comply with the following to participate in the Hoosier Healthwise and Healthy Indiana Plan (HIP) programs:

• Be an Indiana-licensed accident or sickness insurer, or an Indiana-licensed health maintenance organization (HMO). Be fully authorized under Indiana law to arrange or administer the full range and scope of services required under a procurement process undertaken by the State.

• Contract with the State on a prepaid, capitated basis to arrange, administer, and pay for the delivery of healthcare services to its members.

As required by IC 12-15-12-21, if the managed care entity (MCE) was a Hoosier Healthwise vendor before July 1, 2008, the MCE must be accredited by the National Committee for Quality Assurance (NCQA) on or before the contract start date.

Staffing Requirements

The MCE must ensure that all staff members, including subcontractor staff, have appropriate and ongoing training (for example, orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, computer systems, and so forth), education, and experience to fulfill the requirements of their positions. The MCE must institute mechanisms to maintain a high level of performance and data reporting, regardless of staff vacancies or turnover. The MCE must also have an effective method to mitigate the effects of staff turnover (for example, cross-training, use of temporary staff or consultants, and so forth). Processes must also be in place to solicit feedback from MCEs’ staff members to improve the work environment. The MCE must maintain documentation to confirm internal training, curriculum, schedules, and attendance. The MCE must have descriptions for the positions discussed in this section. The descriptions must include the responsibilities of and qualifications for the position, for example, but must not be limited to education (for example, high school, college degree, or graduate degree), professional credentials (for example, licensure or certifications), direct work experience, and membership in professional or community associations.

The State encourages the MCE to have the same key staff member dedicated to its Hoosier Healthwise and HIP lines of business. The MCE must have an office in the state of Indiana from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities, and a major portion of the plan’s operations take place. The contractor shall ensure the location of any staff or operational functions outside of the state of Indiana does not compromise the delivery of integrated services and the seamless experience for members and providers. The contractor shall be responsible for ensuring all staff functions conducted outside of the state of Indiana are readily reportable to the Office of Medicaid Policy and Planning (OMPP) at all times to ensure such locations do not hinder the State’s ability to monitor the contractor’s performance and compliance with contract requirements. Indiana-based staff shall maintain a full understanding of the operations conducted outside of the state of Indiana, and must be prepared to discuss these operations with the OMPP upon request, including during unannounced OMPP site visits.

The MCE must employ specific key staff dedicated as a full-time employee (FTE), and the State reserves the right to approve or deny the individuals in these positions. In addition to the key staff members, the MCE must also employ the additional staff necessary to ensure compliance with the State’s performance requirements. The key staff members are as follows:
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- Chief executive officer – The chief executive officer or executive director has full and final responsibility for the MCE management and compliance with all provisions of the State’s contract with the MCE.

- Chief financial officer – The chief financial officer must oversee the budget and accounting systems of the MCE for the Hoosier Healthwise and HIP programs. This officer, at a minimum, must be responsible for ensuring that the MCE meets the State’s requirements for financial performance and reporting.

- Compliance officer – The MCE must employ a compliance officer who is accountable to the MCE’s executive leadership and is dedicated full-time to the Hoosier Healthwise and HIP programs. This individual is the primary liaison with the State (or its designees) to facilitate communications between the State, the State’s contractors, and the MCE’s executive leadership and staff. The compliance officer must maintain current knowledge of federal and state legislation, legislative initiatives, and regulations that may affect the MCE’s Hoosier Healthwise and HIP programs. It is the responsibility of the compliance officer to coordinate reporting to the State and to review the timeliness, accuracy, and completeness of reports and data submissions to the State. The compliance officer, in close coordination with other key staff, has primary responsibility for ensuring all MCE functions are compliant with the terms of the contract. The compliance officer must meet with the State’s FSSA Program Integrity (PI) unit on a quarterly basis.

- Information systems (IS) coordinator – The MCE must employ an IS coordinator who is dedicated full-time to the Hoosier Healthwise and HIP programs. The IS coordinator, in close coordination with other key staff, is responsible for ensuring all program data transactions are in compliance with the terms of the MCE’s contract with the State. The IS coordinator is responsible for attendance at all Technical Meetings called by the State. If the IS coordinator is unable to attend a Technical Meeting, the IS coordinator must designate a representative to take his or her place. This representative must report back to the IS coordinator on the Technical Meeting’s agenda and action items. This individual oversees the MCE’s Hoosier Healthwise and HIP information systems and serves as a liaison between the MCE and the State fiscal agent or other State contractors regarding the following:
  – Encounter claims submissions
  – Capitation payment
  – Member eligibility
  – Personal Wellness and Responsibility (POWER) Account administration
  – Enrollment and other data transmission interface and management issues

- Medical director – The MCE must employ the services of a medical director who is an Indiana-licensed Indiana Health Coverage Programs (IHCP) provider board certified in family medicine. The medical director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality management components of the MCE’s operations are compliant with the terms of the MCE’s contract with the State. The medical director is responsible for attending all State quality meetings, including the Quality Strategy Committee meetings. If the medical director is unable to attend a State quality meeting, the medical director must designate a representative to take his or her place. This representative must report to the medical director about the meeting’s agenda and action items. If the medical director is not board certified in family medicine, he or she must be supported by a clinical team with experience in pediatrics, behavioral health, adult medicine, and obstetrics/gynecology. The medical director must be dedicated full-time to the Hoosier Healthwise and HIP programs. The medical director must do the following:
  – Oversee the development and implementation of the MCE’s disease management, case management, and care management programs.
  – Oversee the development of the MCE’s clinical practice guidelines; review any potential quality of care problems.
  – Oversee the MCE’s clinical management program and programs that address special needs populations.
  – Oversee health screenings and medically frail assessments.

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- Serve as the MCE’s medical professional interface with the MCE’s primary medical providers (PMPs) and specialty providers.
- Direct the Quality Management and Utilization Management programs, including, but not limited to, monitoring, corrective actions, and other quality management, utilization management, or program integrity activities.

- Member services manager – The MCE must employ a member services manager who is dedicated full-time to Hoosier Healthwise and HIP member services and must be available via the member help line and the member website, including through a member portal. The member services manager must, at a minimum, be responsible for directing the activities of the MCE’s member services, including, but not limited to, member helpline telephone performance, member email communications, member education, the member website, member outreach programs, development, approval and distribution of member materials and employer outreach for HIP members. The member services manager is responsible for the member grievances and appeals process, and works closely with other managers (especially, the quality management manager, utilization management manager, and medical director) and departments to address and resolve member grievances and appeals. The member services manager must oversee the interface with the enrollment broker and must provide an orientation and ongoing training for member services helpline representatives, at a minimum, to accurately inform members about how the MCE operates, availability of covered services, benefit limitations, health screenings, emergency services, PMP assignment and changes, specialty provider referrals, self-referral services, preventive and enhanced services, POWER Account services (HIP only), well-child services (Hoosier Healthwise only) and member grievances and appeals procedures. The member services manager, in close coordination with other key staff, is responsible for ensuring that all the MCE’s member services operations are compliant with the terms of the MCE’s contract with the State.

- Provider services manager – The MCE must employ a provider services manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The provider services manager, at a minimum, must be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider module and education materials, and developing outreach programs. The provider services manager oversees the process of providing information to the State fiscal agent regarding the MCE’s provider network, including PMPs, via the Portal. The provider services manager, in close coordination with other key staff, is responsible for ensuring that all the MCE’s provider services operations are compliant with the terms of the contract.

- Special investigation unit manager – The contractor shall employ a special investigation unit (SIU) manager who is dedicated full-time to the contractor’s Indiana Medicaid product lines. The SIU manager shall be located in Indiana. The SIU manager is responsible for directing the activities of Special Investigation Unit staff, attending meetings with the FSSA and reducing or eliminating wasteful, fraudulent, or abusive healthcare billings and services. The SIU manager shall report to the compliance officer and meet with the FSSA PI Unit at a minimum of quarterly or more frequently as directed by the FSSA PI Unit. The SIU manager shall be a subject-matter expert in Medicaid program integrity and hold qualifications similar to those of state program integrity unit managers. The SIU manager shall be required to interview with the FSSA PI Unit before obtaining the FSSA approval.

- Quality improvement management manager – The contractor shall employ a quality improvement management manager who is dedicated full-time to the contractor’s Indiana Medicaid product lines. The quality improvement management manager shall, at a minimum, be responsible for directing the activities of the contractor’s quality management staff in monitoring and auditing the contractor’s health care delivery system, including, but not limited to, internal processes and procedures, provider networks, service quality and clinical quality. The quality improvement management manager shall assist the contractor’s compliance officer in overseeing the activities of the contractor’s operations to meet the State’s goal of providing health care services that improve the health status and health outcomes of Hoosier Healthwise members.
• Utilization management manager – The MCE must employ a utilization management manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The utilization management manager, at a minimum, must be responsible for directing the activities of the utilization management staff. With direct supervision by the medical director, the utilization management manager must direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of healthcare services, continuity of care, care coordination, and other clinical and medical management requirements. The utilization management manager shall work with the (SIU) manager to assure that service billing and utilization issues are documented and reported to the SIU, and matters requiring SIU review or investigation shall be timely submitted within five business days to enable recovery of overpayments or other appropriate action.

• Behavioral health manager – The MCE must employ a behavioral health manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The behavioral health manager is responsible for ensuring that the MCE’s behavioral health operations, which include the operations of any behavioral health subcontractors, are compliant with the terms of the MCE’s contract with the State. The behavioral health manager must coordinate with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance, and reporting. The behavioral health manager must fully participate in all quality management and improvement activities, including participating in Quality Strategy Committee meetings and in the Mental Health Quality Assurance Committee. The behavioral health manager must work closely with the MCE’s network development and provider relations staff to develop and maintain the behavioral health network and ensure that it is fully integrated with the physical health provider network. The behavioral health manager must collaborate with key staff to ensure the coordination of physical and behavioral healthcare. The behavioral health manager must work closely with the utilization management staff to monitor behavioral health utilization, especially to identify and address potential behavioral health under- or over-utilization. The behavioral health manager or designee must be the primary liaison with behavioral health community resources, including community mental health centers (CMHCs), and be responsible for all reporting related to the MCE’s provision of behavioral health services.
  – If the MCE subcontracts with a managed behavioral health organization (MBHO) to provide behavioral health services, the behavioral health manager will continue to work closely with the MCE’s other managers to provide monitoring and oversight of the MBHO and to ensure the MBHO’s compliance with the contract.

• Data compliance manager – The MCE must employ a data compliance manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The data compliance manager provides oversight to ensure the MCE’s Hoosier Healthwise and HIP data conform to Family and Social Services Administration (FSSA) and the State data standards and policies. The data compliance manager must have extensive experience in managing data quality and data exchange processes, including data integration and data verification. The data compliance manager must also be knowledgeable in healthcare data and healthcare data exchange standards. The data compliance manager manages data quality, change management, and data exchanges with the State. The data compliance manager is responsible for data quality and verification, data delivery, and change management processes used for data extract corrections and modification. The data compliance manager also enforces data standards and policies for data exchanges to the State as defined by the FSSA data architect. The data compliance manager coordinates with the FSSA data architect to implement data exchange requirements.

• POWER Account operations manager – The MCE must employ a POWER Account operations manager who is dedicated full-time to the HIP program’s POWER Account operations. The POWER Account operations manager is responsible for overseeing the accurate and efficient administration of member POWER Accounts, including but not limited to: POWER Account contribution billing, reminders and collections; applying member, state, and third-party contributions; termination or transfer to HIP Basic, as applicable, for nonpayment; POWER
Account Reconciliation files (PRFs); POWER Account statements; POWER Account reconciliation and rollover; POWER Account contribution recalculations; POWER Account transfers; and POWER Account reporting.

- Pharmacy director – The MCE must employ a pharmacy director who is an Indiana licensed pharmacist dedicated full-time to the MCE’s Indiana Medicaid product lines. The pharmacy director shall oversee the pharmacy related operations of the program and is responsible for ensuring that the MCE’s pharmacy benefits are compliant with the terms of the MCE’s contract with the State. This individual shall represent the MCE at all meetings of the State’s Drug Utilization Review (DUR) Board meetings and the Mental Health Quality Assurance Committee (MHQAC). If the MCE subcontracts with a Pharmacy Benefits Manager (PBM) for its Healthy Indiana Plan pharmaceutical services, the pharmacy director shall be responsible for oversight and contract compliance of the PBM, including pharmacy audits, as well as any other audits or responses.

- Transition coordination manager – The MCE must employ a full-time transition coordination manager dedicated to member transitions, including transitions in and out of the various HIP benefit plans, including HIP Maternity coverage, as well as member transitions in and out of the MCE’s enrollment. The transition coordination manager will also oversee transitions related to members identified as medically frail and members referred to the Right Choices Program. This manager will work closely with the medical director, behavioral health manager, provider and members services managers, POWER Account operations manager, and State staff as necessary to manage member transitions and ensure effective communication to providers and members, as well as the State and its contractors. The transition coordination manager will provide input, as requested by the State, at State level meetings.

- Grievance and appeals manager – The MCE shall employ a grievance and appeals manager responsible for managing the MCE’s grievance and appeals process. This individual shall be responsible for ensuring compliance with processing timelines and policy and procedure adherence as outlined in the MCE’s contract with the State. The grievance and appeals manager will ensure the MCE has appropriate representation and/or provides adequate documentation if a member appeals to the State.

- Claims manager – The MCE shall employ a claims manager dedicated full-time to the MCE’s Indiana Medicaid product lines and responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the MCE’s contract with the State. This individual shall work in collaboration with the IS coordinator to ensure the timely and accurate submission of encounter data.

Additional positions must include individuals necessary to ensure the MCE’s compliance with the State’s performance requirements. Suggested staff includes, but are not limited to, the following:

- Grievance and appeals staff – The MCE must employ staff necessary to investigate and coordinate responses to address member and provider grievances and appeals against the MCE and interface with the OMPP and the FSSA Office of Hearings and Appeals.

- Technical support services staff – The MCE must employ technical support services staff to ensure timely and efficient maintenance of information technology support services, production of reports and processing of data requests, and submission of encounter data.

- Quality management staff – The MCE must employ a quality management staff dedicated to perform quality management and improvement activities, and participate in the MCE’s internal Quality Management and Improvement Committee.

- Utilization and medical management staff – The MCE must employ utilization and medical management staff dedicated to performing utilization management and review activities.

- Case managers – The MCE must employ case managers who provide case management, care management, care coordination, and utilization management for high-risk or high-cost members.
receiving physical health and/or behavioral health services. The case managers must identify the
needs and risks of the MCE’s membership, including social barriers; serve as a coordinator to link
members to services; and ensure that members receive the appropriate care in the appropriate
setting by the appropriate providers.

- **Member services representatives** – The MCE must employ member services representatives to
cordinate communications between the MCE and its members; respond to member inquiries; and
assist all members regarding issues such as the MCE’s policies, procedures, general operations,
benefit coverage, and eligibility. Member services staff must have access to real-time data on
members, including eligibility status, POWER Account contributions and transactions, PMP
assignments, and all service and utilization data. Member services staff must have the appropriate
training and demonstrate full competency before interacting with members.

- **Member marketing and outreach staff** – The MCE must employ member marketing and outreach
staff to manage joint marketing and outreach efforts for the Hoosier Healthwise and HIP programs,
paying particular attention to eligible HIP parents and caretaker relatives.

- **Special investigation unit staff** – Supports the SIU manager and help review and investigate the
contractor’s providers and members that are engaging in wasteful, abusive, or fraudulent billing or
service utilization. The SIU staff shall have, at a minimum, one full-time dedicated staff member
for every 100,000 members, excluding the SIU manager. Accordingly, for example, plans servicing
360,000 members shall have a SIU manager and 3.6 FTE additional staff. A majority of SIU staff
including the SIU manager shall work in Indiana to enable sufficient onsite audit capability and
facilitate in-person meeting attendance as directed by the FSSA.

- **Compliance staff** – The MCE must employ compliance staff to support the compliance officer and
help ensure that all MCE functions are compliant with state and federal laws and regulations, the
State’s policies and procedures, and the terms of the contract.

- **Provider representatives** – The MCE must employ provider representatives to develop the MCE’s
network, and coordinate communications between the MCE and contracted and noncontracted
providers, paying particular attention to educating and encouraging providers to participate in the
Hoosier Healthwise and HIP programs and other Indiana Medicaid product lines to ensure
continuity of care for members transitioning between programs.

- **Claims processors** – The MCE must employ claims processors to process electronic and paper
claims in a timely and accurate manner, process claims correction letters, process claims
resubmissions, and address overall disposition of all claims for the MCE, per state and federal
guidelines. The MCE must maintain sufficient staff to ensure the submission of timely, complete,
and accurate encounter claims data.

- **Member and provider education/outreach staff** – The MCE must employ member and provider
education/outreach staff to promote health-related prevention and wellness education and programs;
maintain member and provider awareness of the MCE’s policies and procedures; and to identify
and address barriers to an effective healthcare delivery system for the MCE’s members and
providers.

- **Website staff** – The MCE must employ website staff to maintain and update the MCE’s member
and provider websites and member portal.

- **POWER Account staff** – The MCE must employ POWER Account staff to support the MCE’s HIP
POWER Account operations and POWER Account contributions.

- **Transition coordination staff** – The MCE must employ transition coordination staff to support the
transition coordination manager in the oversight of all member transitions in and out of the various
benefit plans available in the MCE’s Indiana Medicaid programs, as well as in and out of the
MCE’s enrollment. The transition coordination staff shall be responsible for ensuring continuity of
care, member and provider communication, and POWER Account reconciliation through all benefit
plan and MCE transfers.
The MCE must provide written notification to the MCE’s assigned policy analyst of anticipated key staff vacancies within five business days of receiving the key staff person’s notice to terminate employment or five business days before the vacancy occurs, whichever occurs first. At that time, the MCE must present the State’s policy analyst with an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the MCE must notify the State’s policy analyst in writing within five business days after a candidate’s acceptance to fill a key staff position or five business days before the candidate’s start date, whichever occurs first. All key staff must be accessible to the State and its other program subcontractors via voice and electronic mail. The MCE must submit updated contact information for key staff as changes occur. Additionally, MCEs are required to review and complete a contact sheet on a quarterly basis.

In addition to attendance at vendor meetings, all key staff must be accessible to the OMPP and other program subcontractors via telephone, voicemail, and electronic mail systems. As part of its annual and quarterly reporting, the contractor must submit to the OMPP an updated organizational chart including email addresses and telephone numbers for key staff.

Debarred Individuals

In accordance with 42 CFR 438.610, the MCE must not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described previously.

The relationships include directors, officers, or partners of the MCE; persons with beneficial ownership of 5% or more of the MCE’s equity; or persons with an employment, consulting, or other arrangement with the MCE for the provision of items and services that are significant and material to the MCE's obligations under the contract.

In accordance with 42 CFR 438.610, if the State finds that the MCE is in violation of this regulation, the State will notify the Secretary of noncompliance and determine if the agreement will continue.

The contractor shall have policies and procedures in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded. As part of readiness review, the contractor shall demonstrate to the OMPP that it has mechanisms in place to monitor staff and subcontractors for individuals debarred by federal agencies.

The contractor shall be required to disclose to the FSSA PI Unit information required by 42 CFR 455.106 regarding the contractor’s staff and persons with an ownership/controlling interest in the Contractor that have been convicted of a criminal offense related to that persons involvement in Medicare, Medicaid, or Title XX programs.

Staff Training

The MCE must ensure that each staff person, including those of a subcontractor, has appropriate education and experience to fulfill the requirements of his or her position, as well as ongoing training (for example, orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, management information systems, training on fraud and abuse and the False Claims Act, HIPAA, HI-TECH, and so forth). The MCE must ensure that all staff receive training about the major components of the Hoosier Healthwise and HIP programs.
The following staff members must receive additional training:

- Utilization management staff must receive ongoing training regarding interpretation and application of the MCE’s utilization management guidelines. The ongoing training must be conducted, at a minimum, on a quarterly basis and as changes to the MCE’s utilization management guidelines and policies and procedures occur.

- Staff members with POWER Account responsibilities must receive detailed POWER Account education and training on topics including but not limited to the following:
  - Billing and collections
  - POWER Account contribution recalculations
  - POWER Account Impact of benefit plan transfers
  - POWER Account rollover
  - POWER Account termination
  - POWER Account reconciliation file (PRF)
  - 820 transaction
  - 834 transactions

The MCE must update its training materials on a regular basis to reflect program changes. The MCE must maintain documentation to confirm internal staff training, curricula, schedules and attendance, and must provide this information to the State on request and during regular on-site visits. The MCE must be prepared to provide, on request by the State, a written training plan, for utilization management and POWER Account that includes dates, subject matter, and training materials. For its utilization management staff, the contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by the OMPP.

State Meeting Requirements

The State conducts meetings and collaborative workgroups for the Hoosier Healthwise and HIP programs. The MCE must comply with all meeting requirements established by the State, and is expected to cooperate with the State and its contractors in preparing for and participating in these meetings. The State reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format, or add meetings to the schedule, as it deems necessary.

The State reserves the right to meet at least annually with the MCE’s executive leadership to review the MCE’s performance, discuss the MCE’s outstanding or commendable contributions, identify areas for improvement, and outline upcoming issues that may impact the MCE or the Hoosier Healthwise and HIP programs.

Financial Requirements

The State and the Indiana Department of Insurance (IDOI) monitor MCE financial performance and require submission of quarterly financial reports. The State includes IDOI findings in its monitoring activities. The MCE must copy the State on required filings with IDOI, and the required filings must break out financial information for the Hoosier Healthwise and HIP lines of business separately.

Solvency

The MCE must maintain a fiscally solvent operation per state and federal regulations and must meet IDOI requirements for minimum net worth, set reserve amount, and risk-based capital surplus. The MCE must have a process in place to review and authorize contracts established for reinsurance and third-party liability, if applicable.
The MCE must comply with federal requirements for protection against insolvency (pursuant to 42 CFR 438.116), which require a non-federally qualified MCE to:

- Provide assurances satisfactory to the State that its provision against the risk of insolvency is adequate to ensure that its enrollees would not be liable for the MCE’s debts if the MCE became insolvent.
- Meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

**Insurance**

The MCE must comply with all applicable insurance laws of Indiana and of the federal government throughout the term of the contract. No fewer than 90 calendar days before delivering services under this contract, the MCE must obtain Fidelity Bond or Fidelity Insurance from an insurance company authorized to do business in the state of Indiana.

This insurance coverage must be maintained throughout the term of the contract. No fewer than 30 calendar days before each policy’s renewal effective date, the MCE must submit its certificate of insurance to the State for approval. The MCE must submit the certificate of insurance through the State-established document review process.

**Reinsurance**

The following reinsurance requirements apply to the MCE’s Hoosier Healthwise and HIP lines of business. The MCE must purchase reinsurance from a commercial reinsurer and must establish reinsurance agreements meeting the requirements as enumerated in the scope of work. The MCE must submit new policies, renewals, or amendments to the State for review and approval at least 120 calendar days before becoming effective. The MCE must submit through the State-established document review process.

**Agreements and Coverage**

- The attachment point must be equal to or less than $200,000 and must apply to all services. The MCE electing to establish commercial reinsurance agreements with an attachment point greater than $200,000 must provide a justification in its proposal or submit justification to the State in writing at least 120 calendar days before the policy renewal date or date of the proposed change. The MCE must receive approval from the State before changing the attachment point.
- The contractor’s co-insurance responsibilities above the attachment point shall be no greater than 20%.
- Reinsurance agreements must transfer risk from the MCE to the reinsurer.
- The reinsurer’s payment to the MCE must depend on and vary directly with the amount and timing of claims settled under the reinsured contract. Contractual features that delay timely reimbursement are not acceptable.
- The MCE’s coinsurance responsibilities above the attachment point must not be greater than 20%.
- The MCE must maintain a plan acceptable to the commissioner of the IDOI for the continuation of benefits in event of receivership. The MCE must finance the greater of $1 million or total projected costs, as calculated by the form set forth in 760 IAC 1-70-8.
- The MCE must obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums are paid. This coverage must extend to members in acute care hospitals or nursing facilities when the MCE’s insolvency occurs.
during the members’ inpatient stays. The MCE must continue to reimburse for its members’ care under those circumstances (for example, inpatient stays) until members are discharged from the acute care setting or nursing facility.

Requirements for Reinsurance Companies

- The MCE must submit documentation proving that the reinsurer follows the National Association of Insurance Commissioners’ (NAICs’) Reinsurance Accounting Standards.
- The MCE is required to obtain reinsurance from insurance organizations that have Standard and Poor’s claims-paying ability ratings of AA or higher and a Moody’s bond rating of A1 or higher.

Subcontractors

- Subcontractors’ reinsurance coverage requirements must be clearly defined in the reinsurance agreement.
- Subcontractors are encouraged to obtain their own stop-loss coverage with the previously mentioned terms.
- If subcontractors do not obtain reinsurance on their own, the MCE is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

Financial Accounting Requirements

The MCE must maintain separate accounting records for Hoosier Healthwise and HIP. These records must incorporate performance and financial data of subcontractors, particularly risk-bearing subcontractors, as appropriate. The MCE must maintain accounting records in accordance with IDOI requirements.

In accordance with 42 CFR 455.100-104, the MCE must notify the State of any person or corporation with 5% or more ownership or controlling interest in the MCE and must submit financial statements for these individuals or corporations. Annual audits must include an annual actuarial opinion of the MCE’s incurred-but-not-received (IBNR) claims specific to the Hoosier Healthwise program and the HIP program. These annual actuarial opinions must be separate, one for Hoosier Healthwise and one for the HIP program.

Authorized representatives or agents of state and federal governments must have access to the MCE’s accounting records and to the accounting records of its subcontractors for review, analysis, inspection, audit, or reproduction (given reasonable notice and at reasonable times during the performance or retention contract period). The MCE must file financial and other information required by the IDOI with the State insurance commissioner.

Copies of any accounting records pertaining to the contract must be made available by the MCE to the State within 10 calendar days of receiving a written request from the State. If such original documentation is not presented as requested, the MCE must provide transportation, lodging, and subsistence at no cost for all State and federal representatives to carry out audit functions at the principal offices of the MCE or where such records are located. The FSSA, the State, the IDOI, and other State and federal agencies (and their respective authorized representatives or agent) must have access to all accounting and financial records of any individual, partnership, firm, or corporation, as the records relate to transactions with any department, board, commission, institution, or other State or federal agency connected with the contract.

The MCE must maintain financial records pertaining to the contract, including all claims records, for three years following the end of the federal fiscal year during which the contract is terminated, or when all state and federal audits of the contract have been completed, whichever is later (in accordance with
45 CFR 74.53). Financial records must address matters of ownership, organization, and operation of the MCE’s financial, medical, and other recordkeeping systems. However, accounting records pertaining to the contract must be retained until final resolution of all pending audit questions and for one year following the termination of any litigation relating to the contract (if the litigation has not terminated within the three-year period).

In addition, the State requires MCEs to produce the following financial information, on request.

- Tangible Net Equity (TNE) or Risk Based Capital at balance sheet date.
- Cash and Cash Equivalents.
- Claims payment, IBNR, reimbursement, fee-for-service claims, and provider contracts by line of business.
- Appropriate insurance coverage for medical malpractice, general liability, property, workmen’s compensation and fidelity bond, in conformance with State and Federal regulations.
- Revenue sufficiency by line of business/group.
- Renewal rates or proposed rates by line of business.
- Corrective Action Plan documentation and implementation.
- Financial, cash flow, and medical expense projections by line of business.
- Underwriting plan and policy by line of business.
- Premium receivable analysis by line of business.
- Affiliate and intercompany receivables.
- Current liability payables by line of business.
- Medical liabilities by line of business.
- Copies of any correspondence to and from the IDOI.

**Reporting Transactions with Parties of Interest**

The MCE, if not federally qualified, must disclose to the State information on certain types of transactions it has with a party of interest, as defined in the Public Health Service Act (see §§1903(m)(2)(A)(viii) and 1903(m)(4) of the Social Security Act).

Definition of A Party of Interest – as defined in §1318(b) of the Public Health Service Act, a party of interest is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of the HMO; or
- Any organization in which a staff member who is a director, officer or partner has directly or indirectly a beneficial interest of more than 5 percent of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of the HMO;
- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- Any spouse, child, or parent of an individual described in the above bulleted subsections.
Types of Disclosure Transactions

Business transactions which shall be disclosed include the following:

- Any sale, exchange, or lease of any property between the HMO and a party in interest
- Any lending of money or other extension of credit between the HMO and a party in interest
- Any furnishing for consideration of goods, services (including management services), or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions between the contractor and a party in interest listed previously include the following:

- The name of the party in interest for each transaction
- A description of each transaction and the quantity or units involved
- The accrued dollar value of each transaction during the fiscal year
- Justification of the reasonableness of each transaction

In addition to the previous information on business transactions, the contractor may be required to submit a consolidated financial statement for the contractor and the party in interest.

If the contract is an initial contract with the State, but the MCE has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. If the contract is being renewed or extended, the MCE must disclose information about business transactions that occurred during the prior contract period. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All the MCEs’ business transactions must be reported.

Medical Loss Ratio

The State must calculate the MCE’s Medical Loss Ratio (MLR) on an annual basis using the MCE’s IDOI filings. A separate MLR must be calculated for the MCE’s Hoosier Healthwise and HIP lines of business. The MLR calculations must be exclusive of any taxes.

- The MCE must maintain, at minimum, an MLR of 85% for its Hoosier Healthwise line of business.
- The MCE must maintain, at a minimum, an MLR 87% for its HIP line of business.

In addition, the MCE is required to submit MLR reporting as described in the State Hoosier Healthwise/HIP Reporting Manual.

The State reserves the right to recoup excess capitation paid to the MCE if the MCE’s MLR, as calculated by the FSSA on an annual basis, is less than 85% for the Hoosier Healthwise line of business or 87% for the HIP line of business.

Health Insurance Providers Fee

Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 (“annual fee”). The MCE is responsible for a percentage of the annual fee for all health insurance providers as determined by the...
ratio of MCE’s net written premiums for the preceding year compared to the total net written premiums of all entities subject to the annual fee for the same year.

The State shall reimburse the MCE for the amount of the annual fee specifically allocable to the premiums paid during this each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the annual fee for federal and state tax purposes, including income and excise taxes (“MCE’s adjusted fee”). The MCE’s adjusted fee shall be determined based on the final notification of the annual fee amount contractor or contractor’s parent receives from the United States Internal Revenue Service. The state, following its review and acceptance of the MCE’s adjusted fee, will retroactively adjust the contractor’s capitation rates to provide reimbursement for the MCE’s adjusted fee.

To claim reimbursement for the MCE’s adjusted fee, the contractor shall submit a certified copy of its full annual fee assessment within 60 days of receipt, together with the allocation of the annual fee attributable specifically to its premiums. The MCE shall also submit the calculated adjustment for the impact of nondeductibility of the annual fee attributable specifically to its premiums, and any other data deemed necessary by the state to validate the reimbursement amount. These materials shall be submitted under the signatures of its financial officer or executive leadership (for example, president, chief executive officer, or executive director), certifying the accuracy, truthfulness and completeness of the data provided.

Subcontracts

The term subcontracts includes contractual agreements between the MCE and healthcare providers or other ancillary medical providers. The term subcontracts includes contracts between the MCE and another prepaid health plan, physician-hospital organization, any entity that performs delegated activities related to the State MCE contract, and any administrative entities not involved in the actual delivery of medical care. The State encourages the MCE to subcontract with entities located in Indiana.

The State must approve all subcontracts, and changes in subcontractors or material changes to subcontracting arrangements. The State may waive its right to review subcontracts and material changes to subcontracts. This waiver does not constitute any future waivers of review for that or any additional subcontracts. No subcontract may extend past the term of the contract the MCE has with the State. A reference to this provision and its requirement must be included in all provider agreements and subcontracts.

Subcontractor agreements do not terminate the legal responsibility of the MCE to the State to ensure that all activities under the contract are carried out. The MCE must oversee subcontractor activities and submit annual reports on its subcontractors’ compliance, corrective actions, and outcomes of the MCE’s monitoring activities. The MCE is accountable for any functions and responsibilities that it delegates.

The MCE must provide an indemnification clause in all subcontracts. This clause must indemnify and hold harmless the state of Indiana, its officers, and employees from all claims and suits, including court costs, attorney’s fees, and other expenses for injuries or damages sustained because of an act of omission of the MCE or the subcontractor.

This indemnification requirement does not extend to the contractual obligations and agreements between the MCE and healthcare providers, or other ancillary medical providers that have contracted with the MCE. The subcontracts must further provide that the State shall not provide such indemnification to the subcontractor.

If the MCE subcontracts with another prepaid health plan, physician-hospital organization, or other risk-bearing entity that accepts financial risk for services the MCE does not directly provide, the MCE
must monitor the financial stability of the subcontractors with payments equal to or greater than 5% of premium/revenue. The MCE must obtain the following from the subcontractor each quarter:

- Statement of revenues and expenses
- Balance sheet
- Cash flows and changes in equity and fund balance
- IBNR estimates

At least annually, the MCE must obtain from the subcontractor audited financial statements, including a statement of revenues and expenses, balance sheet, cash flows and changes in equity or fund balance, and an actuarial opinion of the IBNR estimates. The MCE must make these documents available to the State on request.

The MCE must comply with 42 CFR 438.230 and the following subcontracting requirements:

- The MCE must obtain the State’s approval before subcontracting any portion of the project’s requirements. The MCE must give the State a written request and submit a draft contract or model provider agreement at least 60 calendar days before using a subcontractor. If the MCE changes the subcontractor contract, the MCE must submit the amendment for the State review and approval 60 calendar days before the revised contract’s effective date. The State must approve changes in vendors for any previously approved subcontracts. All subcontracts must be submitted through the State document review process using the Care Programs Subcontract Checklist. The State will not review a subcontract that is submitted without the checklist attached.

- The MCE must evaluate prospective subcontractors’ ability to perform delegated activities before subcontracting services associated with the Hoosier Healthwise and HIP programs.

- The MCE must have a written agreement in place that specifies the subcontractor’s responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement must comply with and is subject to the provisions of all Indiana statutes. The subcontract cannot extend beyond the term of the State’s contract with the MCE.

- The MCE must collect performance and financial data from its subcontractors; monitor delegated performance on an ongoing basis; and conduct formal, periodic, and random reviews, as directed by the State. The MCE must incorporate all subcontractors’ data into the MCE’s performance and financial data for a comprehensive evaluation of the MCE’s performance and, when appropriate, identify areas for its subcontractors’ improvement. The MCE must take corrective action if deficiencies are identified during a review.

- All subcontractors must fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract.

- The MCE must comply with all subcontract requirements specified in 42 CFR 438.230.

- The MCE must submit a plan to the OMPP to describe how the subcontractor will be monitored for debarred employees.

- All subcontracts, provider contracts, agreements, or other arrangements by which the MCE intends to deliver services must be subject to review and approval by the State, and must be sufficient to ensure the fulfillment of the requirements of 42 CFR 434.6. In accordance with IC 12-15-30-5(b), subcontract agreements terminate when the MCE’s contract with the State terminates.

The MCE must have policies and procedures addressing auditing and monitoring subcontractors’ data, data submissions, and performance. The MCE must integrate subcontractors’ financial and performance data (as appropriate) into the MCE’s information system to accurately and completely report MCE performance and confirm contract compliance.
The State reserves the right to audit the MCE’s subcontractors’ self-reported data and change reporting requirements at any time with reasonable notice. The State may require corrective actions and will assess liquidated damages, as specified in Exhibits 3 and 4 of the contract, for noncompliance with reporting requirements and performance standards.

If the MCE uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the MCE, and the MCE must demonstrate its oversight and monitoring of the subcontractor’s compliance with these requirements. The MCE must require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

While the MCE may choose to subcontract claims processing functions, or portions of those functions, with a State-approved subcontractor, the MCE must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers, and will not result in confusion to the provider community about where to submit claims for payments. For example, the MCE may elect to establish one post office box address for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, it is the MCE’s responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Using this type of method will not lengthen the timeliness standards for claims processing. In this example, the definition of date of receipt is the date of the claim’s receipt at the post office box.

Confidentiality of Members’ Medical Records and Other Information

The MCE must ensure that members’ medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (see 45 CFR parts 160 and 164, subparts A and E). The MCE must also comply with all other applicable state and federal privacy and confidentiality requirements.

Internet Quorum Inquiries

The MCE must respond to Internet Quorum (IQ) inquiries within the time frame set forth by the State. The State forwards all IQs via email to the MCE compliance officer. When forwarding an IQ inquiry to the MCE for a response, the State will designate that the inquiry is an IQ inquiry and identify when the MCE’s response is due. IQ inquiries typically include member, provider, and other constituent concerns and require a prompt response. The MCE’s failure to provide a timely and satisfactory response to IQ inquiries, as determined by the State policy analyst, will subject the MCE to the liquidated damages set forth in RFP 16-035, Attachment D, Contract Exhibit Two of the contract. A satisfactory response must include sufficient information to enable the State to respond to the inquiry thoroughly and accurately within the time frames given. When applicable, the State may request additional details to determine what caused the issue to arise and how the MCE plans to mitigate the issue moving forward.

Material Changes

A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than 5% of the MCE’s membership or provider network.

Before implementing a material change in operation, the MCE shall submit a request to the State for review and approval at least 60 calendar days in advance of the effective date of the change. The
request must contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. The MCE may be required to communicate material changes to members or providers at least 30 days before the effective date of the change. Any member or provider communication material is subject to the review and approval of the State.

**Data Requests**

MCEs can submit data requests to the State for statistics to help manage their member populations. These data requests are produced by the State Data Management Unit. The MCEs are not allowed to make data requests to any other State contracted entities, such as the State fiscal agent.

The MCE representative must complete the State *Data Request Form* and submit the completed form to the MCE’s assigned State policy analyst. The State policy analyst can provide the MCE with an electronic copy, if needed. The *Data Request Form* and process flowchart are available on the *MCO Question and Answer* page at indianamedicaid.com. On receipt of the MCE data request, the State policy analyst evaluates the *Data Request Form* to ensure that all necessary information is provided. The State policy analyst works with the MCE representative to ensure that the *Data Request Form* is properly completed.

The State reviews the data request to determine whether the data will be provided. Data will not be provided for the following scenarios:

- The MCE has access to this data via another mechanism (such as via the 834 enrollment roster).
- There are HIPAA concerns. Data is not released for non-MCE enrolled members.

If the State approves the data request, the State policy analyst forwards the *Data Request Form* to the State Data Management Unit. If the State denies the data request, the State policy analyst notifies the MCE representative via email that the requested data will not be produced and why.

After the data request is complete, the State Data Management Unit sends the data to the State policy analyst for review. The State policy analyst reviews the data and forwards it to the MCE representative to complete the process.
Section 3: Healthy Indiana Plan Billing and Collections

Overview

The MCE will provide all HIP members with a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) Account, which operates similar to a Health Savings Account (HSA) and is used to fund a $2,500 deductible. The maximum State contribution during the reconciliation period is $1,300. The MCE’s HIP membership shall be distributed into various subpopulations based on member eligibility. These subpopulations within HIP will have varying benefits and cost-sharing obligations, and the MCE shall ensure that its HIP members are placed in the appropriate benefit category and that billing and collections activities are appropriate for the member’s benefit category.

• **HIP Plus** – Except in the case of individuals eligible for HIP State Plan benefits or individuals receiving hospital presumptive eligibility benefits, all HIP eligible members will initially be defaulted into an enhanced benefit package (HIP Plus). HIP Plus participation requires members to make monthly POWER Account contributions, except for individuals exempt from cost sharing. Member eligibility in HIP Plus shall not be final until either the first POWER Account contribution or Fast Track Prepayment is paid. To remain eligible for HIP Plus, members must continually make monthly POWER Account contributions.

• **HIP Basic** – HIP members with income at or below 100% FPL who do not make an initial Fast Track Prepayment, or initial and subsequent POWER Account contributions are not eligible for HIP Plus, and are transferred to this category, a more limited benefit package and requires copayments for services (HIP Basic).

• **HIP State Plan** – The MCE shall provide HIP State Plan benefits to HIP members meeting any of these eligibility criteria:
  - Section 1931 eligible parents and caretaker relatives eligible under 42 CFR 435.110
  - Low-income 19- and 20-year-old dependents eligible under 42 CFR 435.222
  - Members determined eligible for transitional medical assistance (TMA) by the State in accordance with Section 1925 of the Social Security Act
  - Individuals determined to be medically frail.

Unless otherwise exempt from cost-sharing, all members receiving HIP State Plan benefits will pay monthly POWER Account contributions consistent with the HIP Plus plan (HIP State Plan Plus) or, if at or below 100% FPL, pay copayments for services as required under the HIP Basic plan (HIP State Plan Basic). There is a category under HIP State Plan Plus where copayments are required (HIP State Plan Plus Copay). A member falls into this category after failing to make POWER Account contributions and as follows:

1. Member income is above 100% FPL and

2. Member is medically frail

All non-exempt HIP-eligible individuals are responsible for making financial contributions toward the cost of their healthcare coverage whether it is through POWER Account contributions (PAC) for those enrolled in HIP Plus or through copayments assessed at the point of service for those enrolled in HIP Basic. The managed care entity (MCE) is responsible for billing, collecting, and applying these member payments. Members exempt from making financial contributions are as follows:
• Pregnant women
• Native Americans.

**Employer POWER Account Payments**

As a third-party entity, employers are permitted to contribute to members’ POWER Accounts in the same manner as previously described and are encouraged to do so. The MCE must develop a program to publicize to members and employers that an employer may contribute to the member’s POWER Account. Appropriate outreach materials must be developed, and the MCE must ensure that its member services staff can address calls from members and employers on this topic. Communications about employer contributions must be ongoing and continuous. The MCE must consider collecting the members’ employment data during the health screening process or during other member outreach activities. The outreach materials for employers must identify the process the employer can use to contribute to employee POWER Accounts.

In addition to lump sum payments, employers are also allowed to make regular payments on a monthly basis toward their employee’s required POWER Account contributions. When an employer fails to provide its share of a member’s POWER Account contribution within 60 calendar days of its due date, the member will have an additional 60 calendar days to pay the overdue amount before being terminated from HIP if they are over 100% of the FPL. Members who are below 100% of the FPL will lose their *HIP Plus* coverage and drop to *HIP Basic* after the additional 60-day grace period.

**POWER Accounts and Copayments**

The MCE must establish and administer a POWER Account for each HIP member. All HIP members will have a POWER Account regardless of the member’s specific benefit package (*HIP Plus*, *HIP Basic*, or *HIP State Plan*). The HIP member uses the funds in their POWER Account to meet their $2,500 deductible. The MCEs are responsible for playing the claims for all covered services when the member’s POWER Account is exhausted.

*HIP Plus* members, the State, employers, and other third parties may contribute to the POWER Account. POWER Accounts are designed to provide incentives for members to stay healthy, be value- and cost-conscious, and to utilize services in a cost-efficient manner, as well as to seek price and quality transparency. HIP members must be aware that prudent management of their healthcare expenditures can leave them with available POWER Account funds at the end of the annual benefit period—and that these funds can be used to lower the following year’s contribution. The process for rollover is described later in this section.

Members enrolled in *HIP Plus* or *HIP State Plan Plus* are required to make contributions into their POWER Accounts. Required contributions are calculated at 2% of the member’s gross annual household income. Notwithstanding the foregoing, the State will divide the monthly contribution between two HIP eligible married adults, and each member is responsible for half of the calculated amount on a monthly basis. However, in no event will a member’s monthly POWER Account contribution be more than $100 or less than $1. A PAC will still be a monthly $1.00 payment for HIP members with no income.

Members enrolled in *HIP Basic* or *HIP State Plan Basic* are not required to make monthly contributions to their POWER Account, but are required to make co-payments which are assessed as one payment per type of service, per provider, per day. See Appendix with list of approved ACA and HIP preventive services that is to include dental and vision preventive services. Copayments are assessed as one payment per type of service, per provider, per day.
• No copayment is required for preventive care, including early periodic screening, diagnostic and testing services, or family planning services

• Four dollar copayment for outpatient services

• Seventy-five dollar copayment for inpatient services

• Four dollar copayment for preferred drugs

• Eight dollar copayment for non-preferred drugs

Other than individuals exempt from cost-sharing or individuals participating in the emergency department copayment random exempt test group (control group), all HIP members are required to pay a copayment for inappropriate usage of the hospital emergency room. This copayment is assessed at $8 for the member’s first inappropriate service or $25 for each subsequent inappropriate visit. Similar to other HIP copayments, the emergency room copayment is to be collected at the point of service by the provider and the member may not use the POWER Account funds to make the copayment.

The control group consists of 5,000 members who will pay $8 copay for each visit that is not an emergency and they will not be assessed the increased copay of $25 for subsequent inappropriate visits. For all individuals who call the MCE hotline 24-hour hotline before using the ER, the copay is waived.

**Member POWER Account Contributions**

MCEs must bill for and collect member PAC payments for all HIP Plus and HIP State Plan Plus members. In no event should the MCE bill for or collect POWER Account contributions from members who are pregnant or members identified as an American Indian/Alaska Native (AI/AN). The State will identify all AI/AN members through the eligibility determination process. In addition, members who have reached their quarterly 5% maximum contribution limit should have their required PAC amounts reduced to the minimum of $1 for the remainder of the quarter.

The MCE will receive the amount of the member’s monthly POWER Account contribution via the State’s fiscal agent. This amount is always calculated by the State. HIP Plus and HIP State Plan Plus members must be allowed to make their PAC payments in equal monthly installments of one-twelfth of the members’ annual POWER Account contribution. There is no penalty or fee for making payments through any of the payment processes, or for paying the PAC in full. Families may make combined POWER Account payments on behalf of each family member enrolled in the MCE’s plan. This needs to be facilitated by the MCEs. MCEs will be able to apply a single payment with a single account number, and will be able to determine how the member payment is to be applied.

When starting a new benefit period with the same MCE, member payments in the new benefit period cannot be applied to the oldest outstanding balance or member debt. For example, when a member makes a payment in month one of their new benefit period, but had missed their payment for month 12 of the previous benefit period, this payment shall be applied to the new benefit period.

Member payments in a new benefit period cannot be applied to past member debt. The difference between debt and past due balances is that members with debt have, at one point, dropped to HIP Basic or were terminated for failure to pay. Members are considered to have past due balances if they have not made their payments by the invoice date but are still within 60 days of the due date.
State POWER Account Funding

The State will fund any gap between a member’s required contribution and the $2,500 deductible. For members on HIP Basic or HIP State Plan Basic who make copayments instead of POWER Account contributions, the State will fund the entire POWER Account. All member claims above $2,500 are the responsibility of the MCE. The maximum amount of the state’s contribution during the reconciliation period would be $1,300.

For example, if a HIP Plus member’s required contribution is $196 annually (2% of $9,800=$196). In this scenario, the State would be responsible for a total of $2,304 of the $2,500 POWER Account, which represents the difference between the fully funded account ($2,500) and the member’s annualized contribution ($196).

The State will make an initial payment of $1,300 to the POWER Account after receiving notice from the MCE that the member’s first POWER Account contribution has been processed. Power Account information is sent from ICES/IEDSS and “promptly” refers to the subsequent capitation cycle. State contributions must be credited to a member’s POWER Account immediately upon receipt by the MCE from the State. At the conclusion of the member’s benefit period, the MCE and the State shall reconcile the POWER Account in accordance with POWER Account Reconciliation procedures as described in this manual, which shall include determining any amounts owed by the State to cover the difference between the State’s total annual POWER Account contribution and the initial $1,300 contribution.

Third-Party POWER Account Contributions

Third-party organizations are permitted to contribute toward an individual’s PAC. Third-party contributions must be credited to a member’s POWER Account upon receipt and cannot exceed more than an individual’s annual POWER Account contribution remaining due at the time of the payment.

To be eligible to contribute, third-party entities must continuously comply with the rules governing third-party contributions established in 405 IAC 10-10-4(d). Specifically, healthcare providers and provider-related entities are only permitted to contribute to a member’s POWER Account if the provider or provider related entity: (i) establishes criteria for providing assistance that does not distinguish between individuals based on whether they receive or will receive services from the contributing provider(s), and (ii) does not include the cost of such payments in either the cost of care for purposes of Medicare and Medicaid costs reporting or included as part of a Medicaid shortfall or uncompensated care for any purposes. MCEs should include this guidance in provider education materials and provider agreements. If the MCE learns of a healthcare provider or provider-related entity in violation of the previously described requirements, then the MCE should report such payments to the State.

The MCE must also allow third-party entities to make lump-sum POWER Account payments. The MCE must ensure that lump-sum payments are credited to the member’s required POWER Account contributions on a first month’s basis. For example, for a member with a $10 per month PAC, if an employer or other third-party entity makes a one-time lump sum $50 contribution, then the MCE must credit the member’s account and apply the payment to cover the immediately following five months of member’s required PACs.

The MCE must keep record of all contributions made by third-party entities on behalf of members and make these records available to the State as outlined in the HIP MCE Reporting Manual.
Billing and Collection Services

Billing and collection services such as invoicing and payment methods are referenced below. Each premium payment program is also referenced, followed by a detailed section for HIP POWER Account processing. Additional eligibility information for HIP is covered in Member Enrollment.

Premium billing and collection services include the following:

• Creating and maintaining Health Insurance Portability and Accountability Act (HIPAA)-compliant POWER Account contribution billing services

• Generating and mailing invoices, although members may opt-in to receiving electronic invoices

• Receiving and posting payments
  Monitoring and tracking missed payments

• Processing returned checks

• Stopping or placing collections on hold, as directed by the State

• Generating past-due notices and other notifications

• Generating other informational materials, as requested by the State

• Providing documentation of account activities and other financial reports.

• Processing and mailing Fast Track Prepayment or POWER Account contribution refunds

• Transferring collected funds, as requested by the State

• Documenting and reconciling funds received and transferred

• Establishing and handling lockbox for HIP

• Providing services online that support and interface with the State’s current website ensuring the integrity and accuracy of data exchanged with or provided to the State, and that the data is compatible with other software, hardware, or systems used by the State.

• Ensuring compliance with current bankruptcy rules, the Cash Management Improvement Act of 1990 guidelines (Public Law 101-453), confidential information, and electronic transaction processing procedures

• Adhering to established healthcare industry standards, in addition to any Medicaid rules, regulations, or mandates, as well as amendments thereto

• Ensuring all mail is date-stamped on receipt

• Maintaining separate post office boxes, bank accounts, and reports for HIP

• Forwarding all change-of-address notifications and mail returned as undeliverable, as specified by the State
Fast Track Enrollment Billing and Collection

MCEs will receive fast track eligible members and this fast track enrollment, billing and collection section replaces the standard enrollment process described below for applicants determined eligible for fast track enrollment by the State. Fast track eligible (FTE) applicants are provided the opportunity to pay a $10 fee, called a Pre-POWER Account Contribution or “PPAC,” which expedites enrollment into the HIP Plus plan after an individual has been determined eligible by the State. The applicant may pay the PPAC at the time of application or following receipt of an invoice from the applicant’s MCE.

Except for American Indian/Alaska Native members, HIP member eligibility shall not be final until either (i) the first day of the month in which the member pays an initial contribution to their POWER Account, or (ii) until the first day of the month in which the initial sixty-day (60-day) POWER Account Fast Track Prepayment period expires for individuals at or below 100% FPL who choose not to participate in HIP Plus. For purposes of clarification, a member may enroll in HIP Plus by choosing to pay an initial PPAC of $10 or his or her first month’s POWER Account contribution in an amount determined by the State; however, the payment is due within 60 days of the initial Fast Track invoice. Members do not receive an additional 60 days to pay their POWER Account contribution.

For applicants who select an MCE and elect to pay via credit card at the time of application, the State will connect the applicant directly to the selected MCE’s third-party payment partner to collect and process each applicant’s credit card payment. The MCE shall store the application ID number, payment amount, and payment date at least until the date the MCE is notified by the State of the applicant’s final eligibility determination. The MCE shall receive pending eligibility files of individuals who selected, or who were auto-assigned to their plan from the State and meet fast track eligibility criteria. The MCE shall review all pending eligibility files and identify applicants who have provided payment information to the MCE via the Indiana Health Coverage Programs application. After the MCE successfully verifies the payment, the MCE shall send the State notice of payment within one business day of receiving the pending eligibility file.

Within two business days of receiving the pending eligibility file of either (i) an applicant who did not pay the fast track payment via credit card on the Indiana Health Coverage Application or (ii) whose credit card information was unable to be successfully verified and/or processed, the MCE shall send an initial invoice to the individual for a POWER Account Fast Prepayment. PPAC. The invoice must include a notice explaining that the individual has not yet been determined eligible for HIP benefits, but the initial Fast Track Prepayment must be paid within 60 calendar days in order for the member to be eligible to receive HIP Plus benefits. The notice shall encourage prompt payment of the Fast Track Prepayment, which could advance the potential member’s benefit start date. Further, the initial invoice must also include a prominent notice stating in substance that the individual has the right to select another MCE at any time before the first payment is made. After a payment is made, a member cannot change MCEs without just cause. Such notice shall include information on how the individual may contact the enrollment broker to change MCEs. In addition, the notice shall clearly indicate that the Fast Track Prepayment is an optional payment that either (i) will be fully refunded to the individual if the pending applicant is determined by the State not to be eligible for HIP, or (ii) will be applied towards the member’s future required POWER Account contribution(s) if the pending applicant is determined eligible for HIP. The notice shall explain that if the member is determined eligible for HIP, their monthly POWER Account contributions may be greater than the initial Fast Track Prepayment, in which case, the member may owe more in the second month in order to continue to receive HIP Plus benefits.

A member’s Fast Track Prepayment or initial POWER Account contribution is due within 60 calendar days of the date the MCE receives on the member’s pending eligible file from the State. The MCE must provide at least two reminders during the 60-day payment period to individuals who have not made their initial Fast Track Prepayment or first monthly POWER Account contribution. Should the pending eligibility file be received less than 15 days before the payment period expires, such as when a member changes MCEs, MCE can send only one reminder letter. The MCE must process all payments.
and notify the State of the payment within 15 calendar days of receiving the payment. The 15-calendar day period allows time to ensure that payments made by check have cleared. Notwithstanding the foregoing, the MCE may elect to hold Fast Track Prepayments received from applicants not yet determined eligible by the State until such time the individual is determined eligible. If the MCE elects to hold such payments, then the MCE must verify the payment and notify the State of receipt of a valid payment method within 15 calendar days of receipt of the eligibility file. Receipt date is the day that the MCE received payment, not processes the payment. The MCE should populate the date paid using the receipt date of the payment, not the date the payment was processed. MCEs should refer to the “Pay File” section of the manual for details about timing and cut-off days for pay file submission. After the individual is determined eligible, the MCE must release the hold and process payment no later than 15 calendar days from the MCE’s receipt of the eligibility file.

A pending applicant who is determined eligible for HIP by the State before the initial Fast Track Prepayment is received and before the expiration of the 60-day payment period is considered conditionally eligible for HIP. A $10 Fast Track prepayment can be made at any time during the 60-day payment period. Within three business days of receiving the conditionally eligible file, the MCE shall send a Welcome Letter to the conditionally eligible member. The Welcome Letter must be tailored to individuals at or below 100% FPL, and those above 100% FPL.

- The Welcome Letter to individuals above 100% FPL must explain that if the initial Fast Track Prepayment or full POWER Account contribution is not received before the expiration of the 60-day fast track payment period, their coverage will not commence and they will have to reapply for HIP.

- The Welcome Letter to individuals at or below 100% FPL must explain that if the initial Fast Track Prepayment or full POWER Account contribution is not received before the expiration of the 60-day fast track payment period, their coverage under HIP Basic begins on the first day of the month in which the payment period expires. The Welcome Letter to all conditionally eligible members who have not yet made a Fast Track Prepayment must include a notice that if the member’s POWER Account contribution is greater than $10, the initial Fast Track Prepayment is the minimum required to obtain HIP Plus benefits and start the program; however, the member will remain responsible for the full amount of the POWER Account contribution during the first month of coverage and such amount is included on the subsequent month POWER Account invoice. The Welcome Letter must also have a notice prominently displayed on the first page stating in substance that the individual has the right to select another MCE at any time before the first payment is made. Such notice shall include information for how the individual may contact the enrollment broker to change MCEs.

Because the MCE may collect the initial Fast Track Prepayment before the member’s individual POWER Account contribution has been determined by the State, the MCE is required to reconcile any overpayments or underpayments resulting from the Fast Track Prepayment. Specifically, if the member’s POWER Account contribution is less than the Fast Track Prepayment, the MCE shall credit the Fast Track Prepayment against the member’s required POWER Account contributions on a first month’s basis. For example, for a member with a $1 per month contribution, the MCE must immediately credit the member’s account and apply the payment to cover the first ten months of required member contributions. By contrast, if the member’s POWER Account contribution is greater than the Fast Track Prepayment, the MCE shall credit the Fast Track Prepayment to the member’s first month’s required POWER Account contribution and add the remaining balance to the member’s subsequent POWER Account contribution invoice. The member shall have 60 calendar days to pay the remaining balance that includes the subsequent PAC.

For individuals who pay their Fast Track Prepayment within the 60 day payment period but who are determined ineligible for HIP, the MCE shall return any such funds within 10 business days of the determination.
Standard Enrollment Billing and Collection

For HIP applicants who do not go through the fast track prepayment process, the MCE shall receive conditional eligibility files of individuals that selected, or were auto-assigned to their plan from the State. Conditionally eligible members are reported to the MCE via the 834 enrollment transaction file. The conditional eligible PAC amount (monthly billing amount for the POWER Account contribution) is included in the transaction. See the 834 MCE Benefit Enrollment and Maintenance Transaction companion guide. Within three business days of receiving the conditional eligibility file, the MCE shall send a Welcome Letter and initial invoice to the individual for their first PAC. The first invoice must reflect the member’s monthly PAC as determined by the State. A conditionally eligible member’s initial PAC is due within 60 days of the date the MCE receives the individual’s 834 enrollment transaction file from the State.

The Welcome Letter must include a notice explaining that the individual must submit their initial payment within the 60 calendar day payment period in order to receive HIP Plus benefits. The notice must be tailored to individuals at or below 100% FPL, and those above 100% FPL. The Welcome Letter to individuals above 100% FPL must explain that if the initial payment is not received within the 60 calendar day payment period, their coverage will not commence and they will have to reapply for HIP. The Welcome Letter to individuals at or below 100% FPL must explain that if the initial payment is not received within the 60 calendar day payment period, their coverage under HIP Basic begins on the first day of the month in which the 60 day payment period ends. The Welcome Letter must also have a notice prominently displayed on the first page stating in substance that the individual has the right to select another MCE before the first payment is made. This notice must include specific information for how the individual may contact the enrollment broker by calling the toll-free HIP line to change MCEs. As with all member communications, the Welcome Letter must be reviewed and approved by the State before distribution.

The MCE must provide at least two reminders within the 60 calendar day period to individuals who have not made their first monthly PAC. If the conditional eligibility file is received less than 15 days before the payment period expires, the MCE can send only one reminder letter.

A conditionally eligible member’s enrollment with the MCE begins on the first day of the month in which either (i) the first PAC is processed, or (ii) the nonpayment determination has been made for individuals at or below 100% FPL who do not make a PAC payment to be enrolled in HIP Plus. The MCE must process all payments received from conditionally eligible members and notify the State of the payment within 15 calendar days of receiving the payment. The 15 calendar day period allows time to ensure payments made by check have cleared.

Members identified as an American Indian/Alaska Native (AI/AN) pursuant to 42 CFR 136.12 are exempt from all cost-sharing and therefore, such member’s enrollment in the MCE’s HIP Plus plan begins the first day of the month in which the individual applied for HIP. The MCE shall not bill members identified as AI/AN by the State.

Invoices

The MCE develops and mails invoices for HIP members that include the following information:

- The name of the MCE
- First name, last name, and address of payor
- First names of members
- Current monthly PAC owed
• POWER Account contribution past due
• Overpayment shown as credit
• PAC due date
• Member identification (RID) number of the person responsible for payment
• Consequences of not paying the PAC
• Notice to send payment in all accepted forms, such as check, money order, online payment, unlimited electronic check or debit card via telephone, payroll deduction, automatic draft withdrawal from a designated account, cash payments or automated clearinghouse (ACH), including instructions on how to perform the transaction;
• How to notify the MCE of an address change
• How to report any change in household or household income
• How to notify the MCE when individuals or families have billing questions or concerns
• How to contact the enrollment broker if the individual desires to change MCEs for just cause
• Legal statement regarding bankruptcy, if applicable
• Information about a rollover credit, if applicable.
• Any additional information as directed by the FSSA

Regardless of whether the MCE subcontracts the billing and collections function to another entity, invoices and any other related billing and collections materials must be sent under the MCE’s name, not the name of the subcontractor.

The MCE must translate invoices into the language specified by the member or the member’s family. At this time, the State notifies the MCE via the 834 transaction if a member’s primary language is Spanish. At this time, there are no additional languages identified and provided to the MCEs.

At a minimum, the invoice mailing must include an invoice with a detachable invoice payment slip and a return envelope without postage paid. Occasional one-page inserts may be required by the State to explain program or billing changes. The MCE must also provide members the option to sign up for and receive invoices via email.

MCEs can choose whether to bill the member for a PAC amount that falls under $1.00 because of the application of rollover.

**POWER Account Procedures for Collecting HIP Plus Member Contributions**

The following are step-by-step procedures for collecting member POWER Account contributions. Member POWER Account contributions are annualized. Although the member owes the entire portion of the PAC (regardless of his or her time enrolled in the program), the State requires that member be allowed to pay in equal monthly installments. MCEs must send invoices to members detailing the amount due each month. The monthly invoice amounts are calculated by the State and provided to the MCE via the 834 enrollment transaction. The required POWER Account contribution is provided to
the MCE in a monthly billing amount. The monthly invoice must include the monthly amount to be paid and must provide members with reasonable notice of the upcoming due date.

1. If applicable, MCEs must allow families with more than one family member enrolled in their plan to make combined payments on behalf of all family members. Members are required to clearly indicate that the payment is for multiple accounts, to which accounts the payment applies, and how the funds are to be distributed. MCEs must provide instruction to members about how to provide payment for multiple accounts.

2. MCEs must provide all the following options for making member POWER Account contributions:
   - Check
   - Money order
   - Automatic payroll deduction
   - Employer withholding (after taxes)
   - Credit card
   - Cash (including cash payments by mail, although this option does not need to be promoted to members as a payment option)
   - Online payment via web portal
   - Unlimited electronic check or debit card payment via telephone
   - Automatic draft withdrawal from a designated account
   - Automated Clearinghouse (ACH)
   - Electronic funds transfer

The cash payment process must be available through a statewide network of banks or other entities. The MCE should seek arrangements with local entities to facilitate the collection of contributions, particularly no-cost options for collecting cash contributions. To assist the MCEs in the development of their statewide network of entities for cash contributions, the State has identified Walmart as a potential vendor for no-cost cash contributions. The MCEs are expected to use commercially reasonable efforts to contract with Walmart (and other potential vendors identified by the State) to implement a statewide solution for the collection of cash contributions at no cost to the member. The MCE must ensure that any cash contributions collected by third-party vendors are credited toward the member’s POWER Account within two business days.

When a member has multiple employers, the MCE is required to provide the payroll deduction option for only one of the member’s employers at any given time. For example, if the member changes employers, the member must be permitted to make payments via payroll deduction with the new employer; however, if a person has multiple jobs, the MCE is required to accept payment from only one employer via payroll deduction.

HIP members must be allowed to pay more than their monthly contributions, up to the amount of their monthly PACs, at any time without penalty. Although additional payments may fully offset future billing, the MCE must continue to send monthly invoices reflecting the amount due and credits on the account.

1. MCEs must deposit checks no later than 24 hours from receipt.
2. An MCE’s member education materials must inform members of the available options for making POWER Account contribution payments.

3. If a member’s check is returned because of insufficient funds, the plan may charge members a reasonable fee for the returned check.

4. If an MCE receives a check improperly made out to the State or the fiscal agent, the plan must follow up with the member and instruct the member to make the check payable to the plan. There are occasions that the State receives a money order from a member. It is the State’s wishes, that the member is not required to send a new money order. In these instances, the State wants to work with the member and the MCE, and the MCE will need to apply the credit to the member’s account.

**Ongoing Billing and Collections**

The MCE must bill for, and collect, PACs on a monthly basis. Partial monthly payments may be accepted by the MCE; however, the member must pay the monthly payment in full within 60 days from the first day of the coverage month for which the POWER Account contribution is owed or be subject to non-payment penalties.

The MCE must create a system to encourage members to make their PACs. The system must include member education, outreach, and reminders. Member education and outreach efforts should be included in new member materials and coordinated with any communication the MCE makes with new members for health screenings, risk assessments, and PMP selections.

The MCE must notify members when the member fails to make a PAC payment by the due date. The MCE must provide at least two written notices of the delinquent payment as a payment reminder. The first such reminder must be sent on or before the seventh calendar day of non-payment. The reminders must include the following information:

- The date by which the contribution must be paid to prevent application of the non-payment penalty, which includes member termination for individuals over 100% FPL or transfer to HIP Basic benefits for individuals at or below 100% FPL.

- An explanation of the nonpayment penalty policies, including a description of the non-payment penalty exceptions. The reminder must also include information on how the member may request a screening for a medically frail determination.

- For individuals over 100% FPL facing termination and lock-out for non-payment, an explanation that any final notice of termination from the program will come directly from the State and will include information about the individual’s appeal rights.

- For individuals over 100% FPL who are not subject to a non-payment penalty exception, a reminder that if the member is terminated from HIP for nonpayment, the member is not be able to participate in HIP for a period of six months and the member’s portion of their POWER Account balance is subject to a 25% penalty of any remaining member POWER Account funds.

- For individuals at or below 100% FPL, a reminder that if the member is transferred to HIP Basic, the member will have a reduction in benefits and potentially increased cost-sharing through required copayments for all services, and that the member may not return to HIP Plus benefits until the member’s redetermination or rollover process occurs. Any remaining balance in member contributions is subject to a 25% penalty.

- An explanation of the member’s appeal rights.

- Information regarding how to report any change in household or household income.
Nonpayment of Monthly POWER Account Contribution

Except for members that qualify for a non-payment penalty exception, HIP members who do not make an initial Fast Track Prepayment before the expiration of the 60 calendar day fast track payment period or do not make a required POWER Account contribution payment within 60 calendar days of its due date will either be (i) terminated from the program and disenrolled from the MCE’s plan if their income is over 100% FPL, or (ii) transferred to HIP Basic benefits for the remainder of the benefit period if they have income at or below 100% FPL. If a member is receiving HIP State Plan Plus benefits and has income over 100% of the FPL and does not make their PAC, they will transfer to HIP State Plan Basic if they are TMA and begin making copayments for services received, but will not be subject to a change in benefits. If a member is in HIP State Plan Plus, medically frail, and over 100% of the FPL, then they will transfer to MAPC category, but stay in HIP State Plan Plus (and retain that level of benefits) but will start to incur copayments as a HIP Basic member would.

A payment made by check that is dishonored because of nonsufficient funds (NSF) is considered nonpayment. Members who make such payments are terminated from the program or transferred to HIP Basic, as applicable, if they are unable to provide the full POWER Account contribution that is in delinquency within 60 calendar days of its original due date. The MCE may charge a reasonable fee for a check returned for NSF. The MCE must develop, print, and mail notices to members if members’ payments are returned from the bank because of nonsufficient funds.

If a member has not paid his or her POWER Account contribution (PAC) within 60 calendar days of its due date, the MCE must notify the Indiana Client Eligibility System (ICES) through Core Medicaid Management Information System (CoreMMIS). This notification must be sent electronically to the State via the fiscal agent, by the monthly adverse action date. Adverse action dates vary each month.

Conditional members are reported to the fiscal agent using the HIP Daily Pay/No Pay files; fully eligible members are reported on the HIP No Pay files. The No Pay file system process runs weekly and the MCE files are picked up by the fiscal agent at 4 p.m. Wednesday. An email from DSIB Prod is generated to the MCE if an error is detected that includes the error type. Any records not posted to DXC by the time deadline or rejected for errors, will not be processed until the following week. The fiscal agent passes the nonpayment notification to ICES once a month by the monthly adverse action date. Any records rejected by ICES for errors will not be processed until the following month.

Pay Files are submitted by the MCEs on a daily basis, Monday through Friday by 4 p.m. As described previously, the No Pay files are to be submitted by the MCEs weekly. If the MCEs do not submit the No-pay files in the weekly no pay file, they will not be processed. It is critical that MCEs do not send No-pays in the Daily Pay file.

If a No-pay file is sent on a HIP Plus or HIP State Plan Plus member with income over 100% FPL who is neither medically frail nor receiving transitional medical assistance, they will be terminated from the program. After the member is terminated from the program, ICES notifies the fiscal agent via an input file to CoreMMIS. An 834 termination record is sent to the MCE. Depending on the timing of nonpayment submission to ICES, members are terminated on the last day of the processing month. The MCE must wait until receiving the termination record from the State to terminate the member from the plan.

If a No Pay file is sent on a HIP State Plan Plus member with income over 100% FPL who is medically frail, they are moved to HIP State Plan Plus with copays. Such medically frail members will continue to receive HIP State Plan benefits, but are required to pay copayments for services consistent with the HIP Basic copayments. In addition, the MCE will continue to send monthly POWER Account invoices and the member will continue to incur debt to the MCE for any unpaid PAC amounts.
Members in the HIP State Plan Plus copays category may only regain access to traditional HIP State Plan Plus benefits without copays at their annual redetermination or rollover, regardless of whether the member becomes current on their PAC payments during the remainder of their benefit period.

If a No Pay file is sent on a HIP State Plan Plus member with income over 100% FPL who is receiving transitional medical assistance (TMA), the member will not be subject to termination for non-payment, but will rather be transferred to HIP State Plan Basic benefits. Such members will no longer be required to pay PAC payments, but rather are charged copayments for services consistent with the HIP Basic copayments for the remainder of their guaranteed TMA period. After the member is transitioned out of the HIP State Plan Plus program, ICES notifies the fiscal agent via an input file to CoreMMIS. An 834 termination record is sent to the MCE. Depending on the timing of nonpayment submission to ICES, members are moved out of HIP State Plan Plus on the last day of the processing month. The MCE must wait until receiving the termination record from the State to move the member to the new aid category.

Nonpayment of PACs will result in a six-month lockout period for individuals above 100% FPL unless such individual qualifies for a lockout exemption, as described below.

If a No Pay file is sent on a HIP Plus or HIP State Plan Plus member who is not medically frail and is at or below 100% FPL, then such member will be transferred to the HIP Basic or HIP State Plan Basic package. ICES notifies the fiscal agent via an input file to An 834 termination record is sent to the MCE with the updated eligibility aid category. Depending on the timing of nonpayment submission to ICES, members are terminated from HIP Plus or HIP State Plan Plus on the last day of the processing month. The MCE must wait until receiving the change record from the State to move the member from the appropriate Plus plan to the appropriate Basic plan. Then HIP members at or below 100% FPL will remain covered by the same Basic benefit package for nonpayment. Members who are enrolled in HIP Basic will have a POWER Account that is fully funded by the State. The member will continue to be incentivized to use the POWER Account properly like a HIP Plus member with the possibility of rollover if there are remaining funds at the end of the benefit period.

Members transitioning from non-HIP categories to HIP, such as, CHIP Members or Pregnant women, will go Basic Potential Plus for 60 days to provide a timeframe for the member to make a payment without a gap in coverage. Those members over the FPL will be terminated, and those under the FPL will remain in Basic benefits. The process for members that have an income increase over 100% FPL will receive Potential Plus, and if those members do not make a payment they will be terminated. Rollover members in Basic get a Potential Plus opportunity as detailed in the Rollover Section.

If a HIP Basic member reports a change in income or family size that increases their income over 100% FPL, then the State will notify the MCE of the change via the 834 transaction. The member is identified as HIP Basic Potential Plus. The MCE is required to begin billing the member. The member is transferred to HIP Plus upon receipt of payment, or terminated from the program following non-payment. Member has 60 days to make a payment. Member income increases are an appealable action.

The Potential Plus designation allows a member to open with HIP Basic coverage or maintain HIP Basic coverage while allowing them a 60 day period to pay a POWER Account contribution to buy up to HIP Plus. Members are given a HIP Basic with potential plus designation when they transition from an IHCP program into the HIP program (such as a member moving from Hoosier Healthwise into HIP). Potential Plus also applies to members who are moving from the Hospital Presumptive Eligibility or Presumptive Eligibility programs, members who are moving from an incarcerated suspended status to HIP, members who have an income increase that moves them over 100% FPL, and when a HIP Basic member earns potential plus as part of the rollover process.
Lockout Exemptions

Members who are subject to a nonpayment lockout may re-enter the program before the expiration of the six-month lockout if they qualify for an exemption. This lockout period is tracked in the state eligibility system (ICES). Exemptions include members who:

- Obtained and subsequently lost private insurance coverage
- Had a loss of income after disqualification because of increased income
- Took up residence in another state and later returned
- Are victims of domestic violence
- Resided in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the 60 calendar days before date of member termination for non-payment
- Are medically frail

Members who file an application and are in a lockout period are sent a HIP Lockout Exemption verification request for a lockout exemption and will need to complete the form and provide documentation to validate the exemption within 13 days. Members who verify a lockout exemption by the deadline are able to reenter HIP before the expiration of their lockout period. These members are placed in a new benefit period.

Verification requests will vary based on the lockout exemption requested and include:

- Obtained and subsequently lost private insurance coverage: Proof of insurance coverage (such as certificate of credible coverage) including the specific dates of the private insurance coverage
- Had a loss of income after a disqualification because of increased income: Proof of income change (such as statement from employer or pay stubs)
- Took up residence in another state and later returned: Proof of residence in another state (such as lease, utility bill, and so forth)
- Is a victim of domestic violence: Provide copies of medical records, police reports, or proof of residence in a domestic violence shelter
- Was residing in a county subject to a disaster declaration: Proof of address in a disaster impacted county (such as lease, utility bill with address for the impacted time period, and so forth) and provide the disaster time period
- Is medically frail: A medically frail review by the State or its vendor

Members who apply and are in a lockout are sent a communication informing them of the lockout and describing the lockout exceptions. In addition, these member’s receive medically frail screening questions. If an individual returns the screening questions in affirmative, they are considered potentially medically frail and shall be screened by the MCE using standard medically frail screening processes and procedures described in this manual. However, if the State determines the individual is otherwise eligible for HIP but for the application of the lockout period, then the individual is considered conditionally eligible for HIP benefits pending the MCE’s medically frail determination. After the MCE completes the medically frail determination, the MCE will notify the State’s fiscal agent within one business day.
A member who meets any of the lockout exceptions will not be subject to the 25% penalty on the member’s refund amount if such member is either terminated from HIP because of non-payment or voluntarily withdraws from HIP before the end of the member’s benefit period. In order to claim a refund of the 25% penalty, a member must contact their MCE to report that they have been granted a lockout exemption. Upon notification, the member’s MCE will research the receipt of a lockout exemption by contacting the State’s fiscal agent and/or ICES staff to verify. If a member’s POWER Account for the prior benefit period has already been reconciled, the member will no longer be entitled to the refund.

POWER Account Recalculations

A member must report all changes to the State that may affect eligibility and POWER Account contributions, including changes in income or family size, such as death, divorce, birth, or family member moving out of the household. The MCE must notify members of how to report a change in income or family size, and explain that, as described in their initial eligibility letter from the Division of Family Resources (DFR), the member is responsible for notifying the State about changes in income and family size via the Change Report Form.

The State notifies the MCE when a member’s POWER Account contribution amount changes via the 834 transaction. Additional information on the HIP 834 transaction is available on the MCO Question and Answer page at indianamedicaid.com under Manuals and in the 834 MCE Benefit Enrollment and Maintenance Transaction companion guide. The MCE must begin billing the new POWER Account contribution or premium amount in the billing cycle immediately following the change. For example, in June, the member has a premium amount of $50. In July, the member loses his or her job and requests a recalculation through the DFR. The DFR notifies the MCE in August that the member’s new POWER Account contribution is $10. The MCE bills the member for the new POWER Account contribution in September.

The PAC is a monthly amount Recalculations could result in the member being paid in full or having a higher contribution amount. ICES will send the MCE the member’s monthly amount for future months and is sent via the HIP 834 transaction.

Use of POWER Account Funds

Each member is responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can be used by the member only to pay for HIP covered services. See Covered Services for a list of the HIP covered services.

In spending POWER Account funds, members must be permitted to apply these funds to the following covered services, even if obtained through out-of-network providers:

- Family planning services, if obtained from an IHCP provider
- Emergency medical services
- Other self-referral services, if obtained from an IHCP provider
- Medically necessary covered services, if the MCE’s network is unable to provide the service within a 60-mile radius of the member’s residence, as specified in 42 CFR 438.206(b)(4) and Section 5.14.
- Nurse practitioner services, if provided by an IHCP provider

Members cannot use POWER Account funds to pay for the emergency room services copayment described under Covered Services.
Members enrolled in HIP Basic or HIP State Plan Basic cannot use POWER Account funds to pay for any plan-required copayments.

**POWER Account Balance Information**

The MCE must maintain up-to-date member POWER Account balance information. This information must be mailed to members on a monthly basis in the form of a POWER Account Statement. It must also be available online via a secure member portal. The information must reflect real-time changes in the member’s POWER Account, as evidenced by paid claims. It must also indicate the member’s annual and monthly contribution amounts and the State’s annual contribution amount.

POWER Account balance information must also be available to members by contacting the MCE’s Member Helpline. The MCE must give members an opportunity to receive email alerts about updated POWER Account balance information on the member’s secure member portal, in addition to or as an alternative to receiving the information by mail.

In providing the required POWER Account balance information, the MCE may combine it with the explanation of benefits (EOB) information required in this manual.

**Interest**

Neither members nor the MCE may retain interest on POWER Accounts. The MCE must keep POWER Account funds in a safe, liquid, interest bearing account. On an annual basis at the end of each calendar year, the MCE must report in the aggregate the interest accrued on its members’ POWER Accounts. The MCE must return this amount to the State within 60 calendar days after the end of each calendar year.

**Audit Requirement**

The MCE must engage an external entity to conduct an annual audit of its POWER Account operations and administration and provide these results to the State.
Section 4: POWER Account and Redetermination

Redetermination of member eligibility in Healthy Indiana Plan (HIP) by the Division of Family Resources (DFR) generally occurs every 12 months and is based on criteria set forth by the State. When a member is determined to remain eligible for HIP at the end of a benefit period, the member’s Personal Wellness and Responsibility (POWER) Account (PAC) contribution is reassessed for the new benefit period. The State recalculates the member’s POWER Account contribution based on any changes in the member’s income recognized during redetermination. A member’s PAC obligation may increase, decrease, or remain the same. Member’s PAC may also change during the year if they experience a change in income. In any of these cases, if a member is HIP Basic at the time of redetermination, they will receive a HIP Potential Plus.

The state’s fiscal agent notifies the managed care entity (MCE) of the member’s POWER Account contribution for the new benefit period. POWER Account and benefit period information is transmitted on the 834 transaction form as soon as it is received from Indiana Client Eligibility System (ICES).
Section 5: POWER Account Reconciliation Process

Healthy Indiana Plan (HIP) member Personal Wellness and Responsibility (POWER) Accounts are funded by a combination of member and state dollars. When the HIP member is first enrolled, the state makes an initial payment to the managed care entity (MCE) of $1,300. During the enrollment period, the member makes monthly payments. When the member’s HIP enrollment period ends, the member’s POWER Account is reconciled. The MCE may be eligible for an additional payment from the state of up to $1,200 on reconciliation depending the amount of claims paid from the POWER Account and the amount of the member’s required annualized POWER Account contribution.

POWER Accounts are reconciled via the POWER Account reconciliation file (PRF) process. This process determines the additional amount that needs to be paid from the state to the MCE or recouped from the MCE back to the state. Applicable member refunds, rollover, and debt are also determined during this this process. In no case will the MCE ever be paid an amount in excess of $2,500 (combination of member and state funds) for a benefit periods POWER Account. POWER Account reconciliation processing differs based on if the member was terminated from HIP, transferred MCEs during the benefit period, or is eligible for rollover.

When performing the POWER Account reconciliation function, the MCE must comply with the procedures set forth in this manual. The MCE must have the capability to transmit the required rollover data electronically.

POWER Account Reconciliation File (PRF)

The PRF contains the following type of information:

- Member data
- POWER Account fund allocation
- Account usage
- Member debt
- Member preventive service utilization
- Member claims

The PRF is used to reconcile POWER Accounts when:

1. HIP members transfer to a new health plan during a benefit year (transfer PRF-IP/FP)
2. HIP coverage ends between months one to 12 of enrollment without continuing HIP enrollment in another benefit year (termination PRF-IT/FT)
3. A member becomes eligible for rollover following completion of a 12-month benefit period and continues enrollment in HIP (PRF- IR/FR & IX/FX), during the final PRF reconciliation,

PRF Voids

In addition to the submission of PRF files, MCEs can void PRF transactions in case of errors. During the PRF void process, the fiscal agent updates CoreMMIS according to the transaction type (plan change, termination, or redetermination).
Note: All dollar amounts must be reported for the PRF void. Any field left as zeroes are interpreted to mean a zero amount and NOT that there was no change to the previous data.

**PRF File Types**

Payments and recoupments between the MCE and the state are reported on the 820 transaction file. PRF file types and reason codes related to these transactions are listed in the following table are located in the 820 MCE Capitation Payment Information Transaction companion guide.

<table>
<thead>
<tr>
<th>PRF Terminology</th>
<th>PRF Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Plan Transfer</td>
<td>IP</td>
</tr>
<tr>
<td>Final Plan Transfer</td>
<td>FP</td>
</tr>
<tr>
<td>Plan Transfer Void</td>
<td>VP</td>
</tr>
<tr>
<td>Initial Term</td>
<td>IT</td>
</tr>
<tr>
<td>Final Term</td>
<td>FT</td>
</tr>
<tr>
<td>Term Void</td>
<td>VT</td>
</tr>
<tr>
<td>Initial Rollover</td>
<td>IR</td>
</tr>
<tr>
<td>Final Rollover</td>
<td>FR</td>
</tr>
<tr>
<td>Void Rollover</td>
<td>VR</td>
</tr>
<tr>
<td>Plan Transfer Rollover</td>
<td>FX</td>
</tr>
<tr>
<td>Initial Plan Transfer Rollover</td>
<td>IX</td>
</tr>
<tr>
<td>Void Transfer Rollover</td>
<td>VX</td>
</tr>
</tbody>
</table>

The same PRF file layout is used for all transactions. The file layout can be found on the State SharePoint site or a copy can be obtained from the fiscal agent’s Managed Care Unit staff. PRF file naming conventions are posted to the MCO Question and Answer page at indianamedicaid.com. The fiscal agent’s Systems Unit accepts only one file from each MCE per day. When the MCE submits more than one PRF file per day, all files are rejected. A folder has been set up for each plan on File Exchange:

- MDwise – Distribution/HIP Program/XXXL
- Anthem – Distribution/HIP Program/XXXL
- MHS – Distribution/HIP Program/XXXL
- CareSource – Distribution/HIP Program/XXXL
Section 6: Determination of Member Annual Contribution

Calculation of the Member Portion of the Account for 12 month Benefit Periods

Use the following procedures to determine the member portion of the Personal Wellness and Responsibility (POWER) Account:

1. Sum the amount the member owed for every month in which a POWER Account contribution was applicable.
   • Example Benefit Period: PAC for Months one to six is $10, PAC for months seven to 12 is $8,

   Table 6.1 – Benefit Period Example

<table>
<thead>
<tr>
<th>Month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAC</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

   Member Portion: Sum(10*6)+(8*6) = $108
   • This represents the amount of the POWER Account the member owes for the benefit period, or the member portion, assuming the entire POWER Account was expended.
   • This represents the amount the state owes for the benefit period, or the state portion, assuming the entire POWER Account was expended.

Calculation of the Annual Member Portion of the POWER Account for Terms and Transfers for Benefit Periods of Less than 12 Months

Member POWER Account contributions are provided to the MCE as a monthly amount, however, to determine the member portion of the account specifically for members who have benefit periods that are less than 12 months, the PAC amount for the last month enrolled is used to determine an annualized amount.

• Example Benefit Period: PAC for months 1-6 is $10, PAC for month 7 is $8, member is termed effective in month 8

   Table 6.2 – Benefit Period Example – Term at Month 8

<table>
<thead>
<tr>
<th>Month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAC</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>8</td>
<td>TERM</td>
<td>TERM</td>
<td>TERM</td>
<td>TERM</td>
<td>TERM</td>
</tr>
</tbody>
</table>

   In the previous example, to calculate the annual member portion of the POWER Account, the PAC amount for the last month of enrollment is used for the remaining months of the 12 month benefit period.

2. Sum the member’s PAC amount for every enrollment month $10*6+$8 = $68
3. For the remaining months of the 12 month benefit, use the PAC from member’s last enrollment month to estimate the member annual portion of the account.

   Example Benefit Period: PAC estimated for as $8 for months 8 to 12.
   • $8*5=40
Table 6.3 – Benefit Period Example – Months 8 thru 12

<table>
<thead>
<tr>
<th>Month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAC</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>8</td>
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<td>TERM</td>
<td>TERM</td>
</tr>
<tr>
<td>Estimated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$8</td>
<td>$8</td>
<td>$8</td>
<td>$8</td>
<td>$8</td>
<td></td>
</tr>
</tbody>
</table>

4. Calculate the member portion of the account by adding the results of Step 2 to Step 3
   • $68 + 40 = $108

Even though the member was only enrolled for seven months, if the entire POWER Account was expended, the member would still owe $108.

**Calculation of Member Pro-Rata Share**

Where members do not fully expend their POWER Account, claims are applied on a pro-rata share basis. The percent of each claim for which the member is responsible for up to $2,500 is calculated as member portion/2,500.

From the previous examples the member pro-rata share is calculated as: $108/2,500 = .0432. In this example, the member is responsible for 4.32% of each claim up to the $2,500 limit (with the $108 member share).

Example: A claim of $250 applies to the POWER Account for this member. $250 is deducted from the POWER Account. The member portion of this claim is $250*.0432 = $10.75. $10.75 is allocated to the member portion of the account and ($250-$10.75)=$239.25 is allocated to the state portion of the account.
Section 7: PRF - Member Termination

Members who are not continuing in Healthy Indiana Plan (HIP) have their Personal Wellness and Responsibility (POWER) Account reconciled through the POWER Account reconciliation file (PRF) termination process. A termination is defined as a member completely terminating out of the HIP program. When a member terminates, any member dollars in the account including; current year payments and prior year rollover are refunded to the member.

If a member becomes ineligible for HIP, then the managed care entity (MCE) must close the member’s current year POWER Account and refund the state’s and member’s shares of the remaining POWER Account balance, if any, in addition to determining if the member owes any debt. This requirement also applies when a pregnant HIP member enrolls in HIP Pregnancy (MAGP) and when an American Indian/Alaska Native member elects to opt out of managed care.

POWER Account Reconciliation Timing

DXC receives an initial term from Indiana Client Eligibility System (ICES) on the Combined Daily Eligibility Interface (CDEE). The CDEE contains data that was previously on the 529 File, and is received from ICES. The MCE receives initial term information on the 834 with record type 001 from DXC on the following day after receipt of the record on the CDEE file indicating the upcoming termination date. MCE receives this term notification record with record type 024 a day after the termination takes effect. Terminations are effective the first day of month following the termination.

For the purposes of POWER Account Reconciliation, “days after termination” are calculated from the first day after the end of the member’s HIP enrollment. On the 30th day after the HIP enrollment period ends, DXC receives an initial POWER Account Reconciliation File from the MCE. On day 31, DXC generates a response file and sends the file to the MCE. The response file informs the MCE whether or not the file was valid. There is no 820 impact on the initial PRF.

On day 120 after the end of the HIP enrollment period, the final POWER Account Reconciliation File is submitted by the MCE. This file identifies the amount of any MCE payments owed, state refunds owed, and member refunds owed. This inbound PRF triggers DXC to send a response file to the MCE. After the receipt of the final PRF is processed via the 820 transaction file, the financial cycle is run, and MCE recoups and MCE true-ups are processed. MCEs refund the member if PRF indicates that the member overpaid or did not have claims to apply against the entire balance of their contributions. Member refunds may have a 25% penalty applied if the member was terminated for a penalty reason such as nonpayment or voluntary withdrawal as detailed under the “Member Termination Refund” section.

Member Termination Refund

If a member becomes ineligible for HIP or otherwise disenrolls from HIP, then the MCE must refund the member’s pro-rata share, as determined previously, of his or her POWER Account balance, if any. The refund must be within 120 calendar days of the member’s date of termination from HIP. If the MCE sends a POWER Account refund check to a member and the check is returned to the MCE because the member cannot be located, then the MCE must handle the member’s unclaimed refund pursuant to Indiana Statute (IC 32-34-1, et seq.).

A deceased member’s estate has a right to the member’s pro rata share of his or her POWER Account funds. Unless a member is terminated from HIP for a penalty reason, use the following steps to determine the amount payable to the member. This termination is for non-payment and voluntary withdrawal.
1. Determine the amount paid into the POWER Account to date by the individual and any third-party entity on the member’s behalf (if any).

2. Determine the total amount paid eligible to be paid into the individual’s POWER Account from all sources.

3. Divide the amount determined in step 1 by the amount determined in step 2.

4. Multiply the ratio determined in step 3 by the total amount remaining in the POWER Account.

5. Subtract member debt owed to the MCE, if any.

When a member (who does not meet any of the disenrollment exceptions) is terminated from HIP for nonpayment, or if a member voluntarily withdraws from HIP, then the member forfeits to the state 25% of his or her pro rata share of remaining member POWER Account contributions. The MCE would use NP (nonpayment) and VW (voluntary withdrawal) as the reason codes to apply the penalty. This means that for member termination from HIP because of nonpayment, the MCE is required to refund 75% of the member’s pro rata share of the POWER Account. Determine the amount payable to the member by using following steps:

1. Determine the member pro rata share of the POWER Account.

2. Multiply the member pro rata share of the POWER Account by the remaining balance of the POWER Account. This will be the balance of the POWER Account.

3. Determine the amount of member POWER Account contributions paid in the benefit period.

4. Subtract the amount in step 2 from the amount in step 3.

5. If the amount in step 4 is positive, then the member is owed a refund, if the amount in step 4 is negative, the member has debt.

6. If the member has a refund, then multiply the refund amount determined under step 4 by 0.75 or 75%, as applicable (nonpayment voluntarily withdrawal)

Member refunds must be reported even if the amount is zero. After the PRF is filed 120 calendar days following a member’s termination, the MCE may not make further adjustments. The MCE is responsible for any claims received after the POWER Account has been reconciled and the member refund has been issued. The MCE shall not pursue the member’s portion of an appealed claim after a member refund has been made.

The penalty should always be applied to members who are terminated for failure to pay, who voluntarily withdraw from the program, or are HIP Basic members who were HIP Plus at some point during the year.

Penalties on member terminations for non-payment and voluntary withdrawal are effective on all PRFs for member terminations after December 2015.
Section 8: PRF – Member Transfers MCEs

Transfers mid-benefit year

Members may transfer managed care entities (MCEs) during a benefit year for just cause. When a member transfers to another MCE during his or her benefit period, the MCE must complete the PRF-IP submission to the State’s fiscal agent. The submission must occur within 30 calendar days of the transfer to provide needed information. When a member transfers MCEs, the member’s Personal Wellness and Responsibility (POWER) Account is transferred to the new MCE, including the Power Account Contribution (PAC) contribution and POWER Account claims paid to the new MCE, as applicable. The fiscal agent will see the initial PRF-IP and post it to the member’s new MCE File Exchange folder.

To transfer a member from one MCE to another, DXC generates 834-02 term record and sends it to the MCE that the member is transferring from (MCE 1). The new MCE (MCE 2) receives the 834 021 add record indicating that member is transferring to them for the current benefit period. The 834 contains all member information, the type of 834 (condition, fully eligible, Presumptive Eligibility (PE) and Fast Track Eligible (FTE). A 834-024 is sent to MCE 1 via 834 while an 834 021 add record is sent to MCE 2.

On day 30, MCE 1 sends the PRF-IP IN to DXC. DXC generates a response file (indicating whether or not the file contained valid or invalid data) and sends the response file to MCE 1. On day 31, DXC sends PRF-IP OUT file to the MCE 2 who will cover the member effective the date of the termination date with MCE 1.

MCE 1 must submit a final PRF-FP to the fiscal agent within 120 calendar days of notification of the transfer to close out the member’s POWER Account and transfer any remaining funds in a manner and method prescribed by the State. On day 120, MCE 1 sends DXC the PRF-FP IN. DXC generates response file to return to MCE 1. On day 121, DXC sends PRF – FP to MCE 2. On day 121, all claims are totaled via PRF, money is exchanged via the 820; true-up and recoups process occurs for MCE 1 while PRF payment is made to MCE 2 (remaining funds from POWER Account).
Section 9: Rollover Process

Redetermination and Rollover

At the end of a benefit period, members have an opportunity to renew their eligibility in Healthy Indiana Plan (HIP) by completing the redetermination process. If the member is redetermined eligible for HIP, then any funds remaining in the member’s Personal Wellness and Responsibility (POWER) Account may be rolled over and applied as a credit toward the member’s required Power Account Contribution (PAC) in the subsequent benefit period. The amount rolled over or discounted, as applicable, depends on whether the member received his or her recommended preventive care services, and what program (HIP Plus or HIP Basic) the member is enrolled in on the last day of their benefit period before the benefit period in which rollover is being calculated for and applied. To allow a claims run-out period, rollover must occur 120 calendar days following the end of the member’s benefit period.

When performing the rollover function, the managed care entity (MCE) must comply with the procedures in this manual. The MCE must have the capability to transmit the required rollover data electronically.

Members who complete a full 12-month benefit period and continue subsequent benefit period in HIP without a gap in coverage may be eligible for the HIP rollover benefit if they have dollars remaining in their prior year $2,500 POWER Account. Member rollover is determined 120 days after the prior benefit period ends to allow for claims processing.\(^1\) Any claims that come in after 120 days are the MCE’s responsibility, but may not be applied to the reconciled POWER Account. Members with shortened benefit periods will have their POWER Accounts reconciled through the PRF termination process. Members are not eligible for rollover even if they have a subsequent HIP benefit period without a gap in coverage. Member’s health plans are responsible for reconciling the member’s POWER Account and calculating the member rollover dollars, state matching rollover dollars, and state discount percentage.

After a 120 calendar day reconciliation period, the MCE must report any rollover amounts or discounts to the State fiscal agent on the PRF. The MCE must notify members of any rollover amounts and/or discounts, as well as any changes in their monthly POWER Account contributions because of rollover. If a member has sufficient rollover dollars (state and member) to cover one month’s PAC, then the MCE will use HIP Plus rollover amount as a credit on the account. If a HIP Basic or HIP State Plan Basic member is eligible for a discount for participation in HIP Plus, then the MCE must notify the member of the opportunity to transfer to HIP Plus benefits or HIP State Plan Plus at the discounted rate.

The amount of leftover and available funds rolled over or discounts applied to current year POWER Account contributions, as applicable, depends on the following:

- The member’s contributions to the POWER Account
- The balance remaining in the member’s POWER Account
- Any member debt
- The member’s receipt of recommended preventive care services
- What program (HIP Plus or HIP Basic) the member is enrolled in on the last day of the rollover benefit period before the current benefit period in which rollover is being applied

\(^1\) System implementations may cause rollovers to be submitted past 120 days, in all other instances MCEs are required to submit PRF-FR on day 120.
Because each individual enrolled in HIP has a separate POWER Account, family size does not impact the POWER Account rollover.

When POWER Account contributions fall under $1.00 because of rollover MCEs can choose whether to bill the member or to adjust off the member balance due.

### Rollover Preventive Services

Each benefit period, the Family and Social Services Administration (FSSA) determines based on Centers for Disease Control recommendations, which recommended preventive care services apply to a specific member’s age, gender, and the member’s health conditions. The preventive services that impact rollover are the Affordable Care Act (ACA) required preventive services, as detailed in the Alternative Benefit Periods (ABPs) and preventive dental and vision visits for HIP Plus members. Preventive guidelines for rollover are uniform across plans and are age and gender specific. MCEs determine if any preventive service was obtained by the member by conducting a claims analysis for the benefit period.

Ninety calendar days before the end of the member’s benefit period, the MCE shall make an initial assessment of whether the member has completed any recommended preventive services. If the member has not received recommended preventive services, the MCE shall send a reminder to the member. The notification must inform the member of the option to self-report preventive services by requesting their doctor to complete an attestation form indicating the preventive service received and the date of service.

### Member Rollover Dollars

Regardless of the member’s benefit plan or use of preventive services, the member dollars in the account always rollover to the next year, unless the member has made an overpayment in the current year. Current year overpayments may be refunded to the member. Applying rollover to an account may cause the member to have overpaid in the current year, depending on how much they rolled over and paid before rollover being applied. Member dollars may rollover even if the dollars rolling over to the next year are more than the member’s required contribution for the next year. Prior year rollover continues to rollover to the next year. Current year overpayments are always refunded to the member, therefore the member’s rollover can never be more than $1,200.
**Section 10: Rollover Definitions**

The following table contains the Rollover descriptions and definitions.

<table>
<thead>
<tr>
<th>Rollover Definitions</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Rollover benefit period** | This is the benefit period that the member completed the actions that qualify him or her for rollover.  
Example: In their first year of Healthy Indiana Plan (HIP) benefits a *HIP Basic* member has $500 in claims and completes preventive services. This member qualifies for rollover. This first year of HIP benefits is the rollover benefit period when rollover is being calculated in year 2. |
| **Current benefit period** | This is the benefit period in which any rollover earned in the rollover benefit period is applied.  
Example: A *HIP Basic* member earned a discount during rollover benefit period. This discount is applied in the member’s current benefit period. |
| **Member claims responsibility ratio** | A member’s claims responsibility ratio is based on the monthly Power Account Contribution (PAC) divided by the total Personal Wellness and Responsibility (POWER) Account funds of $2,500.  
Example: Member has a $10 monthly PAC. Member’s claims responsibility ratio is (120/2500) = .048. For the first $2,500 in claims, this member is responsible for:  
[claim dollar amount used by member multiplied by .048] |
| **Member claims responsibility percentage** | Member claims responsibility ratio multiplied by 100.  
Example: The member has a claims responsibility ratio of .048. The member’s claims responsibility percentage is (.048 x 100) = 4.8%. The member is responsible for 4.8% of each claim for the first $2,500 in claims paid from their POWER Account. |
| **Member claims responsibility** | Total claims in benefit year paid from POWER Account multiplied by the member claims responsibility ratio.  
Example: During rollover reconciliation the POWER Account has $1,000 remaining. The member had $1,500 in claims for the rollover benefit period. The member claims responsibility ratio is .048. The member’s claims responsibility is ($1,500 x .048) = $72 |
| **Member PAC paid** | The amount of PAC the member paid in the rollover benefit period. |
| **Member PAC owed** | The amount of PAC the member owed in the rollover benefit period. |
| **Member Rollover Dollars** | Member remaining dollars less any member debt or member rollover penalty. |

*Member Remaining Dollars*  
Any unused contribution dollars that did not go toward the member’s claims responsibility. A member ending benefits in *HIP Basic* may have member dollars remaining if they were a prior *HIP Plus* member in any proceeding benefit period. If claims responsibility is less than what member paid in toward their PAC, then member dollars will remain (regardless if member is *HIP Plus* or *HIP Basic* at the end of the benefit period).
### Rollover Definitions

<table>
<thead>
<tr>
<th><strong>State Matching Rollover Dollars</strong></th>
<th>Available to members who were in HIP Plus at the end of the member’s rollover benefit period who have member rollover dollars and received preventive care during the rollover benefit period. State matching rollover dollars are equal to member remaining dollars when the member received preventive care. If no preventative services, then, state matching dollars will be zero. State matching dollars are calculated before any member debt being subtracted from rollover dollars.</th>
</tr>
</thead>
</table>
| **State Discount Percentage (members who earned Basic rollover)** | Calculated to determine the dollar amount discount in regards to the PAC. For members that end their rollover period as a HIP Basic member and received preventive care. This is the value of the member’s account 120 days after end of the rollover benefit period divided by $2,500. This is then multiplied by 100 to determine the remaining dollars percentage in the account out of the total $2,500. The maximum state discount percentage is 50%, and any amounts calculated higher than that equal 50%.  
Example:  
120 days after the benefit period a HIP Basic member has a POWER Account balance of $1,000. The HIP Basic member’s state discount percentage is ($1,000/$2,500) x 100 or 40%. If member is currently HIP Basic earns a state discount percentage, then they receive a potential plus at rollover and determine a reduced PAC with a 40% discount. |
| **State Discount Dollars (members who earned Basic rollover)** | For members that end their rollover period as a HIP Basic member and received preventive care. The state discount dollars is the member’s PAC multiplied by the member’s monthly PAC discount percentage, as calculated above. Members that are in HIP Plus when they receive a state discount dollar rollover have the discount applied to their entire contiguous HIP Plus period.  
Example: The member’s state discount percentage is 40% and their PAC is $10/month. The member’s state discount dollars equal 40% multiplied by 10 = $4. The member’s monthly PAC is discounted by $4 state discount dollars, leaving a monthly PAC of $6.  
The discount dollar amount is a “positive” amount.  
The member’s PAC can be under a $1 when a discount is applied. |
| **Contiguous HIP Plus period** | The period of HIP Plus coverage without a break to HIP Basic benefits.  
Example: If a member is HIP Plus in month one of their benefit period (BP), HIP Basic in months two and three and HIP Plus in month four when rollover is applied, then the contiguous HIP Plus period starts in month four and ends at the end of the benefit period when rollover is applied, or when the member drops to HIP Basic, whichever is sooner. |
| **Potential Plus** | Fully-eligible HIP Basic members with a PAC amount have the option to contribute to their POWER Account. A HIP Basic member would have the opportunity to buy up to HIP Plus at redetermination or at rollover. |
| **Member Rollover Penalty** | A HIP Basic member that has member remaining dollars is subject to a member rollover penalty. This is a 25% penalty on the member’s member remaining dollars. The penalty dollars are returned to the State. |
| **Member Debt** | HIP Plus members are responsible for paying a portion of the first $2,500 in claims. When HIP Plus members do not pay their full portion of claims they incur debt. Member’s under and over 100 percent of federal poverty level (FPL) have different caps on debt. Member debt can be subtracted from member rollover dollars and used |
### Rollover Definitions

By the managed care entity (MCE) to clear the member’s debt. Any state matching rollover dollars are calculated prior the MCE subtracting debt from member rollover dollars.

<table>
<thead>
<tr>
<th>For members under 100% FPL the debt is capped at:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PAC owed for months of missed payments when member was in <strong>HIP Plus</strong>, or</td>
<td>Member claims responsibility less member PAC paid whichever is less.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For members over 100% FPL the debt is capped at:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member claims responsibility less member PAC owed, or</td>
<td>10% of claims paid from the POWER Account for the applicable benefit period whichever is less.</td>
</tr>
</tbody>
</table>
Section 11: HIP State Plan Plus and HIP Basic Rollover

Rollover information is sent to the managed care entity (MCE) with the subsequent HIP benefit period (BP), even if the member has terminated at the time rollover is being processed. The member’s subsequent year account will be reconciled after accounting for rollover and the member will receive any refund owed. The rollover process will vary for HIP Plus and HIP Basic.

HIP Plus Rollover

HIP Plus members and HIP State Plan Plus members who consistently contribute to their POWER Account during the plan year will be eligible to rollover their unused pro rata share of the POWER Account balance. Claims payment allocation from a POWER Account should always be based on the current year PAC.

If a HIP Plus or HIP State Plan Plus member receives any recommended preventive care services during the plan year, then the member is eligible to have their unused share, or “rollover amount”, doubled by the State as an added incentive. Because final rollover occurs 120 days after the start of the subsequent benefit period, the rollover amount would be applied on a prospective basis for the remaining benefit period to reduce the member’s future monthly payment. The member’s rollover amount is used first to offset member’s required contribution and could eliminate required contributions in the applicable plan year. After the member rollover amount is exhausted, the additional State rollover incentive amount is used to offset the remaining portion of member’s required contribution and up to the total amount of the member’s contribution for the year. Unused state matching dollars are lost to the member and returned to the state. Unused excess member rollover for that year remains the member’s money and may rollover to the next year; however the money is not eligible to earn state matching dollars.

The MCE must refund any overpayments within 120 calendar days of the end of the member’s benefit period. The refund of overpayments and the rollover of previous year’s rollover balances occurs regardless of whether the member obtained his or her recommended preventive care services. Because a member cannot receive a rollover credit for the first five months in a following benefit period, until reconciliation, they can receive a refund for an overpayment that was made in the first five months before receiving their rollover credit or discount. Refunds for overpayments are issued during the Personal Wellness and Responsibility (POWER) Account reconciliation process. Members that terminate may be refunded prior year member rollover dollars.

The rollover amounts for HIP State Plan Plus and HIP State Plan members are calculated as follows:

1. The member’s portion of the remaining POWER Account balance (the member share) is determined by the following formula:
   - Amount of the member’s required annual contribution for the expiring term abased on the calculator.
   - Plus any balance rolled over from previous coverage terms applied to member contribution
   - Divided by 2,500 (the fully funded POWER Account total)

2. The base rollover amount is determined as follows:
   - Member share multiplied by the remaining balance in the POWER Account
3. The final rollover amount is determined based on whether the member obtained recommended preventive services. The preventive services bonus is applied to the base rollover amount as follows to determine the final rollover amount:

- If preventive services are completed during the plan year:
  - Base rollover amount x 2 = final rollover amount
- If preventive services are not completed during the plan year:
  - Base rollover amount x 1 = final rollover amount

A member’s rollover benefit period is the period in which rollover is earned. For ongoing HIP members, Rollover dollars are applied to the member’s current benefit period. Members that are HIP Plus or HIP State Plan Plus at the end of the rollover benefit period qualify for rollover if:

- They have member remaining dollars in their POWER Account. A member could have member rollover dollars even if they spent all of their $2,500. Rolled over member dollars from previous period would have to be greater than their monthly PAC
- Members that complete preventive services may be eligible for state matching dollars to further reduce or eliminate their contribution in the member’s current benefit period. Members that are in HIP Plus at the end of the rollover benefit period may earn member rollover dollars and state matching rollover dollars
- State matching dollars cannot be more than the member’s total contribution and state match earned in a prior year does not rollover into the next year.
  - For members earning HIP Plus rollover, any state matching dollars for completing required preventive care are calculated before the MCE recouping debt owed from member dollars
  - State and member HIP Plus rollover dollars are applied as a credit on the member’s account and may offset POWER Account payments due or already paid in the current benefit period
  - Member dollar rollover credits may be rolled over to the member’s next benefit period. Member dollars rolled over are not refunded on rollover calculation and continue to rollover until the member leaves HIP or the dollars are used. State matching rollover dollars do not continue to rollover to the member’s next benefit period. State matching rollover dollars that are remaining on calculation of the next benefit period’s rollover are returned to the State.

**HIP Basic Rollover**

**HIP Basic** members and **HIP State Plan Basic** members not contributing to their POWER Accounts may have the ability to “rollover” funds. These individuals will still maintain the incentive to manage the account judiciously and receive recommended preventative care services. The discount available to **HIP Basic** members is related to the percentage of the POWER Account balance remaining at the end of the plan year. For example, if a member has 40% of their POWER Account balance remaining at the end of the plan year, then they may reduce their required **HIP Plus** contribution by 40% in the following year by having the discount apply as a credit, provided they have received their recommended preventive services. However, this discount is limited to a maximum of 50% of the member’s owed contribution.

The rollover amounts for members participating in the **HIP Basic** plan are calculated as follows:
1. The rollover percentage is calculated by the following formula:
• Remaining balance in the POWER Account
• Divided by 2,500 (the fully funded POWER Account total)
• Multiplied by 100 to yield a percentage \( \leq 50 \) percent

1. The determination of the final discounted contribution amount for participation in the \( HIP \ Plus \) plan for the subsequent year would be determined as follows:
   - Required contribution for the subsequent year based on FPL
   - Minus [rollover percentage multiplied by the required contribution]

Most \( HIP \ Basic \) members will not have POWER Account balances. If they do, then members enrolled in the \( HIP \ Basic \) plan will have the remaining member dollars in their previous POWER Account applied as a credit toward \( HIP \ Plus \) required contribution for the applicable benefit period. These members would be subject to a 25% penalty on the rollover of these member dollars because of previous nonpayment of their POWER Account contribution. Like members that earn a \( HIP \ Basic \) rollover for a discount, members with member dollars remaining receive the opportunity to transfer to \( HIP \ Plus \). When member dollars rolled over can cover at least one month of PAC for a member currently in \( HIP \ Basic \), the MCE should apply the member credit to the member’s \( HIP \ Potential \ Plus \) PAC and send a pay file. This member should be moved to \( HIP \ Plus \). If a \( HIP \ Basic \) member earns a percentage discount for preventive care and has member dollars to roll over, then the percentage discount is applied before applying the member dollar credit on the account. For members having their second HIP benefit period calculated for rollover in 2017 this penalty is not applied.

A member’s rollover benefit period is the period in which rollover is earned. For ongoing HIP members, Rollover dollars are applied to the member’s current benefit period. Members that are in \( HIP \ Basic \) or \( HIP \ State \ Plan \ Basic \) at the end of the rollover benefit period qualify for a state discount rollover if:
   - There are still funds in the $2,500 POWER Account
   - The member has completed preventive services
     - \( HIP \ Basic \) members qualify for a state discount percentage, which is translated into state discount dollars or a dollar amount off of their POWER Account contribution for \( HIP \ Plus \) or \( HIP \ Potential \ Plus \) segment (depending on their current status)
     - The state discount percentage is based on the percentage of the POWER Account that is remaining based on members’ claims usage
     - The state discount percentage should not exceed 50%. This percentage is applied against the member’s current PAC to calculate the state discount dollars. \( HIP \ Basic \) members qualify to rollover unused member contributions or prior year rollover that they previously paid in as a \( HIP \ Plus \) member. These can be rolled over even if the member has not completed preventive services. Because of nonpayment and dropping to \( HIP \ Basic \) any member contributions are subject to a 25% member rollover penalty before being applied to the member’s current POWER Account.
     - Rollover discounts apply to the current benefit period and expire at the end of benefit period in which they are applied for members that earned \( HIP \ Basic \) rollover.
     - Members that are \( HIP \ Basic \) members when a percent discount is applied only receive the percent discount on months of \( HIP \ Plus \) coverage following the rollover calculation.
     - Members that are \( HIP \ Plus \) members when a \( HIP \ Basic \) member discount is being applied have the discount applied to their entire contiguous period as a \( HIP \ Plus \) member where they have not had a break to \( HIP \ Basic \) coverage, not just prospectively. Members can receive discounts on PAC already paid in current year when rollover is applied. For a member that changed to \( HIP \ Plus \) in the first of month of the enrollment period the...
Members that are in HIP Plus Copay at the end of their benefit period must meet the same conditions as HIP Basic member to qualify for rollover.

Member rollover dollars and state matching rollover dollars are only on the PRF (IR/FR) and are not transmitted via the 834. Because an individual who is currently HIP Basic (with earned HIP Plus rollover), would experience a PAC change when they become potential plus or if they received preventive services, then only potential plus and state discount and discount dollars come through on the 834.

, then Members that are HIP Basic at the end of the rollover benefit period may have member dollars and percentage discount. In that case, the discount is applied first and then the credits are applied to the remaining balance. For all HIP members who are continuing in the program, MCEs are responsible for submitting a rollover PRF to DXC at the end of the member’s rollover benefit period regardless if the member was eligible for rollover or not. DXC submits rollover information to Indiana Client Eligibility System (ICES) on all members.

For members that are in HIP Plus or HIP State Plan Plus in their current benefit period when rollover is applied:

- Any state discount percentage is applied to all PACs within the member’s current contiguous HIP Plus segment to generate state discount dollars for each month the member has been HIP Plus
- This retroactively reduces the member’s PAC for months before rollover and may create a credit on the member’s account.
- Any state discount percent is applied to the member’s PAC going forward and continues to provide state discount dollars on the member’s PAC. The state discount dollars are recalculated if the member’s PAC changes. Any member rollover dollars or state rollover dollars are applied as a credit on the account after the application of any state discount percentage to the member’s PAC amount
- State discount dollars are listed on the PRF and the 834. The original PAC amount and state discount dollars will both be included on the 834. The MCEs need to invoice the member for any remaining amount due between the PAC and rollover amount and show the discount that is being applied
- State discounts expire at the end of the benefit period in which they were applied or when a member drops from HIP Plus or HIP State Plan Plus to HIP Basic or HIP State Plan Basic
- The state discount dollars applied are funded to the MCE via the 820 process following the PRF reconciliation process for the account.

For members that are in HIP Basic or HIP State Plan Basic in their current benefit period when rollover is being applied – including state discount dollar rollover, member rollover dollars, and/or state matching dollars - this generates a potential plus segment. The HIP Potential Plus indicator and state discount dollars come on the PRF, whereas member rollover dollars and state matching rollover dollars are only on the PRF not transmitted via the 834 and only earned as HIP Plus member.
• If the member qualifies for a potential plus segment, then ICES sends a potential plus to DXC. DXC updates the potential plus loop with any applicable state discount dollar information to the member’s MCE.
  o Current HIP Basic members that qualify for state discount dollars have these dollars applied to reduce their potential plus PAC going forward, members that qualify for member rollover dollars and/or state matching dollars have these dollars applied as a credit on their account
  o If there are enough rollover dollars to cover at least one month of PAC, then the MCE may apply this credit to the PAC owed in the current month and send a pay file for the member to convert them to HIP Plus. If there are not enough rollover dollars to cover at least one month PAC, then the MCE may apply the dollars to the account and invoice the member for the balance
  o State discount dollars are applied to the original PAC (for example, before the application of any member or state rollover dollars)
  o Members that have state discount dollars and experience PAC changes, have the state discount percentage applied to their new PAC and receive an updated state discount dollar amount
• Members in HIP Plus Copay at the end of their rollover benefit period earn rollover like HIP Basic members.
  o Members in HIP Plus Copay when rollover is being applied will direct open into HIP Plus status as it occurs with redetermination
  o Any state discount percentage is applied to the member’s PAC on a go forward basis, it does not reduce the HIP Plus Copay PAC retroactively.
  o Any member rollover dollars or state rollover dollars are applied to the account as a credit
  o If there are enough dollars to cover at least one month of PAC, then the MCE may send a pay file and the member will convert from potential plus copay to HIP State Plan Plus.

Rollover Transfers (PRF-IX/FX)

If a member transfers to a new plan during their redetermination, then the original plan is considered responsible for the POWER Account Reconciliation to determine the member’s rollover amount. The original plan sends POWER Account Reconciliation to the State so that the new MCE can be notified of the member’s rollover amount. MCE 1 remains responsible for determining the amount of member rollover, as well as any amounts that must be credited back to the State. The original MCE is only responsible for all claims with dates of service during the time they had the member enrolled in their plan (regardless of the date the claim was submitted).

MCE 1 is required to submit the PRF-FR so that the rollover amount is provided to the State so the member’s discount can be applied on the new MCE’s 834. Just as with a regular transfer member, termination is effective for MCE 1 on the last day of the month member is ending program, and an add record would be effective first day of following month if member is transferring to MCE 2. The member is treated as terminating with MCE 1 but an add record is generated by DXC for MCE 2.

**PRF Timing - Transfer Members (IX/FX)**

To transfer a member at redetermination, ICES sends CDEE with the new BP indicating redetermination to DXC. DXC sends 834 001 to MCE from DXC.
On day 30 after the end of the rollover benefit period, the MCE for the rollover benefit period sends DXC an initial PRF (IR) to include member rollover dollars, state rollover dollars, and discount amount – dependent on if member got preventive services. DXC receives inbound PRF from MCE with prior benefit period. If the file is successful, then DXC sends PRF outbound to MCE for the current BP. DXC sends the response file indicating that the data was valid before the outbound PRF is generated. On day 31, DXC sends PRF Out to the MCE.

On day 120, no data is sent on the 834. That only happens when 834 records are sent. MCE 1 sends PRF - IN to DXC with all the final data elements (claims, preventive services, and debt), this is the final rollover transfer record type (FR). DXC generates the response file and sends it to the MCE rolling the member over regardless if data was valid. However, an outbound PRF will only be generated if the data was valid. DXC generates outbound PRF. DXC sends ICES supplemental and ICES sends response file.

Depending on type of rollover the member earned (based on status at the end of the prior benefit period) determines if a change record needs to be processed.

If member is HIP Plus on day 120, but earned HIP Basic discount (prior benefit period as a HIP Basic member) – 834 001 change record. Rollover dates need to be aligned with what is sent by ICES reflecting PAC adjustments for previous HIP Plus segment.

If member is HIP Basic on day 120 and earned discount (being basic in prior benefit period), MCE 2 receives 834 001 change record with applicable rollover segments/corresponding rollover segments including potential plus loop.

If member earned a state discount (can be HIP Plus or HIP Basic at the time of application on day 120), then member dollars are transferred on the PRF with state rollover dollars and no pay record is sent. If a member is currently HIP Basic and earned a HIP Basic discount, then they will receive a HIP Potential Plus loop and that is on the 834 (DXC to MCE). 820 is received by the MCE on day 122.

In the final step, DXC receives the true up amount, member payments, and recuperates from inbound PRF for the prior benefit period. The 820 payments are processed and received by the MCE. The financial that cycle runs the second Wednesday of each month will account for true-up and amounts to be recuperated by the State.

On day 121, MCE 1 calculates claims/account usage that member incurred (all on the PRF), money is exchanged via the 820. MCE 2 loads PRF outbound data elements and applies rollover dollars.
Section 12: Member Communication on Rollover and Application

MCEs are required to send letters notifying members that they have earned rollover, how it is applied and what to expect going forward in the program in terms of payments in the following months. MCEs need to send examples of the below items.

Letter samples and notices informing members about rollover.

**Letters**

- Plus rollover applied to current Plus member with and without state match
  - Explanation that after credit is used up, member will need to continue paying PAC
- Plus rollover applied to current Basic member with and without state match
  - Letter should indicate if Basic member has moved to Plus because of rollover or if they have a reduced PAC and are not potential plus. An explanation will also be needed that after credit is used up, member will need to continue paying PAC
- Basic rollover applied to current Basic members
  - Version with only percent/dollar discount and version with member dollars and nonpayment penalty
  - Include explanation of Potential Plus where applicable
  - Amount of discount dollars applied to account going forward
  - For those with enough member dollars remaining for direct transfer to Plus, provide explanation of Plus transfer in addition to explanation that after the credit is used up member will need to pay PAC
- Basic rollover applied to current Plus member
  - Version with only percent/dollar discount and version with member dollars and non-payment penalty
  - Explanation that discount is applied to entire current Plus period (including previous months member was Plus) and is applicable for the rest of the benefit period as long as the member stays in Plus
  - Amount of discount and amount of credit if any for PACs already paid in year, explanation that after the credit is used up that the member will need to continue paying PAC

**Invoices**

- Invoices clearly showing the dollar discount for members that owe PAC and earned a dollar discount
- When member owes part of a PAC after having a credit applied, invoice clearly showing the remaining rollover credit applied to the account and the balance due.
POWER Account Statements

- Clearly showing any member or state dollar credits on the account and explaining they are because of rollover

Call Scripts Explaining Rollover to Members

- Provide script scenarios of what MCE call center representatives are expected to say when asked questions about rollover
Section 13: POWER Account Debt Collection Process

At 120 calendar days following a member’s termination, the managed care entity (MCE) must notify the State fiscal agent of the amount of the member and state refunds and other data. However, initial PRF [Initial Rollover (IP), Initial Termination (IT), Initial Rollover (IR), and Initial Rollover Plan Transfer (IX)] was received by DXC by day 30. This information must be provided on the PRF. The MCE may collect any member debt from the member portion of rollover funds determined in accordance with the rollover calculations specific to HIP Plus and HIP Basic.

Healthy Indiana Plan (HIP) members are responsible for a share of the deductible. A member may incur debt to the MCEs through using the pre-funded POWER Account before fully funding the member’s pro-rata share of the deductible. POWER Account contributions are member contributions toward a deductible and are not a monthly premium. Member debt is based on the percent of the deductible the member was responsible for and how much of the POWER Account was spent to pay the deductible. Based on the HIP 2.0 CMS Special Team (STCs) member debt is subject to maximum liability limitations.

Relative to rollover, member debt may be collected from member rollover. Any current year past due balances are reconciled before calculating rollover; prior year’s debt would be subtracted from member rollover dollars after State matching dollars are calculated. Under no circumstances shall State rollover funds be used to pay member debt. State matching funds must be calculated before determining member owed debt. The owed amount can then be deducted from the amount of member dollars being rolled over into the benefit period.

For purposes of clarification, only the pre-funded amount of the deductible that was used by the member, but not paid before termination or transfer to HIP Basic, will become a debt to the MCE. However, under no circumstance may member debt exceed the following amounts:

- For members with household income above 100% federal poverty level (FPL), the amount must not exceed 10% of the costs of services received,
- For members with household income at or below 100% FPL, the amount must not exceed the sum of the unpaid required monthly contributions during months in which the member received HIP Plus coverage, but was not contributing to the POWER Account.

The MCE may collect any debt owed by the member to the MCE. The MCE must send a letter to the individual explaining they owe debt and the amount owed. If the MCE pursues the member debt, then the MCE must do so in accordance with standard company practice for collection of debt in the individual market segment. However, the MCE may NOT use any of the following debt collection measures in the collection of member debt:

- Sell the member’s debt
- Report the debt to credit reporting agencies
- Place a lien on the member’s home
- Refer the case to debt collector
- File a lawsuit
- Seek a court order to seize a portion of the member’s earnings

The MCE may also collect debt out of the refunds owed to its member, as well as from the member’s portion of rollover each year. All debt collected must be reported in quarterly reporting according to the Reporting Manual and may be subject to an audit. Any debt collected from the member must apply
toward the member’s quarterly 5% cost sharing maximum. However, debt collected out of member refunds or rollover funds do not apply toward the member’s quarterly 5% cost sharing maximum.

**Member pro rata share**

Member pro rata share is equal to the proportion of the POWER Account the member is responsible for contributing.

The proportion is calculated by: Total member annual POWER Account contribution/$2,500.

Taking the resulting proportion and multiplying it by any claims incurred yields member pro rata share of claims.

**Debt for members under 100% FPL**

The amount of debt a member under 100% FPL may accrue is capped at an amount equal to

- The amount of their pro rata share, less contributions made by the member during the coverage term, whatever is less
- The amount of the member’s missed contributions for the months they received HIP Plus and did not pay their contributions, whatever is less.

**Example 1:** Member A has an annual POWER Account contribution responsibility of $120 which the member pays in monthly $10 installments. Member A pays their POWER Account contribution for the first two months of coverage and then stops paying. After a 60 day nonpayment grace period, the member is moved to from HIP Plus to HIP Basic effective the first of the month after the expiration of the grace period. The member has incurred $500 in claims during their HIP Plus enrollment.

The following table shows the calculation of debt for member A.

<table>
<thead>
<tr>
<th>Table 13.1 – Calculation for member A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member pro rata share</td>
</tr>
<tr>
<td>Member pro rata share of claims</td>
</tr>
<tr>
<td>Member contributions paid</td>
</tr>
<tr>
<td><strong>True Debt:</strong> Member remaining share of claims</td>
</tr>
<tr>
<td><strong>Debt Cap:</strong> Member missed contributions</td>
</tr>
<tr>
<td><strong>Maximum debt check</strong></td>
</tr>
<tr>
<td>$4&lt; $20</td>
</tr>
<tr>
<td>Member debt</td>
</tr>
</tbody>
</table>

In this example the members pro rata share of claims incurred is less than the unpaid contributions for the months they had Plus coverage without paying a contribution. The member debt is the lesser amount of $4.

**Example 2:** Member B has an annual POWER Account contribution responsibility of $60 which the member pays in monthly $5 installments. Member B pays their POWER Account contribution for the first month of coverage and then stops paying. After a 60 day nonpayment grace period, the member is moved to from HIP Plus to HIP Basic effective the first of the month after the expiration of the grace period. The member has incurred $1,500 in claims.

The following table shows the calculation of debt for member B.
Debt for members over 100% FPL

The amount of debt a member over 100% FPL may accrue is capped at an amount equal to

- The members pro rata share of claims incurred, less contributions made by the member
- Ten percent of the cost of services received, whichever is less

**Example 3:** Member C has an annual POWER Account contribution responsibility of $240 which the member pays in monthly $20 installments. Member C pays their POWER Account contribution for the first three months of coverage and then stops paying. The member is subject to nonpayment lockout effective the first of the month following the end of their 60 day grace period. The member has incurred $1,000 in claims during their HIP Plus enrollment.

The following table shows the calculation of debt for Member C:

<table>
<thead>
<tr>
<th>Table 13.3 – Calculation for member C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member pro rata share</td>
</tr>
<tr>
<td>Member pro rata share of claims</td>
</tr>
<tr>
<td>Member contributions paid</td>
</tr>
<tr>
<td>Member remaining share of claims incurred</td>
</tr>
<tr>
<td>Maximum debt check</td>
</tr>
<tr>
<td>Member debt</td>
</tr>
</tbody>
</table>

In this example the members pro rata share of claims incurred is less than 10% of the cost of services received. The member debt is the lesser amount of $36.

**Example 4:** Member D has an annual POWER Account contribution responsibility of $300 which the member pays in monthly $25 installments. Member D pays their POWER Account contribution for the first month of coverage and then stops paying. The member is subject to nonpayment lockout effective the first of the month following the end of their 60 day grace period. The member has incurred $2,000 in claims during their HIP Plus enrollment.

The following table shows the calculation of debt for Member D.

<table>
<thead>
<tr>
<th>Table 13.4 – Calculation for member D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member pro rata share</td>
</tr>
<tr>
<td>Member pro rata share of claims</td>
</tr>
<tr>
<td>Member contributions paid</td>
</tr>
<tr>
<td>Member remaining share of claims incurred</td>
</tr>
<tr>
<td>Maximum debt check</td>
</tr>
</tbody>
</table>
$215 < ($2,000 *10%)  |  FALSE

Member debt  |  ($2,000 * .10) = $200

In this example the members pro rata share of claims incurred is more than 10% of the cost of services received. The member debt is the lesser amount of $200.

Collection of Debt

Collection of member debt is subject to 5% quarterly cost sharing limits, accounting for other cost sharing being paid by the member. Any debt paid by the member during the quarter needs to be included in the member 5% cost-sharing limit. If the MCE is aware, or has proof provided by the member of debt paid equal to 5% of their quarterly income, then all other cost sharing should stop for the remainder of the quarter, with the exception of the $1 minimum HIP Plus contribution.

Late Contributions

The STCs indicate that members may have rolling nonpayment periods. Each invoice must be paid within 60 days of the due date. The member does not have to be completely current within 60 days of the due date.

Claims Debt after Refunds

Until July 2016, member refunds are due to members 60 days after the close of their termination from HIP. Members that have been issued a refund, and have a claim received after the refund, but before the Power Account Reconciliation, may not be assigned any claims debt. The State will not fund this debt during the PRF process. The MCE is responsible for adjusting the debt if this occurs. MCEs adjusting the debt is a short-term process and effective July 2016, account reconciliation and refunds occur after 120 days, which eliminates the possibility for this solution to occur.

Past Due Payments and Debt

After a member has been subject to a negative consequence for nonpayment, including dropping to HIP Basic or HIP Plus Copay or termination from HIP, any past due amounts owed by the member become member debt. Repayment of member debt cannot be a contingency of re-entry into HIP or re-entry in HIP Plus if the member receives a potential plus segment.

Example 1: HIP Member starts coverage in January as a HIP Plus Member. Member drops to HIP Basic in April. In May, member gets a potential plus segment. The MCE may only require the member to pay the one month of PAC on the potential plus segment for the member to re-enter HIP Plus. Unpaid balances from the prior plus segment can be collected subject to the debt restrictions.

Example 2: HIP Member terminates from coverage because of nonpayment in May. The member is eligible for a lockout exemption and comes back in for coverage with the same MCE in July. The member pays their PAC amount for July. This payment cannot be applied to the member’s prior nonpayment but must count as a payment in the current benefit period. The prior nonpayments may be collected from the member subject to debt limitations.
## Rollover Scenario Overview

The following table shows the rollover scenario.

<table>
<thead>
<tr>
<th>Rollover Earned in Prior BP</th>
<th>Current HIP Status</th>
<th>Preventive Services (Y/N)</th>
<th>Remaining $2,500 (Y/N)</th>
<th>Member $ Remaining (Y/N)</th>
<th>State Match (Y/N)</th>
<th>State Discount (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Plus</td>
<td>Basic</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>n/a</td>
</tr>
<tr>
<td>2. Plus</td>
<td>Basic</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>3. Plus</td>
<td>Basic</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>n/a</td>
</tr>
<tr>
<td>4. Plus</td>
<td>Basic</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>n/a</td>
</tr>
<tr>
<td>5. Plus</td>
<td>Plus</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>n/a</td>
</tr>
<tr>
<td>6. Plus</td>
<td>Plus</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7. Plus</td>
<td>Plus</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>n/a</td>
</tr>
<tr>
<td>8. Plus</td>
<td>Plus</td>
<td>N</td>
<td>Y</td>
<td>debt +</td>
<td>N</td>
<td>n/a</td>
</tr>
<tr>
<td>9. Basic</td>
<td>Basic</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>10. Basic</td>
<td>Basic</td>
<td>N</td>
<td>Y</td>
<td>n/a</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>11. Basic</td>
<td>Basic</td>
<td>Y</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>12. Basic (started out as Plus)</td>
<td>Basic</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>13. Basic (started out as Plus)</td>
<td>Basic</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>14. Basic (started out as Plus)</td>
<td>Basic</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>15. Basic (Plus @ redeterm)</td>
<td>Basic</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>Y</td>
</tr>
<tr>
<td>16. Basic (Plus @ redeterm)</td>
<td>Basic</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>17. Basic</td>
<td>Plus</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
<td>Y</td>
</tr>
<tr>
<td>18. Basic</td>
<td>Plus</td>
<td>N</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>19. Basic</td>
<td>Plus</td>
<td>Y</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>20. Basic</td>
<td>Plus</td>
<td>N</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>21. Basic (started Plus, ended as B)</td>
<td>Plus</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>Y</td>
</tr>
<tr>
<td>22. Basic (started Plus, ended as B)</td>
<td>Plus</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
<td>N</td>
</tr>
<tr>
<td>23. Basic (started Plus, ended yr B)</td>
<td>Plus</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>n/a</td>
<td>N</td>
</tr>
</tbody>
</table>

### Definitions

- **n/a**: Invalid for type of rollover earned
- **debt+**: Member’s income increased, PAC changed, member owes $.

Note: This always rolls over when Y – also maybe * the ones that should have a 25% penalty applied.
Rollover Scenarios

There are eight scenarios described in the DXC business design document.

**Scenario 1 - Plus to Plus with preventive services (PS) and no penalty**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Monthly PAC</td>
<td>$10</td>
<td>$112</td>
</tr>
<tr>
<td>Member PAC paid</td>
<td>$120</td>
<td>$60</td>
</tr>
<tr>
<td>Claims Used</td>
<td>$1,500</td>
<td>$500</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>State Matching Dollars</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>State Discount (Basic rollover earned)</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Basic Flag</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Year 1 (day 120 of year 2)</th>
<th>Year 2 (YR 2 Post final PRF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Responsibility</td>
<td>$72</td>
<td>$28.80</td>
</tr>
<tr>
<td>Member Dollars Remaining</td>
<td></td>
<td>$96</td>
</tr>
<tr>
<td>Discount Earned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential Plus PAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Dollar Discount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base Rollover</td>
<td>$48</td>
<td>$115.20</td>
</tr>
<tr>
<td>Total Rollover Net of penalty</td>
<td>$96</td>
<td>$115.20</td>
</tr>
<tr>
<td>Member Refund</td>
<td>None</td>
<td>$12</td>
</tr>
<tr>
<td>Refund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Debt</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Result: Member rollover dollars are applied as credit on the account. PACs owed in future months are deducted from the rollover amount, member is remaining in Plus. If enough to cover more than just prospective months, then member currently year payments may result in a refund. Member did not receive preventive services, therefore no state dollars are matched and rolled over.
## Scenario 2 - HIP Plus to HIP Basic with no penalty and received PS

Table 13.7 – HIP Plus to Basic with no penalty and received PS

<table>
<thead>
<tr>
<th>Member was Plus in year 1, started off year 2 as Plus and stopped paying in month 4 and dropped to Basic by the time rollover is applied. There is no penalty applied since member was Plus in the previous benefit period. Member received preventive services as a Plus member.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
</tr>
<tr>
<td>Required Monthly PAC</td>
</tr>
<tr>
<td>Member PAC paid</td>
</tr>
<tr>
<td>Claims Used</td>
</tr>
<tr>
<td>Preventive Services</td>
</tr>
<tr>
<td>State Matching Dollars</td>
</tr>
<tr>
<td>State Discount (Basic rollover earned)</td>
</tr>
<tr>
<td>Basic Flag</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
</tr>
<tr>
<td>Claims Responsibility</td>
</tr>
<tr>
<td>Member dollars Remaining</td>
</tr>
<tr>
<td>Discount (earned Basic rollover)</td>
</tr>
<tr>
<td>Potential Plus PAC</td>
</tr>
<tr>
<td>State Dollar Discount</td>
</tr>
<tr>
<td>Base Rollover</td>
</tr>
<tr>
<td>Total Rollover net of penalty</td>
</tr>
<tr>
<td>Member Refund</td>
</tr>
<tr>
<td>Penalty</td>
</tr>
<tr>
<td>Claims Debt</td>
</tr>
</tbody>
</table>

**Result:** Member and state rollover dollars applied as a credit on the account. Member goes potential plus. If there is enough rollover to cover at least one month's PAC, then the MCE sends a pay file. Member invoice should show that they got rollover and that this was applied and they owe $0 for Plus coverage. Otherwise the member gets an invoice showing their one month PAC discount.

**NOTE:** MCEs need to test to ensure a penalty is not placed on the incurred debt. Debt cannot incur the 25% penalty.
### Scenario 3 - HIP Basic to HIP Plus with member remaining dollars, penalty, and PS

Table 13.8 – HIP Basic to HIP Plus with member remaining dollars, penalty and PS

<table>
<thead>
<tr>
<th>Member started out as Plus during benefit period 1, made payments of $5 a month then stopped paying and dropped to Basic and ended their benefit period with a Basic Status. As a result, the member will incur a penalty on their rollover amount. Member received preventive services. In year 2, Member bought up to Plus at redetermination.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
</tr>
<tr>
<td>Required Monthly PAC</td>
</tr>
<tr>
<td>Member PAC paid</td>
</tr>
<tr>
<td>Claims Used</td>
</tr>
<tr>
<td>Preventive Services</td>
</tr>
<tr>
<td>State Matching Dollars</td>
</tr>
<tr>
<td>State Discount (Basic rollover earned)</td>
</tr>
<tr>
<td>Basic Flag</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
</tr>
<tr>
<td>YR 1, day 120 of year 2</td>
</tr>
<tr>
<td>Total Member Payments</td>
</tr>
<tr>
<td>Claims responsibility</td>
</tr>
<tr>
<td>Member Dollars Remaining</td>
</tr>
<tr>
<td>Discount (Earned Basic Rollover)</td>
</tr>
<tr>
<td>Potential Plus PAC</td>
</tr>
<tr>
<td>State Dollar Discount</td>
</tr>
<tr>
<td>Base Rollover</td>
</tr>
<tr>
<td>Total Rollover</td>
</tr>
<tr>
<td>Member Refund</td>
</tr>
<tr>
<td>Penalty</td>
</tr>
<tr>
<td>Claims Debt</td>
</tr>
</tbody>
</table>

**Result:** Percent discount from basic rollover is applied to PAC during the second benefit period. Member rollover dollars apply to PAC, $20.70 (base rollover). Member received preventive services during BP 1 as a Plus member. Percent discount applies to the entire Plus period (BP 2 since they bought up to Plus at redetermination), not just prospectively. PACs are not retroactively adjusted, but if the member owed $10 a month for the first 5 months and qualifies for a 50% discount, then the member should get a $5 credit (a month) and a 50% discount on each subsequent PAC. Member dollars ($27.60, less the 25% penalty = $20.70), are applied as a rollover credit on the account (months 6 to part of 10). Member still owes $4.30 (October) and $5 each (Nov/Dec) because of discount, which can be taken from their $50 payment (months 1–5), leaving a balance to be refunded of $10.70 because they overpaid by $25 for months 1 – 5.
Scenario 4 - HIP Basic to HIP Plus with penalty and no PS

Table 13.9 – HIP Basic to HIP Plus with penalty and no PS

| Member started out as Plus, made payments of $5 a month then stopped paying and dropped to Basic and ended their benefit period with a Basic Status. As a result, the member will incur a penalty on their rollover amount. Member did not get preventive services. Member is currently Plus at the time rollover is applied. |
| Inputs | Year 1 | Year 2 |
| Required Monthly PAC | $5 | $10 |
| Member PAC paid | $30 | $50 |
| Claims Used | $100 | $2,500 |
| Preventive Services | N | N |
| State Matching Dollars | N | N |
| State Discount (Basic rollover earned) | N | N |
| Basic Flag | Y | Y |
| Outputs | Year 1 (day 120 of year 2) | Year 2 (YR 2 Post final PRF) |
| Total Member Payments | $70.70 (first five months of second BP before rollover processed) $50 + $20.70 total rollover |
| Claims responsibility | $2.40 | $120 |
| Member Dollars Remaining | $27.60 | $20.70 |
| Discount (Earned Basic Rollover) | 0 | n/a |
| Potential Plus PAC | | |
| State Dollar Discount | | |
| Base Rollover | $27.60 | n/a |
| Total Rollover net penalty | $20.70 (with penalty) | n/a |
| Member Refund | None | 0 |
| Penalty | 6.90 | n/a |
| Claims Debt | $0 | $49.30 |

Result: Member dollars rollover, less the 25% penalty, are applied as credit on the account and reduce the member's PAC. MCE should bill the member for the remaining PAC balance in the coming months.
**Scenario 5 – HIP Basic to HIP Basic with member remaining dollars and received PS**

Table 13.10 – Basic to Basics with member remaining dollars and received PS

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Monthly PAC</td>
<td>$5</td>
<td>$0</td>
</tr>
<tr>
<td>Member PAC paid</td>
<td>$30</td>
<td>$0</td>
</tr>
<tr>
<td>Claims Used</td>
<td>$100</td>
<td>$2,500</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>State Matching Dollars</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>State Discount (Basic rollover earned)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Basic Flag</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Outputs</td>
<td>Year 1 (day 120 of year 2)</td>
<td>Year 2 (YR 2 Post final PRF)</td>
</tr>
<tr>
<td>Total Member Payments</td>
<td>$30</td>
<td>n/a Basic @ BP 2</td>
</tr>
<tr>
<td>Claims responsibility</td>
<td>$2.40</td>
<td>$70</td>
</tr>
<tr>
<td>Member Dollars Remaining</td>
<td>$27.60</td>
<td>$0</td>
</tr>
<tr>
<td>Discount (Earned Basic Rollover)</td>
<td>50% (potential Plus)</td>
<td>n/a</td>
</tr>
<tr>
<td>Potential Plus PAC</td>
<td>$0</td>
<td>$10</td>
</tr>
<tr>
<td>State Dollar Discount</td>
<td>$0</td>
<td>$5</td>
</tr>
<tr>
<td>Base Rollover</td>
<td>$27.60</td>
<td>n/a</td>
</tr>
<tr>
<td>Total Rollover net of penalty</td>
<td>$20.70</td>
<td>n/a</td>
</tr>
<tr>
<td>Member Refund</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Penalty</td>
<td>6.90</td>
<td>n/a</td>
</tr>
<tr>
<td>Claims Debt</td>
<td>$0</td>
<td>$14.30</td>
</tr>
</tbody>
</table>

Result: Member was in Plus and made contribution, but since member is Basic (end of BP), percent discount only applies going forward, even if member had a prior month of plus coverage in the BP. In month 6 of BP 2, member has a rollover balance of $20.70 (includes $6.90 penalty) as a Basic member and the 834 indicates they are potential plus. The member’s PAC is $10/month, and the rollover credit is applied to cover month 6, 7,8,9 and part of month 10 ($70). Percent discount from basic rollover is applied to current year PAC and member dollars apply to first month’s PAC. Member dollars, less the 25% penalty, are applied as a credit on the account. If there are enough member dollars to pay for at least one month of PAC, then MCE sends a pay file and the member moves to HIP Plus. Remaining member dollars can be applied to remaining year’s PACs. If there are not enough member dollars to move into HIP Plus, then the dollars are applied to the current month’s required PAC and member gets an invoice for the balance.
Scenario 6 - Basic to Basic with member remaining dollars and no PS

Table 13.11 – Basic to Basic with member remaining dollars and no PS

| Member started out BP 1 as a plus member, paid $5 a month for six months and then stopped paying. Member’s income is 100% of the federal poverty level and drops to Basic by 8 and they are 2 months in arrears. Member ends BP 1 as a Basic Member and does not buy up to Plus at the beginning of the following benefit period. Member remains Basic. |

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Monthly PAC</td>
<td>$5</td>
<td>$0</td>
</tr>
<tr>
<td>Member PAC paid</td>
<td>$30</td>
<td>$0</td>
</tr>
<tr>
<td>Claims Used</td>
<td>$100</td>
<td>$2,500</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>State Matching Dollars</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>State Discount (Basic rollover earned)</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Basic Flag</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Year 1 (day 120 of year 2)</th>
<th>Year 2 (YR 2 Post final PRF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Member Payments</td>
<td>$30</td>
<td>n/a (basic member) at start of BP 2</td>
</tr>
<tr>
<td>Claims responsibility</td>
<td>$2.40</td>
<td>$70 (assuming month 6 is application month)</td>
</tr>
<tr>
<td>Member Dollars Remaining</td>
<td>$27.60</td>
<td>$20.70</td>
</tr>
<tr>
<td>Discount (Earned Basic Rollover)</td>
<td>No preventive services</td>
<td>n/a</td>
</tr>
<tr>
<td>Potential Plus PAC</td>
<td>$0</td>
<td>$10</td>
</tr>
<tr>
<td>State Dollar Discount</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Base Rollover</td>
<td>$27.60</td>
<td>n/a</td>
</tr>
<tr>
<td>Total Rollover Net of Penalty</td>
<td>$20.70</td>
<td>n/a</td>
</tr>
<tr>
<td>Member Refund</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Penalty</td>
<td>6.90</td>
<td>n/a</td>
</tr>
<tr>
<td>Claims Debt</td>
<td>$0</td>
<td>$49.30</td>
</tr>
</tbody>
</table>

Result: Member dollars, less the 25% penalty, are applied as a credit on the account. If there are enough member dollars to pay for at least one month of PAC, then the MCE sends a pay file and the member moves to HIP Plus. Remaining member dollars can be applied to remaining year's PAC. If there are not enough member dollars to move the member into HIP Plus, then the dollars are applied to the current month's PAC and the member receives an invoice for the balance.
### Scenario 7 - HIP Basic to HIP Plus and received PS

Table 13.12 – *HIP Basic* to *HIP Plus* and received PS

Member earned a basic discount and bought up to Plus at redetermination. Member remains Plus through rollover and discount is applied to the first 5 months.

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required Monthly PAC</strong></td>
<td>$0</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Member PAC paid</strong></td>
<td>$0</td>
<td>$72</td>
</tr>
<tr>
<td><strong>Claims Used</strong></td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>State Matching Dollars</strong></td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td><strong>State Discount (Basic rollover earned)</strong></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Basic Flag</strong></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td>Year 1 (day 120 of year 2)</td>
<td>Year 2 (YR 2 Post final PRF)</td>
</tr>
<tr>
<td><strong>Total Member Payments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Claims Responsibility</strong></td>
<td>n/a</td>
<td>$72</td>
</tr>
<tr>
<td><strong>Member Dollars remaining</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discount</strong></td>
<td>40%</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Potential Plus PAC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>State Dollar Discount</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Base Rollover</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total Rollover net of penalty</strong></td>
<td>$0</td>
<td>Months 1-5 ($10, member overpaid by $4/mo). Credit = $20 applied to new PAC of $6/month (starting month 6)n/a</td>
</tr>
<tr>
<td><strong>Member Refund</strong></td>
<td>None</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Penalty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Claims Debt</strong></td>
<td>$0</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**Result:** Discount applied to member PAC based on POWER Account funds remaining. Percent discount applies to the entire Plus period starting in the second benefit period, not just prospectively. PACs are not retroactively adjusted, but if the member owed $10 a month for the first 5 months and qualifies for a 40% discount, then the member gets a $4 credit (for months 1-5) and a 40% discount on each subsequent PAC. Member remains in Plus but gets their Basic discount applied to their current PAC, and a credit for the discount on the first 5 months of coverage.
**Scenario 8 - HIP Basic to HIP Basic with PS**

Table 13.13 – *HIP Basic to HIP Basic with PS*

<p>| Member earned Basic rollover. Currently Basic in benefit period 2 and has preventative services. Member was never Plus in year 1 and they do not have any remaining dollars |</p>
<table>
<thead>
<tr>
<th>Inputs</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Monthly PAC</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Member PAC paid</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Claims Used</td>
<td>$1,500</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>State Matching Dollars</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>State Discount (Basic rollover earned)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Basic Flag</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Outputs</td>
<td>Year 1 (day 120 of year 2)</td>
<td>Year 2 (YR 2 Post final PRF)</td>
</tr>
<tr>
<td>Claims responsibility</td>
<td>$0</td>
<td>n/a</td>
</tr>
<tr>
<td>Member Dollars Remaining</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discount earned</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Potential Plus PAC</td>
<td>n/a</td>
<td>$6/month ($10/mo. less $4 discount)</td>
</tr>
<tr>
<td>Plus to Plus with preventive services (PS) and no penalty</td>
<td>Plus to Plus with preventive services (PS) and no penalty</td>
<td>Plus to Plus with preventive services (PS) and no penalty</td>
</tr>
<tr>
<td>Base Rollover</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total Rollover net of penalty</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Member Refund</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Claims Debt</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>

**Result:** Member goes Potential Plus starting month 6 and receives 40% discount applied to PAC owed going forward. Discount is calculated based on remaining POWER Account funds. Because member is in *HIP Basic*, discount only applies prospectively.
Overview

This section provides information about the services that are covered and excluded from the various programs covered by the managed care umbrella. Covered services for Hoosier Healthwise and Healthy Indiana Plan (HIP) are identified separately when necessary. Information is also included about in-network versus out-of-network services and self-referral services.

Continuity of care is very important to member outcomes, and this section also includes information about members who must transfer to another program because of pregnancy, long-term care, and so forth.

Hoosier Healthwise Covered Services

The services covered by MCEs for which capitation payments are received must be provided to the member in an amount, duration, and scope that is no less than the IHCP-covered services detailed in State regulation 405 IAC 5, in accordance with federal regulation 42 CFR 438.210. Services excluded from the MCE’s scope of responsibility but covered by the Indiana Health Coverage Programs (IHCP) are referred to as carve outs and are addressed later in this section.

Detailed explanations of Medicaid-covered services and limitations are cited in 405 IAC 5; Children's Health Insurance Program (CHIP) (Package C) in 405 IAC 13. The following are broad categories of services provided by the MCE in arrangement with the State:

• Physician services
  – Primary care services
  – Preventive health services (including vaccinations added to the periodicity schedule but not yet available through the Vaccines for Children program)
  – Therapeutic and rehabilitative services
  – Specialty care services

• Hospital services
  – Inpatient care
  – Outpatient services
  – Therapy services
  – Diagnostic studies

• Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
  – Initial and periodic screenings
  – Diagnosis and treatment

• Home health services
  – Physical, occupational, and respiratory therapy
  – Speech pathology
  – Renal dialysis

• Medical supplies and equipment
  – Medical supplies and durable medical equipment
  – Braces and orthopedic shoes
  – Prosthetic devices
  – Hearing aids

• Transportation services
  – Emergency transportation
Section 14: Covered Services

Hoosier Healthwise and Healthy Indiana Plan
MCE Policies and Procedures Manual

14-2

Library Reference Number: MC10009
Published: February 8, 2018
Policies and Procedures as of March 1, 2017
Version: 7.1

– Nonemergency transportation (not available under Package C)
– Transportation
• Diabetes self-management services
• Pregnancy care coordination
• Prenatal care programs targeted to provide better outcomes in high-risk pregnancies
• Newborn healthcare and parenting education
• Smoking cessation services
• Behavioral health services, such as mental health, substance abuse, and chemical dependency services
• Applied Behavioral Analysis (ABA) Therapy
• Chiropractor
• Dental Services
• Prescription Drugs
• Urgent Care Services
• Vision
• Family Planning Services
• Food Supplements, Nutritional Supplements, and Infant Formulas
• Laboratory and Radiology Services
• Podiatry

Special provisions for specific types of service, coverage, and payment policies apply to some services and providers. These provisions, discussed later in this section, include the following:

• Emergency care services
• Out-of-network services
• Self-referral services
• Behavioral health services
• EPSDT services
• Federally qualified health centers (FQHCs) and rural health clinics (RHCs)
• Extended hospital stays for children involved in investigations by protective services
• Hoosier Healthwise carve outs and related services
• Short-term placements in long-term care facilities
• Continuity of care
• Twenty-four hour nurse call line
• Women, Infants, and Children (WIC) program infant formula
• Disease management

Healthy Indiana Plan Covered Services

The following benefits and services are eligible for coverage under the HIP. Pursuant to State regulation 405 IAC 10, the HIP Basic and HIP Plus Alternative Benefit Plans, detailed in the State Plan and a
federal special terms and conditions waiver, these benefits and services must be covered by the MCE if they are medically necessary, not listed as a noncovered benefit or service, or otherwise excluded from coverage.

Table 14.1 – HIP Covered Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description of Amount, Duration, and Scope</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Essential Health Benefits (EHB) Category: Ambulatory Patient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Services ²</td>
<td>Covered Service</td>
<td>1905(a)(5)</td>
</tr>
<tr>
<td>Specialty Physician Visits</td>
<td>Covered Service</td>
<td>1905(a)(5)</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Covered Service. 100 visits per year</td>
<td>1905(a)(7)</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Not Covered</td>
<td>1905(a)(6)</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Covered Service</td>
<td>1905(a)(2)</td>
</tr>
<tr>
<td>TMJ</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Covered Service</td>
<td>1905(a)(13)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered Service</td>
<td></td>
</tr>
<tr>
<td>IV Infusion Services</td>
<td>Covered Service</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered Service</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered Service</td>
<td></td>
</tr>
<tr>
<td>Dental Services</td>
<td>Not Covered</td>
<td>2105(c)(5)</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Not Covered</td>
<td>1905(a)(6)</td>
</tr>
<tr>
<td><strong>EHB Category: Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department Services</td>
<td>Covered Service. Nonemergency visits to the emergency department subject to $8 or $25 copayment</td>
<td>1905(a)(29)</td>
</tr>
<tr>
<td>Emergency Transportation: Ambulance and Air Ambulance</td>
<td>Covered Service</td>
<td></td>
</tr>
</tbody>
</table>

² Includes advanced practice registered nurse practitioners (APRNs).
### Section 14: Covered Services

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care/Emergency Clinics (non-hospital facilities)</td>
</tr>
</tbody>
</table>

**Description of Amount, Duration, and Scope**

| Benefit | Description of Amount, Duration, and Scope |
|-----------------|
| Covered Service |

### EHB Category: Hospitalization

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Inpatient Hospital Care</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
</tr>
<tr>
<td>Inpatient Surgical Services</td>
</tr>
<tr>
<td>Non-Cosmetic Reconstructive Surgery</td>
</tr>
<tr>
<td>Transplants</td>
</tr>
<tr>
<td>Congenital Abnormalities Correction</td>
</tr>
<tr>
<td>Anesthesia</td>
</tr>
<tr>
<td>Hospice Care</td>
</tr>
</tbody>
</table>

**Reference**

| Benefit | Reference |
|-----------------|
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(18) |

**Skilled Nursing Facility**

| Benefit | Description of Amount, Duration, and Scope |
|-----------------|
| Skilled Nursing Facility | Covered Service. Limited to 100 days |

**Reference**

| Benefit | Reference |
|-----------------|
| Covered Service. Limited to 100 days | 1905(a)(4) |

### EHB Category: Mental Health and Substance Abuse

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental/Behavioral Health Inpatient Treatment</td>
</tr>
<tr>
<td>Mental/Behavioral Health Outpatient Treatment</td>
</tr>
<tr>
<td>Substance Abuse Inpatient Treatment</td>
</tr>
<tr>
<td>Substance Abuse Outpatient Treatment</td>
</tr>
</tbody>
</table>

**Reference**

| Benefit | Reference |
|-----------------|
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(2) |
| Covered Service | 1905(a)(1) |
| Covered Service | 1905(a)(2) |

### EHB Category: Prescription Drugs

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Tobacco cessation drugs</td>
</tr>
</tbody>
</table>

**Reference**

<p>| Benefit | Reference |
|-----------------|
| Covered Service | 1905(a)(12) |
| Covered Service | 1905(a)(12) |</p>
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description of Amount, Duration, and Scope</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy, Occupational Therapy, Speech Therapy</td>
<td>Covered Service. Limited to 60 combined visits</td>
<td>1905(a)(11), 1905(a)(13)</td>
</tr>
<tr>
<td></td>
<td>Covered Service. Limited to 75 combined visits</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered Service</td>
<td>1905(a)(29)</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>Covered Service</td>
<td>1905(a)(12)</td>
</tr>
</tbody>
</table>

**EHB Category: Laboratory**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Tests</td>
<td>Covered Service</td>
<td>1905(a)(3)</td>
</tr>
<tr>
<td>X-Rays</td>
<td>Covered Service</td>
<td>1905(a)(3)</td>
</tr>
<tr>
<td>Imaging – MRI, CT, and PET</td>
<td>Covered Service</td>
<td>1905(a)(3)</td>
</tr>
<tr>
<td>Pathology</td>
<td>Covered Service</td>
<td>1905(a)(13)</td>
</tr>
</tbody>
</table>

**EHB Category: Preventive Care**

| Preventive Care Services | Covered Service. Limited to ACA required preventive services | 1905(a)(13) |

**Other Benefits**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency Transportation</td>
<td>Not Covered</td>
<td>1905(a)(10)</td>
</tr>
<tr>
<td>EPSDT for Ages 19 &amp; 20 Only</td>
<td>Covered Service</td>
<td></td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Not Covered</td>
<td>1905(a)(1)</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>Not Covered</td>
<td>1905(a)(4)</td>
</tr>
<tr>
<td>MRO</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Covered Service</td>
<td>1905(a)(29)</td>
</tr>
</tbody>
</table>

---

3 Includes services with an “A” or “B” rating from the United States Preventive Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and additional preventive care screenings for women as provided in the Health Resources and Services Administration guidelines.
## Table 14.2 – Pregnancy services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description of Amount, Duration, and Scope</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Essential Health Benefits (EHB) Category: Ambulatory Patient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Services</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Specialty Physician Visits</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Covered Service. No limits</td>
<td>1931</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Covered Service. 50 therapeutic treatments per year</td>
<td>1931</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>TMJ</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>IV Infusion Services</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td><strong>EHB Category: Hospitalization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Inpatient Hospital Care</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Inpatient Surgical Services</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Non-Cosmetic Reconstructive Surgery</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Transplants</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Congenital Abnormalities Correction</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
</tbody>
</table>

---

4 Includes advanced practice registered nurse practitioners (APRNs).
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description of Amount, Duration, and Scope</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Covered Service. No service limits</td>
<td>1931</td>
</tr>
<tr>
<td><strong>EHB Category: Mental Health and Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral Health Inpatient Treatment</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Mental/Behavioral Health Outpatient Treatment</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Substance Abuse Inpatient Treatment</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Substance Abuse Outpatient Treatment</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td><strong>EHB Category: Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Tobacco cessation drugs</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td><strong>EHB Category: Rehabilitative and Habilitative Services and Devices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy, Occupational Therapy</td>
<td>Covered Service. 12 visits every 30 days without Prior Authorization</td>
<td>1931</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td><strong>EHB Category: Laboratory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Tests</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>X-Rays</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Imaging – MRI, CT, and PET</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>Pathology</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td><strong>EHB Category: Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td><strong>Other Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-emergency Transportation</td>
<td>Covered Service</td>
<td>1931</td>
</tr>
<tr>
<td>EPSDT for Ages 19 &amp; 20 Only</td>
<td>Covered Service</td>
<td></td>
</tr>
</tbody>
</table>
Emergency Care

The MCEs must cover emergency services for all Hoosier Healthwise and HIP members without the need for prior authorization or the existence of a contract with the emergency care provider. Services for treatment of an emergency medical condition, as defined in 42 CFR 438.114 and IC 12-15-12 (subject to the prudent layperson standard), must be available 24 hours a day, seven days a week.

The MCE must cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24, provided to a member who presents to an emergency department with an emergency medical condition. The MCE must also comply with all applicable emergency services requirements specified in IC 12-15-12. For Hoosier Healthwise, the MCE must reimburse out-of-network providers at 100% of the Medicaid rate unless other payment arrangements are made. For HIP, the MCE must reimburse out-of-network providers at the standard HIP reimbursement rates established by the Secretary, unless other payment arrangements are made, as long as the provider is an IHCP provider (IHCP enrollment can be retroactively contracted to facilitate payment). HIP reimbursement rates are based on the comparable Medicare rate, or if there is no Medicare rate, a rate equal to 130% of the Medicaid rate. See the Hospital Assessment Fee module for more information.

The MCE is required to reimburse for the medical screening examination and facility fee for the screening. The MCE is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as emergency medical conditions, unless the MCE authorized the treatment.

In accordance with 42 CFR 438.114, the MCE may not determine what constitutes an emergency on the basis of lists of diagnoses or symptoms. The MCE may not deny payment for treatment obtained when a member had an emergency medical condition, even if the outcomes, in the absence of immediate medical attention, would not have been those specified in the definition of emergency medical condition. The MCE may not deny or pay less than the allowed amount for the Current Procedural Terminology (CPT) code on the claim without a medical record review. When the
MCE conducts a prudent layperson review to determine whether an emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in medicine, nursing, or social work.

The MCE is prohibited from refusing to cover emergency services if the emergency room provider, hospital, or fiscal agent does not notify the member’s primary medical provider (PMP) or the MCE of the member’s screening and treatment within 10 calendar days of presentation for emergency services. The member who has an emergency is not liable for the payment of subsequent screening and treatment required to diagnose or stabilize the specific condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. The physician’s determination is binding, and the MCE may not challenge the determination.

The MCE must comply with policies and procedures set forth in the Emergency Services module regarding emergency room services. If a prudent layperson review determines the service was not an emergency, then the MCE must reimburse for physician services billed on a CMS-1500 claim form. The MCE must reimburse for facility charges billed on a UB-04 claim form if a prudent layperson review determines the service was not an emergency.

The MCE must demonstrate to the State that it has the following mechanisms in place to facilitate payment for emergency services and manage emergency room utilization:

- A mechanism for a plan provider or MCE representative to respond within one hour to all emergency room providers 24 hours per day, seven days per week. The MCE is financially responsible for the post-stabilization services if the MCE fails to respond to a call from an emergency room provider within one hour.
- A mechanism to track the emergency services notification to the MCE (by the emergency room provider, hospital, fiscal agent, or member’s PMP) of a member’s presentation for emergency services.
- A mechanism to document that a member’s PMP referred the member to the emergency room and to pay claims accordingly.
- A mechanism to document a HIP member’s referral to the emergency room by the MCE’s 24-Hour Nurse Call Line, and to waive emergency room copayments for HIP members accordingly. This requirement includes a mechanism to communicate the copayment waiver to the emergency services provider.
- A mechanism to document a HIP member’s inappropriate emergency department utilization, and to communicate emergency room copayments for HIP members accordingly.
- A mechanism and policies and procedures for conducting prudent layperson reviews.

**Post Stabilization Care**

As described in 42 CFR 438.114(e) and IC 12-15-12, the MCE must cover post-stabilization services related to an emergency medical condition to maintain, improve, or resolve the member’s condition. The MCE must demonstrate to the State that it has a mechanism in place to respond to emergency room providers’ requests for authorization to continue post-stabilization care. MCEs must respond to these requests within one hour, 24 hours per day, seven days per week.

**Emergency Room Copayment Procedure for Healthy Indiana Plan**

Except for HIP members otherwise exempt from cost-sharing, a copayment applies when a HIP member uses the emergency room (ER) for nonemergency services, as specifically described in 405 IAC 10-7-9. Providers will collect the copayment from the member, and POWER Account funds cannot be used by the member to pay the nonemergency copayment. The MCE must include copayment information on the member’s ID card that directs the provider to call the MCE for the specific copayment amount due. Provider payments are reduced by the applicable copayment amount.

Most HIP members will incur an $8 copayment for their first inappropriate ER visit; any subsequent inappropriate ER visit within the same 12-month benefit period will require a $25 copayment. The Emergency Room Copay Protocol
provides additional detail and describes how the State plans to test the previous graduated copayment structure for nonemergency use of the ER. The test will examine whether a $25 copay for recurrent nonemergent use of the emergency department reduces unnecessary emergency room use without meaningful harm to the beneficiary’s health.

As part of this test, the State will also identify a control group of HIP members who are exempt from graduated copayments and instead are required to pay an $8 copayment for each inappropriate ER visit. The MCE must also identify control group members and be able to communicate the appropriate copayment amount to providers. In addition, the MCE must track inappropriate ER utilization for members subject to the graduated copayments and members who participate in the control group.

HIP members who are exempt from cost-sharing (for example, members who are pregnant or members identified as American Indians/Alaska Natives (AIs/ANs), pursuant to 42 CFR 136.12), will not be required to pay copayments for nonurgent use of hospital ER services.

The member must receive an appropriate medical screening examination under Section 1867 of the Emergency Medical Treatment and Active Labor Act. Any applicable copayments must be waived or returned if the member is found to have an emergency condition, as defined in Section 1867(e)(1)(A) of the Emergency Medical Treatment and Active Labor Act, or if the person is admitted to the hospital within 24 hours of his or her original visit. In addition, the member copayment must be waived for any member who contacts the MCE’s 24-hour Nurse Call Line before utilizing the ER. The 24-Hour Nurse Call Line should advise members on their medical conditions and the appropriate setting to receive care. Regardless of the advice provided, a member who calls the 24-Hour Nurse Call Line before obtaining ER services for the same medical condition for which the member sought medical advice from the hotline will not be subject to an ER copayment. The MCE must have a process in place to communicate ER copayment waivers to hospital emergency providers on a prospective basis.

When the MCE must refund a copayment that was erroneously collected, the MCE has two options in refunding the member’s copayment:

• Provide the copayment refund to the member; or
• Apply the copayment refund to the member’s POWER Account.

Assuming that a member has an available and accessible alternate nonemergency services provider; that the emergency provider has determined that the individual does not have an emergency medical condition; and that the member did not receive a waiver from the MCE’s 24-Hour Nurse Call Line, the hospital must inform the member of the following before providing the non-emergency services:

• The hospital may require payment of the copayment before the service is provided;
• The hospital can provide the name and location of an alternate nonemergency services provider that is available and accessible;
• An alternate provider may be able to provide the services without a copayment;
• The hospital can provide a referral to coordinate scheduling this treatment; and
• The member cannot use their POWER Account to pay emergency room copayments.

The MCE must instruct its provider network of the emergency room services copayment policy and procedure, such as the hospital’s notification responsibilities (outlined previously) and the circumstances under which the hospital must waive or return the copayment.

**Out-of-Network Services**

With the exception of certain self-referral service providers and emergency medical care, the requirements to allow continuity of care for pregnant women transferring to the MCE in their third trimester, and Members who are Presumptively Eligible and seeking initial services, the MCE may limit its coverage to services provided by in-network providers, after the MCE has met the network access standards set forth in Provider Education and Outreach.
However, in accordance with 42 CFR 438.206(b)(4), the MCE must authorize and pay for out-of-network care if the MCE’s provider network is unable to provide necessary covered medical services within 30 miles of the member’s residence for primary care and within 60 miles of the member’s residence for specialty care. The MCE must authorize these out-of-network services within the time frame established in Authorization of Services and Notices of Action. The MCE must adequately cover the services for as long as the MCE is unable to provide the covered services in network. The MCE must require out-of-network providers to coordinate with the MCE for payment and ensure that the cost to the member is no greater than it would be if the services were furnished in network.

The MCE may require providers not contracted in the MCE’s network to obtain prior authorization from the MCE to render any referral or nonemergent services to MCE members. When the out-of-network provider has not obtained prior authorization, the MCE may deny payment to that out-of-network provider. The MCE must cover and reimburse for all authorized, routine care provided to its members by out-of-network providers.

MCEs must make nurse practitioner or physician extender services available to members and must inform members that these services are available. MCEs must allow members to use the services of out-of-network nurse practitioners if nurse practitioners are not available within the MCE’s network in the member’s service area.

For the HIP, MCEs must make covered services provided by FQHCs and RHCs available to members out-of-network if an FQHC or RHC is not available within the MCE’s network in the member’s service area.

The MCE may not require an out-of-network provider to acquire an MCE-assigned provider number for reimbursement. A National Provider Identifier (NPI) is sufficient for out-of-network provider reimbursement.

### Out-of-Network Provider Reimbursement – Hoosier Healthwise

The MCE must reimburse any out-of-network provider’s claim for authorized services provided to Hoosier Healthwise members at a rate it negotiates with the out-of-network provider, or the lesser of the following:

- The usual and customary charge made to the general public by the provider.
- The established IHCP fee-for-service (FFS) reimbursement rate for participating IHCP providers at the time the service was rendered.
- The MCE encounter claim denies if the out-of-network provider is not an IHCP provider.
- For Hoosier Healthwise, an out-of-network provider may have:
  - Front-end rejection of claims
  - Error code 259 – Billing NPI Not Tied to a Provider ID
- Hoosier Healthwise encounters for these out-of-network providers may also have:
  - Back-end edit denials
  - Error code 1100 – Billing NPI (not reported to a Provider ID)
  - Back-end edit 1120 – Rendering NPI Submitted (not reported to a Provider ID)

### Out-of-Network Provider Reimbursement – Healthy Indiana Plan

The MCE must reimburse any out-of-network provider’s claim for authorized services provided to HIP members at the standard HIP reimbursement rates established by the Secretary. The HIP reimbursement rates are based on the comparable Medicare rate, or if there is not a Medicare rate for the service, on a rate equal to 128% of the Medicaid rate for the covered service.
The MCE will reimburse hospital providers for out-of-network services at standard Medicaid rates, rather than at the higher HIP reimbursement rates when:

- Such out-of-network services are billed by hospital providers; and
- The services are provided to the following HIP members:
  - *Section 1931* low-income parents or caretakers eligible under 42 CFR 435.110
  - Low-income 19- and 20-year-old dependents eligible under 42 CFR 435.222
  - Individuals receiving transitional medical assistance, pursuant to *Section 1925 of the Social Security Act*.

The State will identify individuals eligible pursuant to any of the previously listed categories.

### Self-Referral Services

The MCE must include providers of self-referral services in its contracted network. The MCE and its PMPs may direct members to seek self-referral services from providers contracted in the MCE’s network; however, except for behavioral health (non-psychiatric) and routine dental services (if covered by member plan), the MCE cannot require members to use MCE-network providers.

- When Hoosier Healthwise members choose to receive self-referral services from self-referral providers that are not contracted with the MCE, the MCE is responsible for payment to these providers up to the applicable benefit limits and at IHCP FFS rates.

- With the exception of family planning services and emergency or urgent care services, when HIP members choose to receive self-referral services from self-referral providers that are not contracted with the MCE, the MCE is responsible for payment of self-referral services up to the applicable benefit limits and at a rate not less than the Medicare rate, or 130% of Medicaid if there is no Medicare rate.

The following services are considered self-referral services, in that they do not require a PMP referral. Self-referral limitations are indicated for each type of service:

- Emergency services [any provider; require IHCP enrollment to facilitate payment]
- Urgent care services [any IHCP-enrolled provider]
- Family planning [any IHCP-enrolled provider]
- Immunizations [any IHCP-enrolled provider]
- Podiatry [any IHCP-enrolled provider]
- Psychiatric services [any IHCP-enrolled provider]
- Eye care (except surgery) [any IHCP-enrolled provider; HIP subject to benefit plan coverage]
- Diabetes self-management training [any IHCP-enrolled provider subject to MCE PA requirements]
- Chiropractic services [any IHCP-enrolled provider subject to MCE PA requirements; HIP subject to benefit plan coverage]
- Behavioral health (nonpsychiatric) [any MCE network provider]
- Dental (routine) [any MCE network provider; HIP subject to benefit plan coverage]
The Indiana Administrative Code 405 IAC 5 (Hoosier Healthwise) and 405 IAC 9-7 (HIP) provide further detail about the self-referral benefits.

- Chiropractic services may be provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-1. Non-MCE-network providers are subject to MCE PA requirements. Chiropractic services may only be provided to members receiving services through Hoosier Healthwise, HIP State Plan, or while receiving the additional HIP pregnancy-only benefits.

- Eye care services, except surgical services, may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-24 (optometrist) who has entered into a provider agreement under IC 12-15-11. Eye care services may be provided to members receiving services through Hoosier Healthwise, HIP State Plan, HIP Plus, or while receiving the additional HIP pregnancy-only benefits.

- Routine dental services may be provided by any in-MCE-network licensed dental provider who has entered into a provider agreement under IC 12-15-11. Dental services may be provided to members receiving services through Hoosier Healthwise, HIP State Plan, HIP Plus, or while receiving the additional HIP pregnancy-only benefits.

- Podiatric services may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-29 (doctor of podiatric medicine) who has entered into a provider agreement under IC 12-15-11. Podiatry services are covered for members receiving services through Hoosier Healthwise or HIP State Plan only.

- Psychiatric services may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) who has entered into a provider agreement under IC 12-15-11.

- Family planning services under federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Abortions and drugs or devices that cause abortions are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning services, including providers that are not in the MCE’s network. Members may not be restricted in their choice of a family planning service provider, so long as the provider is an IHCP provider. The Family Planning Services module provides a complete and current list of family planning services. Under the MCE’s HIP and Hoosier Healthwise lines of business, the MCE must provide all covered family planning services and supplies.

- Emergency services are covered without the need for prior authorization or the existence of an MCE contract with the emergency care provider. Emergency services must be available 24 hours a day, seven days a week, subject to the prudent layperson standard of an emergency medical condition, as defined in 42 CFR 438.114 and IC 12-15-12.

- Urgent care services
- Immunizations are self-referred to any IHCP-enrolled provider and are covered regardless of where they are received.
- Diabetes self-management services are covered if rendered by any IHCP-enrolled provider authorized to render these services. Non-MCE-network providers are subject to MCE PA requirements.
- Behavioral health services are self-referred if rendered by an in-network provider. Members may self-refer, within the MCE’s network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse, and chemical dependency services rendered by mental health specialty providers. The mental health providers to which the member may self-refer within network are:
  - Outpatient mental health clinics
  - Community mental health centers
Section 14: Covered Services

Behavioral Health

Behavioral health services, with the exception of Medicaid Rehabilitation Option (MRO) and 1915(i) services, are a covered benefit under both the Hoosier Healthwise and HIP programs. The MCE is responsible for managing and reimbursing all such services in accordance with the requirements in this section. In furnishing behavioral health benefits, including any applicable utilization restrictions, the MCE shall comply with the Mental Health Parity and Additions Equity Act (MHPAEA). This includes, but is not limited to:

- Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits.
- Ensuring compliance with MHPAEA for any benefits offered by the MCE to members beyond those otherwise specified in this Scope of Work.
- Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential members, or contracting provider upon request.
- Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.
- Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

The MCE must provide behavioral health services, which include mental health and substance abuse services, according to the requirements in this section. In doing so, the MCE must ensure that behavioral health services are integrated with physical care services, and that behavioral health services are provided as part of the treatment continuum of care. The MCE must develop protocols to do the following:

- Provide care that addresses the needs of members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health.
- Provide a written plan and evidence of ongoing, increased communication between the PMP, the MCE, and the behavioral healthcare provider.
- Coordinate management of utilization of behavioral healthcare services with Medicaid Rehabilitation Option (MRO) and 1915(i) services and services for physical health.
Behavioral Healthcare Services

The MCE must provide all medically necessary community-based, partial hospital, and inpatient hospital behavioral health services as identified in Covered Services section of this policy manual and MCE Contract Exhibit 3. MCEs must pay CMHCs at no less than:

- The Indiana Medicaid FFS rate for any covered non-MRO service that the CMHC provides to a Hoosier Healthwise member; and
- The HIP reimbursement rates established by the Secretary, which are based on Medicare rates or 130% of Medicaid FFS for any covered non-MRO service that the CMHC provides to a HIP member.

The MCE provides behavioral health services through hospitals, offices, clinics, in home, at school (Hoosier Healthwise only), and other locations, as permitted under state and federal law. A full range of services, including crisis services, indicated by the behavioral healthcare needs of members, must be available to members.

Behavioral health services codes billed in a primary care setting must be reviewed for medical necessity and, if appropriate, be paid by the MCE.

The MCE must allow members to self-refer to any behavioral healthcare provider in the MCE’s network without a referral from the PMP or without MCE authorization. Members may also self-refer to any IHCP-enrolled psychiatrist.

The MCE is contractually mandated that its behavioral healthcare network providers notify a member’s MCE within five calendar days of the member’s visit, and submit information about the treatment plan, the member’s diagnosis, medications, and so forth. Disclosure of mental health records by the provider to the MCE and to the PMP is permissible under the Health Insurance Portability and Accountability Act (HIPAA) and State law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records.

The MCE must develop mechanisms for facilitating communication between behavioral health and physical health providers to ensure the provision of integrated member care. Incentive programs, case managers, behavioral health profiles, and so forth, are mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The MCE must require the behavioral health provider to share clinical information directly with the member’s PMP.

Behavioral Health Provider Network

The State requires MCEs to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network must include psychiatrists, psychologists, clinical social workers, and other licensed behavioral healthcare providers. In addition, MCEs must provide inpatient care for a full range of mental health and substance abuse diagnoses. All services covered under the clinic option must be delivered by licensed psychiatrists and health service provider in psychology (HSPP), or by an advanced practice nurse or person holding a master’s degree in social work, marital and family therapy, or mental health counseling. MCEs are required to provide at minimum access to two psychiatrists within 60 miles of the member’s residence.

For non-psychiatrist providers, the MCE is encouraged to contract with all Division of Mental Health and Addiction (DMHA)-certified community mental health centers (CMHCs). If all CMHCs are not included in the provider network, then the MCE must demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services. Further, the MCE must, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs and must provide physical health and other medical information to the appropriate CMHC for every member.

The Division of Mental Health and Addiction (DMHA) conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in CMHCs. In addition to the regular oversight that the MCE provides for
contracted CMHCs, the MCEs must utilize the results of DMHA’s review to inform contracting decisions, to monitor contracted CMHCs, and to develop improvement plans with contracted CMHCs.

The MCE must train its providers to identify and treat members with behavioral health disorders, and must train PMPs and specialists on when and how to refer members for behavioral health treatment. The MCE must also train providers to screen and treat individuals who have co-existing mental health and substance abuse disorders. The MCE is responsible for ensuring that its behavioral health network providers are trained in cultural diversity, and can respectfully and effectively interact with individuals with varying racial, ethnic, and linguistic differences. The MCE must provide to the State its written training plan, including dates, methods (such as seminars, web conferences, and so forth), and subject matter for integration and cultural competency training.

Members must be able to receive timely access to medically necessary behavioral health services.

In urban areas, the MCE must provide at least one behavioral health provider within 30 minutes or 30 miles from the member’s home. In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles from the member’s home. The availability of professionals will vary, but access problems may be especially acute in rural areas. The MCE must provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas. The MCE also must monitor utilization in rural and urban areas to assure equality of service access and availability.

The following list represents behavioral health providers that should be available in the MCE’s network:

- Outpatient mental health and addiction clinics
- Community mental health centers
- Psychologists
- Certified psychologists
- Health services providers in psychology (HSPPs)
- Certified social workers
- Licensed 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
- Marital and family therapist
- Licensed mental health counselors

The MCE must provide a sufficient number and geographic distribution of inpatient psychiatric facilities to serve the expected enrollment. The transport distance to an inpatient psychiatric facility from the member’s home shall be the usual and customary, not to exceed 60 miles. Exceptions must be justified and documented to the State on the basis of community standards for accessing care.

**Case Management for Members Receiving Behavioral Health Services**

The MCE must provide case management for members receiving behavioral health services, and for any member at risk for an inpatient psychiatric or substance abuse hospitalization. The MCE must ensure the coordination of physical and behavioral healthcare among all providers treating the member. At least quarterly, the MCE must send a behavioral health profile to the respective PMP. The behavioral health profile lists physical and behavioral treatment received by the member during the previous reporting period.
The MCE must employ or contract with case managers with training, expertise, and experience in providing case management services for members receiving behavioral health services. At a minimum, the MCE must provide case management services for any member at risk for inpatient psychiatric or substance abuse hospitalization, and for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than 90 calendar days following that inpatient hospitalization. Case managers must contact members during an inpatient behavioral health hospitalization, or immediately when they are notified of a member’s inpatient behavioral health hospitalization. The case managers must schedule an outpatient follow-up appointment to occur no later than seven calendar days following discharge for the inpatient behavioral health hospitalization.

Case managers must use the results of health screenings and more detailed health assessments (including the medically frail health assessments) to identify members who need case management services. Case managers must also monitor members receiving behavioral health services who are new to the MCE’s plan to ensure that the members are linked to appropriate behavioral health providers. The case manager must monitor whether members are receiving appropriate services and whether members are at risk of over- or under-utilizing services. The State must provide access CoreMMIS to allow the MCE to monitor MRO utilization, which is covered by Medicaid FFS.

Case managers must regularly and routinely consult with the member’s physical and behavioral health providers to facilitate sharing of clinical information, and to develop and maintain a coordinated physical health and behavioral health treatment plan for the member. In addition, with the appropriate consent, case managers must notify PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers must provide this notification within five calendar days of the hospital admission or emergency treatment.

Documentation of case management procedures, contacts, interventions, and outcomes shall be made available to the FSSA upon request.

**Behavioral Healthcare Coordination**

The MCE must ensure the coordination of physical and behavioral healthcare among all providers treating the member. The MCE must coordinate services for individuals with multiple diagnoses of mental illness, substance abuse, and physical illness. The MCE must facilitate reciprocal exchange of health information between physical and behavioral providers treating the member.

The State requires that the MCE share members’ medical data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member’s consent, when required. The MCE must contractually mandate that its behavioral health care network providers notify the MCE within five calendar days of the member’s visit and submit information about the treatment plan, the member’s diagnosis, medications, and other pertinent information. Disclosure of mental health records by the provider to the MCE and to the member’s physician is permissible under the Health Insurance Portability and Accountability Act (HIPAA) and state law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records. MCEs must contractually require every provider contracted with the MCE, including behavioral health providers, to ask and encourage members to sign a consent for releasing substance abuse treatment information to the MCE and to the PMP or behavioral health provider, if applicable.

MCEs must, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The behavioral health profile lists the physical and behavioral health treatment received by that member during the previous reporting period. Information about substance abuse treatment and HIV/AIDS should only be released if member consent has been obtained.

For each member receiving behavioral health treatment, the MCE contractually requires behavioral health providers to document and share the following information for that member with the MCE and PMP:

- Written summary of the member’s treatment session
• Primary and secondary diagnoses
• Findings from assessments
• Medication prescribed
• Psychotherapy prescribed
• Any other relevant information

MCEs must, at a minimum, establish referral agreements and liaisons with both contracted and noncontracted CMHCs, and must provide physical health medical information to the appropriate CMHC for every member.

The MCE must develop additional mechanisms for facilitating communication between behavioral health and physical health providers to ensure the provision of integrated member care. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The MCE must require the behavioral health provider to share clinical information directly with the member’s PMP. The MCE shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes.

Documentation of integration policies and procedures, contacts, behavioral health profile templates, and outcomes data must be made available to the State on request.

Behavioral Health Continuity of Care

The MCE must use behavioral health case managers to monitor the care of members receiving behavioral health services who are new to the MCE, or who are transitioning to another MCE or other treatment provider, to ensure the medical records, treatment plans, and other pertinent medical information follow each transitioning member. The behavioral health case manager must notify the receiving MCE or other provider of the member’s previous behavioral health treatment, and must offer to provide to the new provider the member’s treatment plan, if available, and consultation with the member’s previous treating provider. The current MCE and receiving MCE must coordinate information regarding prior authorized services for members in transition.

The MCE must require, through provider contract provisions, that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and continuing treatment before discharge. This treatment must be provided within seven calendar days from the date of the member’s discharge. If a member misses an outpatient follow-up or continuing treatment, then the MCE must ensure that a behavioral healthcare provider or the MCE’s behavioral health case manager contacts that member within three business days of the missed appointment.

Existing Hoosier Healthwise members receiving Psychiatric Residential Treatment Facility (PRTF) services under Hoosier Healthwise moved to fee-for-service (FFS) effective January 1, 2011. To facilitate the appropriate claims payment methodology, a level of care is established for members receiving PRTF services. PRTF providers must contact the PA vendor when an RBMC member is admitted to their facility so that the appropriate level of care is assigned. On discharge from the facility, the member is re-enrolled in the most appropriate Medicaid program.

The Mental Health and Addiction Services module provides detailed information about RBMC members admitted to PRTFs.

Partial Hospitalization Services for Behavioral Health

The State supports the implementation of partial hospitalization programs to provide a range of care to prevent hospitalization or act as a step-down service to transitioning members from inpatient hospitalization to community care. These programs must be highly intensive, time-limited medical services that provide a transition from inpatient psychiatric hospitalization to community-based care or serve as a substitute for inpatient admission. Partial hospitalization programs are highly individualized, with treatment goals that are measurable and medically necessary.
Treatment goals must include specific time frames for achievement of goals and must be directly related to the reason for admission. To receive partial hospitalization services, members must have a diagnosed or suspected behavioral health condition and one of the following:

• Short-term deficit of the individual’s daily functioning
• Serious deterioration of the individual’s general medical or behavioral health is highly probable without structured intervention

The full service description and program requirements for coverage of partial hospitalization are located in the Indiana Administrative Code 405 IAC 5-20-8. See the Mental Health and Addiction Services module for billing instructions.

In accordance with 42 CFR 438.3(e)(2), the MCE may cover services or settings in lieu of services or settings covered under the State Plan, including short-term stays no more than 15 days in a calendar month in an Institution for Mental Disease (IMD) for members ages 21 to 64.

For Indiana Health Coverage Programs (IHCP) members enrolled in Hoosier Healthwise, MCEs can authorize stays in an IMD for mental health, behavioral health, and substance use disorder inpatient services in lieu of other settings under the Medicaid State Plan. IHCP follows the definition in accordance with 42 CFR 435.1010 for establishing eligible IMD providers. Identified providers are provided to the MCE. The Plan may not require or create incentives for the member to receive services in an IMD versus a setting covered under the State Plan.

In accordance with 42 CFR 435.1010, an IMD “means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.” This may include a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services.

If the member’s IMD stay exceeds 15 days in a calendar month and the member has been ordered to a state operated facility for treatment but is awaiting placement in a state hospital, then the member is disenrolled from the Plan and enrolled in fee-for-service. The Plan shall ensure the member is properly transitioned and there is not a break in coverage.

For stays exceeding 15 days in a calendar month where the member is not awaiting placement in a state hospital, the member will remain enrolled in the Plan and the Plan will continue to provide care coordination services and reimburse all covered services. Additionally, for these stays, the State shall recover the entire monthly capitation payment for the member.

The Plan must submit data related to IMD stays as outlined in the MCE Reporting Manual.

The proposed services and settings are reimbursable and subject to the requirements contained in 42 CFR part 438.

**Early and Periodic Screening, Diagnosis, and Treatment Services**

EPSDT is a federally mandated preventive healthcare program designed to improve the overall health of Medicaid-eligible infants, children, and adolescents from birth to 21 years old.

EPSDT/HealthWatch is the name of Indiana’s EPSDT program. EPSDT/HealthWatch services are available for all Hoosier Healthwise children and HIP members under age 21. EPSDT/HealthWatch includes all IHCP-covered preventive, diagnostic, and treatment services, as well as other prior-authorized treatment services that the screening provider determines to be medically necessary. In addition, EPSDT services include the provision of medically necessary services to members less than 21 years old in institutions of mental disease (IMDs).
The primary goal of HealthWatch is to ensure that children enrolled in the IHCP receive age-appropriate comprehensive, preventive services. Early detection and treatment can reduce the risk of more costly treatment or hospitalization resulting from delayed treatment. See the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch module for details regarding components and recommended frequency of HealthWatch screenings.

**Hoosier Healthwise Early and Periodic Screening, Diagnosis, and Treatment Services**

The MCE must provide all covered EPSDT services for Hoosier Healthwise members. In covering well-child visits, the MCE must follow the latest guidance from the American Academy of Pediatrics (AAP).

The State encourages MCEs to work with prenatal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourage mothers to schedule preventive visits for their infants.

Lead-level screening is an important component of HealthWatch. Based on the State’s obligation to monitor the MCE’s performance in this area, in accordance with IC-12-15-12-20, the State requires MCEs to screen children for lead poisoning. Lead poisoning may cause anemia, permanent brain damage, learning disorders, loss of balance, kidney damage, blindness, hearing loss, seizures, coma, and death. With early screening and treatment, the serious effects of lead poisoning can be prevented.

It is a high priority for the State that all IHCP children between twelve months and six years are tested for lead poisoning, and that children with elevated lead levels are identified and receive the recommended follow-up treatment. Children may be tested earlier than 12 months if an assessment indicates the child is at high risk for lead exposure.

**Healthy Indiana Plan Early and Periodic Screening, Diagnosis, and Treatment Services**

The MCE must cover lead screening and hearing aids for 19- and 20-year-old HIP members. Lead screening services are a preventive service and are not subject to the $2,500 deductible.

**Federally Qualified Health Centers and Rural Health Clinics**

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are essential safety net providers. The State strongly encourages each MCE to contract with FQHCs and RHCs that are willing to meet all the MCE’s requirements to provide quality services. The MCE must reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the MCE would make to a non-FQHC or non-RHC provider for the same services.

MCEs must make covered services provided by FQHCs and RHCs available to HIP member’s out-of-network if an FQHC or an RHC is not available in the member’s service area within the MCE’s network. In accordance with section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), the MCE shall pay any out-of-network American Indian/Alaska Native healthcare provider that is an FQHC for covered services provided to an American Indian/Alaska Native member at a rate equal to the amount of payment that the MCE would pay to an in-network FQHC that is not an American Indian/Alaska Native healthcare provider for the same services.

In accordance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the State makes supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the MCE. These supplemental payments represent the difference, if any, between the payment to which the FQHC or RHC would be entitled for covered services under the Medicaid provisions of BIPA and the payments made by the MCE.

The State requires the MCE to identify, and obtain the State approval of, any performance incentives it offers to the FQHC or RHC. The MCE must report all FQHC and RHC incentives that accrue during the contract period related to the cost of providing FQHC-covered or RHC-covered services to its members. This reporting must also include any fee-for-service and capitation payments in determining the direct reimbursement paid by the MCE to the FQHC or
RHC. In its reporting to the State, the MCE must specify whether the incentives vary between its Hoosier Healthwise and HIP lines of business.

The MCE must perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may have an impact on the clinic’s annual reconciliation conducted by the State.

Annually, the State requires the MCE to provide the MCE’s utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. A separate report must be provided for the MCE’s Hoosier Healthwise and HIP lines of business. The report must be completed in the form and manner set forth in the Hoosier Healthwise/HIP Reporting Manual. For Hoosier Healthwise, the data must be submitted on an incurred-claims basis, including separate reporting of Package A/P FFS claims, Package A/P capitation claims, Package C FFS claims, and Package C capitation claims. For HIP, the data must be submitted on a paid-claims basis. The State reserves the right to require Hoosier Healthwise data to be submitted on a paid-claims basis.

For both programs, the submitted FQHC and RHC data must be accurate and complete. The MCE must pull the data by NPI or Provider ID, rather than other means, such as a federal tax ID number. The MCE must establish a process for validating the completeness and accuracy of the data, and a description of this process must be available to the State on request. The claims files must not omit claims for practitioners rendering services at the clinic, and the files must not contain claims for practitioners who did not practice at the clinic.

In addition, the State requires the FQHC or RHC and the MCE to maintain and submit records documenting the number and types of valid encounters provided to members each month. Capitated FQHCs and RHCs must also submit encounter data (such as in the form of shadow claims to the MCE) each month. The number of encounters is subject to audit by the State or its representatives.

The MCE must work with each FQHC and RHC to assist the State and its designee in resolving disputes of year-end reconciliations between the federally required interim payments made by the State to each FQHC and RHC on the basis of provider-reported encounter activity and the final accounting, based on the actual encounter data provided by the MCE.

Extended Inpatient Hospital Stays for Children Investigated by the Department of Child Services

When there is a delay in discharge from an inpatient stay because of Department of Child Services (DCS) involvement, the extended stay days (or delay days) are reimbursed through the IHCP, rather than through the MCEs. This reimbursement is issued as a retroactive quarterly settlement, based on a settlement request form submitted to Myers & Stauffer LC by the hospital. Myers & Stauffer calculates the settlement amounts based on the information submitted by the provider and may request additional information required to complete its review, including documentation of the child’s release by DCS.

In the case of claims paid by MCEs, the MCE must submit separate documentation of payment to Myers & Stauffer before the IHCP can reimburse for the extended stay days. The most recent version of the CPS Request for Settlement form is available on the Forms page at indianamedicaid.com.

Healthy Indiana Plan Preventive Services

HIP Preventive Services may be updated yearly by October 1, and any age and gender appropriate preventive service can be obtained to qualify a member for rollover to apply for the member’s following year’s POWER Account contribution. The MCE must send preventive service reminders to its members throughout the benefit period, including in the monthly POWER Account statements and redetermination correspondence.

The MCE must have mechanisms in place to monitor when a member has obtained the preventive care services recommended for his or her age and gender, as well as pre-existing conditions, and report this information on the POWER Account Reconciliation File (PRF) 185 calendar days following the end of the member’s benefit period.
The MCE must monitor whether a member has received recommended preventive care services by:

1. Using claims data to determine if any of the certain specified disease conditions exist.
2. Using claims data to determine if required services have been obtained (the State must provide the qualifying CPT and ICD codes).
3. Receiving verification from the member that he or she obtained preventive services.

Members are required to complete disease-specific preventive services only if they were diagnosed with the disease before the beginning of the benefit period. When a disease develops mid-benefit period, the member is not required to complete preventive care services related to that disease until the next benefit period.

Ninety calendar days before the end of a member’s predefined benefit period, the MCE must make an initial assessment of whether the member has completed a recommended preventive services. If the member has not received recommended preventive services, the MCE must send a reminder to the member. The reminder must notify the member that the MCE’s records indicate that the member has not received any recommended preventive services based on medical claims received as of a specified date. A general listing that outlines what was required for different ages, genders, and disease types is sufficient; it does not need to be specific to the member. The reminder must also explain that if the member receives the recommended preventive services, the member is eligible to roll over the entire remaining POWER Account balance at the end of the benefit period, including the State’s contribution. This correspondence must be coordinated with the other redetermination reminders and provided no later than 60 calendar days before the end of the member’s benefit period.

Sixty calendar days after the end of the member’s benefit period, the MCE must make an assessment (through claims and other information, as described previously) to determine if the member has completed a recommended preventive services. The MCE must send a letter to the member informing him or her of the assessment’s outcome. This letter must go out within the 60 calendar day period. The following criteria must be considered for this letter:

• The letter to the member does not need to spell out what services the member received and what were not received. The letter must indicate only that a qualifying preventive care service were not completed.
• The letter to the member must list what the qualifying preventive care services were for the member’s benefit period. A general listing that outlines what was required for different ages, genders, and disease types is sufficient; it does not need to be specific to the member.
• The MCE must develop a form that can be easily completed by a member’s physician, which verifies that a service appropriate for the member’s age and sex have been obtained. This form must be included in the letter to the member.
• If the MCE’s records indicated that the member has not received the recommended preventive services, then the MCE must allow the member to file a grievance on the decision by submitting documentation that indicates that the member did in fact receive qualifying preventive care. The form included in the member’s letter can be used as supporting documentation, but must be completed by the member’s physician.
• The letter must indicate that the member has 33 calendar days from receipt of the letter to file a grievance on the decision and submit additional information using the attached form. The MCE may incorporate this grievance process into its existing grievance and appeals process, but must ensure that the grievance is resolved in a time period that allows for timely submission of a complete and accurate PRF to the State.
• If a member changes MCEs during redetermination, then the MCE (for example, original MCE) is responsible for sending the letter and giving the member an opportunity to file a grievance.

Example language that must be included in the letter to the member includes:

• The required preventive services for the year were X.
  – For HIP Plus members: Because you regularly contributed to your POWER Account throughout the year, you are eligible to rollover your unused share of the remaining POWER Account balance. If you also received a
qualifying preventive service, your “rollover amount” is doubled by the State in order to further reduce the cost of the plan in the next benefit period.

– For HIP Basic members: If you received a qualifying preventive service, you are eligible to receive a discount on the required monthly POWER Account contributions if you choose to participate in HIP Plus in the next benefit period. The discount is based on a percentage of your remaining POWER Account balance at the end of your current benefit period.

• A preliminary review of our records indicates that you have not received a qualifying preventive service.

• If you believe our preliminary determination is in error and you have received the preventive service listed previously please fill out the attached form and submit it to X. The form must be filled out by your physician and returned within thirty (30) calendar days.

Preventive services mandated by the Affordable Care Act (ACA) to include “A” and “B” services recommended by the United States Preventive Services Task Force Advisory Committee on Immunization Practices (ACIP)-recommended vaccines; preventive care and screening for infants, children, and adults recommended by Health Resources and Services Administration’s (HRSA’s) Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM), are provided as first dollar coverage and are not paid out of the POWER Account. HIP members have no cost-sharing on preventive services. For preventive services other than those mandated by the ACA, the first $500 in claims for covered preventive care services to members at no cost. This is referred to as $500 of first dollar coverage for preventive care services because it is not subject to the annual deductible. The POWER Account funds must not be used to pay for the first $500 of non-ACA mandated preventive care services. Additional preventive care services received by members that are outside of the ACA mandate are subject to the deductible unless the MCE chooses to offer a more generous preventive care services benefit.

The following Preventive Services qualify for Exemption from Payment from HIP Basic, HIP Plus, HIP State Plan Plus, and HIP State Plan Basic Member POWER Accounts (payment is subject to HIP benefits).

Table 14.4 – HIP Covered Preventive Services

<table>
<thead>
<tr>
<th>Diagnosis Code Match Required?</th>
<th>CPT and HCPCS Code</th>
<th>CPT and HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>00810</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum (including MAC)</td>
</tr>
<tr>
<td>Y</td>
<td>00902</td>
<td>Anesthesia for anorectal procedure (when specified as endoscopic procedure) (including MAC)</td>
</tr>
<tr>
<td>Y</td>
<td>36410</td>
<td>Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)</td>
</tr>
<tr>
<td>Y</td>
<td>36415</td>
<td>Collection of venous blood by venipuncture</td>
</tr>
<tr>
<td>Y</td>
<td>36416</td>
<td>Collection of capillary blood specimen (eg, finger, heel, ear stick)</td>
</tr>
<tr>
<td>Y</td>
<td>45300</td>
<td>Proctosigmoidoscopy collection of capillary blood specimen (eg, finger, heel, ear stick)</td>
</tr>
<tr>
<td>Y</td>
<td>45305</td>
<td>Proctosigmoidoscopy, rigid; with biopsy, single or multiple</td>
</tr>
</tbody>
</table>
### Diagnosis Code Match Required?

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT and HCPCS Code</th>
<th>CPT and HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>45308</td>
<td>Proctosigmoidoscopy</td>
</tr>
<tr>
<td>Y</td>
<td>45330</td>
<td>Flexible Sigmoidoscopy</td>
</tr>
<tr>
<td>Y</td>
<td>45331</td>
<td>Sigmoidoscopy, flexible; with biopsy, single or multiple</td>
</tr>
<tr>
<td>Y</td>
<td>45333</td>
<td>Sigmoidoscopy</td>
</tr>
<tr>
<td>Y</td>
<td>45334</td>
<td>Sigmoidoscopy, flexible; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
</tr>
<tr>
<td>Y</td>
<td>45338</td>
<td>Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
</tr>
<tr>
<td>Y</td>
<td>45339</td>
<td>Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>Y</td>
<td>45341</td>
<td>Sigmoidoscopy, flexible; with endoscopic ultrasound examination</td>
</tr>
<tr>
<td>Y</td>
<td>45378</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>Y</td>
<td>45380</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple</td>
</tr>
<tr>
<td>Y</td>
<td>45381</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with directed sub mucosal injection(s), any substance colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple</td>
</tr>
<tr>
<td>Y</td>
<td>45382</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
</tr>
<tr>
<td>Y</td>
<td>45383</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>Y</td>
<td>45384</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
</tr>
<tr>
<td>Y</td>
<td>45385</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
</tr>
<tr>
<td>Y</td>
<td>45391</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; w/endoscopic ultrasound examination</td>
</tr>
<tr>
<td>Y</td>
<td>74270</td>
<td>Radiologic examination computed tomographic colonography (i.e., virtual colonoscopy); screening</td>
</tr>
<tr>
<td>Y</td>
<td>76770</td>
<td>Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete</td>
</tr>
</tbody>
</table>
### Diagnosis Code Match Required? | CPT and HCPCS Code | CPT and HCPCS Code Description
--- | --- | ---
Y | 76775 | Ultrasound, retroperitoneal (eg, renal, aorta, nodes), b-scan and/or real time with image documentation; limited
Y | 77051 | Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)
N | 77052 | Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)
Y | 77055 | Mammography; unilateral
Y | 77056 | Mammography; bilateral
N | 77057 | Screening mammography, bilateral
Y | 77080 | Bone density
Y | 80047 | Basic metabolic panel (calcium, ionized)
Y | 80048 | Basic metabolic panel (calcium, total)
Y | 80050 | General health screen panel
Y | 80051 | Electrolyte panel. This panel must include the following: carbon dioxide (82374) chloride (82435) potassium (84132) sodium (84295)
Y | 80053 | Comprehensive metabolic panel
Y | 80055 | Obstetric panel this panel must include the following: hemogram, automated, and manual differential WBC count (CBC)(85022) or hemogram and platelet count, automated, and automated complete differential WBC count (CBC) (85025) hepatitis B surface antigen (HBsAg) (87340) antibody, rubella (86762) syphilis test, qualitative (eg, VDRL, RPR, ART) (86592) antibody screen, RB (86850) blood typing, ABO (86900) and blood typing, Rh (d)
Y | 80061 | Lipid panel
Y | 80069 | Renal function panel
Y | 80076 | Hepatic function panel
Y | 81000 | Urinalysis, by reagent strips, any number of components; with microscopy
Y | 81001 | Urinalysis by dipstick or tablet reagent for bilirubin glucose etc; automated with microscopy
### Diagnosis Code Match Required? | CPT and HCPCS Code | CPT and HCPCS Code Description
---|---|---
Y | 81002 | Urinalysis, by reagent strips, any number of components; without microscopy
Y | 81003 | Urinalysis, by dipstick or tablet reagent for bilirubin, etc w/o microscopy, automated
Y | 81007 | Urinalysis; bacteriuria screen, except by culture or dipstick
N | 81211 | BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants
N | 81212 | BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants
N | 81213 | BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants
N | 81214 | BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (i.e., exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)
N | 81215 | BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
N | 81216 | BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
N | 81217 | BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
Y | 82040 | Albumin; serum
Y | 82247 | Bilirubin; total
Y | 82248 | Bilirubin direct
Y | 82270 | Blood, occult, by peroxidase activity
Y | 82274 | Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
Y | 82310 | Calcium, blood; chemical
Y | 82374 | Carbon dioxide, combining power or content
Y | 82435 | Chlorides; blood (specify chemical or electrometric)
Y | 82465 | Cholesterol, serum or whole blood, total
Y | 82565 | Creatinine; blood
### Covered Services

<table>
<thead>
<tr>
<th>Diagnosis Code Match Required?</th>
<th>CPT and HCPCS Code</th>
<th>CPT and HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>82947</td>
<td>Glucose; blood (except reagent strip)</td>
</tr>
<tr>
<td>Y</td>
<td>82948</td>
<td>Glucose; blood, reagent strip</td>
</tr>
<tr>
<td>Y</td>
<td>83020</td>
<td>Hemoglobin fractionation and quantitation; electrophoresis (e.g., A2, S, C, and/or F)</td>
</tr>
<tr>
<td>Y</td>
<td>83021</td>
<td>Hemoglobin fractionation and quantitation; chromatography (e.g., A2, S, C, and/or F)</td>
</tr>
<tr>
<td>Y</td>
<td>83036</td>
<td>Hemoglobin; glycosylated (A1C)</td>
</tr>
<tr>
<td>Y</td>
<td>83498</td>
<td>Hydroxyprogesterone, 17-d</td>
</tr>
<tr>
<td>Y</td>
<td>83655</td>
<td>Lead, quantitative; blood</td>
</tr>
<tr>
<td>Y</td>
<td>83718</td>
<td>Lipoprotein, direct measurement; high density cholesterol</td>
</tr>
<tr>
<td>Y</td>
<td>83719</td>
<td>Lipoprotein, direct measurement, VLDL cholesterol</td>
</tr>
<tr>
<td>Y</td>
<td>83721</td>
<td>Lipoprotein, direct measurement, LDL cholesterol</td>
</tr>
<tr>
<td>Y</td>
<td>84030</td>
<td>Phenylalanine (PKU), blood</td>
</tr>
<tr>
<td>Y</td>
<td>84075</td>
<td>Phosphatase, alkaline, blood;</td>
</tr>
<tr>
<td>Y</td>
<td>84132</td>
<td>Potassium; blood</td>
</tr>
<tr>
<td>N</td>
<td>84152</td>
<td>Prostate specific antigen (PSA); complexed</td>
</tr>
<tr>
<td>N</td>
<td>84153</td>
<td>Prostate specific antigen</td>
</tr>
<tr>
<td>N</td>
<td>84154</td>
<td>Prostate specific antigen (PSA); free</td>
</tr>
<tr>
<td>Y</td>
<td>84155</td>
<td>Protein, total, serum; chemical</td>
</tr>
<tr>
<td>Y</td>
<td>84202</td>
<td>Protoporphyrin, RBC; quantitative</td>
</tr>
<tr>
<td>Y</td>
<td>84203</td>
<td>Protoporphyrin, RBC; screen</td>
</tr>
<tr>
<td>Y</td>
<td>84295</td>
<td>Sodium; blood</td>
</tr>
<tr>
<td>Y</td>
<td>84436</td>
<td>Thyroxine; total</td>
</tr>
<tr>
<td>Y</td>
<td>84437</td>
<td>Thyroxine; requiring elution (eg, neonatal)</td>
</tr>
<tr>
<td>Y</td>
<td>84439</td>
<td>Thyroxine; free</td>
</tr>
<tr>
<td>Y</td>
<td>84443</td>
<td>Thyroid stimulating hormone (TSH), RIA or EIA</td>
</tr>
<tr>
<td>Y</td>
<td>84450</td>
<td>Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method</td>
</tr>
<tr>
<td>Diagnosis Code Match Required?</td>
<td>CPT and HCPCS Code</td>
<td>CPT and HCPCS Code Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Y</td>
<td>84460</td>
<td>Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method</td>
</tr>
<tr>
<td>Y</td>
<td>84478</td>
<td>Triglycerides</td>
</tr>
<tr>
<td>Y</td>
<td>84520</td>
<td>Urea nitrogen, blood (bun); quantitative</td>
</tr>
<tr>
<td>Y</td>
<td>85004</td>
<td>Blood count; automated differential WBC count</td>
</tr>
<tr>
<td>Y</td>
<td>85007</td>
<td>Blood count; blood smear, microscopic examination w/ manual differential WBC count</td>
</tr>
<tr>
<td>Y</td>
<td>85009</td>
<td>Blood count; manual differential WBC count, buffy coat</td>
</tr>
<tr>
<td>Y</td>
<td>85013</td>
<td>Hematocrit</td>
</tr>
<tr>
<td>Y</td>
<td>85014</td>
<td>Hematocrit</td>
</tr>
<tr>
<td>Y</td>
<td>85018</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>Y</td>
<td>85025</td>
<td>Blood count; complete (CBC), automated (HGB, HCT, RBC, WBC and platelet count) and automated differential WBC count</td>
</tr>
<tr>
<td>Y</td>
<td>85027</td>
<td>Blood count; complete (CBC), automated (HGB, HCT, RBC, WBC and platelet count)</td>
</tr>
<tr>
<td>Y</td>
<td>86481</td>
<td>Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension</td>
</tr>
<tr>
<td>Y</td>
<td>86580</td>
<td>TB intradermal test</td>
</tr>
<tr>
<td>Y</td>
<td>86592</td>
<td>Syphilis test; qualitative (eg, VDRL, RPR, ART)</td>
</tr>
<tr>
<td>Y</td>
<td>86631</td>
<td>Antibody; chlamydia</td>
</tr>
<tr>
<td>Y</td>
<td>86632</td>
<td>Antibody; chlamydia, IgM</td>
</tr>
<tr>
<td>Y</td>
<td>86689</td>
<td>HTL or HIV antibody confirmatory tests</td>
</tr>
<tr>
<td>Y</td>
<td>86701</td>
<td>Antibody; HIV-1</td>
</tr>
<tr>
<td>Y</td>
<td>86702</td>
<td>Antibody; HIV-2</td>
</tr>
<tr>
<td>Y</td>
<td>86703</td>
<td>Antibody; HIV-1 and HIV-2, single assay</td>
</tr>
<tr>
<td>Y</td>
<td>86780</td>
<td>Antibody; treponema pallidum</td>
</tr>
<tr>
<td>Y</td>
<td>86803</td>
<td>Hepatitis C antibody</td>
</tr>
<tr>
<td>Y</td>
<td>86880</td>
<td>Antihuman globulin test (Coombs test); direct, each antiserum</td>
</tr>
<tr>
<td>Y</td>
<td>86901</td>
<td>Blood typing; Rh (D)</td>
</tr>
<tr>
<td>Diagnosis Code Match Required?</td>
<td>CPT and HCPCS Code</td>
<td>CPT and HCPCS Code Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Y</td>
<td>87081</td>
<td>Culture, presumptive, pathogenic organisms, screening only;</td>
</tr>
<tr>
<td>Y</td>
<td>87084</td>
<td>Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart</td>
</tr>
<tr>
<td>Y</td>
<td>87086</td>
<td>Culture, bacterial; quantitative colony count, urine</td>
</tr>
<tr>
<td>Y</td>
<td>87088</td>
<td>Culture, bacterial; with isolation and presumptive identification of each isolate, urine</td>
</tr>
<tr>
<td>Y</td>
<td>87110</td>
<td>Culture, chlamydia, any source</td>
</tr>
<tr>
<td>Y</td>
<td>87205</td>
<td>Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types</td>
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<tr>
<td>Y</td>
<td>87210</td>
<td>Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)</td>
</tr>
<tr>
<td>Y</td>
<td>87270</td>
<td>Infectious agent antigen detection by immune-fluorescent technique; Chlamydia trachomatis</td>
</tr>
<tr>
<td>Y</td>
<td>87320</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis</td>
</tr>
<tr>
<td>Y</td>
<td>87340</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis B surface antigen (HBsAg)</td>
</tr>
<tr>
<td>Y</td>
<td>87485</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique</td>
</tr>
<tr>
<td>Y</td>
<td>87490</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique</td>
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<tr>
<td>Y</td>
<td>87491</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique</td>
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<tr>
<td>Y</td>
<td>87492</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification</td>
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<tr>
<td>Y</td>
<td>87534</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique</td>
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<tr>
<td>Y</td>
<td>87537</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique</td>
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<tr>
<td>Y</td>
<td>87590</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhea, direct probe technique</td>
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<tr>
<td>Y</td>
<td>87591</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhea, amplified probe technique</td>
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</table>
### Covered Services

<table>
<thead>
<tr>
<th>Diagnosis Code Match Required?</th>
<th>CPT and HCPCS Code</th>
<th>CPT and HCPCS Code Description</th>
</tr>
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<tbody>
<tr>
<td>Y</td>
<td>87592</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhea, quantification</td>
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<tr>
<td>Y</td>
<td>87800</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique</td>
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<tr>
<td>Y</td>
<td>87801</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique</td>
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<tr>
<td>Y</td>
<td>87810</td>
<td>Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis</td>
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<tr>
<td>Y</td>
<td>87850</td>
<td>Infectious agent detection by immunoassay with direct optical observation; Neisseria gonorrhea</td>
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<tr>
<td>N</td>
<td>88141</td>
<td>Cytopathology cervix/vagina requiring interpretation by physician</td>
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<tr>
<td>N</td>
<td>88142</td>
<td>Cytopathology cervix/vagina collected in preservative fluid</td>
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<tr>
<td>N</td>
<td>88143</td>
<td>Cytopathology, cervical or vaginal with manual screening and rescreening under physician supervision</td>
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<tr>
<td>N</td>
<td>88147</td>
<td>Cytopathology smears, cervical or vaginal; screening by auto</td>
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<tr>
<td>N</td>
<td>88148</td>
<td>Cytopathology, smears, cervical or vaginal; screened by autom</td>
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<tr>
<td>N</td>
<td>88150</td>
<td>Cytopathology, smears, cervical or vaginal (eg, pa)</td>
</tr>
<tr>
<td>N</td>
<td>88152</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>88153</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>88154</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>88155</td>
<td>Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation</td>
</tr>
<tr>
<td>N</td>
<td>88164</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda system); manual screening under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>88165</td>
<td>Cytopathology, slides cervical or vaginal (the Bethesda System); with manual screening and re screening under physician supervision</td>
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<tr>
<td>N</td>
<td>88166</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda sys</td>
</tr>
<tr>
<td>N</td>
<td>88167</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda system); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision</td>
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<tr>
<td>Diagnosis Code Match Required?</td>
<td>CPT and HCPCS Code</td>
<td>CPT and HCPCS Code Description</td>
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<tr>
<td>N 88174</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer prep, auto screened under physician supervision.</td>
<td></td>
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<tr>
<td>N 88175</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer prep; with auto screen and manual rescreening under physician supervision.</td>
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<tr>
<td>N 90470</td>
<td>H1N1 immunization administration (intramuscular, intranasal), including counseling when performed.</td>
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<tr>
<td>N 90471</td>
<td>Immunization administration (includes percutaneous, intradermal).</td>
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</tr>
<tr>
<td>N 90472</td>
<td>Immunization administration (includes percutaneous, intradermal).</td>
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</tr>
<tr>
<td>N 90473</td>
<td>Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).</td>
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<tr>
<td>N 90474</td>
<td>Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure).</td>
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<tr>
<td>N 90632</td>
<td>Hepatitis A vaccine, adult dosage, for intramuscular use.</td>
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<tr>
<td>N 90636</td>
<td>Hepatitis A and Hepatitis B vaccine (HEPA-HEPB), adult dosage.</td>
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<tr>
<td>N 90645</td>
<td>Hemophilus influenza B vaccine (HIB), HBOC conjugate (4 dose).</td>
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<tr>
<td>N 90646</td>
<td>Hemophilus influenza B vaccine (HIB) PRP-D conjugate for booster use only, intramuscular use.</td>
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<tr>
<td>N 90647</td>
<td>Hemophilus influenza B vaccine (HIB), PRP-OMP conjugate (3 dose schedule), for intramuscular use.</td>
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<tr>
<td>N 90648</td>
<td>Hemophilus influenza B vaccine (Hib), Prp-T Conjugate (4 Dose).</td>
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<tr>
<td>N 90649</td>
<td>Human papilloma virus (HPV) vaccine, type 6, 11, 16, 18 ( quadrivalent), 3 dose schedule, for intramuscular use.</td>
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<tr>
<td>N 90650</td>
<td>Human papillomavirus (HPV) vaccine, types 16 and 18, bivalent, 3 dose schedule, for intramuscular use.</td>
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<tr>
<td>N 90654</td>
<td>Influenza virus vaccine, split virus preservative free, for intradermal use.</td>
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<tr>
<td>N 90656</td>
<td>Influenza virus vaccine, split virus, preservative free, when administered to 3 years and above, for intramuscular.</td>
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<tr>
<td>N 90658</td>
<td>Influenza virus vaccine, split virus, 3 years of age and older.</td>
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<tr>
<td>N 90660</td>
<td>Influenza virus vaccine, live, for intranasal use.</td>
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<tr>
<td>N 90661</td>
<td>Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use.</td>
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<tr>
<td>Diagnosis Code Match Required?</td>
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<td>CPT and HCPCS Code Description</td>
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<tr>
<td>N</td>
<td>90662</td>
<td>Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use</td>
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<tr>
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<td>90663</td>
<td>Influenza virus vaccine, pandemic formulation, H1N1</td>
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<td>N</td>
<td>90669</td>
<td>Pneumococcal conjugate vaccine, polyvalent, for intramuscular use</td>
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<tr>
<td>N</td>
<td>90670</td>
<td>Pneumococcal conjugate vaccine, 13 valent, for intramuscular use</td>
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<tr>
<td>N</td>
<td>90672</td>
<td>Influenza virus vaccine, quadrivalent, live, for intranasal use</td>
</tr>
<tr>
<td>N</td>
<td>90673</td>
<td>Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use</td>
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<tr>
<td>N</td>
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<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use</td>
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<tr>
<td>N</td>
<td>90688</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use</td>
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<tr>
<td>N</td>
<td>90698</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza type B, and poliovirus vaccine, inactivated (DTAP P HIB P IPV), for intramuscular use</td>
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<tr>
<td>N</td>
<td>90703</td>
<td>Immunization, active; tetanus toxoid</td>
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<tr>
<td>N</td>
<td>90704</td>
<td>Mumps virus vaccine, live, for subcutaneous use</td>
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<tr>
<td>N</td>
<td>90705</td>
<td>Measles virus vaccine, live, for subcutaneous use</td>
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<tr>
<td>N</td>
<td>90706</td>
<td>Immunization, active; rubella virus vaccine, live</td>
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<tr>
<td>N</td>
<td>90707</td>
<td>Immunization, active; measles, mumps and rubella virus vaccine</td>
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<tr>
<td>N</td>
<td>90708</td>
<td>Measles and rubella virus vaccine, live, for subcutaneous use</td>
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<tr>
<td>N</td>
<td>90710</td>
<td>Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use</td>
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<tr>
<td>N</td>
<td>90714</td>
<td>Tetanus and diphtheria toxoids (TD) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use</td>
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<tr>
<td>N</td>
<td>90715</td>
<td>Tetanus, diphtheria toxoids and acellular pertussis vaccine</td>
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<tr>
<td>N</td>
<td>90716</td>
<td>Immunization, active; varicella (chicken pox) vaccine</td>
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<tr>
<td>N</td>
<td>90719</td>
<td>Diphtheria toxoid, for intramuscular use</td>
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<td>Diagnosis Code Match Required?</td>
<td>CPT and HCPCS Code</td>
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<tr>
<td>N</td>
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<td>Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and hemophilus influenza B vaccine</td>
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<tr>
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<td>90721</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine and hemophilus influenza B vaccine</td>
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<tr>
<td>N</td>
<td>90723</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B and poliovirus vaccine</td>
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<tr>
<td>N</td>
<td>90732</td>
<td>Immunization, active; pneumococcal vaccine, polysaccharide</td>
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<td>90733</td>
<td>Immunization, active; meningococcal polysaccharide</td>
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<td>90734</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use</td>
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<tr>
<td>N</td>
<td>90736</td>
<td>Zoster (shingles) vaccine, live, for subcutaneous injection</td>
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<tr>
<td>N</td>
<td>90740</td>
<td>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use</td>
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<tr>
<td>N</td>
<td>90746</td>
<td>Immunization active Hepatitis B vaccine 20 years</td>
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<tr>
<td>N</td>
<td>90747</td>
<td>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use</td>
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<tr>
<td>N</td>
<td>90748</td>
<td>Hepatitis B AND hemophilus influenza B vaccine (HepB-Hib), for intramuscular use</td>
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<tr>
<td>N</td>
<td>92551</td>
<td>Screening test, pure tone, air only</td>
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<tr>
<td>Y</td>
<td>92552</td>
<td>Pure tone audiometry (threshold); air only</td>
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<tr>
<td>Y</td>
<td>92567</td>
<td>Tympanometry (impedance testing)</td>
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<tr>
<td>N</td>
<td>92558</td>
<td>Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis</td>
</tr>
<tr>
<td>Y</td>
<td>92586</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</td>
</tr>
<tr>
<td>Y</td>
<td>92587</td>
<td>Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)</td>
</tr>
<tr>
<td>Y</td>
<td>96040</td>
<td>Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family</td>
</tr>
<tr>
<td>Y</td>
<td>96150</td>
<td>Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment</td>
</tr>
</tbody>
</table>
### Covered Services

<table>
<thead>
<tr>
<th>Diagnosis Code Match Required?</th>
<th>CPT and HCPCS Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>97802</td>
<td>Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
</tr>
<tr>
<td>Y</td>
<td>97803</td>
<td>Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
</tr>
<tr>
<td>Y</td>
<td>97804</td>
<td>Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes</td>
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<tr>
<td>Y</td>
<td>99000</td>
<td>Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory</td>
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<tr>
<td>Y</td>
<td>99140</td>
<td>Anesthesia complicated by emergency conditions (specify) (list separately in addition to code for primary anesthesia procedure)</td>
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<tr>
<td>Y</td>
<td>99149</td>
<td>Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time</td>
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<tr>
<td>Y</td>
<td>99150</td>
<td>Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (list separately in addition to code for primary service)</td>
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<tr>
<td>Y</td>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
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<tr>
<td>N</td>
<td>99381</td>
<td>Preventive med services; initial visit; new patient infant (age younger than 1 year)</td>
</tr>
<tr>
<td>N</td>
<td>99382</td>
<td>Preventive med services; initial visit; new patient early childhood (age 1 through 4 years)</td>
</tr>
<tr>
<td>N</td>
<td>99383</td>
<td>Preventive med services; initial visit; new patient late childhood (age 5 through 11 years)</td>
</tr>
<tr>
<td>N</td>
<td>99384</td>
<td>Preventive med services; initial visit; new patient adolescent (age 12 through 17 years)</td>
</tr>
<tr>
<td>N</td>
<td>99385</td>
<td>Preventive med services; initial visit; new patient 18-39 years.</td>
</tr>
<tr>
<td>N</td>
<td>99386</td>
<td>Preventive med services; initial visit; new patient 40-64 years.</td>
</tr>
<tr>
<td>N</td>
<td>99387</td>
<td>Preventive med services; initial visit; new patient 65 years and older.</td>
</tr>
<tr>
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</tr>
<tr>
<td>N</td>
<td>99391</td>
<td>Preventive med services; established patient; infant (age younger than 1 year)</td>
</tr>
<tr>
<td>N</td>
<td>99392</td>
<td>Preventive med services; established patient; early childhood (age 1 through 4 years).</td>
</tr>
<tr>
<td>N</td>
<td>99393</td>
<td>Preventive med services; established patient; late childhood (age 5 through 11 years).</td>
</tr>
<tr>
<td>N</td>
<td>99394</td>
<td>Preventive med services; established patient; adolescent (age 12 through 17 years)</td>
</tr>
<tr>
<td>N</td>
<td>99395</td>
<td>Preventive med services; established patient; 18-39 years.</td>
</tr>
<tr>
<td>N</td>
<td>99396</td>
<td>Preventive med services; established patient; 40-64 years.</td>
</tr>
<tr>
<td>N</td>
<td>99397</td>
<td>Preventive med services; established patient; 65 years and older.</td>
</tr>
<tr>
<td>N</td>
<td>99401</td>
<td>Preventive medicine, individual counseling, healthy – 15 minutes</td>
</tr>
<tr>
<td>N</td>
<td>99402</td>
<td>Preventive medicine, individual counseling, healthy – 30 minutes</td>
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<tr>
<td>N</td>
<td>99403</td>
<td>Preventive medicine, individual counseling, healthy – 45 minutes</td>
</tr>
<tr>
<td>N</td>
<td>99404</td>
<td>Preventive medicine, individual counseling, healthy – 60 minutes</td>
</tr>
<tr>
<td>N</td>
<td>99406</td>
<td>Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes</td>
</tr>
<tr>
<td>N</td>
<td>99407</td>
<td>Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes</td>
</tr>
<tr>
<td>N</td>
<td>99408</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes</td>
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<tr>
<td>N</td>
<td>99409</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes</td>
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<tr>
<td>N</td>
<td>G0008</td>
<td>Administration of influenza virus vaccine</td>
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<tr>
<td>N</td>
<td>G0009</td>
<td>Administration of pneumococcal vaccine</td>
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<tr>
<td>N</td>
<td>G0010</td>
<td>Administration of Hepatitis B vaccine</td>
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<tr>
<td>N</td>
<td>G0101</td>
<td>Cervical or vaginal cancer screening; pelvic and clinical breast examination</td>
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<tr>
<td>N</td>
<td>G0102</td>
<td>Prostate cancer screening; digital rectal examination</td>
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<tr>
<td>N</td>
<td>G0103</td>
<td>Prostate cancer screening; prostate specific antigen test</td>
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### Diagnosis Code Match Required?

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>N</td>
<td>G0104</td>
<td>Colorectal cancer screening; flexible sigmoidoscopy</td>
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<tr>
<td>N</td>
<td>G0105</td>
<td>Colorectal cancer screening; colonoscopy on individual at high risk</td>
</tr>
<tr>
<td>N</td>
<td>G0106</td>
<td>Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema</td>
</tr>
<tr>
<td>N</td>
<td>G0120</td>
<td>Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema</td>
</tr>
<tr>
<td>N</td>
<td>G0121</td>
<td>Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk</td>
</tr>
<tr>
<td>N</td>
<td>G0123</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid automated thin layer preparation, screening by cytotechnologist under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>G0124</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid automated thin layer preparation, requiring interpretation by physician</td>
</tr>
<tr>
<td>N</td>
<td>G0141</td>
<td>Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician</td>
</tr>
<tr>
<td>N</td>
<td>G0143</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>G0144</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>G0145</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>G0147</td>
<td>Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision</td>
</tr>
<tr>
<td>N</td>
<td>G0148</td>
<td>Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening</td>
</tr>
<tr>
<td>N</td>
<td>G0202</td>
<td>Screening mammography, producing direct digital image, bilateral, all views</td>
</tr>
<tr>
<td>Y</td>
<td>G0204</td>
<td>Diagnostic mammography, producing direct digital image, bilateral, all views</td>
</tr>
<tr>
<td>Diagnosis Code Match Required?</td>
<td>CPT and HCPCS Code</td>
<td>CPT and HCPCS Code Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Y</td>
<td>G0206</td>
<td>Diagnostic mammography, producing direct digital image, unilateral, all views</td>
</tr>
<tr>
<td>Y</td>
<td>G0270</td>
<td>Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes</td>
</tr>
<tr>
<td>Y</td>
<td>G0271</td>
<td>Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0328</td>
<td>Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations</td>
</tr>
<tr>
<td>N</td>
<td>G0389</td>
<td>Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening</td>
</tr>
<tr>
<td>Y</td>
<td>G0396</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes</td>
</tr>
<tr>
<td>Y</td>
<td>G0397</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0402</td>
<td>Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment</td>
</tr>
<tr>
<td>Y</td>
<td>G0432</td>
<td>Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening</td>
</tr>
<tr>
<td>Y</td>
<td>G0433</td>
<td>Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 OR HIV-2, screening</td>
</tr>
<tr>
<td>Y</td>
<td>G0435</td>
<td>Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening</td>
</tr>
<tr>
<td>N</td>
<td>G0436</td>
<td>Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0437</td>
<td>Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0438</td>
<td>Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit</td>
</tr>
<tr>
<td>N</td>
<td>G0439</td>
<td>Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit</td>
</tr>
<tr>
<td>N</td>
<td>G0442</td>
<td>Annual alcohol misuse screening, 15 minutes</td>
</tr>
</tbody>
</table>
### Diagnosis Code Match Required?

<table>
<thead>
<tr>
<th>Diagnosis Code Match Required?</th>
<th>CPT and HCPCS Code</th>
<th>CPT and HCPCS Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>G0443</td>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0444</td>
<td>Annual depression screening, 15 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0445</td>
<td>High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0446</td>
<td>Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, bi-annual, 15 minutes</td>
</tr>
<tr>
<td>N</td>
<td>G0447</td>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
</tr>
<tr>
<td>N</td>
<td>Q0091</td>
<td>Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory</td>
</tr>
<tr>
<td>N</td>
<td>Q2033</td>
<td>Influenza vaccine, recombinant hemagglutinin antigens, for intramuscular use (FluBlok)</td>
</tr>
<tr>
<td>N</td>
<td>S0613</td>
<td>Annual gynecological examination, clinical breast examination without pelvic examination</td>
</tr>
<tr>
<td>Y</td>
<td>S9470</td>
<td>Nutritional counseling, dietitian visit</td>
</tr>
</tbody>
</table>

*This list is accurate as of June 2015. MCEs are required to cover additional services as they are updated by either the “A” and “B” services recommended by the United States Preventive Services Task Force Advisory Committee on Immunization Practices (ACIP)-recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM). MCEs must monitor these guidelines and update coverage as necessary.*

### Table 14.5 – Qualifying HIP Covered Preventive Services

<table>
<thead>
<tr>
<th>Covered Preventive Care Services</th>
<th>Male 19-34</th>
<th>Female 19-34</th>
<th>Male 35-49</th>
<th>Female 35-49</th>
<th>Male 50-64</th>
<th>Female 50-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual physical</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mammogram</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Pap smear</td>
<td>N/A</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Cholesterol testing *</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>45+</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood glucose screen *</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tetanus-diphtheria screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Flu shot *</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Annual or as required by your disease/history specific condition
2008: Preventive Office Visit

2009-2014: Preventive Office Visit or Age/Gender/Disease Specific Service with exception to immunizations

Table 14.6 – Eye care benefits for the following plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Eye Exams:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP Plus</td>
<td>One eye exam per year for members under 21 years old.</td>
</tr>
<tr>
<td>HIP Basic members ages 19 - 20</td>
<td>One eye exam every two years for members over 21 years old.</td>
</tr>
<tr>
<td>HIP State Plan Plus</td>
<td>Additional examinations must be medically necessary.</td>
</tr>
<tr>
<td>HIP State Plan Basic</td>
<td></td>
</tr>
<tr>
<td>All pregnant HIP members</td>
<td></td>
</tr>
</tbody>
</table>

Dental benefits are available to people in the following plans.

Table 14.7 – Dental benefits for the plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP Plus</td>
<td>Oral exams every six months</td>
</tr>
<tr>
<td></td>
<td>Emergency oral exams</td>
</tr>
<tr>
<td></td>
<td>Dental x-rays</td>
</tr>
<tr>
<td></td>
<td>– Complete set every three years</td>
</tr>
<tr>
<td></td>
<td>– Bite-wing x-rays once every 12 months</td>
</tr>
<tr>
<td></td>
<td>Teeth cleaning once every six months</td>
</tr>
<tr>
<td></td>
<td>Extractions and Fillings – Limit four fillings or extractions per 12 month period</td>
</tr>
<tr>
<td></td>
<td>(includes surgical removal of erupted or impacted tooth)</td>
</tr>
<tr>
<td></td>
<td>Major restorative services like crown</td>
</tr>
<tr>
<td>HIP Basic (members 19-20 years old)</td>
<td>Oral exams every six months</td>
</tr>
<tr>
<td>HPE (hospital presumptive eligibility) members 19-20 years old</td>
<td>Oral exams every six months</td>
</tr>
<tr>
<td></td>
<td>Emergency oral exams</td>
</tr>
<tr>
<td></td>
<td>Dental x-rays</td>
</tr>
<tr>
<td></td>
<td>– Complete set every three years</td>
</tr>
<tr>
<td></td>
<td>– Bite-wing x-rays once every 12 months</td>
</tr>
</tbody>
</table>
### Section 14: Covered Services

<table>
<thead>
<tr>
<th>HIP State Basic</th>
<th>HIP State Plus</th>
<th>All HIP Pregnancy Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Teeth cleaning once every six months</td>
<td>• Oral exams every six months</td>
<td>• Teeth cleaning once every six months</td>
</tr>
<tr>
<td>• Emergency oral exams</td>
<td>• Dental x-rays</td>
<td>• Fillings (limit one filling per tooth, per year)</td>
</tr>
<tr>
<td></td>
<td>– Complete set once every three years</td>
<td>• Extractions – Surgical removal of erupted or impacted tooth (No limit)</td>
</tr>
<tr>
<td></td>
<td>– Bite-wing x-rays once every 12 months</td>
<td>• Dentures and denture repairs</td>
</tr>
</tbody>
</table>

### IHCP-Covered Services Excluded from Hoosier Healthwise

Broad categories of service, covered by the IHCP but excluded from managed care, are payable as FFS claims by the State fiscal agent. If a managed care member becomes eligible for any of these services, then the member is disenrolled from Hoosier Healthwise managed care. Excluded services include the following:

- **Long-term institutional care:** Package A members and HIP members requiring long-term care in a nursing facility or intermediate care facility (ICF) for members with intellectual and developmental disabilities must be disenrolled from the Hoosier Healthwise or HIP programs and converted to fee-for-service eligibility in the IHCP. (See the process flowchart on the [MCO Question and Answer](https://indianamedicaid.com) page at indiana Medicaid.com for details.) Before the nursing facility can be reimbursed by the IHCP for the care provided, the nursing facility must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State must then approve the PASRR request, designate the appropriate level of care in CoreMMIS, and disenroll the member from Hoosier Healthwise or HIP.

  The MCE must coordinate care for its members who are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the [Long Term Care](https://indianamedicaid.com) module. The MCE is responsible for payment for up to 60 calendar days for its members placed in long-term care facilities while the level of care determinations are pending. However, the MCE may obtain services for its members in a nursing-facility setting on a short-term basis, such as for fewer than 30 calendar days. This may occur if this setting is more cost-effective than other options, and the member can obtain the care and services needed in the nursing facility. The MCE may negotiate rates for reimbursing the nursing facilities for these short-term stays.

- **Hospice care:** Hospice care is not covered under the Hoosier Healthwise program; however, terminally ill members may qualify for hospice care under the fee-for-service Medicaid program after they are disenrolled from Hoosier Healthwise. The hospice provider can submit a hospice election form for the member to the IHCP Prior Authorization Unit. The IHCP Prior Authorization Unit initiates the disenrollment of the member from managed care and facilitates hospice coverage. The MCE must coordinate care for its members who are transitioning into...
hospice by providing to an IHCP hospice provider any information required to complete the hospice election form for the MCE’s terminally ill members desiring hospice, as described in the Hospice Services module.

- **Home and community-based waiver services:** Home and community-based waiver services are also excluded from the Hoosier Healthwise and HIP programs. Similar to the situations described previously, members who have been approved for these waiver services must be disenrolled from managed care, and the MCE must coordinate care for its members who are transitioning into a HCBS waiver program until the disenrollment from Hoosier Healthwise or HIP is effective.

- **Psychiatric treatment in a State hospital:** Hoosier Healthwise members receiving psychiatric treatment in a state hospital are disenrolled from Hoosier Healthwise. HIP members receiving psychiatric treatment in a state hospital are not disenrolled from HIP, but must be directed to an alternative inpatient facility.

- **Psychiatric Residential Treatment Facility (PRTF) Services:** Members receiving treatment in a PRTF are not the MCE’s responsibility and are disenrolled from Hoosier Healthwise. When the prior authorization vendor enters a PRTF level of care for a Hoosier Healthwise member, the managed care assignment is automatically end-dated as of the date the PRTF level of care is entered in CoreMMIS. After the member is discharged from the PRTF and the level of care (LOC) is end-dated, the auto-assignment process immediately reassigns the member to his or her previous MCE with an effective date of the 15th of the month for discharges occurring on day one through day 14 of the month; or effective the first day of the following month for discharges that occur on day 15 through the last day of the month.

MCE members who qualify for long-term institutional care, hospice care, or waiver services are disenrolled from their Hoosier Healthwise managed care plans, according to the member disenrollment criteria outlined in Member Enrollment. MCEs must note that it is possible for a member’s Indiana Pre-Admission Screening/Pre-Admission Screening Resident Review (IPAS/PASRR) process to be underway (but not complete) when the member is linked to an MCE. In this situation, the financial responsibility lies with the MCE for no more than 60 days.

### Hoosier Healthwise Carve-outs and Related Services

Categories of service excluded from the capitation payment for an MCE’s enrolled Hoosier Healthwise membership but included in the managed care benefit package are called “carved-out” services. While the MCE retains responsibility for the delivery and payment of most care for its members, carve-outs remain the financial responsibility of the State and are reimbursed as fee-for-service (FFS) claims under the fiscal agent contract.

Services related to the carved-out services remain the financial responsibility of the MCE. Examples of related services include:

- Transportation.
- Ambulatory surgical center (ASC) and acute care hospital expenses that may have been incurred by the member during treatment.
- ASC expenses incurred in relation to a covered dental procedure remain the financial responsibility of the MCE, even though the MCE may not be liable for the primary procedure.
- When an MCE is notified that a carve-out service is provided, the MCE can attempt to manage the care by requesting that a provider use the MCE network facilities and other ancillary providers. If the provider uses out-of-network facilities, then the MCE must reimburse the facility and ancillary providers for medically necessary services.

### Other Services Carved Out of Risk-Based Managed Care Capitation

The following are other services that are carved out of capitation payments to the MCEs:

- Medicaid Rehabilitation Option services rendered by provider specialty 111 – Community Mental Health Center – to individuals, families, or groups living in the community who need intermittent aid for emotional disturbances or...
mental illness. MRO services include outpatient mental health services, partial hospitalization, case management, and assertive community treatment (ACT) intensive case management. MCEs are also responsible for care coordination for members receiving MRO services. For additional information about MRO services, see the Medicaid Rehabilitation Option (MRO) Services module.

- Dental services from providers enrolled in an IHCP dental specialty and billed on a dental claim form. Specialties include endodontist, general dentistry practitioner, oral surgeon, orthodontist, pediatric dentist, periodontist, pedodontist, mobile dentist, prosthodontist, and dental clinic. CMS-1500 claims and UB-04 claims submitted by dental providers and oral health services provided by nondental specialists (for example, anesthesiology) are not included in this carve-out and must continue to be submitted to the appropriate MCE.

- Services rendered by provider specialty 120 – School corporation – as part of a student’s individualized education plan (IEP). The MCEs must coordinate with the schools to ensure continuity of care and avoid duplication of services.

Pharmacy Benefits: Healthy Indiana Plan and Hoosier Healthwise

Prescription drugs are a benefit under the HIP and Hoosier Healthwise program to be covered by the MCE. The MCE shall support the FSSA in promptly responding to public and legislative inquiries involving the design and management of the MCE’s pharmacy benefit. If the MCE elects to subcontract with a PBM, then the MCE must ensure compliance with all subcontracting requirements as described in the contract between the State and the MCE, including but not limited to conducting regular audits and monitoring of the subcontractor’s data and performance, as well as requiring their PBM to conduct regular audits of their pharmacy provider networks.

Drug Rebates

The MCE shall ensure compliance with the requirements under Section 1927 of the Social Security Act. In accordance with the ACA, manufacturers that participate in the Medicaid drug rebate program are required to pay rebates for drugs dispensed to individuals enrolled with a Medicaid Managed Care Entity. To facilitate collection of these rebates, the FSSA must include utilization data of - MCEs when requesting quarterly rebates from manufacturers as well as in quarterly utilization reports to the CMS. Thus, the MCE shall submit their pharmacy encounter data to the State, in a manner required by the State. The MCE shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of paid amounts. The State intends to use and share the MCE paid amount information on the State’s pharmacy claim extracts for rebate purposes. Requirements for pharmacy encounter claims are outlined in Section 10.

The report will include information on the total number of units of each dosage form, strength and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to MCE members and such other data that the Secretary of the CMS determines necessary for the State to access rebates. This reporting shall include physician-administered drugs.

Additionally, the MCE shall assist the FSSA or the State’s PBM contractor in resolving drug rebate disputes with the manufacturer.

HIP Preferred Drug List and Formulary Requirements

The MCE shall maintain a distinct preferred drug list (PDL) for the MCE’s HIP State Plan package, as well as one distinct formulary applicable to the MCE’s HIP Plus and HIP Basic packages. In establishing its HIP formulary, the MCE shall ensure that the prescription drug benefit covers at least the same level of services as the base benchmark pharmacy benefit, including one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. Further, the HIP formulary must support the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3.
While the underlying drug formulary for the HIP Plus and the HIP Basic plans are identical, additional pharmacy services will differ between the plans in order to align the benefits with the overall program goals aimed at encouraging member participation in HIP Plus. Therefore, the HIP Basic pharmacy benefit is more restrictive than HIP Plus, as it only offers members access to brand name drugs through either step therapy or prior authorization, and the prescription supply is limited to 30 days. Also, prescriptions obtained by a HIP Basic or HIP State Plan Basic member and that are not otherwise exempt on the basis of being preventive, family planning, or maternity, are subject to member copayment requirements. Copayments assessed to the HIP Basic or HIP State Plan Basic member at the point of sale may not exceed the total cost of the drug.

Similarly, the HIP Plus pharmacy benefit must provide additional enhanced pharmacy services including the following: (i) greater access to many brand-name drugs, without prior authorization requirements; (ii) 90-day prescription supplies of routine maintenance medications, when requested by the member; (iii) mail order pharmacy benefit; (iv) Medication Therapy Management (MTM) Services; (v) and no copayment for any filled prescription. These additional pharmacy services shall only be made available to individuals participating in HIP Plus and HIP State Plan Plus benefits.

Before implementing a PDL or formulary, the MCE must (i) submit the PDL or formulary to the FSSA for submission to the Drug Utilization and Review (DUR) Board; and (ii) receive approval from the FSSA in accordance with IC 12-15-35-46.

At least 45 days before the intended implementation date of the PDL and formulary, the MCE shall submit its proposed PDL and formulary to the FSSA. The FSSA shall submit the PDL and formulary to the Drug Utilization Review (DUR) Board for review and recommendation. The MCE shall be accessible to the DUR Board to respond to any questions regarding the PDL and formulary. The DUR Board will provide a recommendation regarding approval of the PDL and formulary in accordance with the terms of IC 12-15-35-46. The FSSA will approve, disapprove, or modify the PDL and/or formulary based on the DUR Board’s recommendation. The MCE shall comply with the decision within 60 days after receiving notice of the decision.

The MCE shall utilize a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to the PDL and/or formulary. In accordance with IC 12-15-35-47, before removing one or more drugs from the PDL and/or formulary or otherwise placing new restrictions on one or more drugs, the MCE shall submit the proposed change to the FSSA, which shall forward the proposal to the DUR Board. Such changes shall be submitted at least 45 calendar days in advance of the proposed change. The MCE shall also meet with the FSSA staff, as directed by the FSSA, to answer questions about the clinical rationale for the proposed change. The DUR Board will provide a recommendation regarding approval of the proposed change to the PDL and/or formulary in accordance with the terms of IC 12-15-35-47. The FSSA will approve, disapprove, or modify the PDL and/or formulary based on the DUR Board’s recommendation. The MCE is not required to seek approval from the State in order to add a drug to the PDL or formulary; however, the MCE shall notify the FSSA of any addition to the PDL and/or formulary within 30 days after making the addition.

The PDL and formulary shall be made readily available to providers in the MCE’s network and to members. The PDL and formulary shall be updated to reflect all changes in the status of a drug or addition of new drugs. The MCE shall also support e-prescribing technologies to communicate the PDL and formulary to prescribers through electronic medical records (EMRs) and e-prescribing applications. The MCE shall develop provider education and outreach aimed at educating providers about the HIP PDL and formulary as well as the utilization of e-prescribing technologies to ensure appropriate prescribing for members based on the member’s benefit plan.

The MCE may opt to utilize the State’s PDL for its HIP State Plan pharmacy benefits and to contract with the State’s PBM contractor for HIP State Plan pharmacy claims processing. If the MCE takes this approach, then the MCE shall be permitted to utilize the work of the Therapeutics Committee and DUR Board in maintaining the State’s PDL for the MCE’s HIP State Plan benefits.
Hoosier Healthwise Preferred Drug List and Formulary Requirements

The Contractor shall maintain a distinct preferred drug list (PDL) for the Contractor’s Hoosier Healthwise packages.

The Hoosier Healthwise formulary shall support the coverage and non-coverage requirements for legend and non-legend drugs by Indiana Medicaid. More information can be found in 405 IAC 5-24-3, 405 IAC 5-24-4, 405 IAC 5-24-5 and 407 IAC 3-10-1.

Prior to implementing a PDL or formulary, the Contractor shall: (i) submit the PDL or formulary to the OMPP for submission to the Drug Utilization and Review (DUR) Board; and (ii) receive approval from the OMPP in accordance with IC 12-15-35-46.

At least forty-five (45) days before the intended implementation date of the PDL and formulary, the Contractor shall submit its proposed PDL and formulary to the OMPP. The OMPP shall submit the PDL and formulary to the Drug Utilization Review (DUR) Board for review and recommendation. The Contractor shall be accessible to the DUR Board to respond to any questions regarding the PDL and formulary. The DUR Board will provide a recommendation regarding approval of the PDL and formulary in accordance with the terms of IC 12-15-35-46. The OMPP will approve, disapprove or modify the PDL and/or formulary based on the DUR Board’s recommendation. The Contractor shall comply within sixty (60) days after receiving notice of the decision.

The Contractor shall utilize a Pharmacy and Therapeutics Committee which shall meet regularly to make recommendations for changes to the PDL and/or formulary. In accordance with IC 12-15-35-47, prior to removing one (1) or more drugs from the PDL and/or formulary or otherwise placing new restrictions on one (1) or more drugs, the Contractor shall submit the proposed change to the OMPP which shall forward the proposal to the DUR Board. Such changes shall be submitted at least forty-five (45) calendar days in advance of the proposed change. The Contractor shall also meet with the OMPP staff, as directed by the OMPP, to answer questions about the clinical rationale for the proposed change. The DUR Board will provide a recommendation regarding approval of the proposed change to the PDL and/or formulary in accordance with the terms of IC 12-15-35-47. The OMPP will approve, disapprove or modify the PDL and/or formulary based on the DUR Board’s recommendation. The Contractor is not required to seek approval from the State in order to add a drug to the PDL or formulary; however, the Contractor shall notify the OMPP of any addition to the PDL and/or formulary within thirty (30) days after making the addition.

The PDL and formulary shall be made readily available to providers in the Contractor’s network and to members. The PDL and formulary shall be updated to reflect all changes in the status of a drug or addition of new drugs. The Contractor shall also support e-Prescribing technologies to communicate the PDL and formulary to prescribers through electronic medical records (EMRs) and e-Prescribing applications. See Section 3.4.5 for additional requirements on e-Prescribing. Consistent with the requirements of Section 5.7, the Contractor shall develop provider education and outreach aimed at educating providers about the HIP PDL and formulary as well as the utilization of e-Prescribing technologies to ensure appropriate prescribing for members based on the member’s benefit plan.

The Contractor must consider, in its proposal, using the State’s PDL for all of its pharmacy plan benefits and to contract with the State’s PBM contractor for all pharmacy claims processing. The Contractor shall be permitted to utilize the work of the Therapeutics Committee and DUR Board in maintaining the State’s PDL for the Contractor’s HIP State Plan benefits.

Assure that non-drug products approved for use in compounding are not subject to rebating manufacturer requirements.

DUR Board Reporting Requirements

In accordance with IC 12-15-35-48, the DUR Board shall review the prescription drug programs of the MCE at least one time per year. This review shall include, but is not limited to, review of the following:

- An analysis of the single source drugs requiring prior authorization in comparison to other contractor’s prescription drug programs in the HIP program.


Dispensing and Monitoring Requirements

The MCE shall administer pharmacy benefits in accordance with all applicable state and federal laws and regulations. The MCE shall comply with the requirements of IC 12-15-35.5-3 in establishing prescribing limits to mental health drugs. For any drugs that require prior authorization, the MCE shall provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization. Additionally, the MCE shall provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation as required under 42 U.S.C 1396r-8(d)(5)(B). The MCE must employ an automated system for approval of a 72-hour emergency supply of a restricted drug. The automated system must allow the pharmacist to dispense the 72-hour supply and then follow-up with the MCE or provider the next business day.

The MCE may require prior authorization requirements, such as general member information, justification for drug related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number of drugs provided and duration of treatment. The MCE is required to have a process in place to provide the member drugs that are medically necessary but not included on the formulary.

The MCE shall provide online and real-time rules-based point-of-sale (POS) claims processing for pharmacy benefits. The MCE shall maintain prospective drug utilization review edits and apply these edits at the POS.

Additionally, the MCE shall implement retrospective drug use review to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and individuals receiving benefits, or associated with specific drugs or groups of drugs.

Administration of all criteria, common or independent, shall be performed by the MCE or its subcontracted PBM. The MCE shall regularly report findings on audits performed and outcomes completed by the PBM about providers as follows:

- The MCE shall regularly report findings on audits performed and outcomes completed by the MCE on its PBM
- The MCE shall immediately report, to the OMPP,
  - Claims processing outages experienced by the MCE and/or its PBM
- The MCE shall provide a root cause analysis of the outage to the office of Medicaid Policy and Planning (OMPP) in a timely manner
- Claims processing errors
  - The MCE shall provide a root cause analysis of the claims processing error to the office in a timely manner

The MCE shall monitor their PBM and report to the OMPP when the PBM does not meet the following service levels:
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• Escalation of requests to the appropriate contact within one business day
• Notification to the requestor of all escalations within one business day
• Provide call logs requested by the Contractor within one business day
• Answer at least 90% of all calls within 30 seconds (“answered” means the call is picked up by a qualified staff person)
• Average hold time shall not exceed 30 seconds
• Resolve all PA requests within 24 hours
• Resolve 95% of all call queries with the first call
• Notification to the Contractor of call breaches or system downtimes within one hour

E-Prescribing

The MCE shall support e-prescribing services. Much of the e-prescribing activity is supported by prescribing providers through web- and office-based applications or certified electronic health record (EHR) systems to communicate with the pharmacies. When EHR systems are used, the MCE shall supply the EHR systems with information about member eligibility, patient history, and the applicable PDL or drug formulary.

Services Excluded from Healthy Indiana Plan

The following benefits and services are noncovered under HIP:

• Services that are not medically necessary.
• Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly.
• Except for HIP State Plan, nonemergency transportation services (for example, transportation services that are unrelated to an emergency medical condition).
• Except for HIP State Plan, chiropractic services, except for services covered under the plan that are within the scope of practice of a chiropractor (for example, physical therapy) - Update 6-2011 IAC 9.
• Long-term or custodial care provided only to members on State Plans (plus or basic).
• Experimental and investigative services, as determined by the State.
• Day care and foster care.
• Personal comfort or convenience items.
• Cosmetic services, procedures, equipment or supplies, and complications directly relating to cosmetic services, treatment or surgery, with the exception of reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or a previous medically necessary procedure.
• Hearing aids and associated services, except for individuals 19 or 20 years of age - update 6-2011 IAC 9.
• Safety glasses, athletic glasses and sunglasses.
• LASIK and any surgical eye procedures to correct refractive errors.
• Vitamins, supplements, and over-the-counter medications, with the exception of insulin.
• Wellness benefits, other than tobacco use cessation.
• Diagnostic testing or treatment in relation to infertility.
• In vitro fertilization.
• Gamete or zygote intrafallopian transfers.
• Artificial insemination.
• Reversal of voluntary sterilization.
• Transsexual surgery.
• Treatment of sexual dysfunction.
• Body piercing.
• Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reiki therapy, massage therapy and herbal, vitamin, or dietary products or therapies.
• Treatment of hyperhidrosis.
• Court-ordered testing or care, unless medically necessary.
• Travel-related expenses including mileage, lodging, and meal costs.
• Missed or canceled appointments for which there is a charge.
• Services and supplies provided by, prescribed by, or ordered by immediate family members, such as spouses, caretaker relatives, siblings, in-laws, or self.
• Services and supplies for which an enrollee would have no legal obligation to pay in the absence of coverage under the plan.
• Evaluation or treatment of learning disabilities (except for individuals 19 or 20 years of age eligible for EPSDT services)
• Routine foot care, with the exception of diabetes foot care.
• Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia.
• Any injury, condition, disease, or ailment arising out of the course of employment, if benefits are available under any Worker’s Compensation Act or other similar law.
• Examinations for the purpose of research screening.
• Elective abortions and abortifacients.
• Abortions are covered only if the pregnancy is the result of an act of rape or incest, or if a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. No other abortions are covered.

Healthy Indiana Plan Pregnancy

HIP provides coverage for pregnancy-related services. If a woman becomes pregnant while enrolled in the HIP, then she may choose to remain in HIP or receive services through the pregnant women Medicaid aid category (MAGP). For members with income at or below 138% of the FPL, both of these options are marketed to the members as “HIP Maternity” in order to promote seamless transitions for members moving between HIP and MAGP. Members who apply for services while pregnant should be enrolled in Hoosier Healthwise, however there may be times when an already pregnant member is enrolled in HIP 2.0 based upon the enrollment process and when she notifies of her pregnancy. In these instances, the member should be treated as any other member who becomes pregnant while on HIP 2.0.
In addition to member self-reporting, the MCE shall also develop policies and procedures for quickly identifying pregnant HIP members. The MCE shall notify the State’s fiscal agent within one business day of confirming a member’s pregnancy. The notice must include the pregnancy start date as well as the expected delivery date. The date of confirmation means the date the MCE receives notification of member pregnancy from the provider. If the MCE discovers member pregnancy before provider confirmation, such as through claims data, then the MCE shall confirm member pregnancy with the provider within three business days of discovery.

The MCE is responsible for informing the member of the option to remain in HIP or to receive State Plan benefits through MAGP, and this information must, at minimum, be included in the MCE’s Member Handbook. The MCE shall also work closely with its providers to complete the Notification of Pregnancy risk assessment on all pregnant members.

If a pregnant woman chooses to stay in HIP, then she will receive maternity services through her existing HIP benefit package, as well as additional benefits during her pregnancy, such as non-emergency transportation. Pregnant members shall not be subject to any cost-sharing. After pregnancy has been confirmed and following notification from the State, the MCE must suspend the member’s POWER Account and all member cost-sharing, including POWER Account contributions and/or copayments, as applicable, effective the first day of the month following the notification. Pregnancy notifications received by the State less than six business days before the end of the month are processed to be effective the first day of the subsequent month. Notwithstanding the foregoing, at no time shall claims with a diagnosis of pregnancy be subject to member cost-sharing. The MCE shall have policies and procedures in place for quickly identifying pregnant members and suspending all cost-sharing. If the member is still in HIP at the time of her annual redetermination, then she is transferred to MAGP.

The submission of the supplemental file indicating that a member delivery has occurred generates a maternity delivery capitation payment for HIP members.

If the member chooses to transfer or is automatically transferred at redetermination to MAGP, then she is disenrolled from HIP and her POWER Account is closed, but she will remain in the MCE’s plan to receive her MAGP benefits (unless she requests a plan transfer or if the MCE’s provider network does not provide sufficient access to obstetricians/gynecologists). Pregnant women who transfer to MAGP can re-enroll in HIP after their pregnancy ends if they still meet HIP eligibility requirements. Instead of having to reapply after the pregnancy coverage ends, the member would become Basic Potential Plus and would have 60 days to make her payment.

**Eligibility Transfer**

When a member becomes pregnant, she must notify the State or MCE of her pregnancy. If the woman wishes to obtain coverage under HIP Maternity (MAGP), then she must request a transfer through the DFR. (See 405-IAC- 9).

MCEs and providers can help pregnant members transfer to MAGP coverage or obtain maternity coverage under HIP. (See 405 IAC 9-8-5.) Pregnant women can also contact the DFR call center directly to report a pregnancy and request a transfer from HIP to MAGP.

The DFR flags a woman as pregnant and changes her PAC to $0 if she chooses to remain in HIP during her pregnancy. The HIP MCE is notified of the member’s pregnancy via the 834 transaction. The MCE will freeze the member’s POWER Account and suspend billing the member during her pregnancy.

The DFR moves a woman requesting transfer to MAGP or flags her as pregnant and leaves her in HIP. If a woman chooses to transfer to MAGP, then the HIP MCE is notified of the member’s HIP termination date via the 834 transaction, after which the HIP MCE disenrolls the member. Until the HIP MCE receives notice of the member’s termination, the HIP MCE may reject pregnancy-related claims, but must cover all other services. The member is reassigned to the same MCE for Hoosier Healthwise that she had for HIP. Member will remain on HIP during the transition period to MAGP.

After a member is transferred to MAGP, the MCE shall issue the member a new ID card that will not include cost-sharing information. The MCE is responsible for issuing member ID cards to all pregnant women covered under the
MCE’s Hoosier Healthwise line of business, regardless of whether they were previously transferred from HIP. Based on the member FPL information provided by the State, the MCE shall ensure that all such ID cards issued to MAGP members with income at or below 138% FPL include the “HIP Maternity” program name, while member ID cards issued to MAGP members with income greater than 138% FPL should be designated as “Hoosier Healthwise.”

After a pregnant woman transfers to MAGP, she remains enrolled in MAGP until the completion of her postpartum period. Consider the following:

- A woman requesting re-enrollment in HIP
- If a woman re-enrolls in HIP, then she is eligible for a new 12-month benefit period.
- If a woman re-enrolls in HIP after her postpartum period, then she is disenrolled from MAGP.
- A member is not allowed to transfer from HIP to MAGP if the first pregnancy-related claim incurred is for covered standard HIP services, such as spontaneous abortion or any covered expense related to a termination of pregnancy – the involved MCE pays claims appropriately and is sensitive to the member’s case.

If a woman moves from HIP to MAGP and/or re-enrolls in HIP after her pregnancy, then the assigned MCE must provide for continuity of care and the coordination of medically necessary healthcare services during the transition period. If the member is transitioning from a different plan, then the HIP MCE must honor the prior MCE’s care authorizations for a minimum of 30 calendar days.

### Healthy Indiana Plan Pregnant Member Education

MCEs must establish policies and procedures to identify pregnant members and explain the option to enroll in MAGP or remain in HIP to receive pregnancy-related services. The MCE’s procedures must include a description of the process they use to follow up with pregnant members and make sure the member successfully obtains MAGP coverage, if the member chooses. (See 405 IAC 98-5.)

The MCE’s policies and procedures must specify that after the MCE becomes aware of a member’s pregnancy, the MCE informs the member of the member’s options during pregnancy to receive pregnancy-related services. These policies and procedures must specify or provide the following:

- Submit monthly reports to the State about members who become pregnant. This monthly report is called the Pregnancy Identification report, and it is due 30 days after the end of each month. These reports must include members ID numbers.
- Explain the option and process for transferring into MAGP.
- Establish provider education programs that inform providers about the HIP pregnancy policy.

In addition, the MCE must inform members, in writing, that in order to receive HIP coverage following the end of pregnancy, the member must promptly report the end of pregnancy before the expiration of her 60-day post-partum period. The notice must incentivize members to report the end of pregnancy to the MCE as soon as possible to minimize the chance of a coverage gap.

### Short-Term Placements in Long-Term Care Facilities

MCEs may allow their enrolled members to receive services in a nursing or long-term care (LTC) facility on a short-term basis (up to 30 days) if this setting is more cost-effective than other options, and if the member can obtain the care and services needed.

The MCE is financially responsible for short-term placement fees made to the nursing facility for Hoosier Healthwise members at the IHCP FFS rate or at a rate negotiated with the facility. For HIP, member reimbursement is at Medicare rates, or 130% of Medicaid rates if the service does not have a Medicare reimbursement rate. Refer to the following section for MCE responsibility after 30 days.
Hoosier Healthwise and Healthy Indiana Plan Members Pending Level of Care Determination

When a patient is admitted to or screened at an LTC facility, such as a nursing facility, community residential facility for the developmentally disabled (CRF/DD), or an intermediate care facility for individuals with intellectual disability (ICF/IID), the LTC provider must verify the patient’s IHCP eligibility and healthcare program to determine whether the individual is enrolled in a managed care program. The LTC provider must contact the managed care plan responsible for the patient’s care.

When eligibility information indicates that the patient is enrolled in Hoosier Healthwise, the LTC provider must contact the MCE identified by the Eligibility Verification System (EVS). The provider must verify the patient’s IHCP eligibility, not only at admission and screening, but again on the first and 15th of every month thereafter, because the member may change from FFS Medicaid to a managed care health plan.

When a managed care member is undergoing screening for admission to an IHCP-certified LTC or nursing facility, the facility must complete the level of care (LOC) paperwork and submit it to the appropriate agency. It is not until the LOC determination is entered into CoreMMIS that managed care enrollment is blocked or managed care disenrollment occurs. For additional information about this process, see the Long-Term Care module.

If the facility determines that a patient is enrolled with an MCE, then the provider must notify the MCE within 72 hours. If the provider fails to verify an IHCP member’s coverage or fails to contact the MCE within 72 hours of admission, then the provider is responsible for any charges incurred until the member is disenrolled from the MCE. When the provider notifies the MCE within 72 hours of admission, the MCE is liable for charges up to 60 days while the LOC determination is pending.

If the provider fails to complete the paperwork for the appropriate LOC determination, and the member is still enrolled in Hoosier Healthwise or HIP after two months, then the MCE is no longer liable for payment. However, as long as the patient is a member of the MCE, claims submitted to the State fiscal agent are denied payment. If the individual needs ongoing skilled nursing facility care (such as longer than 60 days), then a pre-admission screening must be completed, and the continued stay must be authorized, by the local Area Agency on Aging (AAA) before the 60th day. If a member is approved for long-term nursing facility placement by the AAA, then the long-term services are not covered by the MCE. For long-term stays, the nursing facility must complete the Physician Certification of Long Term Care Service Form 450B.

A member approved for long-term nursing facility placement is disenrolled from the Hoosier Healthwise or HIP and converted to FFS eligibility in the IHCP at the time the appropriate LOC information is entered in CoreMMIS. The MCE plays a critical role in monitoring its members who receive care in a nursing facilities and helping coordinate the transition to long-term care.

Continuity of Care

The State is committed to providing continuity of medical care during a member’s transition period among the various IHCP programs. The MCE is financially responsible for providing medically necessary care during the transition from one MCE to another Medicaid aid category/program. The MCE must have mechanisms in place to ensure the continuity of care and coordination of medically necessary healthcare services for its members. Some examples of the need for special consideration for continuity of care include, but are not limited to, the following:

- Transitions for members receiving behavioral health services, especially for those members who have received prior authorization from their previous MCE or through fee-for-service.
- Members transitioning into the Hoosier Healthwise or HIP program from traditional fee-for-service.
- Members transitioning between MCEs, particularly during an inpatient stay.
- Members transitioning between IHCP programs, particularly when a HIP member becomes pregnant or disabled.
• A HIP member’s transition following a medically frail determination.
• Members exiting the Hoosier Healthwise or HIP program to receive excluded services.
• HIP members transitioning to private insurance or Marketplace coverage.
• A HIP member’s transition to or from HIP Link coverage.
• Members transitioning to no coverage.
• A member’s transition between HIP benefit plans (for example, HIP Plus, HIP Basic, and HIP State Plan).

Newly enrolled members in the third trimester of their pregnancy may continue to receive prenatal, delivery, and postpartum care from their previous physicians. When the member notifies the MCE that she wishes to maintain the existing relationship for the duration of the pregnancy, the MCE contacts the doctor to confirm the existing relationship and arrange for payment of services to the out-of-network provider.

In situations such as a member or PMP disenrollment, the MCE must facilitate care coordination with other MCEs or other PMPs. When receiving members from another MCE or fee-for-service, the MCE must honor the previous care authorizations for a minimum of 30 calendar days from the date of enrollment with the MCE. The MCE must establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member’s enrollment in their plan. For purposes of clarification, the date of member enrollment for purposes of the prior authorization time frames set forth in this section begin on the date the MCE receives the member’s fully eligible file from the State.

When members enroll with an MCE or when they change MCEs, they may have received authorizations for services or procedures that were not completed on the effective dates of their enrollment in their new health plan. The prior authorizations may be for specific procedures, such as surgery, or for ongoing procedures authorized for specified durations, such as physical therapy or home healthcare. Requiring duplicate authorizations from the new health plan places an additional burden on the provider and can delay or inappropriately deny member’s treatments or services. MCEs must honor outstanding prior authorizations given for services within the IHCP (whether through managed care or traditional FFS) for the first 30 days of a member’s effective date in the new health plan. This authorization extends to any service or procedure previously authorized, including, but not limited to, surgeries, therapies, pharmacy, home healthcare, and physician services. MCEs may be required to reimburse out-of-network providers during the 30-day transition period.

When a member transitions to another source of coverage, the MCE shall be responsible for providing the receiving entity with information on any current service authorizations, utilization data, and other applicable clinical information such as disease management, case management, or care management notes.

The MCE is responsible for ensuring continuity of care coordination whenever a member disenrollment from the MCE occurs during an inpatient stay.

- In instances where reimbursement for the stay is based on a diagnosis-related group (DRG) methodology, the admitting MCE is responsible for the entire inpatient stay through member discharge. The admitting MCE is financially responsible for the hospital DRG payment and any outlier payments (without a capitation payment) until the member is discharged from the hospital or the member’s eligibility in Medicaid terminates. If the member is transitioning from the admitting MCE to another MCE or from the admitting MCE to Traditional Medicaid, the admitting MCE is responsible for care coordination, including coordination of discharge plans, with the receiving MCE or with the inpatient provider, as applicable.

- In instances where reimbursement for the inpatient stay is based on a level-of-care (LOC) methodology, the admitting MCE is responsible for the days of the inpatient stay during which the member is enrolled with the MCE and for the transition of care coordination for the remainder of the stay. The admitting MCE is financially responsible for the per diem payments and any outlier payments (without capitation payment) associated with the days the member remains enrolled with the admitting MCE. If the member is transitioning from the admitting MCE to another MCE or from the admitting MCE to Traditional Medicaid, the receiving MCE or the Traditional Medicaid program is responsible for the per diem payments associated with the days
the member is enrolled with the receiving MCE or in Traditional Medicaid, until the member is discharged from the hospital or the member’s eligibility for Medicaid terminates. The admitting MCE is responsible for the transition of care coordination with the receiving MCE or with the inpatient provider, as applicable.

The entity that issued the original prior authorization provides the new health plan with the following:

- Member identification number (RID)
- Provider ID number
- Procedure codes
- Duration and frequency of authorized services
- Other information pertinent to the determination

This information can be provided in spreadsheet format, computer screen prints, authorization form copies, or any other mutually agreed-upon format.

24-hour Nurse Call Line

The MCE must provide nurse triage telephone services for members to receive medical advice 24 hours a day, seven days a week from trained medical professionals. The 24-hour nurse call line must be well publicized and designed to help discourage members’ inappropriate use of the emergency room, particularly for members in disease management. The 24-hour nurse call line must have a system in place to communicate all issues with the member’s PMP. In addition, the 24-hour nurse call line must be equipped to provide advice and copayment waivers for HIP member’s seeking services from hospital emergency departments. Refer to Section 4, Emergency Room Copayment Procedure for Healthy Indiana Plan for more information on the State’s graduated emergency department copayment application for HIP members and available copayment waivers.

Women, Infants and Children Infant Formula for Hoosier Healthwise Members

For Medicaid-covered nutritionals that are covered by the Women, Infants and Children (WIC) program, the MCE is not the payer of last resort. The MCE must not deny these types of claims in Hoosier Healthwise because the member has other insurance.

Disease Management

The MCE must offer Hoosier Healthwise and HIP members disease management services, at minimum, for the following:

- Asthma
- Depression
- Pregnancy
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism/Pervasive Developmental Disorder (PDD)
- Coronary Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Chronic Kidney Disease (CKD)
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• Congestive Heart Failure (CHF)
• Diabetes disease management programs
• HIV
• Hepatitis C

Members with excessive utilization or under-utilization for conditions other than those listed must also be eligible for the disease management services described in this section. Members with these conditions must be identified through the health screening tool referenced in Section 5: Member Services and by identification of conditions based on claims.

The MCE must make a spectrum of disease management tools available to the population, including population-based interventions, and case and care management. All case and care management disease management programs must identify members’ psychosocial issues that may contribute to poor health outcomes and provide appropriate support services for addressing such issues.

The MCE must submit quarterly reports to the State on disease management programs, as outlined in the Hoosier Healthwise/HIP Reporting Manual. The quarterly reports must include participation rates and utilization and cost statistics of both total members enrolled in the disease management programs, as well as HIP medically frail members enrolled in the disease management programs. For example, the diabetes disease management quarterly report will include (i) all medically frail members with two or more claims in the calendar year for diabetes, and the numerator shall include all members with two or more claims in the calendar year for diabetes; and (ii) all members with two or more claims in the calendar year for diabetes, and the numerator shall include those members enrolled in case or care management as defined below. Separate, mutually exclusive calculations for members in case and care management shall be conducted. The reports must also identify any member at least three standard deviations outside of the mean of utilization of inpatient days, emergency department visits, and home health service days for the population group.

All disease management programs must encourage compliance with national care guidelines (such as American Diabetic Association) and offer incentives for a member’s healthy behaviors. All members must be sent population-based disease management materials (such as educational fliers, screening reminders, and so forth). The State believes that the MCE’s disease management programs serves as a critical area for pursuing continuous innovation in improving member health status, and disease management programs may be subject to on-site visits or external quality reviews.

The State reserves the right to require the MCE to have disease management programs for additional conditions in the future. The State provides three months’ advance notice to the MCE if the State decides to add new diseases to the requirements of the disease management program.

The MCE is encouraged to offer additional disease management programs beyond those required in the Scope of Work. If the MCE provides additional disease management programs, then the MCE must also provide annual updates to the State documenting the strategies, outcomes, and efficacy of the additional disease management programs.

The State reserves the right to examine the MCE’s disease management programs at any time, including during the proposal review process, before contract execution, during the readiness review, and during the term of the contract. The MCE must obtain the State’s approval of materials related to disease management programs that is distributed to members or providers.

Disease management consists of three levels of MCE-member interaction:

• Population-based interventions
• Case management
• Care management
Population-Based Interventions

The MCE must engage members with the conditions of interest, or the parents of children with conditions of interest, through disease-specific and population-based preventive-care interventions, including educational materials, and appointment and preventive care reminders. All pregnant members must receive standard pregnancy care educational materials, the State-approved tobacco cessation materials, and access information for 24-hour nurse call lines. Members may be eligible for more than one condition. Materials must be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials, including clinical practice guidelines. Materials must also be at a fifth-grade reading level. All members with conditions of interest must receive materials no less than biannually. The MCE must document the number of members with conditions of interest, mailings, and website hits.

Case Management

The MCE’s protocol for referring members to case management must be reviewed by the State and must be based on identification through the health screening, or when the claims history suggests need for intervention. In addition to population-based disease management educational materials and reminders, these members must receive more intensive services. Members with newly diagnosed conditions, increasing health services or emergency services utilization, evidence of pharmacy noncompliance for chronic conditions, and identification of special healthcare needs, must be strongly considered for case management. Case management services include direct consumer contacts to assist members with the following:

• Scheduling appointments
• Locating specialists and specialty services
• Transportation needs
• 24-hour nurse line
• General preventive services, such as mammography
• Disease-specific reminders, such as Hgb A1C
• Pharmacy refill reminders
• Tobacco cessation
• Education about using primary care and emergency services

The MCE must make every effort to contact members in case management via telephone. Materials must also be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials, including clinical practice guidelines. Materials must be developed at the fifth-grade reading level. All members with conditions of interest must receive materials no less than quarterly. The MCE must document the number of persons with conditions of interest, outbound telephone calls, telephone contacts, category of intervention, intervention delivered, mailings, and website hits. Case management must be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program is not a replacement for case management.

Care Management

The MCE’s protocol for referring members to care management must be reviewed by the State and must be based on identification through the health screening as having special care needs, a condition of interest named previously, or a chronic or comorbid disease history that indicates the need for real-time, pro-active intervention. Persons with clinical medical training must be required to develop the member’s care plan, and care plans must be reviewed by the medical director. Care plans developed by the MCE must include clearly stated healthcare goals, defined milestones to document progress, clearly defined accountability and responsibility, and timely, thorough review with appropriate corrections (course changes), as indicated. The MCE’s care management services must involve the active management
of the member and his or her group of healthcare providers, including physicians, medical equipment, transportation, and pharmacy. The member’s healthcare providers must be included in the development and execution of member care plans. Care plans and care management must take into account comorbidities being jointly managed and executed. Separate care plans for each medical problem for the same member may fragment care and add to the potential of missing interactive factors.

The MCE must contact members via telephone and in person, as indicated by their need. Care managers must engage in care conferences with the member’s healthcare providers, as necessary. Members must receive the same educational materials, delivered in the same manner, as to those persons receiving case management.

**Provision of Enhanced Services in Risk-Based Managed Care**

In addition to mandated covered benefits and services, MCEs are encouraged to offer enhanced services to their members. In particular, MCEs are encouraged to offer enhanced services that address prevention, personal responsibility, and cost and quality transparency.

For enhanced services developed for HIP, the enhancements must be developed to align with the overall program goals aimed at creating a commercial market experience and encouraging member participation in HIP Plus. Therefore, enhanced benefits and services shall only be offered to HIP Plus and HIP State Plan Plus members. POWER Account funds for HIP members may be used to pay for enhanced services obtained before the member’s $2,500 deductible has been met. However, notwithstanding the foregoing, the MCE may elect to provide enhanced benefits and services to HIP Basic and HIP State Plan Basic members, provided that such benefits and services are NOT applied against the member’s POWER Account.

The MCE may not offer gifts or incentives greater than $10 in value for each individual, and such incentives are limited to $50 per year per individual. The MCE may petition the State for authorization to offer items or incentives with a higher value if the items are intended to promote the delivery of certain preventive care services. Member incentive programs may not be advertised to non-members. The State does not approve any mass marketing materials that describe member incentive programs. MCEs must advertise incentives only to current members through media such as member handbooks, letters, or telephone calls directed to current membership.

MCEs must submit proposals in writing to the State sixty (60) calendar days before implementing the enhanced service. All enhanced services must comply with marketing, education, and outreach guidelines.

Enhanced services may include, but are not limited to, such items as:

- Enhanced transportation arrangements (for example, transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.)
- Enhanced tobacco cessation services
- Additional disease management programs
- Healthy lifestyles incentives
- Group visits with nurse educators and other patients

**Member Financial Responsibility**

**Copayments and Cost-sharing in Hoosier Healthwise Package C**

Certain services such as emergency transportation and pharmacy may be subject to member copayments in Hoosier Healthwise Package C. Providers cannot refuse to see members based on the members’ inability to pay the copayment, and must accept IHCP reimbursement as payment in full for the services rendered. However, pharmacies may deny pharmacy services based on inability to pay the Package C copayment for that expense, if it is the custom and policy
of that pharmacy to deny services to any person based on inability to pay. The pharmacy’s custom and policy to deny services based on inability to pay cannot apply to IHCP members only.

There are no member copayments or cost-sharing obligations in Hoosier Healthwise Packages A and P.

**Copayments and Cost-sharing in the Healthy Indiana Plan**

All HIP members (with the exception of members exempt from cost-sharing) are required to pay monthly contributions towards their POWER Account or copayments for services received. Specific cost-sharing requirements vary by plan type.

- **HIP Plus Member Cost-Sharing**: In order to participate in HIP Plus or HIP State Plan Plus, individuals are required to help fund the $2,500 deductible by contributing to their POWER Account on a monthly basis. Required contributions shall be calculated at 2% of the member’s gross annual household income. For married couples participating in HIP Plus, the State will divide the monthly contribution between the two HIP-eligible married adults, and each member is responsible for half of the calculated amount on a monthly basis. Regardless, in no event will a member’s monthly POWER Account contribution be more than $100 or less than $1. The State will determine the individual’s required monthly POWER Account contribution and will notify the MCE of this amount.

- **HIP Basic Member Cost-Sharing**: Members enrolled in HIP Basic or HIP State Plan Basic are not required to make monthly contributions to their POWER Account, but are required to pay the following copayments at the time services are rendered:

  Copayments are collected based on one charge per type of service, per provider, per date of service:

  – No copayment is required for preventative care, maternity services, or family planning services.
  – $4.00 copayment for outpatient services.
  – $75.00 copayment for inpatient services.
  – $4.00 copayment for preferred drugs.
  – $8.00 copayment for non-preferred drugs.

- **HIP State Plan Member Cost-Sharing**: Members receiving HIP State Plan benefits must either pay POWER Account contributions in an amount equivalent to HIP Plus members, if the member is enrolled in HIP State Plan Plus, or copayments for services in an amount equivalent to HIP Basic members, if the member is enrolled in HIP State Plan Basic.

- **Exempt Populations**: Pursuant to federal law, the MCE may not collect POWER Account contributions or impose any other cost-sharing, including co-payments for non-urgent use of hospital emergency departments, on members who are pregnant or members identified as an American Indian/Alaska Native (AI/AN) pursuant to 42 CFR 136.12. The State will identify all AI/AN members through the eligibility determination process.

**Charging Members for Services Rendered**

In limited instances, a provider can charge IHCP members, including those in Hoosier Healthwise, for services. Services not covered by the IHCP, such as cosmetic procedures or services that have been denied through the prior authorization process, can be billed to the member if the provider receives and retains the member’s signed statement accepting financial responsibility for the services. This statement must be specific about the services to be billed; must be signed by the member before receiving the services; and must be retained as documentation in the patient’s medical record. See the Charging Members for Noncovered Services section of the Provider Enrollment module for additional information about member billing.

A provider may bill a Hoosier Healthwise or HIP member if the provider has taken appropriate action to identify a responsible payer, and the member failed to inform the provider of his or her eligibility before the one-year claim filing limitation.
Healthy Indiana Plan Member’s Maximum Total Annual Aggregate Cost-sharing

Total member cost sharing will not exceed 5% of family income as calculated on a quarterly basis, except that all HIP Plus or HIP State Plan Plus members whose household income is at or below 5% of the FPL are required to contribute, at a minimum, monthly $1 POWER Account contributions. The MCE will work with the State to consider all contributions made by the household in the calculation and monitoring of the 5% contribution limit.

As used in this section, total aggregate cost-sharing means POWER Account payments, HIP copayments, ER copayments, Medicaid copayments, member debt collected by the MCE during the quarter, and/or other cost-sharing information available to the MCE. Any service not specifically listed as a covered benefit in the applicable HIP alternative benefit plan may not be applied against the member’s 5% contribution calculation. For purposes of this section, the household income includes the income considered in 407 IAC 2-2-2.

The MCE and member are responsible for monitoring their total aggregate cost-sharing for the benefit period to ensure that it has not reached 5% of the family’s income. It is recommended that the member maintain all documentation to substantiate the amount of cost sharing paid by the family. When a family’s total cost-sharing expenditures come close to exceeding 5% of the family’s income in the quarterly period, the MCE shall be required to notify the State. The MCE shall also coordinate with the State to notify providers and the family that additional cost-sharing during the period is reduced or waived.

When the MCE identifies a member or a member notifies their MCE with satisfactory documentation that substantiates that their total aggregate cost-sharing has reached 5% of their income for the benefit quarter:

- The MCE will notify the State that the member has reached their cost-sharing maximum for the benefit quarter.
- The State will notify the MCE via the 834 benefit transaction of the member new $0 cost sharing for the remainder of the benefit quarter.
- Members are not required to pay any further POWER Account contributions or any copayments for the remainder of the benefit quarter. The members will still be billed $1.00 PAC, even if they met the 5 percent cost share.
- The MCE refunds any ER copayments paid during the remainder of the benefit quarter.
- The MCE notifies the HIP program manager via email and includes the member’s name, RID, the member’s current benefit period span, the member’s total income, the member’s total aggregate cost-sharing amount documented by the member, and the date that the member reached the 5% maximum.
- Members with income below $27 will have their cost share obligation.

Annual and Lifetime Benefit Caps in the Healthy Indiana Plan

The HIP has no annual or lifetime benefit caps.
Section 15: Member Services

Overview

The State encourages the managed care entity (MCE) to promote its plans as a solution for the entire family and must include information about Hoosier Healthwise and Healthy Indiana Plan (HIP) in its marketing and outreach activities. All promotional efforts must jointly market the MCE’s Hoosier Healthwise and HIP products and services. All marketing efforts must be targeted to the general community in the MCE’s entire service area. In accordance with 42 CFR 438.104, the MCE cannot conduct, directly or indirectly, door-to-door, telephone, or other cold-call marketing enrollment practices. Cold-call marketing is defined in 42 CFR 438.104 as any unsolicited personal contact by the MCE with a potential Medicaid enrollee. Additionally, the MCE must not distribute any marketing materials without first obtaining the State approval.

Marketing and Outreach

The MCE may market by mail, mass media advertising (for example, radio and television), and community-oriented marketing directed at potential members. The MCE must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The MCE must provide information to potentially eligible individuals who live in medically underserved rural areas of the State. Marketing materials must include the requirements and benefits of the MCE’s health plans and provider network.

The MCE cannot, under any circumstances, encourage a potential member to join its health plan by offering any other type of insurance as a bonus for enrollment. The MCE must make every effort to ensure that all potential members make their own decision as to whether or not to enroll. Marketing materials and plans must be designed to reach a distribution of potential members across age and sex categories. Potential members must not be discriminated against based on their health status or their need for healthcare services, or any other basis inconsistent with state or federal law.

The MCE may offer potential members tokens or gifts of nominal value, so long as the MCE acts in compliance with all marketing provisions provided for in 42 CFR 438.104, and other federal and state regulations and guidance regarding incentives for the Medicare and Medicaid programs.

The MCE must submit to the State an annual marketing plan. The annual marketing plan is due within 60 calendar days of the beginning of each calendar year. All member marketing and outreach materials must be submitted to the State for approval before distribution.

Any outreach and marketing activities (written and verbal) must be presented and conducted in an easily understood manner and format, at a fifth-grade reading level, and must not be misleading or designed to confuse or defraud. Examples of false or misleading statements include, but are not limited to, the following:

- Any assertion or statement that the member or potential member must enroll in the MCE’s health plan to obtain benefits or to avoid losing benefits
- Any assertion or statement that the MCE is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, or a similar entity
- Any assertion or statement that the MCE’s health plan is the only way to obtain benefits under the Hoosier Healthwise or HIP programs

The MCE may distribute or mail an informational brochure or flyer to potential members or provide (at its own cost, including any costs related to mailing) such brochures or flyers to the State for
distribution to individuals that apply for the Hoosier Healthwise and HIP programs throughout the State.

The MCE may submit promotional poster-sized wall graphics to the State for approval. If approved, then the MCE may make these posters available to the local Division of Family Resources (DFR) offices and other enrollment centers for display in an area where application and MCE selection occurs. The local DFR offices and enrollment centers may display these promotional materials at their discretion. The MCE may display these same promotional materials at community health fairs or other outreach locations. The State must pre-approve all promotional and informational brochures or flyers, and all graphics, before they are displayed or distributed.

**New Member Materials**

Within five calendar days of a new member’s enrollment, the MCE must send new members a Welcome Packet. The Welcome Packet must include, but is not limited to, a new member letter, explanation of where to find information about the MCE’s provider network, and a copy of the member handbook. For HIP members, the Welcome Packet may also include a Medicaid ID card. The Medicaid ID card must include the member’s RID and the applicable emergency services copayment amount.

The Welcome Packet must also include information about selecting a primary medical provider (PMP), completing a health screening, and any unique features of the MCE. For example, when the MCE provides incentives to members for completing a health screening, a description of the member incentive must be included in the Welcome Packet. The MCE can use the health assessment to determine the member’s health such as medically frail, etc. For HIP members, the Welcome Packet must also include educational materials about the POWER Account and POWER Account rollover, as well as the recommended preventive care services for the member’s benefit year.

**General Information Review, Approval, and Requirements**

The MCE must develop, and include, an MCE-designated inventory control number on all member promotional, education, or outreach materials with date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate the State’s review and approval of member materials and to document its receipt and approval of original and revised materials. The MCE must keep a log of all member materials used during the year, and must submit its member handbook to the State annually for review.

The MCE must submit all marketing, promotional, educational, and outreach materials to the State for review and approval at least 30 calendar days before the materials’ expected use and distribution. The MCE must get the State’s approval to use or display program logos each time the MCE wishes to do so. The MCE must not assume the State will approve using the logo just because the State has previously approved the logo’s use. The MCE must obtain the State’s approval before distributing or using materials. The State shall assess liquidated damages or other remedies if the MCE uses or distributes unapproved member materials.

All State-approved member and potential member communication materials must be available on the MCE’s provider website within three business days of distribution.

The MCE must produce member materials and may distribute member materials only if they are approved by the State and compliant with 42 CFR 438.10. If the State requests, then the MCE must provide information about how the materials are used for member education and enrollment.

This information may include, but is not limited to, the following:
Section 15: Member Services

- A provider directory listing the MCE’s providers and identifying each provider’s specialty, service locations, hours of operation, telephone numbers, public transportation access, and other demographic information, in accordance with 42 CFR 438.10(f)(6)(i).

- MCE member bulletins or newsletters issued not fewer than four times a year that provide updates related to covered services and access to providers.

- Updated policies and procedures specific to the Hoosier Healthwise and HIP populations.

- MCE telephone system scripts and commercials-on-hold.

- MCE-distributed literature about all health or wellness programs the MCE offers.

- The MCE’s marketing and promotional brochures and posters.

- A member handbook that describes the terms and nature of services offered by the MCE and contact information, including the MCE’s website address.

The MCE must make written information available in English and Spanish and other prevalent non-English languages, as identified by the State, at the member’s request. The MCE must identify additional languages that are prevalent among members, inform members that information is available on request in alternative formats, and tell members how to obtain alternative formats (the State defines alternative formats as Braille, large-font letters, audiotape, prevalent languages, and verbal explanations of written materials). To the extent possible, written materials must not exceed a fifth-grade reading level. The MCE must notify its members of the respective programs’ covered services that the MCE does not cover on moral or religious grounds, and must offer guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102. The MCE must provide this information to members before and during enrollment, and within 90 calendar days after adopting the policy with respect to any particular service. The MCE must inform members that, at a member’s request, the MCE provides information on the structure and operation of the MCE and, in accordance with 42 CFR 438.6(h), provides information on the MCE’s provider incentive plans.

The MCE is responsible for developing and maintaining member education programs designed to offer members clear, concise, and accurate information about the MCE’s program, the MCE’s provider network, and the Hoosier Healthwise and HIP programs. The State encourages the MCE to incorporate community advocates, support agencies, health departments, other governmental agencies, and public health associations in its outreach and member education programs. The State also encourages the MCE to develop community partnerships with these types of organizations to promote health and wellness within its membership.

### Electronic Communications

The MCE must provide an opportunity for members to submit questions or concerns electronically, via email, and through the member website. If a member’s email address is required to submit questions or concerns electronically to the MCE, then the MCE must help the member establish a free email account.

The MCE must respond within 24 hours to questions and concerns submitted by members electronically. If the MCE is unable to answer or resolve the member’s question or concern within 24 hours, then the MCE must notify the member that additional time is required and identify when a response is provided. A final response must be provided within three business days.

The MCE must have reporting capability for email communications received and responded to, such as total volume and response times. The MCE must be prepared to provide this information to the State on request.
The MCE shall collect information on member’s preferred mode of receipt of MCE-generated communications and send materials in the selected format. Options shall include the ability to receive paper communications via mail or electronic communications through email or a secure web portal when confidential information is to be transmitted. When a member notifies the MCE of selection to receive communications electronically, that choice shall be confirmed through regular mail with instructions on how to change the selection if desired. Additionally, emails shall be sent to members alerting them anytime an electronic notice is posted to the portal; no confidential information shall be included in emails. In the event such a notification email is returned as undeliverable, the MCE shall send the notice by regular mail within three business days of the failed email. When applicable, the MCE shall comply with a member’s preferred mode of communication.

**Website**

The MCE must provide information to members through an Internet website in a State-approved format, compliant with Section 508 of the *US Rehabilitation Act*, to ensure compliance with existing accessibility guidelines. The website must be live and meet the requirements of this section on the effective date of the contract. The State must preapprove the MCE’s website information and graphic presentations. The website must be accurate and current, culturally appropriate, written at a fifth-grade reading level, and available in English and Spanish. The MCE must inform members that information is available in alternative formats on request and advise how to request another format. To minimize download and wait times, the website must avoid techniques or tools that require significant memory or disk resources, or require special intervention on the user side to install plug-ins or additional software. The MCE must date each webpage, change the date with each revision, and allow users print access to the information. Such website information must include, at minimum, the following:

- MCE’s searchable provider networks for Hoosier Healthwise and HIP – Identifying each provider’s specialty, service locations, hours of operation, telephone numbers, public transportation access, and other demographic information.
- Updates to the online provider network information at least every two weeks.
- Contact information for member inquiries, member grievances, or appeals.
- Member services telephone number, telecommunications device for the deaf (TDD) number, hours of operation, and after-hours access numbers.
- Member portal with access to electronic explanation of benefits (EOB) statements.
- For HIP members, the member portal must also include up-to-date POWER Account balance information, including the required annual and monthly contribution amounts and payments made.
- Preventive care and wellness information.
- For HIP, this information must include the preventive care services covered under the preventive care benefit and the preventive care services that qualify a member for POWER Account rollover.
- Information about well-child visits, EPSDT, and the MCE’s prenatal services.
- Information about the cost and quality of healthcare services.
- A list of covered benefits and services by program.
- Wellness and prevention programs or prenatal services.
- Description of the MCE’s disease management programs.
- Marketing brochures and posters.
- Notification letters to members regarding MCE decisions to terminate, suspend, or reduce previously authorized covered services.
Member Information, Outreach, and Education

The MCE must provide the information listed in this section within a reasonable period, following notice from the State fiscal agent of the member’s enrollment in the MCE. This information must be included in the member handbook. In addition, the MCE must notify members at least once per year of their right to request and obtain the information listed in this section. If the MCE makes significant changes to the information provided under this section, then the MCE must notify the member in writing of the intended change at least 30 calendar days before the intended effective date of the change, in accordance with 42 CFR 438.10(f)(4). The State defines significant changes as any changes that may affect member accessibility to the MCE’s services and benefits.

The MCE’s educational activities and services must also address the special needs of specific Hoosier Healthwise and HIP subpopulations (such as pregnant women, newborns, children during early childhood, at-risk members, medically frail members, and children with special needs), as well as its general membership. The MCE must demonstrate how these educational interventions reduce barriers to healthcare and improve health outcomes for members.

The MCE must have in place policies and procedures to ensure that materials are accurate in content, accurate in translation relevant to language or alternate formats, and do not defraud, mislead, or confuse the member. The MCE must provide information requested by the State, or the State’s designee, for use in member education and enrollment, on request.

The MCE must comply with the requirements of 42 CFR 422.128 for maintaining written policies and procedures for advance directives with respect to all adult individuals receiving medical care by or through the MCE’s health plan. Specifically, each MCE must maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489. Advance directives are defined in 42 CFR 489.100 as “a written instruction, such as a living will or durable power of attorney...
for healthcare, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated."

Written information about the MCE’s advance directive policies, including a description of applicable State law, must be provided to members, in accordance with 42 CFR 438.10(g)(2) and 438.6(i). Written information must reflect changes in State law as soon as possible, but no later than 90 calendar days after the effective date of the change. Each MCE must provide written information to those individuals with respect to their rights under state law, and the MCE’s policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR 422.128(b) for further information regarding this requirement.

The MCE must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State.

The MCE must inform the members that, upon the member’s request, the MCE will provide information on the structure and operation of the MCE and, in accordance with 42 CFR 438.6(h), will provide information on the MCE’s provider incentive plans.

Grievance, appeal, and fair hearing procedures and time frames must be provided to members in accordance with 42 CFR 438.10(g)(1). See Section 6.9 in the RFS #10-40 – Contractor Scope of Work for further information about grievance, appeal, and fair hearing procedures, as well as the kind of information the MCE must provide to members.

**Member Handbook**

The MCE must develop a member handbook for Hoosier Healthwise and HIP members. The MCE may choose to develop separate handbooks for Hoosier Healthwise and HIP lines of business. The MCE’s member handbook must be submitted annually for the State’s review. The member handbook must include the MCE’s contact information and Internet website address, and describe the terms and nature of services offered by the MCE, including the following information required under 42 CFR 438.10(f)(6).

The HIP member handbook must include the following:
- Contractor’s contact information (address, telephone number, TDD number, website address);
- The amount, duration and scope of services and benefits available under the Contract in sufficient details to ensure that participants are informed of the services to which they are entitled, including, but not limited to the differences between the HIP Plus and HIP Basic benefit options;
- The procedures for obtaining benefits, including authorization requirements;
- Contractor’s office hours and days, including the availability of a 24-hour Nurse Call Line;
- Any restrictions on the member’s freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers;
- The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f)(6)(viii), such as what constitutes an emergency;
- The post-stabilization care services rules set forth in 42 CFR 422.113(c);
- The extent to which, and how, urgent care services are provided;
- Applicable policy on referrals for specialty care and other benefits not provided by the member’s PMP, if any;
• HIP pregnancy policies, including, but not limited to a description of the HIP Maternity program and the member’s ability to transfer to MAGP during pregnancy, information on how to initiate the transfer, as well as information on requirements for transferring back to HIP following end of pregnancy;

• HIP cost-sharing policies, including, but not limited to non-payment penalties resulting in lock-out or transfer to HIP Basic, as well as the exceptions to such non-payment penalties, as detailed in Section 4.8.1;

• HIP co-payments for emergency room services, and the ability to receive a waiver by calling the 24-hour Nurse Call Line prior to utilizing a hospital emergency department;

• Information about the availability of pharmacy services and how to access pharmacy services;

• Member rights and protections, as enumerated in 42 CFR 438.100, which relates to enrollee rights. See Section 7.8 for further detail regarding member rights and protections;

• Responsibilities of members;

• Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside the Contractor’s network;

• Procedures for obtaining out-of-network services;

• Standards and expectations to receive preventive health services;

• Policy on referrals to specialty care;

• Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites;

• Procedures for appealing decisions adversely affecting members’ coverage, benefits or relationship with the Contractor, including, but not limited to a medically frail determination;

• Procedures for changing PMPs;

• Standards and procedures for changing MCEs, and circumstances under which this is possible, including, but not limited to providing contact information and instructions for how to contact the enrollment broker to transfer MCEs due to one of the “for cause” reasons described in 42 CFR 438.56(d)(2)(iv), including, but not limited to, the following:
  o Receiving poor quality of care;
  o Failure to provide covered services;
  o Failure of the Contractor to comply with established standards of medical care administration;
  o Lack of access to providers experienced in dealing with the member’s health care needs;
  o Significant language or cultural barriers;
  o Corrective action levied against the Contractor by the office;
  o Limited access to a primary care clinic or other health services within reasonable proximity to a member’s residence;
  o A determination that another MCE’s formulary is more consistent with a new member’s existing health care needs;
  o Lack of access to medically necessary services covered under the Contractor’s contract with the State;
  o A service is not covered by the Contractor for moral or religious objections, as described in Section 9.3.3;
  o Related services are required to be performed at the same time and not all related services are available within the Contractor’s network, and the member’s provider determines that receiving the services separately will subject the member to unnecessary risk;
  o The member’s primary healthcare provider disenrolls from the member’s current MCE and reenrolls with another MCE; or
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- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

- The process for submitting disenrollment requests. This information shall include the following:
  - HIP member may only change MCEs for cause, unless the change is requested prior to either (i) making their initial POWER account contribution or fast track prepayment or (ii) being enrolled in HIP Basic or HIP State Plan Basic in accordance with Section 4.7, whichever occurs first;
  - Members are required to exhaust the MCE’s internal grievance and appeals process before requesting an MCE change due to poor quality of care;
  - Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing, after exhausting the MCE’s internal grievance and appeals process; and
  - The MCE shall provide the Enrollment Broker’s contact information and explain that the member must contact the Enrollment Broker with questions about the process. This information shall include how to obtain the Enrollment Broker’s standardized form for requesting an MCE change.

- The process by which an American Indian/Alaska Native member may elect to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State;

- Procedures for making complaints and recommending changes in policies and services;

- Grievance, appeal and fair hearing procedures as required at 42 CFR 438.10(g)(1), including the following:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process;
  - The toll-free numbers that the member can use to file a grievance or appeal by phone;
  - The fact that, if requested by the member and under certain circumstances: (1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and (2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.

- For a State hearing describe (i) the right to a hearing, (ii) the method for obtaining a hearing, and (iii) the rules that govern representation at the hearing.

- Information about advance directives;

- How to report a change in income, change in family size, etc.;

- How to request a medically frail determination during the benefit year;

- Information about the availability of the prior claims payment program for certain members and how to access the program administrator;

- Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats;

- Information on how to contact the Enrollment Broker;

- Statement that Contractor will provide information on the structure and operation of the health plan; and

- In accordance with 42 CFR 438.6(h), that upon request of the member, information on the Contractor’s provider incentive plans will be provided.

The Hoosier Healthwise member handbook shall include the following:

- Contractor’s contact information (address, telephone number, TDD number, and website address);
• The amount, duration and scope of services and benefits available under the Contract in sufficient
details to ensure that participants are informed of the services to which they are entitled, including,
but not limited to the differences between the benefit options;
• The procedures for obtaining benefits, including authorization requirements;
• Contractor’s office hours and days, including the availability of a 24-hour Nurse Call Line;
• Any restrictions on the member’s freedom of choice among network providers, as well as the extent
to which members may obtain benefits, including family planning services, from out-of-network
providers;
• The extent to which, and how, after-hours and emergency coverage are provided, as well as other
information required under 42 CFR 438.10(f)(6)(vii), such as what constitutes an emergency;
• The post-stabilization care services rules set forth in 42 CFR 422.113(c);
• The extent to which, and how, urgent care services are provided;
• Applicable policy on referrals for specialty care and other benefits not provided by the member’s
PMP, if any;
• Information about the availability of pharmacy services and how to access pharmacy services;
• Member rights and protections, as enumerated in 42 CFR 438.100, which relates to enrollee rights.
See Section 4.8 for further detail regarding member rights and protections;
• Responsibilities of members;
• Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims)
that may apply to services obtained outside the Contractor’s network;
• Procedures for obtaining out-of-network services;
• Standards and expectations to receive preventive health services;
• Policy on referrals to specialty care;
• Procedures for notifying members affected by termination or change in any benefits, services or
service delivery sites;
• Procedures for appealing decisions adversely affecting members’ coverage, benefits or relationship
with the Contractor;
• Procedures for changing PMPs;
• Standards and procedures for changing MCEs, and circumstances under which this is possible,
including, but not limited to providing contact information and instructions for how to contact the
enrollment broker to transfer MCEs due to one of the “for cause” reasons described in 42 CFR
438.56(d)(2)(iv), including, but not limited to, the following:
  o Receiving poor quality of care;
  o Failure to provide covered services;
  o Failure of the Contractor to comply with established standards of medical care administration;
  o Lack of access to providers experienced in dealing with the member’s health care needs;
  o Significant language or cultural barriers;
  o Corrective action levied against the Contractor by the office;
  o Limited access to a primary care clinic or other health services within reasonable proximity to a
member’s residence;
  o A determination that another MCE’s formulary is more consistent with a new member’s
existing health care needs;
  o Lack of access to medically necessary services covered under the Contractor’s contract with
the State;
o A service is not covered by the Contractor for moral or religious objections, as described in Section 6.3.3;
o Related services are required to be performed at the same time and not all related services are available within the Contractor’s network, and the member’s provider determines that receiving the services separately will subject the member to unnecessary risk;
o The member’s primary healthcare provider disenrolls from the member’s current MCE and reenrolls with another MCE; or
o Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

• The process for submitting disenrollment requests. This information shall include the following:
o Hoosier Healthwise members may change MCEs after the first ninety (90) calendar days of enrollment only for cause;
o Members are required to exhaust the MCE’s internal grievance and appeals process before requesting an MCE change;
o Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing, after exhausting the MCE’s internal grievance and appeals process; and
o The MCE shall provide the Enrollment Broker’s contact information and explain that the member must contact the Enrollment Broker with questions about the process. This information shall include how to obtain the Enrollment Broker’s standardized form for requesting an MCE change.

• The process by which an American Indian/Alaska Native member may elect to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State;

• Procedures for making complaints and recommending changes in policies and services;

• Grievance, appeal and fair hearing procedures as required at 42 CFR 438.10(g)(1), including the following:
o The right to file grievances and appeals;
o The requirements and timeframes for filing a grievance or appeal;
o The availability of assistance in the filing process;
o The toll-free numbers that the member can use to file a grievance or appeal by phone;
o The fact that, if requested by the member and under certain circumstances: (1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and (2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.

• For a State hearing describe (i) the right to a hearing, (ii) the method for obtaining a hearing, and (iii) the rules that govern representation at the hearing.

• Information about advance directives;

• How to report a change in income, change in family size, etc.;

• Information about the availability of the prior claims payment program for certain members and how to access the program administrator;

• Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats;

• Information on how to contact the Enrollment Broker;

• Statement that Contractor will provide information on the structure and operation of the health plan; and

• In accordance with 42 CFR 438.6(h), that upon request of the member, information on the Contractor’s provider incentive plans will be provided.
HIP pregnancy policy, including but not limited to, a description of the HIP Maternity program and the member’s ability to transfer to MAGP during pregnancy, information on how to initiate the transfer, as well as information on requirements for transferring back to HIP following end of pregnancy

- HIP copayments for HIP Basic and for emergency room services.
- Members must be provided specifics about cost sharing for both POWER account and copayments for services.
- Members have the ability to receive a waiver of ER copay by calling the 24-hour nurse line prior to utilizing a hospital ER department.
- Information about the availability of pharmacy services and how to access pharmacy services.
- Member rights and protections, as enumerated in 42 CFR 438.100.
- Member responsibilities.
- Special benefit provisions that may apply to services obtained outside the MCE’s network (for example, copayments, deductibles, limits, or rejections of claims).
- Procedures for obtaining out-of-network services.
- Standards and expectations to receive preventive health services.
- Policy on referrals to specialty care.
- Procedures for notifying members affected by termination or change in any benefits, services, or service delivery sites.
- Procedures for appealing decisions adversely affecting members’ coverage, benefits, or relationship with the MCE.
- Procedures for changing PMPs.
- Procedures for changing MCEs.
- Procedures for making complaints, filing grievances, and recommending changes in policies and services.
- Information about advance directives.
- Information about requesting a POWER Account contribution or Hoosier Healthwise Package C (CHIP) premium recalculation of a change in income, change in family size, and so forth.

**Preventive Care Information – Hoosier Healthwise and HIP**

The MCE is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care standards. For Hoosier Healthwise members under the age of 21, this includes information about Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), well-child services, and blood-lead screenings. For HIP members, the plans must include reminders that encourage members to obtain the State-recommended preventive care services for their age, gender, and pre-existing conditions, including an explanation of the member’s ability to roll over the entire POWER Account balance when recommended preventive services are obtained.

**POWER Account Education for HIP**

The MCE must establish a variety of methods, approved by the State, to educate members about their POWER Accounts. The MCE must emphasize those features of POWER Accounts that help members stay healthy, be value- and cost-conscious, and use services in a cost-efficient manner. The MCE must explain the impact members’ health-seeking behavior has on their ability to use leftover POWER
Account balances to reduce the next benefit period’s required POWER Account contribution. The MCEs must also explain the members’ right to obtain partial refund of their POWER Accounts if they leave the HIP program.

POWER Account educational materials must include, at minimum, information about:

- Employer’s and other third parties’ opportunity to contribute to member POWER Accounts.
- Nonpayment policies, including:
  - Termination from HIP for individuals above 100% FPL or transfer to HIP Basic for individuals at or below 100% FPL if a contribution is not received within 60 calendar days of its due date
  - Inability for terminated individuals above 100% FPL to reapply for HIP for six months
  - Lock-out exceptions
  - Inability for members transferred to HIP Basic to obtain HIP Plus benefits until the member’s next redetermination period
  - HIP debt policies
  - Forfeiture of 25% of remaining POWER Account balance
- Policies regarding how members may report a chance in income or family size that may impact their eligibility or benefits.
- POWER Account rollover policies and obtaining recommended preventive care for HIP Plus and HIP Basic.
- POWER Accounts may not be used to pay for HIP Basic copayments or required copayments.

Managed Care Entity Member Services Helpline

The MCE must maintain a single statewide toll-free telephone helpline for Hoosier Healthwise and HIP members who have questions, concerns, or complaints. The MCE must staff its member services helpline to provide sufficient live-voice access to its members during (at a minimum) a 12-hour business day, Monday through Friday. The member services helpline must offer language translation services for members whose primary language is not English, and must offer telephone-automated messaging in English and Spanish. A member services messaging option must be available after business hours in English and Spanish, and member services staff must respond to all members’ messages by the end of the next business day. If the MCE’s member services helpline number or function changes, then the MCE must notify the State and the fiscal agent’s managed care director about those changes.

The MCE call centers are authorized to close on the following holidays:

- New Year’s Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day (July 4th)
- Labor Day
- Thanksgiving
- Christmas
If the holiday falls on a weekend but is recognized on a weekday, then the MCE member helpline must remain operational on that weekday. Additionally, each MCE may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request must be submitted to the State at least 30 days in advance of the date being requested for limited staff attendance and must be approved by the State.

Member services helpline staff must be trained in both Hoosier Healthwise and HIP programs to ensure that member questions and concerns are resolved as quickly as possible. The MCE must provide TDD services for hearing-impaired members. The MCE must also give their helpline staff the ability to transfer members directly to outside entities. This includes, but is not limited to, the enrollment broker, the DFR, the general HIP hotline, provider offices, and, when appropriate, the fiscal agent.

The MCE must maintain a system for tracking and reporting the number, type of member calls, and the inquiries received during business hours and nonbusiness hours. The MCE must monitor its member services helpline and report telephone service performance to the State on a regular basis. The MCE’s member services helpline staff must be prepared to respond to member concerns or issues including, but not limited to, the following:

- Access to healthcare services
- Identification or explanation of covered services
- Special healthcare needs
- Procedures for submitting a member grievance or appeal
- Potential fraud or abuse
- Changing PMPs
- POWER Accounts, POWER Account balances, and POWER Account debit cards (HIP only)
- HIP benefit packages (HIP only)
- POWER Account contributions and Hoosier Healthwise Package C (CHIP) premiums, including initial payment due dates, and non-payment penalties
- Incentive programs
- Disease management services
- Recommended age- and sex-appropriate preventive services (HIP only)
- Transfer to Hoosier Healthwise for pregnant women (HIP only)
- Employer or other third-party POWER Account contributions (HIP only)
- Balance billing issues
- Presumptive Eligibility benefit periods, services, and processes
- Participating in clinical studies of special health care needs as directed by the State

**Health needs screening and comprehensive health assessment**

MCEs must conduct a health screening for new members who enroll in their plan. The health screening helps identify the member’s physical and behavioral healthcare needs, and special healthcare needs, and identifies members who might need disease management, case management, or care management services. The health screening may be conducted in person, by telephone, online, or by mail. The State encourages the MCEs to conduct the screening at the same time the PMP selection outreach occurs.
The MCE must use the standard health-screening tool developed by the State, the Health Risk Screener (HRS). The MCE is permitted to supplement the State health-screening tool with additional questions. Any additions to the State HRS must be approved by the State. For pregnant Hoosier Healthwise members, a completed Notification of Pregnancy (NOP) form fulfills the health-screening requirement. See Health Risk Screener Response Guidelines.

Effective February 1, 2011, the MCEs are responsible for conducting health-needs screening for all new members. The Contractor shall not be required to conduct HNS for members enrolled in the Contractor’s plan prior to Jan 1 2017. For purposes of the health-screening requirement, new members are defined as members that have not been enrolled in the MCE’s plan in the previous 12 months. The health screening must be conducted within 90 calendar days of a new member’s enrollment in the MCE’s plan. The MCE is encouraged to conduct the health screening at the same time it assists the member in selecting a PMP. The MCE is also required to conduct a subsequent health screening when a member’s healthcare status is determined to have changed since the original screening, such as evidence of overuse of healthcare services identified through such methods as claims review.

All screener questions are REQUIRED and must be asked of all members, depending on question-related rules, such as gender specific, age range, follow-up based on response. See Health Risk Screening forms. The HRS layout provides a list of valid responses for each question. Valid responses are noted on the screener form in a check-box format. There are additional valid responses not shown on the HRS form, as follows:

- Member refusal – MR must be reported when member does NOT answer a question.
- Not applicable – NA must be reported only when a question does not apply to the member. NA is appropriate only where it is indicated as a valid response on the HRS layout.

Children Health Risk Screener information:
- Birth through 17 years old.
- Completed by parent or caretaker.
- Total of 34 questions.
- Some questions age- or gender-specific.
- Some questions call for follow-up, which requires further, in-depth assessment.

Adult Health Risk Screener information:
- For adults 18 years and older.
- Self-report or by proxy, if necessary.
- Total of 23 questions.
- Some questions age or gender specific.
- Some questions call for follow-up, which requires further, in-depth assessment.

The MCE nonclinical staff may conduct the health screening. The results of the health screening must be transferred to the State in the form and manner required by the State. Data from the health screening or NOP form, current medications, and self-reported medical conditions are used to develop stratification levels for members in Hoosier Healthwise and HIP. While the MCE may use its own proprietary stratification methodology to determine which members must be referred to specific disease management programs, ranging from member detailing to care management, the State applies its own stratification methodology which may, in future years, be used to link stratification level to the per member, per month capitation rate.

Sometimes, the initial screening indicates that the member has a special healthcare need or requires follow-up. In this case, the initial health screening must be followed by a detailed health assessment by
a healthcare professional followed up by a detailed Comprehensive Health Assessment Tool (CHAT). The detailed health assessment may include, but is not limited to, discussion with the member, a review of the member’s claims history, and contact with the member’s family or healthcare providers. These interactions must be documented and available for review by the State. The MCE must keep up-to-date records of members with special healthcare needs, based on the initial screening, including documentation of the detailed health assessment and contacts with the member, their family, or healthcare providers.

**Medically Frail HIP Members**

Consistent with 42 CFR §440.315(f), a HIP member will be considered medically frail if he or she has one or more of the following:

- Disabling mental disorder
- A chronic substance abuse disorder
- Serious and complex medical conditions
- Physical, intellectual, or developmental disability that significantly impair the individuals’ ability to perform one or more activities of daily living
- A disability determination based on Social Security Administration criteria

The medically frail process is operationalized utilizing the Milliman Medical Underwriting Guidelines, which assign a point value to health conditions, including behavioral health and substance use disorders. Members who have verified conditions and meet the specified medically frail debit point thresholds using the Milliman Medical Underwriting Guidelines are eligible to receive State Plan benefits. The provision of State Plan benefits will not change the underlying HIP program plan in which the member is enrolled. For example, a member enrolled in HIP Basic who is determined medically frail are transferred to HIP State Plan Basic benefits, while a member enrolled in HIP Plus are transferred to HIP State Plan Plus. HIP State Plan Basic and HIP State Plan Plus is provided by the same managed care entities (MCEs) and have the same cost-sharing structures as the standard HIP Basic and HIP Plus plans. However, the State Plan benefit package for medically frail members provides additional benefits that are not covered in the HIP Basic or HIP Plus plans.

The HIP member’s MCE will verify the member’s frail status through claims or supplemental information utilizing the Milliman Medical Underwriting Guidelines. Medically frail members may self-identify to their MCE at any point during the year by reporting that they believe they may qualify for medically frail status. MCEs have 30 calendar days from the date the member self-reported to the MCE to determine if the member is medically frail. In addition, MCEs may also independently identify a member as medically frail at any time during the year based on the member’s medical and/or pharmacy claims history.

**Identifying Medically Frail**

Each MCE is responsible for identifying and verifying all of its members who are medically frail. Notwithstanding the foregoing, members with a disability determination based on Social Security Administration criteria or members who are confirmed to have HIV or AIDS by the Indiana State Department of Health are automatically confirmed medically frail by the State. The MCE will not be responsible for verifying the medically frail designation of the members identified as such by the State, and such members are directly opened into HIP State Plan benefits.

The MCE may identify potentially medically frail members through the following methods:

- Member claims data
• Results of Health Needs Screening and/or Comprehensive Health Assessment
• Member self-identification
• Provider identification
• Member appeal
• An applicant that has been locked out of the program and indicates that he/she has a medically frail condition and qualifies for the medically frail lock-out exemption

The MCE shall establish processes to allow current members to self-identify as medically frail and for providers to identify members to the MCE as potentially medically frail. If requested by the member or by a provider on behalf of the member, then the MCE shall conduct a medically frail assessment within 30 calendar days from the date in which the member or provider, as applicable, contacted the MCE. Members who self-report medically frail status but who cannot be confirmed medically frail must receive written notice from the MCE that their condition could not be confirmed or does not qualify them for medically frail status. Members must be notified of the outcome of the assessment within three business days of the completed assessment.

**Lockout exemption for Medically Frail Members**

A member who is in a lockout period and indicates that they are now medically frail must reapply for benefits if they have not previously been confirmed frail or if their frail confirmation is more than 12 months old. Form 2032 along with the lockout exemption form are sent to the potential member. The form with the “I am frail” checked with be sent to the OMPP. The OMPP will send the MCE selected on the application or the member’s most recent MCE if one is not selected, a request to assess the potential member within 10 days. The MCE will make their determination and alert the OMPP of medically frail status. If the potential member is medically frail, then they are allowed to re-enroll.

**Medically Frail Assessment**

After a member has been identified as potentially medically frail, the MCE must utilize the Milliman Medical Underwriting Guidelines (“Milliman Guidelines”) to designate the member as medically frail. A HIP member may be designated as medically frail at any time during the member’s 12-month benefit period, provided such designation is supported by the Milliman Guidelines. Once designated as medically frail, the member’s medically frail status is active for 12 months from the original confirmation date. If the MCE receives information during the 12-month period that would make them suspect that the member is not medically frail or that the confirmation was made in error, then the MCE must take action to revoke the member’s frail status and provide the member with the opportunity to appeal such action as noted below.

The MCE must apply the Milliman Guidelines to the member’s claims history to generate debit points for the member. In the alternative, if claims data is not available, then the MCE must manually apply the Milliman Guidelines to the information obtained in the initial health needs screening and comprehensive health assessment or submitted medical records.

Members qualify as medically frail based on the member’s qualifying conditions and related risk scores as follows:

• 150 debit points for indicated medical conditions
• 75 debit points for indicated behavioral health conditions
• 75 debit points for indicated substance abuse conditions
• 150 debit points for any combination of indicated medical, behavioral health, or substance abuse conditions
• Needs assistance with one of the activities of daily living (ADL) based on ADL screener

If the results of applying the Milliman Guidelines supports a medically frail designation, then the MCE must document and support the decision. Documentation must include, but is not limited to, all of the following, as applicable: (i) output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated; (ii) completed comprehensive health assessment tool; (iii) documentation of attempts to make contact with their member and/or physician(s); (iv) recorded responses to the ADL screener and supporting information indicating member impairment in ALDs; (v) supplemental information gathered by the MCE in order to make a complete decision (such as lab results, physician notes, or lifestyle factors).

The MCE shall notify the State’s fiscal agent within one business day of making any affirmative medically frail determination. If the MCE determines a member is not medically frail, then the MCE shall notify the State’s fiscal agent within one business day of making the determination only if the determination would change a member’s current benefit package.

The notice to the State’s fiscal agent must identify (i) the medically frail designation; (ii) the date of the medically frail determination; and, (iii) after the supplemental file is available, the method utilized by the MCE to make the medically frail determination, specifically, whether the MCE relied solely on the Milliman Guidelines or if supplemental information was relied upon. If the MCE relied on supplemental information, then the MCE shall maintain documentation of all information utilized to support the medically frail determination. The State will develop a form and a process by which the MCE may submit this information to the State’s fiscal agent. After the form and process is developed, the MCE shall submit a Medically Frail Supplemental File to the State’s fiscal agent on a monthly basis in a format specified by the State, which contains a generic description of the supplemental information utilized by the MCE to support the medically frail designation. The State will utilize this information to conduct audits of the MCE’s medically frail determinations. At all times, the MCEs must maintain all documentation, generate high-level and detailed reports on their medically frail population, and provide member data for audit purposes as requested by the State.

Upon receipt of the medically frail determination, the State will transfer the member to the appropriate benefit package effective the first day of the month following receipt of the medically frail determination.

MCEs may apply the Milliman Guidelines in an automated fashion against member claims data on a monthly basis to all HIP membership to confirm or reconfirm member medically frail status.

**Medically Frail Notice and Appeals**

The MCE must provide written notice to any member whose benefits will change because the MCE’s medically frail designation, regardless of how the member was identified to the MCE. In addition, the MCE must provide written notice of the MCE’s medically frail designation to any member who self-identified as medically frail or who was identified by a provider as potentially medically frail, regardless of whether the determination will impact member benefits. The written notice of medically frail determination must include the following information: (i) the medically frail determination; (ii) if applicable, the reason for a denial; (iii) any resulting changes to the member’s benefits; and (iv) a description of the member’s right to file an appeal, including the process for requesting an appeal from the MCE. MCE notices must include required language as designated by the state and notices must be approved through the standard approval process before being sent to members. If the member was identified to the MCE by the member’s provider, then a notification of the final determination must also be sent to the referring provider. The MCE must provide this notice within three business days of the determination being made.

Members, or providers acting on the member’s behalf in accordance with 42 CFR 438.402, shall have 33 days from the date of action notice within which to file an appeal to the MCE. The MCE shall process and dispose of all medically frail appeals in accordance with the MCE’s standard grievance process.
and appeals process as detailed in Section 7.9 of the Scope of Work. Upon final resolution of the member appeal with the MCE, the MCE shall provide written notice of the resolution to the member as specified below.

- For appeals not resolved wholly in favor of the member, the notice shall also include information regarding the member’s right to request a State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. This notice must incorporate the state fair hearing language as provided by the state.

- For appeals that result in the member’s medically frail status being confirmed, the MCE may systematically confirm the member’s medically frail status on a going forward basis only. The MCE may also request through the Rapid Response Team (RRT) process that the State back date the medically frail status to no earlier than the first day of the month in which the notice is dated that the member found to not meet the medically frail criteria.

For member adverse action appeals related to the MCE’s medically frail determination that result in a reduction of the member’s benefit package (for example, a member is determined no longer medically frail at annual redetermination), the MCE must ensure continuation of State Plan benefits upon appeal, provided the member timely files the appeal before the expiration of their State Plan benefits. To ensure continuation of State Plan benefits during appeal, the MCE should send a Frail= ‘Y’ indicator through the state’s fiscal agent. The MCE must maintain documentation of the appeal record, and when the supplemental file is implemented, input a frail confirmation reason specifying that the member frail indicator was changed to ‘Y’ because of appeal. Members that appeal after the expiration of their benefits are not entitled to continuation of medically frail benefits during the appeal, and the MCE should not send a frail ‘Y’ during the appeal for these members. Upon final resolution of the medically frail appeal with the MCE, the MCE shall provide written notice to the member:

- That their medically frail status has been confirmed, and update the existing frail confirmation reasons within the file.

- If the member’s medically frail status could not be confirmed upon appeal to meet the medically frail criteria, then the MCE will
  - Provide written notice to the individual that they do not meet the medically frail criteria, including an explanation as to how the determination was made, and detailing their state appeal rights as provided by the state
  - Change the member’s medically frail status in the member record from “Y” to “N” and submit the change to the state’s fiscal agent

If a member timely appeals an adverse appeal decision to the State following the MCE’s final notice, then the State will ask for the MCE to confirm if the member exhausted their appeal with the MCE. Upon receipt of a request from the State Hearings and Appeals, the MCE will confirm whether the member has exhausted their MCE appeal process within two business days of receiving notification of the member’s request for a state fair hearing. In addition, if requested by the FSSA, the MCE shall promptly respond to all requests for documentation required for the state fair hearing within the timeframes identified in the specific request.

If the member’s State Plan benefits are reinstated and backdated following a state fair hearing decision, then the MCE shall send a medically frail confirmation to the State within two business days of the decision and the State shall, as applicable, back date the medically frail confirmation to the date specified by hearings and appeals decision.

**Medically Frail Annual Review**

The MCE must maintain documentation that every medically frail member meets the specific medically frail criteria, as set forth by the FSSA, for receipt of HIP State Plan benefits. For members initially determined medically frail by the MCE, the MCE must confirm a member’s medically frail
status at least once every 12 months in accordance with a process determined by the FSSA. At minimum, the MCE shall affirm the medically frail designation by conducting an annual review of the member’s claim history and/or pharmacy data against the Milliman Guidelines. For members initially determined medically frail by the State, the MCE shall confirm medically frail status by conducting a review of the member’s claim history and/or pharmacy data against the Milliman Guidelines only when requested by the State in accordance with the timeframe and process determined by the FSSA.

Following the completion of the annual medically frail confirmation, the MCE shall notify the State’s fiscal agent of the results, including any updated medically frail diagnostic indicators, no later than 15 calendar days before the one year anniversary of the MCE’s previous medically frail determination or confirmation, as applicable.

If a member is determined no longer medically frail, then the member is transferred to either: (i) HIP Plus if they are currently making the required POWER Account contributions, or if they have income over 100% FPL; or (ii) HIP Basic if they are currently paying copayments at the time of service and have income at or below 100% FPL. The MCE is required to send a member notice with appeal rights and follow the procedures indicated above for members losing medically frail benefits.

If the member’s medically frail status expires at the end of their benefit period and the member is transferring to another MCE, then the original MCE is responsible for the member’s medically frail appeal. If the member’s medically frail status expires after the transfer, then the new MCE is responsible for managing the member’s medically frail appeal. MCEs are expected to share information to support the confirmation of medically frail status for individuals who transition to another MCE at or near the time their medically frail status is set to expire.

State Audit

The State will conduct regular audits of the MCE’s medically frail confirmations. Before the implementation of the monthly Medically Frail Supplemental File, the MCEs is responsible for submitting to the State, upon request, generalized data on its medically frail confirmations as well as specific details, including all documentation and supplemental information requested for specific members selected for detailed audit. The State anticipates that less than 10% of the MCE’s total HIP population is designated as medically frail. The MCE shall consistently apply the comprehensive health assessment tool and Milliman Guidelines to every medically frail determination and review.

Members with Special Healthcare Needs

The MCE must have plans for provision of care for the special needs populations, and for provision of medically necessary, specialty care through direct access to specialists. The Hoosier Healthwise managed care program uses the definition and reference for children with special healthcare needs as adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

> Children with special healthcare needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

The health screening tool will assign children to one of the Living with Illness Measures (LWIM) screener health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screener identifies a child as potentially having a special health care need if the screening identifies needs in one or more of seven (7) different health domains:

- Functional limitations only
- Dependency on devices only
Section 15: Member Services

Service use or need only
Functional limitations and a dependency on devices
Functional limitations and a service use or need
Dependency on devices and a service use or need
Functional limitations, a dependency on devices and a service use or need

In accordance with 42 CFR 438.208(c)(2), the MCE must have a healthcare professional assess the member through a detailed health assessment if the health screening identifies the member as potentially having a special healthcare need. When further assessment confirms the special healthcare need, the member must be placed in care management. The MCE must offer continued coordinated care services to any member transferring into the MCE from another MCE with special healthcare needs. MCE activities supporting special healthcare needs populations must include, but are not limited to the following:

- Conducting the initial screening and more detailed health assessment to identify members who may have special needs.
- Scoring the initial screening and more detailed health assessment results.
- Distributing findings from the health assessment to the member’s PMP, the State, and other appropriate parties, in accordance with State and federal confidentiality regulations.
- Coordinating care through a Special Needs Unit, or comparable program, services in accordance with the member’s care plan.
- Analyzing, tracking, and reporting to the State issues related to children with special healthcare needs, including grievances and appeals data.
- Participating in clinical studies of special healthcare needs, as directed by the State.
- Members’ Rights.

The MCE must guarantee the following rights protected under 42 CFR 438.100 to its members:

- The right to receive information, in accordance with 42 CFR 438.10.
- The right to be treated with respect and due consideration for his or her dignity and privacy.
- The right to receive information about available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.
- The right to participate in decisions regarding his or her healthcare, including the right to refuse treatment.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations pertaining to the use of restraints and seclusion.
- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E.
- The right to be furnished healthcare services, in accordance with 42 CFR 438.206 through 438.210.

The MCE must also comply with other applicable State and federal laws regarding member rights, as set forth in 42 CFR 438.100(d). The MCE must have written policies in place regarding the protected member rights listed previously.
The MCE must have a plan in place to ensure that its staff and network providers consider member rights when furnishing services to the MCE’s members. Members must be free to exercise protected member rights. The MCE must not discriminate against a member who chooses to exercise his or her rights.

**Cost and Quality Information**

The MCE must make cost and quality information available to members to encourage more responsible use of healthcare services and educated healthcare decision-making. Example cost information includes average cost of common services, urgent versus emergent care costs, and so forth.

For services which may be at risk for improper payments, the Contractor must develop processes to verify with members that said targeted services billed by providers were actually received by said members, in order to obtain direct verification of services rendered and increase oversight. Contractor’s processes must be identified in Contractor’s Program integrity Plan.

The MCE must provide explanation of benefits (EOBs) to all members or a statistically valid sample of all members on a monthly basis, at minimum. This includes members in the HIP, HHW, and HCC programs. EOBs shall be available via paper and secure web based portal. EOBs shall be delivered to members based on their preferred mode of receipt of MCE communications. At a minimum, EOBs shall be designed to address requirements in 42 CFR § 433.116(e) and (f), and 455.20. To maintain member confidentiality, EOBs shall not be sent on family planning services. For HIP members, the EOB statements must indicate when services are paid with POWER Account funds. POWER Account Statements and EOB information may be combined in a single statement for HIP members. The MCE must give HIP members an opportunity to receive email alerts about EOB information on the member’s secure web portal, in addition to receiving the information by mail.

The MCE must capture quality information about its network providers, and must make this information available to members. In making the information available to members, the MCE must identify any limitations of the data. The MCE must also refer members to quality information compiled by credible external entities, such as Hospital Compare, Leap Frog Group, and so forth.

**Redetermination Assistance**

MCEs may assist members in the eligibility redetermination process, and are permitted to do the following:

- Conduct outreach calls or send letters to members reminding them to renew their eligibility and reviewing redetermination requirements with the member.
- Answer questions about the redetermination process.
- Help the member obtain required documentation and collateral verification needed to process the application.

In providing assistance during redetermination, MCEs are not permitted to do the following:

- Discriminate against members, particularly high-cost members or members who have indicated a desire to change MCEs.
- Talk to members about changing MCEs; refer questions about changing MCEs to the enrollment broker.
- Provide any indication about the member’s eligibility; refer questions about eligibility to the DFR.
- Engage in or support fraudulent activity associated with helping the member complete the redetermination process.
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- Sign the member’s redetermination form.
- Complete or send redetermination materials to the DFR on behalf of the member.

MCEs must provide redetermination assistance equally across their membership and be able to demonstrate to the State that their redetermination procedures are applied consistently.

**Member-Provider Communication**

According to 42 CFR 438.102, the MCE must not prohibit or restrict a healthcare professional from advising a member about his or her health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the Hoosier Healthwise or HIP programs, as long as the professional is acting within his or her lawful scope of practice. This provision does not require the MCE to provide coverage for a counseling or referral service if the MCE objects to the service on moral or religious grounds.

In accordance with 42 CFR 438.102(a), the MCE must allow health professionals to advise the member on alternative treatments that may be self-administered and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits, and consequences of treatment or nontreatment.

The MCE must not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The MCE may not take punitive action against a provider that requests an expedited resolution or supports a member’s appeal.

**Member Inquiries, Grievances, and Appeals**

The MCE must have written policies and procedures governing the resolution of grievances and appeals. At a minimum, the grievance system must include a grievance process, an appeal process, expedited review procedures, external review procedures, and access to the State’s fair hearing system. The MCE’s grievances and appeals system, including the policies for recordkeeping and reporting grievances and appeals, must comply with 42 CFR 438, Subpart F, as well as IC 27-13-10 and IC 27-13-10.1 [when the MCE is licensed as a health maintenance organization (HMO)] or IC 27-828 and IC 27-8-29 (when the MCE is licensed as an accident and sickness insurer).

The term appeal is defined as a request for a review of an action. An action, as defined in 42 CFR 438.400(b), is the following:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner, as defined by the State.
- Failure of an MCE to act within the required time frames.
- Denial of a member to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network when the member resides in a rural area with only one MCE.

The term grievance, as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an action as defined previously. This may include dissatisfaction related to the quality of care of services rendered or available, rudeness of a provider or employee, or failure to respect the member’s rights.
The MCE must notify the requesting provider, and give the member written notice, of any decision considered an action taken by the MCE, including any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404. See Authorization of Services and Notices of Action for additional information.

The MCE appeals process must accomplish the following:

• Allow members, or providers, acting on the member’s behalf, 33 days from the date of action notice to file an appeal according to Indiana Administrative Code (LSA Document #11-724). A provider, acting on behalf of the member and with the member’s written consent, may file an appeal.

• Ensure that verbal requests seeking to appeal an action are treated as appeals. However, a verbal request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

• Maintain an expedited review process for appeals when the MCE, or the member’s provider, determines that pursuing the standard appeals process could seriously jeopardize the member’s life or health, or ability to attain, maintain, or regain maximum function. The MCE must dispose of expedited appeals within 48 hours after the MCE receives notice of the appeal, unless this time frame is extended, pursuant to 42 CFR 438.408(c). In addition to the required written decision notice, the MCE must make reasonable efforts to provide the member with verbal notice of the disposition of the appeal.

• If the MCE denies the member’s request for an expedited resolution of an appeal, then the MCE must transfer the appeal to the standard 30 calendar-day time frame and give the member written notice of the denial within two days of the expedited appeal request. The MCE must also make a reasonable attempt to provide prompt verbal notice to the member.

• The MCE must acknowledge receipt of each standard appeal within three business days.

• The MCE must make standard, non-expedited, appeal decisions within 30 calendar days of receipt of the appeal. This period may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

The MCE’s policies and procedures governing appeals must include provisions that address the following:

• The MCE must not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102. A provider, acting on behalf of the member and with the member’s written consent, may file an appeal.

• The MCE must not take punitive action against a provider that requests or supports an appeal on behalf of a member.

• The MCE must consider the member, representative, or estate representative of a deceased member as parties to the appeal throughout the appeals process.

• The MCE must allow the member and member representative an opportunity to examine the member’s case file, including medical records, and any other documents and records.

• The MCE must allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing.

• The MCE must ensure that there is no delay sending the appeal decision to the member and member’s representative. The MCE’s appeal decision notice must describe the actions taken, the reasons for the action, the member’s right to request a State fair hearing, the process for filing a fair hearing, and other information set forth in 42 CFR 438.408(e).
In accordance with IC 27-13-10.1-1 and IC 27-8-29-1, the MCE must maintain an external grievance procedure for the resolution of decisions related to an adverse utilization review determination, an adverse determination of medical necessity, or a determination that a proposed service is experimental or investigational. An external review does not inhibit or replace the member’s right to appeal an MCE decision to a State fair hearing.

Within 33 calendar days of receipt of the appeal decision, a member or a member’s representative may file a written request for a review of the MCE’s decision by an independent review organization (IRO). Within 72 hours, for an expedited appeal, or 15 business days for a standard appeal, the IRO will render a decision to uphold or reverse the MCE’s decision. The determination made by the independent review organization is binding on the MCE.

The FSSA maintains a fair hearing process that allows members the opportunity to appeal the MCE’s decisions to the State. Appeal procedures for applicants and recipients of Medicaid are found at 405 IAC 1.1. The State fair hearing procedures include the following requirements:

- The member may request an FSSA fair hearing within 33 calendar days of exhausting the MCE’s internal procedures according to the Indiana Administrative Code (LSA Document #11-724).
- The parties to the FSSA fair hearing must include the MCE, as well as the member and his or her representative or the representative of a deceased member’s estate.
- The MCE must include the FSSA fair hearing process as part of the written internal process for resolution of appeals and must describe the fair hearing process in the member handbook.
- In certain member appeals, the MCE is required to continue the member’s benefits pending the appeal, in accordance with 42 CFR 438.420.

The MCE must authorize or provide disputed services promptly, and as expeditiously as the member’s health condition requires if the services were not furnished while the appeal was pending and the MCE or the FSSA fair hearing officer reverses a decision to deny, limit, or delay services.

The MCE must pay for disputed services, in accordance with State policy and regulations, if the MCE or the FSSA fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending.

The MCE’s internal grievance and appeals procedures must include the following components:

- The MCE must acknowledge receipt of each grievance and appeal.
- The MCE must notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if the MCE is licensed as an HMO) or IC 27-8-28-16 (if the MCE is licensed as an accident and sickness insurer).
- The MCE must provide assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

The MCE must ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and are healthcare professionals with clinical expertise in treating the member’s condition or disease if the decision is in regard to any of the following:

- An appeal of a denial based on lack of medical necessity
- A grievance regarding denial of expedited resolution of an appeal
- Any grievance or appeal involving clinical issues

The MCE’s policies and procedures governing grievances must include provisions that allow for the following filing, notice, and resolution time frames:
• Members must be allowed to file grievances verbally or in writing within 33 calendar days of the occurrence that is the subject of the grievance. Members may file a grievance regarding any matter other than those described in the definition of an action.

• The MCE must acknowledge receipt of each grievance within 30 calendar days. The MCE must make a decision on non-expedited grievances within 14 calendar days of receipt of the grievance. This period may be extended up to 10 business days if resolution of the matter requires additional time. A letter notifying the member of this extension is required.

Member Notice of Grievance, Appeal, and Fair Hearing Procedures

The MCE must provide specific information about member grievance, appeal, and State fair hearing procedures and time frames to members, as well as to providers and subcontractors when they contract with the MCE. The information provided must be approved by the State and, as required under 42 CFR 438.10(g)(1), include the following:

• The right to file grievances and appeals.

• The requirements and time frames for filing a grievance or appeal.

• The availability of assistance in the filing process.

• The toll-free numbers that the member can use to file a grievance or appeal by telephone.

The fact that, if requested by the member and under certain circumstances, the following will occur:

• Benefits will continue if the member files an appeal or requests an FSSA fair hearing within the specified time frames.

• The member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.

The FSSA fair hearing information must include the following:

• The right to a hearing

• The method for obtaining a hearing

• The rules that govern representation at the hearing

Verbal Interpretation Services

The MCE must provide free verbal interpretation services to its members seeking healthcare-related services in a provider’s service location, in accordance with 42 CFR 438.10 (c)(4). The MCE must notify its members of the availability of these services and how to obtain them.

Oral interpretation services must include sign-language interpretation for the deaf.

Cultural Competency

The MCE must provide services in a culturally competent manner. The MCE must incorporate the Office of Minority Health’s National Standards on Culturally and Linguistically Appropriate Services (CLAS) into the provision of healthcare services for its members.
Managed Care Entity Application Assistance and Distribution to Nonmembers

The State permits contracted vendors in the HIP and Hoosier Healthwise programs to distribute applications to the general community, but forbids them from acting as a State employee or a choice counselor of applicants. According to federal regulations, no cold-call marketing is allowed. The State defines cold-call marketing as any unsolicited personal contact by the MCE with a potential enrollee for the purpose of selling, promoting, surveying, or soliciting a State-sponsored health insurance plan.

Note: The term applicant in this document refers to non-Medicaid members who are applying for State Medicaid assistance.

MCEs must abide by all federal regulations when outreaching and must obtain approval from the State before distributing any materials to members or potential members. The MCE must give the FSSA a written request and submit a draft at least 30 calendar days before the distribution of materials through the established document review process. On the cover sheet, the MCE must indicate if the materials are distributed at outreach events for Medicaid applications.

The MCE must ensure that the distribution of the State Medicaid application abides by the following requirements:

- MCEs cannot act as agents of the State or represent themselves as State caseworkers.
- MCEs may hand out applications at outreach events such as, health fairs. MCEs are not permitted to be enrollment centers or act as qualified providers (QPs) for Presumptive Eligibility (PE). MCE satellite offices or permanent distribution areas are not permitted to distribute applications.
- MCEs cannot allow an applicant to authorize the MCE to act as the applicant’s representative or to act on behalf of the applicant.
- MCEs may set up an area with a table, chair, clipboard, and writing utensils, where members can fill out applications.
- MCEs must not indicate whether the member is eligible; this decision must be made by Division of Family Resources.
- MCEs will not sign the member’s forms.
- MCEs will not influence MCE selection; if members are unsure about which MCE to choose, MCEs must refer them to the enrollment broker.
- MCEs may not keep the applicant’s completed application or submit the application. The applicant can leave the application at a State-registered enrollment center.
Section 16: Member Enrollment

Overview

The Division of Family Resources (DFR) is responsible for determining Indiana Health Coverage Programs (IHCP) eligibility, including for Hoosier Healthwise and Healthy Indiana Plan (HIP). The DFR is also responsible for updating member eligibility and personal data, such as changes in household, including births, deaths, and so forth, for continuing enrollees at periodic eligibility redetermination dates. This data is entered into Indiana Client Eligibility System (ICES).

The fiscal agent for the State receives ICES enrollee eligibility files daily to update CoreMMIS. Enrollee data stored in CoreMMIS is used to confirm eligibility for various IHCP programs, including HIP and Hoosier Healthwise, during claims and capitation processing. Providers check enrollee eligibility through CoreMMIS via the Eligibility Verification System (EVS).

The enrollment broker assists Hoosier Healthwise, HIP, and Presumptive Eligibility (PE) members with managed care entity (MCE) selection if the enrollee does not select an MCE during the application process. The enrollment broker also helps PE members select a PMP. The State retains sole responsibility for maintaining general IHCP member eligibility and aid categories. The State is also responsible for maintaining and updating member demographics. The fiscal agent cannot change member demographics. MCEs may contact the DFR if they have different information about the member than what is found in CoreMMIS.

Risk-Based Managed Care and Aid Categories

Enrollment in a Hoosier Healthwise managed care plan is mandatory for members in these broadly defined groups:

- Pregnancy Medicaid – Includes pregnant women. The full scope of benefits is available to women who meet strict income criteria. Pregnancy-related coverage is provided to women who meet eligibility requirements without regard to resources.

- Children’s Medicaid – Includes children who are younger than 19 years old and meet the eligibility requirements.

- Children’s Health Insurance Program (Phase I expansion) – Effective July 1, 1998, includes children from 1 to 19 years old who are uninsured and otherwise ineligible for IHCP benefits, and whose family meets the eligibility requirements.

- Children’s Health Insurance Program (CHIP) (Phase 2 expansion – Package C) – As of January 1, 2000, includes children from birth to 19 years old who are uninsured and otherwise ineligible for IHCP benefits, and whose families meet eligibility requirements. Unlike other categories of eligibility in Hoosier Healthwise, continued eligibility in Package C depends on payment of monthly premiums. Enrollees remain conditionally eligible until they have made their first CHIP premium payment.

The State identifies potential managed care enrollees based on the aid categories established by ICES. Aid categories determine the benefit packages for which enrollees are entitled. Hoosier Healthwise enrollees are eligible for one of the following four benefit packages and aid categories:

- Package A (Standard plan) – This package covers children and some pregnant women with a full range of IHCP benefits.
  - MA-X – Born to Mother on Medicaid Age: 0-1 No FPL standard.
  - MA-Y – Children younger than 1 year; income up to 208% of FPL
MA-Z – Children 1-5; income up to 141% of FPL
MA-2 – Children ages 6-18; income up to 106% of FPL
MA-9 – Children ages 1-5 (141-158% of FPL); 6-18 (106-158%)
MA-GP – Pregnancy; income up to 208%
MA-F – Children in families, no income determination requirement for up to 12 months because of new or increased earnings of a parent or caretaker

• Package C (Children’s health plan) – This package covers children younger than 19 years old in families with incomes greater than 208% but less than 250% of the FPL for emergency, preventive, primary, and acute care services. Aid category is MA-10 (K2).

• Package P (Presumptive Eligibility - PE) – This package covers women pregnant with incomes at or less than 208% of the FPL, who are not current IHCP members and whose pregnancy has been confirmed by a qualified provider. Coverage includes pregnancy-related outpatient services only and excludes all delivery and postpartum services. Members approved for PE do not receive Medicaid ID cards until determination of the member’s Medicaid eligibility. See Presumptive Eligibility and Notification of Pregnancy for more information. Aid category is MA-PE.

**Healthy Indiana Plan and Aid Categories**

HIP eligibility requirements are as follows:

• Person between the ages of 19 and 64.
• If over 64, but considered a Low Income Parent/Caretaker that is not receiving Medicare, then may continue to be enrolled in HIP
• U.S. citizen.
• Lawful permanent residents (LPRs) have to be in the U.S. for at least five years.
• MA Q coverage can start in the month a refugee is in Indiana, has refugee status and meets all of the eligibility requirements, and is not eligible under another Medicaid or HIP category in that month.
• Indiana resident.
• Household income at or below 133% with a 5% disregard FPL for enrollment in HIP Plus
• Household income at or below 100% FPL for enrollment in HIP Basic

Enrollees are conditionally eligible until they have made their first Personal Wellness Responsibility (POWER) Account contribution or $10 pre-POWER Account Contribution (PPAC). MCEs send payment records to the fiscal agent, which then sends the record to ICES, finalizing the members’ enrollment in HIP. If an enrollee has household income at or below 100% FPL and does not make their first POWER Account contribution, the enrollee are enrolled in HIP Basic. If a conditionally eligible individual has income above100% FPL, the individual is determined ineligible for HIP and must reapply.

The file layout for the Conditional Pay/No-Pay file can be found in the file format section of the MCO Question and Answer page at indiana Medicaid.com. The password is mcoquestion. The conditional pay/no-pay process runs daily Monday through Friday. A DSIB Prod email notice is generated to the MCE if an error is detected. Error type is included. If the file is not corrected and reposted within 30 minutes, the system carries on without processing the daily file. The MCE can then correct the records and add them to the next day’s file.

Eligibility typically takes effect the first day of the month in which ICES registers contribution payment. Eligible HIP members are effective the first day of the month, and have term dates that are the last day of a month. The exception is if a member dies; then, the end date is the date of death.
Retroactive Eligibility

Traditional Medicaid allows retroactive eligibility in some circumstances, as determined by the DFR. CoreMMIS receives retroactive eligibility dates, along with daily eligibility information. MCEs are not responsible for reimbursement for services provided to members during periods of retroactive eligibility, except in cases of newborns whose mothers were enrolled in the MCE at the time of birth. After enrollment in the IHCP, newborns are automatically enrolled in their mothers’ MCEs, retroactive to the birth date. Several days to a few months may elapse between the birth of a newborn and the creation of a record in ICES that passes to CoreMMIS. On payment of the premium, CHIP Package C members are retroactively eligible to the first day of the month in which the member submitted his or her application. However, the retroactive months are covered on a fee-for-service basis.

The State requires the MCE to accept as enrolled all individuals appearing on the enrollment rosters and are financially responsible for all members for whom the MCE receive a capitation payment. Additional capitation information is located in the Information Systems section in this manual. Some IHCP enrollees are not eligible for the Hoosier Healthwise managed care program, even though the enrollees are in an otherwise eligible aid category. Some examples of these groups follow:

- Immigrants whose alien status is unverified and immigrants without documentation who are eligible for limited IHCP benefits (Package E).
- Members who are eligible for Medicare.
- Members who have been State-approved for long-term care and the level of care has been entered into CoreMMIS.
- Members who receive IHCP hospice care.
- Members who receive services under the Home and Community-Based Services (HCBS) program or are residing in long term care facilities.
- Other members and potential members who are determined ineligible for Hoosier Healthwise by the State.
- Members who are admitted to a Psychiatric Residential Treatment Facility (PRTF).

Members in these subgroups are disenrolled from the managed care program when they are identified. Member Disenrollment later in this section provides additional information about disenrollment dates.

Identification Cards

The MCE issues identification cards to its Hoosier Healthwise and HIP members when they enroll in the program. The identification card must identify the member and provide current benefit information to their providers. New members are assigned Member IDs by the State when their information is first entered in the ICES. Member IDs, unique to each member, are randomly generated and assigned for life. The state will provide the MCE with each new Member ID for inclusion on the member identification card. The managed care entity must produce and mail the identification card to the new member within five business days after receiving enrollment confirmation from the State’s fiscal agent.

Identification cards are not reissued for members who become eligible again after a period of ineligibility, unless cards are lost or stolen. If a card become lost or stolen, the members must contact their plan to request another ID card.

Hoosier Healthwise Card must display the following information:

- Member’s name
- Member ID
Telephone numbers are printed on the card for the following:
- Managed care entities member services
- Emergency 911
- NURSE on-call
- Member services for Pharmacy
- Pharmacy Prior Authorization and POS Helpline
- The HIP program name

The HIP member ID card must contain the following information:
- HIP logo
- Member name
- Member ID
- Applicable emergency room (ER) copayment, or at minimum, include that ER copayments may apply and direct the provider to call the MCE for specific amounts
- Applicable copayments, or at minimum, include that copayments may apply and direct the provider to call the MCE for specific amounts
- Deductible amount
- Bank identification number (BIN), if the member identification card also serves as the member’s POWER Account debit card

Providers are responsible for verifying eligibility before rendering services. A plan identification card does not guarantee current eligibility; providers must verify eligibility using the EVS before rendering services. The member information is also sent on the 834s received daily by the plans.

Generally, providers and MCEs can verify eligibility by using the Member IDs supplied by the member. If there are two Member IDs, they are normally linked and either Member ID provides the eligibility information required along with the active Member ID. Occasionally, ICES or an MCE identifies members who have been issued more than one Member ID in error, and the Member IDs have not been linked. In these cases, the MCE personnel who identify a member with a multiple active Member IDs that are not linked must contact the fiscal agent with the information.

**Member Enrollment**

Applicants for the Hoosier Healthwise and HIP programs have an opportunity to select an MCE on their application. MCEs are expected to conduct marketing and outreach efforts to raise awareness of both the programs and their product. The enrollment broker (EB) is available to help members choose an MCE. Applicants who do not select an MCE on their application, is assigned to an MCE, according to the State’s auto-assignment methodology.

Individuals enrolled in Hoosier Healthwise have 90 days to switch MCEs after they have been enrolled, either in the MCE they selected, or in the MCE that was auto-assigned to them.

Individuals enrolled in HIP may change MCEs without cause at any time before making the member’s initial POWER Account contribution or within 60 days of being assigned to the MCE, whichever comes first. HIP members do not have traditional Medicaid retroactive coverage. However, because HIP members must make an initial contribution before becoming fully eligible with the program effective the first day of the month in which the payment was made, there will typically be a small
window of retroactive eligibility in the HIP plan for the period of time between when the payment was made (or in the case of HIP Basic, when the non-payment determination was made) and the effective date back to the first of that month. For example, if an MCE receives a HIP payment in the middle of the month, the MCE submits the payment record and requests an effective date back to the first of the month in which the payment was made.

**Member Enrollment Rosters**

The State requires the MCE to accept as enrolled all individuals appearing on the enrollment rosters and are financially responsible for all members for whom the MCE receive a capitation payment. Additional capitation information is located in the Information Systems section in this manual. Some IHCP enrollees are not eligible for the Hoosier Healthwise managed care program, even though the enrollees are in an otherwise eligible aid category. Some examples of these groups follow:

- Immigrants whose alien status is unverified and immigrants without documentation who are eligible for limited IHCP benefits (Package E).
- Members who are eligible for Medicare.
- Members who have been State-approved for long-term care and the level of care has been entered into CoreMMIS.
- Members who receive IHCP hospice care.
- Members who receive services under the Home and Community-Based Services (HCBS) program or are residing in long term care facilities.
- Other members and potential members who are determined ineligible for Hoosier Healthwise by the State.
- Members who are admitted to a Psychiatric Residential Treatment Facility (PRTF).

Members in these subgroups are disenrolled from the managed care program when they are identified.  
**Member Disenrollment** later in this section provides additional information about disenrollment dates.

On behalf of the State, the fiscal agent notifies each MCE of all members enrolled in its Hoosier Healthwise and HIP programs. Using information obtained from ICES transmissions and from MCE assignments entered in CoreMMIS by self-selection and auto-assignment, the fiscal agent generates daily Health Insurance Portability and Accountability Act (HIPAA) 834 MCE benefit enrollment and maintenance transactions, also known as enrollment rosters. The processes that create data for both programs’ rosters begin each evening Monday through Friday. The rosters are typically generated the early morning hours of Tuesday through Saturday. Exceptions are State holidays. Because ICES files do not run on holidays, rosters are not generated. The following holidays affect ICES processing if they overlap business days:

- New Year’s Eve
- New Year’s Day
- Martin Luther King, Jr. Day
- Good Friday
- Primary Election Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
• Election Day
• Veteran’s Day
• Thanksgiving Day
• Day after Thanksgiving
• Christmas Eve
• Christmas Day

See the 834 MCE Benefit Enrollment and Maintenance Transaction companion guide for file layout and data usage.

MCE member enrollment rosters provide MCEs with detailed lists of members for whom the MCE is responsible. Change files indicate new, terminated, or deleted members, or changes to continuing member records that have occurred since the previous change file was created. Audit files, created once a month (HIP) or twice a month (Hoosier Healthwise), list all members effective with the MCE and region as of the date the audit file was created. HIP audit files run on the first day of each month. Hoosier Healthwise audit files run dates are the 1st and 15th of each month.

The segments of the member enrollment rosters are categorized in the 834 MCE Benefit Enrollment and Maintenance Transaction companion guide change files as follows:

• Continuing enrollees
• New enrollees
• Terminated enrollees
• Deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated before the actual effective date with the MCE

Summary reports are also generated and posted to File Exchange for each of the MCE and region files. There are occasions when an MCE or region may not have any data to report for a given cycle. A systematic email is sent to the affected MCE’s distribution list, indicating that there was no data to be reported, and therefore, no file to be produced. This applies mostly to change files. Enrollment roster enhancements for 2012 included the following:

• Reporting cross-region changes for Hoosier Healthwise and Presumptive Eligibility (PE) as single change records instead of dual Add and Term records. This reduces system processing by the MCEs. HIP is statewide, so it is not affected by this change.

• Modifying termination reporting functionality to pass a Term record only when the member is truly termed. This modification applies to Hoosier Healthwise and HIP; PE is not affected by this change. This change prevents confusion for members with prospective termination dates that re-open before their terminations take effect.

• Adding MCE-level assignment dates to the Hoosier Healthwise, HIP, and PE records, giving the MCEs the baseline effective date of members with their plans.

**Hoosier Healthwise Enrollment**

After IHCP eligibility has been determined or redetermined, members in eligible aid categories must enroll in Hoosier Healthwise. MCE choice is provided on the Hoosier Healthwise application. The applicant’s plan selection is disregarded if the member was previously enrolled in the Right Choices Program (RCP). In this case, the member is automatically assigned to his or her last MCE. Potential Hoosier Healthwise members receive program information and education from the enrollment broker by calling the Hoosier Healthwise Helpline at 1-800-889-9949.
Effective January 1, 2011, MCEs assign their members to a PMP. Enrollees self-select the MCE when they apply or are auto-assigned to the plan. The enrollment broker may help members select their MCE.

The Hoosier Healthwise Helpline representative asks the caller to confirm that the education process has been completed before entering the MCE selection in CoreMMIS. If the potential member has not received education about the Hoosier Healthwise program, the representative provides the necessary education before taking selection information.

The MCE assignment effective date for HHW members will follow the same process as HIP. That is, the DFR identified HHW eligibility effective date will be used as the MCE assignment effective date. There will be no gap when a member moves from one MCE to another.

**Elements Unique to Hoosier Healthwise Enrollment Rosters**

- Aid category – ICES-assigned designation for IHCP benefits.
- MCE assignment reasons – Numeric identifier that provides the assignment start and stop reasons that linked the member to the plan.
- Open enrollment status record – Provides the status of the member’s open enrollment. O – Open, C – Closed.
- Open enrollment effective and end dates – Provides the time spans of the member’s open enrollment and when MCE changes can occur.
- Auto-assignment indicator – Identifies members who were auto-assigned regardless of reason (previous MCE, case ID, default), described previously. This indicator helps the MCE identify members who were auto-assigned.
- Benefit packages – Provides the member’s benefit package.
- Capitation categories – Provides the capitation categories for which the MCE is reimbursed.
- Member region – Provides the member’s residence geographical region

**Member Disenrollment**

Hoosier Healthwise or HIP members can be disenrolled from the IHCP Hoosier Healthwise and HIP programs. A flowchart of the process is available on the MCO Question and Answer page at indianamedicaid.com under Flowcharts. The following are reasons for disenrollment:

- The member was enrolled in error or because of a data-entry error.
- The member loses eligibility in the IHCP.
- The member moves out of state.
- The member becomes eligible in another Medicaid aid category.
- The member passes away.
- The member voluntarily withdraws from the program.

Examples of reasons for member disenrollment from the Hoosier Healthwise managed care program to participate in another IHCP program include but are not limited to the following:

- The member is determined ineligible for managed care under the terms of the state plan.
- A change in aid category causes the enrolled member to become ineligible for managed care.
Section 16: Member Enrollment

Hoosier Healthwise and Healthy Indiana Plan

MCE Policies and Procedures Manual

- The member is admitted to a PRTF. At admission, a level of care is assigned in CoreMMIS, and the member is transitioned to fee-for-service.

- A residency change causes the enrolled member to become ineligible for managed care. Hoosier Healthwise members who have out-of-state addresses are systematically identified and disenrolled by the fiscal agent. Former Hoosier Healthwise members can retain IHCP eligibility during a defined notification period, as required in the Indiana Administrative Code (IAC). Disenrollment from Hoosier Healthwise prevents further payment of capitation during this notification period. However, members can have out-of-state designations and not be disenrolled when the DFR county staff has changed a member’s address to an out-of-state location but failed to change the Indiana county code.

- The enrolled member meets long-term care (LTC) criteria, determined by Indiana Pre-Admission Screening (IPAS) and the Federal Pre-Admission Screening Resident Review (PASRR). Package A members and HIP members requiring long-term care in a nursing facility or Intermediate Care Facilities for Persons with Intellectual Disability (ICF/ID) must be disenrolled from the Hoosier Healthwise or HIP program and converted to fee-for-service eligibility in the IHCP. Before the nursing facility can be reimbursed by the IHCP for the care provided, the nursing facility must request a PASRR for nursing facility placement. The State must approve the PASRR request, designate the appropriate level of care in CoreMMIS, and disenroll the member from Hoosier Healthwise or HIP. For HIP members, the DFR must disenroll the member; there is no fee-for-service for HIP members. The MCE must coordinate care for its members who are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the Long Term Care module. The MCE is responsible for payment for up to 60 calendar days for its members placed in a long-term care facility while the level of care determination is pending.

- MCEs must monitor the care of members who are potential candidates for LTC, so MCEs can help facilitate disenrollment from managed care. Hoosier Healthwise members can become eligible for HCBS waiver services. Because IHCP enrollees can participate in only one waiver program at a time, Hoosier Healthwise members who participate in another waiver program must be disenrolled from Hoosier Healthwise. MCEs that become aware of this circumstance must contact the Hoosier Healthwise Helpline at 1-800-889-9949 to begin the disenrollment process.

- An Hoosier Healthwise enrolled member becomes eligible for and enrolls in the IHCP Hospice Program. To receive hospice benefits, a member must elect hospice services; the attending physician must make a certification of terminal illness; and a plan of care must be in place. When a Hoosier Healthwise member elects to enroll in the IHCP Hospice Program, the member must be disenrolled from Hoosier Healthwise, so the appropriate LOC can be entered in CoreMMIS. The contractor’s hospice analyst requests that the enrollment broker immediately disenroll the Hoosier Healthwise member. The member becomes eligible for hospice care on the managed care disenrollment effective date. This process ensures that both the MCE and the hospice providers have an accurate effective date on which to end or begin services. Hospice benefit begins the day after managed care disenrollment. For purposes of clarification, the MCE is responsible for providing hospice services to all HIP members in accordance with the limits set forth in the HIP alternative benefit plans.

- An enrolled member who is admitted to a state psychiatric hospital is no longer eligible to participate in the Hoosier Healthwise program. MCEs are not financially responsible for any day of the member’s stay for psychiatric treatment in the State hospital. The prior authorization vendor tasked with approving the PRTF PA also enters a level of care code, which systematically disenrolls the member from Hoosier Healthwise. For purposes of clarification, disenrollment only applies to Hoosier Healthwise members. HIP members receiving psychiatric treatment in a state hospital shall not be disenrolled from HIP, but should be directed to an alternative inpatient facility.

- An enrolled member who becomes eligible for Medicare is no longer eligible to participate in the Hoosier Healthwise or HIP programs. A member is disenrolled only after the Medicare indicator is
received. It can take up to one week for a member to be disenrolled after the Medicare indicator is received. For HIP members, they go through the normal notification process and may remain in HIP while notification timelines continue and/or any appeal is filed with DFR. MCEs aware of a member with Medicare, should treat HIP as secondary insurance coverage.

- A Hoosier Healthwise member who has other medical coverage in a managed care plan may be required to select a PMP in that plan. If the PMP in the commercial network is not in a Hoosier Healthwise health plan, and coordination of benefits is not appropriate because of a documented reason or circumstance, the member can be disenrolled from Hoosier Healthwise and placed in the IHCP FFS program.

- An enrolled member who is designated an *undocumented person* is limited to emergency services under IHCP Package E. They should not be enrolled in managed care.

- Other enrolled members as determined by the State.

**Member Disenrollment Specific to HIP**

The following disenrollment causes also apply to HIP members:

- The member was enrolled in error or because of a data entry error.
- The member becomes eligible for another Medicaid aid category or Medicare.
- The member moves out of state.
- The member passes away.
- The member voluntarily withdraws from the program.
- The member, who is not determined medically frail, fails to make his or her POWER Account contribution timely, and has household income greater than 100% FPL.
- The member fails to submit timely their redetermination paperwork.
- The member fails to verify changes that impact their eligibility for HIP.
- The member income increases over the HIP income standard.

A HIP member may disenroll from an MCE while retaining eligibility in the HIP program. Circumstances where this occurs include the following:

- The member selects another MCE before making his or her initial contribution.
- The member selects another MCE at the beginning of a new coverage period.
- The member’s MCE disenrolls from the HIP program.
- The member is granted a change request because a just cause determined by the State. See Changing MCEs for without Cause for more details.

**Healthy Indiana Plan and Children’s Health Insurance Program Enrollment**

HIP and CHIP applicants also have the opportunity to select an MCE. For HIP and CHIP applicants, the applicant’s plan selection is disregarded if the member was previously enrolled in the RCP.

For CHIP, if an MCE selection is not made on an individual’s application, the individual has 14 calendar days from their eligibility effective date to contact the enrollment broker for choice counseling and another opportunity to make an MCE selection, before auto-assignment by the State fiscal agent.
For HIP, after the DFR has determined that an individual is conditionally eligible, the individual’s HIP conditional eligibility information is sent to the appropriate MCE via ICES and the 834 transaction from the fiscal agent. Within three calendar days of receiving the conditional eligibility file, the MCE must send a welcome letter and initial invoice notifying the individual that the first contribution is due within 60 calendar days of his or her conditional eligibility date. The MCE must also send at least two reminders to individuals who have not made their first monthly contribution.

Though the fiscal agent is responsible for CHIP II premium-payment processing, it is not responsible for notifying the MCEs of CHIP conditional eligibility. MCEs are notified of CHIP members via ICES and the 834 transaction from the fiscal agent after the member has paid their premium and the member is fully eligible.

Eligibility is not finalized for HIP until the individual makes his or her first contribution. If an individual pays his or her first contribution within 60 days of the conditional eligibility date, the MCE must notify ICES of the payment via the fiscal agent. ICES transmits fully eligible enrollment to the State fiscal agent, and the fiscal agent sends final eligibility to the MCE via the 834 transaction. This transaction also specifies the individual’s effective date of coverage with the MCE. After the MCE receives the final eligibility information from the State fiscal agent via the 834 transaction, the individual is enrolled with the MCE effective the first date of the month in which the individual’s payment was received by the MCE.

For example, a member sends her HIP payment on October 27, and the plan submits the pay record on October 31. The member’s assignment is effective with the HIP program effective October 1.

If the individual has household income greater than 100% FPL and fails to make his or her first HIP Plus contribution within 60 days of the date of conditional eligibility was submitted to the fiscal agent, then the MCE must notify ICES of the failure to pay via the daily pay/no pay file submitted to the fiscal agent. MCEs must not send conditional no-pay records on the monthly file. ICES then transmits a denial record to the State fiscal agent, and the fiscal agent sends final eligibility to the MCE via the 834 transaction. These individuals are determined ineligible for HIP, but are not subject to the program lockout, and, if they later feel they can afford the contribution, are allowed to reapply through the DFR at any time. These individuals do not receive any preferential treatment and must go through the entire application process again.

If the individual has household income at or below 100% FPL and fails to make his or her first HIP Plus contribution within 60 days of the date of conditional eligibility was submitted to the fiscal agent, the MCE must notify ICES of the failure to pay via the daily pay/no pay file submitted to the fiscal agent. MCEs must not send conditional no-pay records on the monthly file. ICES then transmits an open record to the State fiscal agent for HIP Basic, and the fiscal agent sends final eligibility to the MCE via the 834 transaction. The member is not eligible to voluntarily transfer to HIP Plus until their annual redetermination period.

Generally, terminations are effective as of the last day of the month in which the triggering termination event occurred. If a member dies, the termination is effective on the date of death. The MCEs receive notice of member terminations via the 834 transaction.

**Elements Unique to HIP Enrollment Rosters**

- **Member POWER Account contribution amount** – The monthly amount owed by the member to be eligible to participate in the HIP program. Determined by the DFR, based on income.
- **Emergency room copay amount** – Member’s copay amount based on whether the individual is participating in the control group.
- **Member’s specific HIP benefit group**.
• Any applicable eligibility flags (for example, Section 1931 parent or caretaker, medically frail, 19/20 year old, etc.)

Eligibility Verification

Enrollment transactions reflect members’ status in CoreMMIS as of the day the roster was produced. As explained earlier in this section, ICES eligibility is updated in CoreMMIS daily. The eligibility verification options described in the following subsection are updated with the daily ICES information; therefore, they contain the most current eligibility status. MCEs must advise providers to verify member eligibility each time a service is rendered. The most accurate way to verify eligibility is by using the member’s name and date of birth or Social Security number, rather than the Member ID. This method provides the current Member ID. Failure to verify eligibility may result in a provider rendering services to an ineligible member. All the EVS options provide an inquiry verification number that must be recorded in case it is required for subsequent transactions. MCEs must assume all telecommunication and hardware costs associated with these eligibility systems.

Eligibility Verification System

The EVS consists of three interactive, real-time options:

• The Interactive Voice Response (IVR) system,

• The 270/271 HIPAA-compliant eligibility inquiry and response transaction

After the user enters the provider identification number, applicable provider identification requirements, the member name and date of birth or Social Security number, and the from and through dates of service, eligibility information is transmitted online. The eligibility information includes the current Member ID, and the name and telephone number of the member’s PMP, along with the MCE’s name, telephone number, network (if applicable), and network telephone number (if applicable). If the member is not linked to a PMP, then the EVS indicates the PMP is not assigned.

Member Information Changes

Members are required to report information changes to the Division of Family Resources (DFR) within 10 days and should do so via the online benefits portal or by calling 1-800-403-0864. Members that call the MCE to report income, address, or other demographic changes should be referred to the DFR. The DFR is the official source of record for member demographic information. The MCE is required to report changes and discrepancies in member demographic information about which they become aware (such as address changes, dates of death, etc.) within 30 calendar days. (Note: The MCE is encouraged to periodically scan its systems to identify obvious errors – such as nonsense addresses, etc.) The MCE should report changes or discrepancies in member information via the Constituent Care email box at cc@fssa.in.gov. (The MCE should no longer use State Form 44151, Report of Change to report this information.) In general, MCE reports should relay the details related to the change or discrepancy, including the member’s identification number or RID, as well as the MCE’s source for the change or discrepancy. Notices of member deaths should include the following specifics:

• Member’s full name

• Member’s address

• Member’s SSN

• Member ID
• Date of death

(Note: The MCE has no authority to pursue recovery against the estate of a deceased IHCP member.)

The DFR will evaluate reported changes and discrepancies against DFR records and verify the accuracy of the information. If the DFR cannot confirm or cannot otherwise correct the issue, the DFR will relay such to the MCE via an email response. If the need for a change is confirmed, the DFR will make updates to the member’s file, which will in turn be relayed to CoreMMIS.

Additional Citations

• IHCppM 2220.00.00-Individuals are given 10 days to report any changes to the Division of Family Resources.

• 42 CF 438.608(a)(3) requires MCEs to notify the state of member address changes and date of death.

Auto-Assignment

Members are auto-assigned in CoreMMIS if they do not choose a plan. Auto-assignment considers prior plan, family relationships, and then a default process that considers plans by rotation. However, the default process is currently set to assign all members to CareSource if a previous assignment cannot be identified. At such time as CareSource reaches their target member enrollment, the default process will be reset to assign by rotation.

CoreMMIS first considers if the member was previously enrolled in the RCP, and reassigns them to the previous Right Choices MCE immediately, effective on the first or 15th day of the month. Notwithstanding the foregoing, HIP eligibility is always effective on the first day of the month.

Exceptions are subject to immediate auto-assignment and are as follows:

• Hoosier Healthwise members with less than a two-month gap and more than 90 days from the annual open enrollment period.

• Members whose PRTF LOC has ended.

• HIP members who transfer to Hoosier Healthwise eligibility.

CoreMMIS checks the member’s previous MCE assignment over a 12-month look-back period. In the absence of a previous MCE, CoreMMIS looks for a member with the same case ID with an MCE assignment.

If a case ID cannot be matched, CoreMMIS searches for a member with the same companion case ID who has an MCE assignment. Companion case ID is the mechanism ICES uses to link HIP and Hoosier Healthwise families. The two programs do not share the same case ID in ICES. If a companion case ID is found, CoreMMIS assigns the member to the same MCE. If companion case ID and MCE linkages are not found, CoreMMIS uses default logic to make the assignment.

Hoosier Healthwise and HIP-eligible members are assigned at the default level to a MCE on a target percentage basis. The State reserves the right to amend the auto-assignment logic and may incorporate HEDIS or other quality indicators into the auto-assignment logic at a future date.

After an assignment is made, CoreMMIS transfers the assignment to the respective MCE as an Add record on the 834 Benefit and Enrollment transaction.
Preferred Medical Provider Selection

The MCE must ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member’s needs, and who is able to coordinate each member’s physical and behavioral health care and make any referrals as required. Following a member’s enrollment, the MCE must assist the member in choosing a PMP. Unless the member elects otherwise, the member must be assigned to a PMP within 30 miles of the member’s residence.

If the member fails to initially select a PMP, the MCE shall assign the member to a PMP within 30 calendar days of the member’s enrollment. The member must be assigned to a PMP within 30 miles of the member’s residence, and the MCE must consider any prior provider relationships when making the assignment. The MCE’s PMP auto-assignment process must comply with any guidelines provided and must be approved by State before implementation.

Other considerations for PMP assignment or auto-assignment by the MCEs are as follows:

- Must authorize out-of-network care by any IHCP provider if panel slots are not available for the appropriate scope of practice within 30 miles of member’s residence.
- Must consider PMP assignment history (the fiscal agent provides 12 months of history; can also use MCE claims history).
- Must take panel limits into consideration.
- Must ensure provider scope of practice considered.
- Must maintain lock-in PMP assignment when member is in the RCP.
- Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists, advance practice nurses, and endocrinologists (if primarily engaged in internal medicine).

The MCE is required to notify the member in writing of the auto-assigned PMP provider. The notice must detail the member’s right to change PMPs, including the process by which the member may change PMP.

Preferred Medical Provider Assignment History File from Fiscal Agent to the Managed Care Entities

When a member is assigned to a new MCE, the fiscal agent sends the receiving MCE the member’s prior 12 months of PMP history. It includes assignments for PE and Hoosier Care Connect, if applicable. The 12-month look-back is based on dates that are less than the start date of the new segment and fall within the previous 365-day time frame, regardless of how far in the future the placeholder assignment starts. For example, a placeholder created on February 3 for an effective date of March 1 starts counting 365 days backward from March 1. If the placeholder effective date is February 15, the countdown begins from February 15. This update to the logic therefore captures members affected by PMP disenrollment/re-enrollment.

This history is an electronic file that is posted to File Exchange. It is a proprietary file and is not Health Insurance Portability and Accountability Act (HIPAA) compliant. The PMP Assignment History files are generated in response to placeholder assignments received from the MCEs. The assignment history files are not generated by regions like the 834s; one file generates per program when the process runs. The PMP Assignment History file layout is available on the MCO Question and Answer page at indianamedicaid.com under File Format and by selecting Hoosier Healthwise Outbound or HIP Outbound.
The member’s PMP assignment history file includes the following information, from most recent to oldest:

- Member ID – 12 numeric characters.
- PMP name – Up to 30 alphanumeric characters.
- PMP Provider ID (LPI) – Nine numeric characters.
- PMP group ID (Provider ID), if any – Nine numeric characters.
- PMP location, group or individual – One alpha character.
- PMP start reason.
- PMP stop reason.
- Effective date for each instance of a member’s PMP linkage – Required, eight characters (CCYYMMDD).
- End date for each instance of a member’s PMP linkage – Required, eight characters (CCYYMMDD).

For Hoosier Healthwise, the PMP assignment file captures PMP assignment history for any recipients who have a placeholder segment added during the current report cycle and whose previous MCE assignment does not match the current assignment.

PMP assignments must meet the following criteria to be captured on the PMP history file.

- The member changed MCEs during open enrollment.
- The member changed MCEs for just cause.
- The member had a gap in the IHCP eligibility and is now assigned to a different MCE than he or she was previously assigned.
- Same-plan assignments may appear in this case if the member was assigned to the placeholder MCE before the member’s last assignment with a different MCE, as long as the assignment is within the past 365 days.
- The member was assigned to another program under a different MCE (for example, the member is changing from Hoosier Care Connect to Hoosier Healthwise).
- The member was assigned to another program under the same MCE (for example, the member is changing from HIP to Hoosier Healthwise under the same plan. The MCE IDs are different).

Assignments that are not captured are as follows:

- Members whose most recent assignment was with the same MCE, regardless if there was a gap in coverage. MCEs must be aware of their prior members’ history.
- Members who have already been captured on the history file for a given placeholder assignment. These members do not make repeat appearances on subsequent file runs.
- Members who had a gap of more than 365 days with an MCE, even if that MCE is different than the one they have just been assigned.

**Preferred Medical Provider Assignments from the Managed Care Entities to Fiscal Agent**

MCEs must report PMP assignments to the fiscal agent so the information can be stored in CoreMMIS. Providers see the member’s PMP when verifying eligibility using the IHCP eligibility verification systems. MCEs must submit files for Hoosier Healthwise and HIP PMP assignments. Files
must be submitted by 6 p.m. daily, Monday through Friday. Only one file per day is processed. See *PMP Assignments from MCEs* for details about the file.

**Changing Managed Care Entities – Hoosier Healthwise**

Hoosier Healthwise members can change health plans only at the following times:

- Anytime during their first 90 days enrolled with a new health plan; referred to as the free-change period.
- Annually during their open enrollment period.
- Anytime there is just cause.

Each Hoosier Healthwise member has 14 days after their eligibility is received from ICES by the fiscal agent to select an MCE following eligibility determination. If a member does not make a selection, he or she is auto-assigned to an MCE. Following enrollment with an MCE, in accordance with federal requirements, members maintain the right to change MCEs during their open enrollment period. Following this 90-day period, eligible members remain enrolled with the same MCE for nine months, unless they have just cause.

Just cause reasons include but are not limited to the following:

- Receiving poor quality of care.
- Failure to provide covered services.
- Failure of the MCE to comply with established standards of medical care administration.
- Lack of access to providers experienced in dealing with the member’s healthcare needs.
- Significant language or cultural barriers.
- Corrective action levied against the MCE by the office.
- Limited access to a primary care clinic or other health services within reasonable proximity to a member’s residence.
- Lack of access to medically necessary services covered under the MCE’s contract with the State.
- A service not covered by the MCE for moral or religious objections.
- Related services are required to be performed at the same time and not all related services are available within the MCE’s network, and the member’s primary medical provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- The member’s PMP disenrolls from member’s current MCE, and reenrolls with another MCE. In such an event, the member can change plans to follow his or her PMP to the new MCE.
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

Before the member contacts the enrollment broker, the member must first contact his or her MCE, so the health plan can attempt to resolve the concern. If the member remains dissatisfied with the outcome, the member can contact the enrollment broker to request disenrollment. The enrollment broker reviews the request and makes a disenrollment determination.

The enrollment broker requests a copy of the member’s grievance and appeals record from the MCE. The MCE is expected to respond to the enrollment broker’s request within three business days.
The enrollment broker receives and reviews a copy of the member’s grievance and appeals record from the MCE, to confirm that the grievance and appeals process was exhausted. The enrollment broker makes a preliminary recommendation to the State about approving or denying the member’s request. The enrollment broker must make the recommendation within seven business days of receiving the record. The State makes the final decision.

If the member’s request is approved, the enrollment broker notifies the State fiscal agent about the member’s disenrollment with Plan #1, and the member’s new enrollment with Plan #2. The fiscal agent processes the member’s disenrollment with Plan #1 and enrollment with Plan #2 via the 834 transaction concurrently, according to established procedures.

MCEs must detail the process for submitting disenrollment requests in its member handbook and on its member website. This information must include the following:

- Members may change MCEs for cause only during the 12-month coverage term. For cause is defined as receiving poor quality of care.
- Members are required to exhaust the MCE’s internal grievance and appeals process before requesting an MCE change for poor quality of care.
- Members may submit requests to change MCEs to enrollment brokers verbally or in writing, after exhausting the MCE’s internal grievance and appeals process.
- The MCE must provide the enrollment broker’s contact information and explain that the member must contact the enrollment broker if the member has questions about the process. This information must include how to obtain the enrollment broker’s standardized form for requesting an MCE change.

Open Enrollment Period – Hoosier Healthwise

A member letter is sent 60-90 days before end of the 12-month enrollment period. The letter advises that the member may choose a new MCE with an effective date on the first day following the end of his or her 12-month enrollment period. If the member does not choose to change MCEs, he or she stays enrolled with that MCE for the next 12 months. The data entry cutoff date is the 25th of each month. Changes are not accepted if they are requested after the last business day before the 25th day of the last month of the member’s 12-month enrollment period. If the member chooses to change MCEs, he or she has a new 90-day free-change period beginning on the enrollment date with the new MCE.

Open Enrollment Scenarios – Hoosier Healthwise

Open enrollment statuses include the following:

- No Status: Enrollment broker (EB) may make the initial self-selection health plan assignments for a member.
- Open Status (O): EB may make a health plan assignment change.

Note: A date segment accompanies this status, indicating when the member is in his or her 90-day free-change period.

- Closed Status (C): EB may not make a health plan assignment change without just cause or a change in the household member health plan assignment.

Note: At the close of a member’s 12-month enrollment, a date segment accompanies the closed status, indicating the date the member was assigned to the MCE and when the assignment period ends with his or her chosen MCE.
With the closed status, the enrollment broker may make a future date assignment for the upcoming annual open enrollment period when the member is 60-90 days from the end of his or her closed status. A date segment accompanies the status when sent to the enrollment broker to help make the future date assignment.

Assumptions – Hoosier Healthwise

- Members become eligible for Medicaid the first day of the month.
- The DFR identified HHW eligibility effective date will be used as the MCE assignment effective date.
- Newborn children of MCE members have retroactive MCE assignment to the date of birth.
- Members who change MCEs during the 90-day free-change period or for just cause reasons are always effective with their new MCE enrollment on the first day of the month.
- Members continue to maintain the right to change PMPs within their MCE at any time.
- Members can maintain their PMP relationship if the PMP leaves the member’s MCE after the 90-day free-change period has expired. For instance, if the PMP disenrolls with the member’s current MCE but remains enrolled with another MCE, the member can change MCEs to stay with his or her current PMP.
- Members cannot be locked in to an MCE for more than 12 months.

General Enrollment Framework

Figure 16.1 – General Enrollment Framework

Continuing current practice, each Hoosier Healthwise member has 14 days to select an MCE. If a member does not choose within 14 days, he or she is auto-assigned to an MCE. Following enrollment with an MCE, in accordance with federal requirements, members maintain the right to change MCEs during the first 90 days of enrollment. This time frame is called the free-change period. Members remain enrolled with the same MCE for 12 months unless they have just cause (such as quality of care concerns and so forth). The 90-day free-change period and the 12-month enrollment period begin the same day.

Member Changes Managed Care Entities during 90-Day Free-change Period – Hoosier Healthwise

Following enrollment with an MCE, in accordance with federal requirements, members maintain the right to change MCEs during a first 90 days of enrollment. Following this 90-day period, eligible members remain enrolled with the same MCE for nine months, unless they have “just cause.”

Figure 16.2 – Member Changes MCEs during 90-Day Free-change Period
Member Changes Managed Care Entities for Just Cause

When a member changes MCEs for just cause, he or she receives another 90-day free-change period. Additionally, the member’s 12-month enrollment period restarts on the date of enrollment with the new MCE.

Figure 16.3 – General Just Cause Time Line

Members who have a break in eligibility greater than two months are given another 14-day choice period and are not required to return to their original MCE. This starts a new 12-month enrollment period. Members who have a break in eligibility of less than two months and regain eligibility less than 90 days before the end of their 12-month enrollment periods are also given a new 14-day choice period, 90-day free-change period, and new 12-month enrollment period.

Figure 16.4 – Just Cause Time Line – Less than Two Months' Eligibility Gap
If a member loses eligibility during his or her 90-day free-change period, and the eligibility gap is less than two months, the member’s free-change period resumes where it left off when the member regains eligibility to equal a full 90 days. In this scenario, the member is auto-assigned back to his or her initial MCE and has the remainder of his or her 90-day free-change period to maintain the right to change MCEs.

Exceptions to 12-Month Managed Care Entity Enrollment

If a member leaves Hoosier Healthwise and is then enrolled in Hoosier Care Connect or the Healthy Indiana Plan, and subsequently regains eligibility in Hoosier Healthwise, then the member is given another open enrollment period. The member is reassigned to the original MCE but can make a change within the first 90 days.

Newborn Scenario

There can be a delay in assigning newborns a Member ID. Newborns whose mothers are enrolled in Hoosier Healthwise are retro-assigned to the mothers’ MCE to the date of birth. Because of this delay and subsequent retro-assignment, the newborn’s 90-day free-change period begins the date he or she is assigned a Member ID, not the date of birth. CoreMMIS accommodates both dates. In the case of newborns who are not retro-assigned to date of birth (for example, the mother was not assigned to an MCE on the date of birth, or the baby is on Package C), the baby’s free-change period begins on the date of enrollment with the MCE, the same as any other member.
Family Member Free-Change Periods

Members of the same family often have different eligibility effective dates. The family members also have different enrollment time frames. The free-change periods within a family do not coincide and could potentially enroll family members in different MCEs, requiring families to call multiple times throughout the year to change MCEs during each family member’s free-change period. Families can avoid this by opting to change additional family members’ MCE enrollment when one family member is in a free-change period. Family member relationships are confirmed by the case ID provided by ICES/IEDSS and stored in CoreMMIS.

Changing Managed Care Entities in Healthy Indiana Plan

An individual may change his or her MCE selection at any time before making his or her first POWER Account contribution, or within 60 days of assignment to an MCE, whichever comes first.

Following the same process described previously for changing MCEs in Hoosier Healthwise for just cause, HIP members may change their MCE selection at any time during the 12-month benefit period for just cause.

Just-cause reasons include, but are not limited to, the following:

- Receiving poor quality care
- Failure of the MCE to provide covered services
- Failure of the MCE to comply with established standards of medical care administration
- Lack of access to providers experienced in dealing with the member’s healthcare needs
- Significant language or cultural barriers
- Corrective action levied against the MCE by the State
- Limited access to a primary care clinic or other health services within reasonable proximity to a member’s residence
- A determination that another MCE’s formulary is more consistent with a new member’s existing healthcare needs
- Lack of access to medically necessary services covered under the MCE’s contract with the State
- Services not covered by the MCE for moral or religious objections
- Related services are required to be performed at the same time but are not available within the MCE’s network; and the member’s primary medical provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- The member’s PMP disenrolls from the member’s current MCE and reenrolls with another MCE. In such an event, the member can change plans to follow his or her PMP to the new MCE.
• Other circumstances determined by the State or its designee to constitute poor quality healthcare coverage

HIP members also have the opportunity to change HIP plans during the redetermination process at the end of each 12-month coverage term. Ninety days before the end of the coverage term, the DFR sends a notice to the member about redetermination and the member’s right to change MCEs during redetermination. The notice also states that the request is because the enrollment broker 45 days before the end of the coverage term. If the member does not contact the enrollment broker to change MCEs 45 days before the end of his or her coverage term, the member remains assigned to his or her original MCE. The original MCE receives the member’s updated benefit period and POWER Account amounts.

If the member contacts the enrollment broker and selects a new MCE, the enrollment broker must update CoreMMIS according to established procedure. CoreMMIS processes the disenrollment with Plan #1 and enrollment with Plan #2 effective the first day of the member’s new coverage term. Plan #1 must continue to provide coverage for the member until the end of the coverage term. The enrollment broker must not process the request to change MCEs without cause if the request is not received 45 days before the end of the member’s coverage term.

Plan #1 must notify CoreMMIS of the rollover amount (even if it is zero) for which the member qualifies after the conclusion of the 120-day reconciliation period. This notice must also detail any refund amounts due to the State. The member’s rollover amount is moved through CoreMMIS from Plan #1 to Plan #2.

During the member transfer, Plan #1 and Plan #2 must provide for continuity of care. During and after the member transfer, Plan #2 (the new plan) is responsible for answering any questions the member may have about the transfer. Plan #2 is also responsible for resolving any transition issues that may arise.

HIP Basic or HIP State Plan – Basic members are also given the opportunity to change to HIP Plus or HIP State Plan – Plus, as applicable, at redetermination by paying their Potential Plus invoice. If the member chooses a new MCE at redetermination, the member must pay the Potential Plus invoice to the new MCE to ensure enrollment into HIP Plus or HIP State Plan – Plus.

Hospital Based Presumptive Eligibility and Presumptive Eligibility (Hospital PE and PE)

Presumptive eligibility provides immediate, temporary coverage for certain groups of individuals who are likely to be eligible for HIP or other Medicaid coverage.

Aid categories eligible for Hospital PE include:
• Low-income children who qualify for the IHCP
• Low-income parents or caretakers
• Non-disabled adults, ages 19–64
• Former foster care children
• Pregnant women
• Individuals eligible for the Family Planning Eligibility Program only

Individuals who qualify for Hospital PE/PE in categories that are HIP-eligible is placed into managed care immediately upon approval for Hospital PE/PE. All other individuals are placed into the fee-for-service program during their presumptive eligibility period.
The Hospital PE/PE process allows qualified acute care and psychiatric hospitals, federally qualified health clinics (FQHCs), rural health clinics (RHCs), community mental health centers (CMHCs), and local health departments to make PE determinations. Qualified PE providers make a preliminary assessment of eligibility based on a short list of eligibility questions, including age, income, pregnancy status, and residency status. Individuals found presumptively eligible have temporary health coverage starting that same day. The member receives a PE acceptance letter that serves as proof of coverage during the temporary PE coverage period. Members who are found eligible in other categories (not Adult PE) are placed in the fee-for-service program, and their benefits last until the last day of the month following their PE determination or, if they apply to the IHCP, until a decision is made on their IHCP application.

Individuals determined presumptively eligible for HIP is identified as Adult PE. Under this category, the member is enrolled with a managed care entity (MCE) from the date of PE determination and receives benefits equivalent to the HIP Basic benefit package, including all copayments. The PE benefits are temporary. The duration of the PE coverage period depends on whether the individual files an IHCP application and when the State makes a final HIP eligibility determination.

The following scenarios summarize the various coverage and HIP enrollment time frames via the PE pathway:

- **IHCP application not filed** – A presumptively eligible member who does not file an IHCP application receives PE benefits until the last day of the month following the month in which the PE determination was made. All PE members receive a Fast Track Prepayment invoice. If this invoice is paid and the member does not file an IHCP application, the amount is refunded.

- **IHCP application filed and denied** – A presumptively eligible member whose IHCP application is filed and denied by the Family and Social Services Administration (FSSA) receives PE benefits until the date of the State’s adverse eligibility decision. All PE members receive a Fast Track Prepayment invoice. If this invoice is paid and the member is determined not eligible, the amount is refunded.

- **IHCP application filed and approved** – A presumptively eligible member who files an IHCP application that is ultimately approved by the FSSA receives PE benefits until one of the following occurs:
  - **Applicant pays required POWER Account contribution:** Like all HIP applicants, presumptively eligible members have the opportunity to pay a PPAC in order to expedite coverage with HIP Plus or HIP State Plan – Plus benefits. A PE member who pays the Fast Track Prepayment at application, or who pays the Fast Track Prepayment or the initial POWER Account contribution within 60 days of the initial invoice, has PE benefits through the last day of the month in which the payment or the eligibility determination is made, whichever is later. The member begins HIP Plus or HIP State Plan – Plus coverage, as applicable, effective the first day of the month following the month in which the payment is made or the eligibility determination is made, whichever is later, with no gap in coverage.
  
  - **Applicant does not pay required POWER Account contribution and applicant is over 100% FPL:** A PE member with household income greater than 100% of the federal poverty level (FPL) who does not pay the Fast Track Prepayment or make a POWER Account contribution within 60 days of the initial invoice will have PE benefits terminated at the end of the invoice payment period.
  
  - **Applicant does not pay required contribution and applicant is at or below 100% FPL:** A PE member with household income equal to or less than 100% of the FPL who does not pay the Fast Track Prepayment or make a POWER Account contribution within 60 days of the initial invoice will have PE benefits until the first day of the month following the month in which the 60-day payment period ends. The individual begins HIP Basic or HIP State Plan – Basic benefits, as applicable, effective on termination of the PE period, with no gap in coverage.
**MCE Responsibilities during Hospital PE/PE**

**Eligibility**

Effective February 1, 2015, individuals determined presumptively eligible for HIP in accordance with 42 CFR §435.1110 will be enrolled with an MCE for a presumptively eligible period, which begins on the day a qualified hospital or other authorized entity makes a determination that the individual is presumptively eligible.

The presumptively eligible (PE) applicant is able to select an MCE at the time of PE application. If an applicant fails to select an MCE at the State will auto-assign the applicant to an MCE according to the State’s auto-assignment methodology.

During the member’s PE period, the MCE shall provide health benefits equivalent to the HIP Basic plan benefits. The member will not be provided a POWER Account during the PE period; however, the member is subject to copayments for services as set forth in the contract Section 4.1.2. The MCE shall reduce reimbursement to providers for services rendered to a PE member by the amount of the individual’s required copayment.

Within one business day of receiving the PE file, the MCE shall send an invoice to the PE member for a $10 Fast Track Prepayment, in accordance with contract Section 4.7.2. This initial “fast track” invoice notifies the PE member that the prepayment is an optional payment that is fully refundable within 60 day of being determined not eligible for HIP. Further, the initial fast track invoice must also include a prominent notice stating that the individual has the right to select another MCE before the first payment is made.

The MCE must conduct outreach to PE members to encourage them to complete an IHCP application for health benefits within their PE period. The MCE must work with their authorized QP providers to ensure that PE members are provided information at the time of the presumptive eligibility determination regarding the HIP program, the difference between HIP Plus and HIP Basic, and the importance of completing an application for health coverage and the importance of paying the initial $10 pre-POWER Account Contribution (PPAC) to maintain HIP benefits. Such education should also encourage members to include their unique presumptive eligibility RID on their IHCP application.

- The presumptive eligibility period will continue until one of the following occurs: In the case of a presumptively eligible member whose application for health benefits has been filed and approved by the FSSA, and who has made his or her pre-POWER Account Contribution (PPAC) or initial POWER Account contribution within 60 days of the date of the invoice, the presumptive eligibility period will end effective the first day of the month in which the payment was made or the eligibility determination was made, whichever is later. Such individuals must begin HIP Plus or HIP State Plan – Plus benefits, as applicable, effective immediately upon the termination of the presumptively eligible period, with no gap in coverage.

- In the case of a presumptively-eligible member with income equal to or less than 100% FPL, whose application for health benefits has been filed and approved by the FSSA and who does not pay a PPAC or initial POWER Account contribution within 60 days of the date of invoice, the presumptive eligibility period will end effective the last day of the following month into HIP Basic with potential plus. This will be effective immediately upon the termination of the presumptively eligible period with no gap in coverage. Such individual shall begin HIP Basic or HIP State Plan – Basic benefits, as applicable, effective immediately upon the termination of the presumptively eligible period, with no gap in coverage.

- In the case of a presumptively eligible member with income greater than 100% FPL whose application for health benefits has been filed and approved by the FSSA and who does not pay the PPAC or initial POWER Account contribution within 60 days of the date of invoice, the presumptive
eligibility period will end effective the date the nonpayment determination has been made for such individual.

- The PE period will end when the member does not complete and file an IHCP application for health benefits by the end of the month following the month in which PE coverage begins. The MCE must return any pre-payment funds received on behalf of such a member within 10 calendar days of the termination of the PE period.

- A PE period for a member whose IHCP application for health benefits has been filed and denied by the FSSA will end effective the date the State makes the adverse eligibility decision on the member’s application. The MCE shall return any prepayments received on behalf of such a member within 10 calendar days of the termination of the PE period.

The MCE will be required to process all payments, notify the State of receipt of payment, and reconcile any POWER Account over- or underpayments resulting from prepayments received from a member during their presumptive eligibility period, in accordance with the process and time frame established in Section 4.7.2.

Hospital Presumptive Eligibility (HPE)/Presumptive Eligibility (PE) Covered Services and Provider Access

When a PE member is determined to be presumptively eligible by a QP outside the MCE’s network, the MCE must work with the QP to provide reimbursement for the initial services rendered to the member.

PE Adult members are eligible to receive all services that are available to members in HIP Basic. Members will have copayments during their PE period.

PA and Appeal Rights

The MCE must have processes in place to provide prior authorization (PA) or prior approval (PA) for services rendered to PE members from the date that their PE eligibility is established. This date may pre-date the MCEs being able to see the member in Provider Health Care Portal.

MCEs can use a copy or fax of the member’s PE approval letter as evidence of PE eligibility before the member’s file is sent from Hospital PE to the MCE. MCEs may ask providers to hold claims and submit them after eligibility is established. A temporary PA may be used for members who are not yet loaded into the MCE’s system. The MCE may use a retrospective PA process for PE members.

Change of Plan

PE Adult members may change their MCE during their PE period only if they have completed an application for health benefits, have been found eligible for the HIP program, and have not made payment to the MCE from which they would like to depart.

HPE/PE Capitation

MCEs will receive the designated HPE/PE capitation rates for members who are assigned to them during their PE segment. HPE/PE capitation rates are paid as either a full capitation or half capitation. HPE eligibility can begin on any date of the month. HPE enrollment that covers 18 days or more in a given month will be paid a full capitation rate. HPE enrollment that covers 17 days or less in a month will be paid at a half capitation rate.
Presumptive Eligibility for Pregnant Women (PEPW)

Presumptive Eligibility (PE) provides earlier coverage for individuals who will likely be eligible for Medicaid. Presumptive Eligibility for Pregnant Women (PEPW) provides earlier prenatal care and improved birth outcomes for eligible pregnant women. Low-income pregnant women are determined eligible for Medicaid through a simplified application process. PE is different from pending Medicaid, because providers are eligible for reimbursement at the time services are rendered versus waiting for retroactive coverage when Medicaid eligibility is determined. Pregnant women found to be PE by qualified providers have coverage for her healthcare following her enrollment in PEPW.

Presumptive Eligibility for Pregnant Women Qualified Providers

MCEs must encourage their network providers to enroll as qualified providers (QPs). IHCP providers can enroll as QPs through the fiscal agent’s provider enrollment process. Providers that meet the criteria are encouraged to enroll as QPs by completing the QP enrollment in the Portal Provider Maintenance.

QPs must meet the following federal regulations:

- Enrollment as an IHCP provider.

- Provides outpatient hospital, rural health clinic, or clinic services, as defined in sections 1905 (a)(2)(A) or (B), 1905(a)(9), and 1905(l)(l) of the Social Security Act.

- Trained and certified by the State (or designee) to perform PE functions.

QPs must meet the following State requirements:

- Be able to verify pregnancy via a professionally administered pregnancy test (home-administered and over-the-counter tests do not meet this requirement).

- Be able to provide Internet, telephone, printer, and fax access to facilitate the PE and health benefit application process.

- Ability to access the Portal.

In addition, federal requirements dictate that QPs be one of the following:

- Family or general practitioner
- Pediatrician
- Internist
- Obstetrician or gynecologist
- Certified nurse midwife
- Advanced practice nurse practitioner
- Federally qualified healthcare center
- Medical clinic
- Rural health clinic
- Outpatient hospital
- Local health department
- Family planning clinic
After the minimum QP enrollment requirements are met, the State fiscal agent sends an automated email notification of their QP status. A fiscal agent field consultant contacts the approved QP to schedule a training session, which is the final step in the QP enrollment process. After completing the training session, QPs receive certification and are able to provide QP services.

Hoosier Healthwise managed care entities (MCEs) are provided a daily data file of the approved qualified providers (QPs) using file transfer protocol (FTP). See the MCO Question and Answer page at indianamedicaid.com for the file layout under File Formats\General Layouts\Outbound\Qualified Providers\QP_ELIG_PROV_File. A web tool is also available on indianamedicaid.com to search for individual QPs. The list of all QPs is printable. The PE QP enrollment requirements and processes are in the Presumptive Eligibility for Pregnant Women module and in the Presumptive Eligibility module at indianamedicaid.com.

Presumptive Eligibility Member Eligibility for PEPW

A woman must visit a QP to apply for the PE program. Before April 2014, a woman was required to meet eligibility criteria such as a doctor-verified pregnancy and having a gross family income less than 200% of the federal poverty level. The FSSA implemented changes to the eligibility criteria (and PE application) in early 2014. Presumptive eligibility introduced a new acronym “PEPW” to distinguish Presumptive eligibility for pregnant women from hospital presumptive eligibility (PE).

The following changes are effective April 1, 2014:

- Verbally attest to being pregnant
- Not be a current Medicaid member
- Be an Indiana resident
- Be a U.S. citizen or qualified noncitizen
- Not be currently incarcerated
- Have gross family income less than 213% of the federal poverty level

The application process was also modified to make certain fields optional rather than required:

- Social Security number (SSN)
- Race
- Ethnicity
- Gender
- Marital Status
- Pending Indiana Application for Health Coverage

A woman’s presumptive eligibility period begins on the date a QP determines the woman to be PE. The woman’s Medicaid eligibility determination is subsequently completed by the DFR. Failure on behalf of the PE member to cooperate with the DFR to complete the application for health benefits results in termination of PE benefits.

The following are the codes defined for PEPW:

- Aid category – PE
- Benefit Package – P
- The PEPW ID will begin with the digits 550, except in cases where the applicant is found to have had previous IHCP coverage, in which case, her originally assigned RID becomes her PEPW ID.
After it is determined the woman meets all PE requirements, the QP completes the Presumptive Eligibility for Pregnant Women application. The determination notice, including instructions for completing the Indiana Application for Health Coverage, is printed by the QP. The IHCP application for health benefits will no longer be printed along with the determination letter effective April 1, 2014.

The QP provides PE applicants a telephone to contact the enrollment broker, who helps select an MCE and PMP. PE members are not auto-assigned. Unlike Hoosier Healthwise and HIP, the enrollment broker makes the actual PMP assignment for PEW members. Before April 2014, the PEW member had to choose an MCE and PMP to activate her PEW coverage. Effective April 1, 2014, a PEW member no longer has to choose a PMP on the same day as her activation, although she is encouraged to do so. If she only chooses an MCE, the member is assigned to the PMP placeholder ID number 999999990.

Preferred Medical Provider and Managed Care Entity Assignment Changes During the PEW Eligibility Period

PEW members can change MCEs during the Presumptive Eligibility (PE) period. PEW members must follow the normal Hoosier Healthwise MCE assignment processes when changing MCEs; however, if a contracted PMP terminates from the MCE, then the MCE must coordinate the member’s assignment to a new PMP. MCEs are responsible for reassigning members within their plan, and communicating the PMP change to the fiscal agent.

PEW members must make the MCE and PMP selection during the first visit to the QP’s office. If the PEW member wants to change her PMP and MCE from the plan she originally selected, then she must contact the enrollment broker to make changes.

The member must record the MCE and PMP selection on the PEW determination notice. The determination notice includes the member’s RID. Denied members receive a notice with the denial reason and are given the opportunity to apply for coverage using a prepopulated IHCP application. The QP must provide a copy of the prepopulated application, which the member must review and sign. The QP must fax the application to the appropriate DFR office. Detailed instructions for the QP enrollment process and the Presumptive Eligibility Application for Pregnant Women are located in the Presumptive Eligibility for Pregnant Women Module. Additional PE State-approved training documents are available on indiana.medicaid.com.

For approved members, the determination letter is used as a Medicaid identification card for healthcare services. MCEs generate the welcome letter that provides confirmation of the member’s MCE and PMP choice. If the member loses her determination letter, then providers can verify eligibility using the EVS (IVR, 270/271 transaction, the Portal) by searching the member’s name and date of birth, or Social Security number.

The PE period begins the day the QP determines PE and continues until the DFR makes an eligibility determination. If the member does not apply for coverage by the last day of the month following her PE determination, then her PEW is terminated. When the pregnancy is terminated, then the fiscal agent end-dates the day following identification of the pregnancy termination. PE eligibility is termed at the end of the following month if member does not have an IHCP application for health benefits pending approval.

Upon an eligibility determination, the PEW segment is end-dated. If the member qualifies for coverage, then her benefit package changes from Package P to the appropriate benefit package. A Medicaid ID card is issued to the member with the member’s RID. If Medicaid eligibility is denied then PE is end-dated effective the day following receipt of denial from the DFR.

To provide members with constant coverage (without gaps), CoreMMIS was developed to accept members who appear to have “overlapping” MCE-enrollment segments. CoreMMIS design prohibits
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the “retroactive” closure of MCE-enrollment segments, ergo there will be occasions when members appear to be in two segments.

CoreMMIS was designed to accept all valid eligibility segments and utilize a hierarchy to determine which segment is appropriate.

Following are scenarios, which show the interplay between PE and Medicaid eligibility. These examples are for reference only and do not represent all possible scenarios. Scenario 1

• PE member becomes eligible January 1 and is assigned to an MCE the same day, January 1.

• On March 15, ICES sends a record with an active eligibility segment dated March 1. This record indicates the member is in HIP. If necessary, the 550 and 1099 RIDS are linked in CoreMMIS.

• Member’s eligibility shows that she was effective with the MCE from January 1, with PE benefits through February 28, and continued with the MCE, but at Medicaid benefit level from March 1, to end of time.

Scenario 2

• PE member becomes eligible January 1, and is fee-for-service (FFS).

• On March 15, ICES sends a Medicaid record with a retroactive Medicaid date of March 1. This record indicates the member is in RBMC. If necessary, the 550 and 1099 RIDS are linked in CoreMMIS.

• Member’s eligibility shows that she was effective from January 1, with PE benefits in FFS through February 28; she is Medicaid FFS from March 1 – March 31 (because she was not auto-assigned until after March 15, when the retro record was received), and assigned to an MCE with an effective date of April 1.

Scenario 3

• PE member becomes eligible January 1, and is assigned to an MCE effective January 1.

• On March 15, ICES sends a Medicaid record with a future Medicaid date of April 1. This record indicates the member is in RBMC. If necessary, the 550 and 1099 RIDS are linked in CoreMMIS.

• Member’s eligibility shows that she was effective from January 1, with PE benefits assigned to an MCE through March 31; eligibility shows Medicaid RBMC with the same MCE from April 1, to end of time.

Note: For future-dated Medicaid eligibility: Women who are awarded Medicaid that is not effective until some future date (as seen from the date that PE ends) often have an MCE assignment that continues into the Medicaid coverage period. This may appear to be an error if a woman is in a nonmanaged care-eligible aid category, but after the actual Medicaid effective date comes to pass, the existing managed care logic evaluates whether a given MCE assignment is valid, given the Medicaid coverage in force at the time. If the MCE assignment is valid, no action is taken. If invalid, CoreMMIS end-dates the MCE assignment as of the date of the evaluation.

Scenario 4

• PE member becomes eligible January 1, and is assigned to an MCE effective January 1; she continues on PE through mid-March.

• On March 15, ICES sends a Medicaid record with a retroactive Medicaid date of March 1. This record indicates the member is in FFS. If necessary, the 550 and 1099 RIDS are linked in CoreMMIS.
• Member’s eligibility shows that she was effective from January 1, with PE benefits and assigned to an MCE February 28. From March 1–March 15, she shows as Medicaid RBMC, assigned to the same MCE she had while in PE. From March 15, to end of time, she shows as Medicaid FFS.

**Appeal Rights for PEPW**

Presumptive eligibility coverage begins the day the applicant is determined by a QP to be PE. PE coverage ends the last day of the month following the month the woman was found PE, unless she has filed an Indiana Application for Health Coverage with the DFR, at which point, coverage ends when her eligibility determination has been approved or denied. PE applicants do not have appeal rights related to decisions regarding whether or not applicants are eligible for PE.

**PEPW Member Enrollment Information**

MCEs receive the PE member enrollments daily (Tuesday-Saturday) via the HIPAA-compliant 834 Benefit Enrollment and Maintenance Transaction (Change file). The 834 MCE Benefit Enrollment and Maintenance Transaction companion guide outlines the file-layout requirements. The file also informs the MCEs when the PE member is determined Hoosier Healthwise eligible. The MCE receives the PE termination on the PE 834 and the Hoosier Healthwise enrollment information on the subsequent Hoosier Healthwise 834. PEPW members are also included in the Hoosier Healthwise 834 Benefit Enrollment and Maintenance Transaction (Audit file).

**Eligibility Verification System for PEPW**

As with all Medicaid members, providers are encouraged to verify the eligibility of women who are PE for Medicaid before rendering services. Providers must check eligibility for PE members using the Social Security number (SSN) or name and date of birth to identify the correct RID on the date of service. Providers must contact the member’s MCE if there are questions about prior authorization. The EVS identifies the following:

• Member’s eligibility for Presumptive Eligibility Prenatal Care Only – Package P.
• Member’s PE PMP and the corresponding PMP contact telephone number.
• Member’s assigned MCE and the corresponding MCE provider services contact information.

**PEPW Covered Services**

PEPW members are covered under Package P, effective on the same date as of the date of the PE determination. Package P includes all outpatient pregnancy-related services.

Covered services are services related to the pregnancy and may include the following:

• Doctor visits
• Transportation
• Outpatient services
• Prescription drugs (covered fee-for-service)
• Lab and X-ray services
• Immunizations
• Dental services (covered fee-for-service)
• Mental health
• Home health
• Treatments of conditions that may complicate the pregnancy, including outpatient emergency services

The following services are excluded under PE:
• All inpatient services
• All long-term care
• All hospice services
• Labor, delivery, abortion, and postpartum services
• Ectopic pregnancy; abnormal products of conception
• Contraception
• Sterilization
• Services unrelated to the pregnancy or birth outcome

MCEs cannot require prior authorization for noncovered PE services. Prior authorization must be requested retroactively by the provider if full Hoosier Healthwise eligibility is granted after the DFR eligibility determination process.

**PEPW Claims Processing**

The MCEs process claims for the previous services with the exception of carved-out services. Services considered carved out are not the MCEs’ financial responsibility. The MCEs must submit the PE encounters through the existing Hoosier Healthwise Electronic Data Interchange (EDI) process using the appropriate Member ID. PE noncovered services denied while the member was eligible for PE may later be resubmitted using the Hoosier Healthwise Member ID if the woman is approved for Hoosier Healthwise. Flowcharts for this process are available on the MCO Question and Answer page at indianamedicaid.com.

QPs are not reimbursed for the administration processes related to PE enrollment. If the pregnant woman is approved for PE during the first visit with the QP, all covered health services provided by the QP during that visit are covered and paid by PE. If the woman is not approved for PE during the QP visit, the services provided by the QP are the patient’s responsibility.

**PEPW Capitation**

The MCEs receive capitation payments for each PE member enrolled with their organization through the existing capitation processes. The PE member is included on the Hoosier Healthwise 820 transaction and identified as a PE PW member by the PE 550 RID.

**Capitation Rate Cells for PEPW**

PE capitation applies to the following Hoosier Healthwise capitation rate cells.

Table 16.1 – Hoosier Healthwise Capitation Rate Cells for PEPW

<table>
<thead>
<tr>
<th>Description</th>
<th>Capitation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package A/P Child Ages 6-12 PH PKg A Pregnancy</td>
<td>A6PH</td>
</tr>
</tbody>
</table>
Important Presumptive Eligibility Capitation Information

- Capitation is based on the MCE and PMP assignment. Two active assignments in one month (for instance, one PE assignment and one Hoosier Healthwise assignment) could equal two full capitation payments. This could happen with Hoosier Healthwise alone; it most often happens in combination with PE. As long as a member has two Member IDs that are not linked during a month and two MCE and PMP assignments, capitation is paid for both Member IDs and assignments. Also, the linked Member IDs do not mean that capitation is not paid under both, because there could be active PMP assignments under the PE RID and the 1099 RID.

- If a member has PE for a portion of a month and Hoosier Healthwise for a portion of a month, the capitation rate is based on the MCE and PMP assignment and pays accordingly. If the MCE assignment changes from one MCE to another, capitation would pay to both MCEs, based on the assignment dates. A member assignment for 17 days or less results in half capitation, and an assignment of 18 days or more results in a full capitation payment.

- If member has PE regardless of Medicaid history (with or without prior IHCP eligibility) and she is determined ineligible for Medicaid, capitation is paid, as long as the PE segment is active and there is an MCE assignment for the PE period. Capitation is not recouped from an MCE for a PE member if she is determined ineligible for Medicaid.

- There are times when a member’s PE segment is not closed by the DFR caseworker after Medicaid eligibility is granted. Because of the two active assignments, duplicate capitation is paid for Hoosier Healthwise and PE. When the PE segment is eventually identified and closed, the fiscal agent recoups the duplicate payments. If the PMP assignment is retroactively ended, the systematic capitation reconciliation process recoups back to the end date of the assignment. If the PE PMP assignment is removed, capitation reconciliation recoups all capitation payments formerly covered by the PE PMP assignment that no longer exists.

- Regardless of whether the PE member is granted bisect eligibility, retroactive eligibility, or future-dated eligibility, capitation is based on the MCE and PMP assignment. If the MCE and PMP assignment is open and active, capitation is paid. However, variables can occur that affect the capitation rate such as:
  - Changes in aid category – For all other aid categories, including PE, gender and age are the deciding factors and determine the capitation rate. For instance, when a woman is on PE, she is on regular Medicaid, which is the same capitation rate as MA (Package A). After the woman is approved for Medicaid, her eligibility may actually be Package C if she is under the age of 19. Because Package A and Package C are paid at different rates, the capitation rate may change from PE (Package A capitation rate) to the Package C capitation rate, which generates an adjustment to the capitation payment, assuming that the Medicaid eligibility segment overlays the PE eligibility segment.
  - Change in member’s residence
  - Change of gender

Notification of Pregnancy

Early prenatal care can address potential health risks that contribute to poor birth outcomes. The State Neonatal Quality Committee, made up of Indiana health professionals, identified this as a focus area for prenatal care. The goal of the Notification of Pregnancy (NOP) initiative is to identify the health-risk factors of expectant mothers as early as the first trimester of pregnancy.
Portal Recognized Providers for Notification of Pregnancy

To submit and receive payment for an NOP, the Hoosier Healthwise risk-based managed care (RBMC) woman must be assigned to one of the MCEs. Providers must be enrolled with the IHCP in one of the following specialties to submit and be reimbursed for the completion of the NOP form:

- Family or general practitioner
- Pediatrician
- Internist
- Obstetrician or gynecologist
- Neonatologist
- Certified nurse midwife
- Advanced practice nurse practitioner
- Federally qualified health center
- Medical clinic
- Rural health clinic
- Outpatient hospital
- Local health department
- Family planning clinic
- Nurse practitioner clinic

Notification of Pregnancy Process

To submit an NOP form, the recognized provider must access the NOP form using the Portal. A recognized provider verifies the member’s eligibility through the Portal. After logging on to Portal, the recognized provider selects the Eligibility Inquiry function to verify the member’s eligibility. On verification, the recognized provider can complete the NOP form and electronically submit it via the Portal. For technical assistance with the Portal, the provider can contact the EDI Solutions Services Desk at 1-877-877-5182.

If the recognized provider begins the NOP process and CoreMMIS identifies that the NOP appears to be for the same woman and the same pregnancy as a previously submitted NOP, the recognized provider must explain why the new NOP is not a duplicate. The recognized provider can continue the process; however, the duplicate NOP is not valid and is not eligible for reimbursement.

At completion of all NOP form sections, the recognized provider is prompted to Print NOP or Close. A message that indicates whether the NOP is successfully submitted and eligible for reimbursement appears.

Successful submission results in an NOP that is determined valid or conditional.

Valid – An NOP that is not identified as being for the same woman and the same pregnancy as a previously submitted NOP. Valid NOPs must be submitted by the recognized provider within five calendar days of the date of service on the NOP form and must be for a member that was not 30 or more weeks pregnant on the date of service on the NOP form. Recognized providers are reimbursed $60 for successfully submitting a valid NOP.
Conditional – An NOP that is not identified as being for the same woman and the same pregnancy as a previously submitted NOP but for which the recognized provider explained why this is a different pregnancy than the pregnancy covered by the previously submitted NOP. Conditional NOPs must be submitted by the recognized provider within five days of the date of service on the NOP form and must be for a member that was not 30 or more weeks pregnant on the date of service on the NOP form. Recognized providers are reimbursed $60 for successfully submitting a conditional NOP, as long as it is not later found to be not valid. The following three reasons are available for explaining why an NOP is not a duplicate:

- Member abortion
- Member preterm delivery
- Member miscarriage

Not Valid – An NOP that is identified as being submitted for the same woman and the same pregnancy as a previously submitted NOP, submitted more than five calendar days from the date of service on the NOP form, or for a member who is 30 or more weeks pregnant on the date of service on the NOP form.

Note: Recognized providers are not reimbursed $60 for successfully submitting an NOP that is later determined not valid.

The recognized provider that initiated and completed the NOP has access to the completed NOP through the Portal. Any provider that matches its national provider identifier (NPI) or Provider ID to an NOP with any corresponding Member ID can view the submitted NOP at any time. The completed NOP can be printed any time after submission. After the NOP is submitted, the details cannot be amended or revised.

The NOP information form submitted by a recognized provider is sent to the appropriate MCE by File Exchange Protocol (FTP). MCEs use the NOP data to determine the health risk level associated with the woman’s pregnancy and the need for prenatal care coordination. The MCEs stratify the member’s risk level as being in one of three risk levels – high, medium, or low. The chosen risk level is returned to the State fiscal agent within 12 calendar days of the date the NOP was posted to the FTP. The MCEs receive $60 for each submitted NOP. The MCEs reimburse the recognized provider the full $60 per member, per pregnancy for each valid or conditional NOP submission. For each NOP completed and submitted, the State must deposit $40 into a birth outcomes bonus pool. The MCE may be eligible to receive a bonus payment from this fund, as outlined in the MCE contract with the State.

The MCE may use methods other than a nurse (or medical staff) to complete the risk assessment. For example, the MCEs may build an algorithm to identify the risk level. The MCEs must also include other methods of identification of risk including (but not limited to) the following:

- Interactions with the pregnant woman
- Contact with the physician
- Coordination with a prenatal care coordinator, if a relationship is already established.

Notification of Pregnancy Form Requirements

Specific fields on the NOP form must be completed for successful form submission of a complete NOP form. Completion of the NOP form requires the recognized provider to check all fields specific to that member and pregnancy. The NOP form is available on the MCO Question and Answer page at indianamedicaid.com under Project Documentation/Notification of Pregnancy Documentation. The recognized provider can print a blank PDF copy of the NOP form to complete by hand during the
member’s prenatal visit. The PDF version cannot be submitted electronically via the Portal. Therefore, the information documented on the hardcopy form must be entered and submitted via the Portal.

Prepopulated member data appears as determined in the Eligibility Verification System when the recognized provider completes the NOP through the Portal. Prepopulated areas facilitate quick, accurate completion of the NOP form.

The following fields are required for the NOP to be considered valid:

At the header level:
- Person completing the form
- Date of service
- Member name (prepopulates when completed through the Portal)
- Member address (prepopulates when completed through the Portal)
- Member telephone number (prepopulates when completed through the Portal)
- Date of birth and age (prepopulates when completed through the Portal)
- Member ID (prepopulates when completed through the Portal)
- Physician name (prepopulates when completed through the Portal)
- Physician telephone (prepopulates when completed through the Portal)
- NPI/ Provider ID (prepopulates when completed through the Portal)
- Prepregnancy weight
- Current weight
- Body mass index (BMI)
- Height
- Delivery system (prepopulates when completed through the Portal)
- Race
- Ethnicity
- Member’s primary language
- Date first prenatal visit
- Date last menstrual period (LMP)
- Number of weeks pregnant
- Taking prenatal vitamins
- Toxicology ordered

Section 1: Maternal Obstetrical History – Conditions identified in this pregnancy and past pregnancies must be checked in this section. If no current or historical conditions apply, the recognized provider must select If none above apply, please check here. This section is a required field.

The following question must also be answered in Section 1: < 12 months between births Yes/No. The system does not allow the user to continue if the provider has left this question unanswered.
Section 2: Previous Infant/Findings – This section refers to the history of birth outcomes a member may have had with previous pregnancies. This section may not apply to all members. Please check all relevant birth outcomes the woman experienced with any of her previous pregnancies.

Section 3: Maternal Medical History – Conditions identified in this pregnancy and past medical history must be checked in this section. If no current or historical conditions apply, the recognized provider must select If none above apply, please check here. This section is a required field.

The following questions must be answered in Section 3:

HIV/AIDS tested Yes/No. The system does not allow the user to continue if the recognized provider has left this question unanswered.

ER or hospitalization in last 6 mos. Yes/No and If yes, how many? The system does not allow the user to continue if the recognized provider has left this question unanswered.

Section 4: List All Current Medications – List any and all current medication. This is an open field that allows the recognized provider to list as much detail as necessary. If no medications are entered, the provider must choose None, or the system does not allow the completion of the NOP.

Section 5: Psycho-Neurological History – If the member has a condition that applies to this section, the diagnosis must be checked. If there are no current or historical conditions to report, the recognized provider must select If none above apply, please check here.

Section 6: Substance Abuse/Use History – If the member is currently using or has a history of substance abuse and use, this must be indicated in this section. If there is no current or historical use, the recognized provider must select If none above apply, please check here.

Section 7: Tobacco History – If the member is currently using cigarettes or tobacco, or has a history of use, this must be indicated in this section. The system does not allow the user to continue if the recognized provider has left this question unanswered.

Section 8: Social Risk Factors – Social risk factors often lead to referrals for support services outside the recognized provider’s office. If the member does not identify social risk factors from the list, the recognized provider must select If none above apply, please check here.

Section 9: Diagnosis of Pregnancy Risk – The recognized provider must determine the diagnosis of pregnancy risk as a Normal Pregnancy or a High Risk Pregnancy. The provider must also indicate Gravida and Para and must list any other medical or psychological problems not addressed elsewhere on the form.

Section 10: Referrals – Recognized providers are encouraged to identify services to which the pregnant woman was referred. This better prepares the MCEs to follow up with women about these referrals.

State-Approved Training Documents and Forms

Other NOP State-approved training documents and instructions are also found on indianamedicaid.com. On the home page, from the right menu under Quick Links, click Presumptive Eligibility. The Presumptive Eligibility page appears. Click Notification of Pregnancy from the left-side menu.

Notification Of Pregnancy Data Extracts

The NOP data extract automatically posts to File Exchange for each MCE on a daily basis. The process runs Monday – Friday at 6 a.m. Eastern Time (ET). Monday’s run contains data from Friday, Saturday, and Sunday. The data extract runs for the prior full day’s information and includes only the new
submissions or updates received since the last extract. The data extract is provided in XML format and includes member-specific information, applicable NOP information as populated by the recognized provider, and fiscal agent initial risk. Fields that are not populated by the recognized provider are omitted from the extract.

The following codes are included in the NOP data extract and provide an explanation of the reasons an NOP is considered not valid or suspect:

- S01 Miscarriage
- S02 Abortion
- S03 Pre-Term Del
- I01 Duplicate
- I02 > 5 days DOS
- I03 > 30 wks Gest

The system specifications and fields for this data extract, process flowchart, and schema XML format are available on the MCO Question and Answer page at indianamedicaid.com under Project Documentation/Notification of Pregnancy Documentation.

Each NOP form has a unique NOP ID. The NOP ID generates at the time the NOP is submitted. The MCE risk level is received and stored with the corresponding NOP ID. The date the MCE returned the first risk stratification is stored in the data extract as DATE_RECEIVED. The risk values are as follows:

- Fiscal Agent Initial – Stored on submission of NOP form and recorded by the fiscal agent. Risk level is High, Med, or Low.
- MCE Initial – This field is populated on initial receipt of the NOP XML file returned by the MCE. Risk level is High, Med, or Low.
- MCE Latest – This field is populated on receipt of NOP XML file returned by the MCE and used to store updated risk levels. Each receipt of updated risk level is an overlay to existing data. Risk level is High, Med, or Low.

Notification Of Pregnancy Summary Reports

The NOP Summary Report distributed by the State is produced by the Business Objects application. This report provides the State with a monthly summary of NOP data submitted during the previous month. The NOP Summary report provides an executive level of NOP reporting metrics. An audit report identifies invalid NOP submissions and associated claim payments. The report is automated in Business Objects and is posted in PDF format into the file location: P:\Managed Care\Meeting Minutes. The report contains the following data:

- NOP Submission
- Delivery System
  - MDwise
  - MHS
  - Anthem
  - FFS
  - NOP Status
  - Valid
  - Invalid
  - Suspect
• Member Demographics Age:
  • Age
  • Under 15
  • 15-18
  • 19-25
  • 26-35
  • 36-45
  • 46-55
  • Over 55

Member Demographics Race:
  • White
  • Black
  • American Indian
  • Asian
  • Other

Member Demographics Ethnicity:
  • Hispanic
  • Non-Hispanic

Member Demographics Primary Language:
  • English
  • Spanish
  • Other

• Number of Weeks Pregnant
  • 1-12 weeks
  • 13-27 weeks
  • 28 or more weeks

• Obstetrical – Top 10
  • Top five most selected as “Current”
  • Top five most selected as “History”

• Medical – Top 10
  • Top five most selected as “Current”
  • Top five most selected as “History”
  • Top five selections for those not current or history

• Previous Infant/Findings
  • Stillbirth > 28 wks
  • Preterm birth < 30 wks
  • Preterm birth 30-36 wks
  • Birth weight < 2,500 gms
  • Birth weight < 4,000 gms

• Diagnosis of Pregnancy Risk
  • V22
  • V23

• Prenatal Vitamin Usage
  • Yes
  • No

• Body Mass Index
  • BMI > 30
  • BMI < 19

• Referrals
  • Indiana Family Helpline
- Tobacco Quitline
- WIC
- Childbirth/Parenting
- Domestic Violence
- Mental Health/Substance Abuse
- Prenatal Substance Use Prevention

- Psycho-Neurological History Clinical Depression:
  - History
  - Current
  - On Medication

- Psycho-Neurological History Postpartum Depression:
  - History
  - Current

- Psycho-Neurological History Suicide attempt/thoughts:
  - History
  - Current

- Psycho-Neurological History Borderline Personality Disorder:
  - History
  - Current

- Other
  - History
  - Current

- Substance Abuse/Use History
  - Marijuana
  - Amphetamine
  - Alcohol
  - Methadone
  - Cocaine/crack
  - Narcotics/heroin
  - Sedative/tranquilizer
  - Inhalants/glue
  - Other
  - Percent ready to quit next 30 days

- Tobacco History
  - Current use
  - Past 12 months
  - Percent ready to quit next 30 days

- Social Risk Factors Abuse:
  - Yes to one Question
  - Yes to two Questions

- Social Risk Factors Other:
  - Food Insecurities
  - Homeless in shelter
  - Transportation problems
  - Education < 10th grade
  - Learning Disability/MR
  - Rape
    - Current
    - History
  - Lives alone
  - Unemployed
• No telephone  
• Unstable home  
• No family support

NOP Data Extract Risk Level Update File from MCEs to the Fiscal Agent

After the MCEs receive the NOP data extract file, the MCE is required to complete and return to the fiscal agent, a risk stratification for each NOP within 12 calendar days using the NOP Update XML format. The data extract includes the date sent (DTE_SENT field: Date fiscal agent posted to FTP), which starts the 12-calendar-day time period. The MCE receives an error message if the file returned to the fiscal agent does not contain a risk level or if the file is not in the correct format:

• Date Received  
• XML Valid – True/false  
• Error Message – If the XML format is not valid  
• Number of total updates on the file  
• Number of accepted updates  
• Number of rejected updates

NOP information for each NOP update attempted verifies the following data:

• Identification number  
• Success – True/false  
• Error Message – If the NOP update was not successful  
  S01 = Miscarriage  
  S02 = Abortion  
  S03 = Pre-Term Del  
  I01 = Duplicate  
  I02 = > 5 days DOS  
  I03 = > 30 wks Gest

Provider Billing Guidelines

NOP information must be submitted via the Portal for the recognized provider to receive reimbursement for completing the NOP form.

Billing guidelines for NOP are as follows:

• NOP can only be billed for a Hoosier Healthwise/RBMC-enrolled woman using procedure code 99354 with modifier TH and submitted to the MCE of record on the date of service.  
• Recognized provider reimbursement for submission of a successfully submitted complete NOP is $60 per member, per pregnancy. Recognized providers must successfully submit a complete NOP via the Portal within five calendar days of the date of service to be reimbursed. If the time line is not met, the submission no longer qualifies for the $60 reimbursement. The date of service is the date the member risk assessment is completed by the recognized provider.  
• Duplicate NOPs, those for the same woman and the same pregnancy, do not qualify for $60 reimbursement. One NOP per member, per pregnancy is eligible for reimbursement. Recognized providers receive a systematic message if the NOP appears to be a duplicate. Recognized providers may continue to complete the NOP or cancel the NOP for that pregnant woman.  
• NOPs for pregnant members with gestations of 30 weeks or more are not eligible for $60 reimbursement.
• NOPs completed for traditional fee-for-service women are not eligible for $60 reimbursement.

• Recognized providers that complete a NOP on a PE member must allow 24 hours from the assignment date of the PE RID to submit an NOP via the Portal. The 24 hour timeframe allows the EVS time to accurately display the PE member data.

High-risk Pregnancy Payment and NOP

To document medically high-risk pregnancies for Hoosier Healthwise members, providers must complete and submit the NOP through the Portal. The NOP is the only acceptable method of documentation for high-risk pregnancies; the Prenatal Risk Assessment Form or other standardized risk-assessment tools are no longer accepted forms of documentation. For women who are determined high risk after 30 weeks, the provider must complete an NOP for the High Risk Modifier to be paid. As previously mentioned, NOPs completed after 30 weeks cannot receive the $60 reimbursement. Also, for those who already have the NOP completed, the High Risk Modifier will normally work regardless of the stratification of the NOP. The provider must always have documentation available to prove the pregnancy was high risk in the event of an audit.

Capitation

The MCE capitation payment process runs on the normal capitation cycle, the third Wednesday of every month, and is included in the 820 MCE Capitation Payment Transaction. The NOP payments are identified by the capitation codes of NP (Package A/B), UP (Package A MA-U), or CP (Package C). Payment reasons codes are PN (Normal Payment) or RN (Recoupment – Notification of Pregnancy).

The following scenarios prevent a capitation payment to the MCEs:

• The NOP submission is considered duplicate (the same woman and the same pregnancy as a previously submitted NOP).

• The fiscal agent does not have a risk stratification on file from the MCE when the capitation cycle is generated. If the MCE returned the risk stratification more than 12 calendar days from the date the NOP XML file was posted to the FTP site, the State must review and approve the exceptions before processing.

• The NOP was submitted by the recognized provider more than five calendar days from the date of service.

• The NOP was submitted by the recognized provider for a woman 30 or more weeks pregnant on the date of service.

• The MCE submitted a risk stratification for an NOP ID that is not found in CoreMMIS.

Newborn Prebirth Selection

Pregnant mothers’ MCEs coordinate PMP preselections for newborn members. CoreMMIS retroactively assigns newborns to their respective mothers’ MCEs as soon as the newborns’ eligibility is passed from ICES to CoreMMIS. The MCE must notify CoreMMIS of the newborn’s PMP using the PMP assignment input file.

Provider-Initiated Requests for Member Reassignment

The Hoosier Healthwise and HIP programs encourage positive and continuous relationships between members and PMPs. In rare instances, a PMP may request reassignment of a member to another PMP within the MCE. The MCE must approve and document these situations. The reasons for these situations include the following:
• Missed appointments (with appropriate documentation and criteria).
• Member fraud (upper-level review required).
• Uncooperative or disruptive behavior on the part of the member or member’s family (upper-level review required).
• Medical needs that could be better met by a different PMP (upper-level review required).
• Breakdown in physician and patient relationship (upper-level review required).
• The member accesses care from providers other than the selected or assigned PMP (upper-level review required).
• Previously approved termination.
• Member insists on medically unnecessary medication.

The MCE’s medical director or a committee appointed by the medical director performs an upper-level review – a thorough review of the individual case – to determine whether the cause and documentation are sufficient to approve a reassignment. The upper-level review includes monitoring to improve the overall quality of the program and to ensure that the MCE’s guidelines and policies are consistent with those of the program.

The following, developed and finalized by the Hoosier Healthwise Quality Improvement Committee (QIC), provides guidelines for situations outlined previously:

• Missed appointments – A member may miss at least three scheduled appointments without defensible reasons before a PMP may request member reassignment. The PMP or staff is responsible for educating the member, on the first occurrence, about the problems and consequences associated with missed appointments. Hoosier Healthwise members are not penalized for an inability to leave work, for lack of transportation, or for other defensible reasons. Missed appointments must be documented in the member’s chart that is accessible to the PMP and staff. On documentation of the third missed appointment for nondefensible reasons, the MCE may approve the PMP’s request for the member’s reassignment within the MCE.

MCEs are encouraged to have procedures in place to assist members and PMPs with missed appointments and are expected to intervene as required to resolve issues, while supporting the overall goals of the Hoosier Healthwise program.

• Member fraud – This reason for member reassignment must be restricted to cases referred to the Indiana Bureau of Investigation or the Office of the Inspector General (OIG).

• Threatening, abusive, or hostile actions by members – The PMP can request a member’s reassignment when the member or the member’s family becomes threatening, abusive, or hostile to the PMP or to the office staff after attempts at conflict resolution have failed. The request must be consistent with the PMP’s office policies and with criteria used to request reassignment of commercial patients. The MCE must have conflict resolution procedures designed to address these concerns.

• Member’s medical needs may be better met by another PMP – A PMP may request member reassignment because the PMP believes a member’s medical needs would be better met by a different PMP. This request must be documented as to the severity of the condition and must be reviewed by the MCE’s medical director. The MCE’s medical director must review the request based on the specific condition or severity of the condition as a PMP scope-of-practice matter, not based on a bias against an individual member.

• Breakdown of physician and patient relationship – The MCE must conduct an upper-level review, as defined previously, to ensure that the breakdown in the relationship between the PMP and the member is mutual.
• Member accessing care from other than the selected or assigned PMP – The MCE must conduct member education about the health plan and the PMP selection process. If the member does not initiate a PMP change and continues to access primary care services from a provider other than the PMP, the PMP may request the member’s reassignment. Misuse of the emergency room is not a valid reason for requesting a member’s reassignment.

Most of these situations can be resolved by facilitating the member’s selection of another PMP within the health plan. Members who require services of providers not available within the health plan generally are not disenrolled but remain in the MCE, with the MCE managing and reimbursing for out-of-network services.

MCEs must use PMP-initiated requests for member reassignments to identify issues and concerns documented in quality improvement processes. Each MCE must develop an internal policy for approval of PMP-initiated member reassignments, based on the criteria outlined previously. Unacceptable reasons for PMP-initiated member reassignment requests:

• For good cause – This term is used for member-initiated PMP change requests.
• Non-compliance with mutually agreed-to treatment – Members are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
• Demand for unnecessary care – A PMP-initiated request for member reassignment is not approved for this reason unless there is documentation of threatening, abusive, or hostile behavior, as described.
• Language and cultural barriers – PMPs who have difficulty with a member’s language or other cultural barriers must request assistance from the MCE to address the problem.
• Unpaid bills incurred before Hoosier Healthwise enrollment – PMPs may not initiate member transfer requests because of unpaid medical bills incurred before Hoosier Healthwise enrollment. PMPs can pursue charges outstanding before Hoosier Healthwise enrollment through the normal collection process.
Section 17: Redetermination

Overview

Eligibility redetermination for Hoosier Healthwise and Healthy Indiana Plan (HIP) members occurs at intervals determined by the Division of Family Resources (DFR). Intervals vary for Hoosier Healthwise members, but HIP members must renew their eligibility every 12 months.

Managed care entities (MCEs) may assist members in the redetermination process, but must offer the same level of assistance to all members equally. Members are ultimately responsible for completing redetermination materials, signing the redetermination form, and submitting these materials to the DFR by the required deadline.

MCEs must also reconcile Personal Wellness and Responsibility (POWER) Accounts for HIP members whose eligibility is redetermined for another coverage period.

Hoosier Healthwise Eligibility Redetermination

Hoosier Healthwise members who have gaps in Indiana Health Coverage Programs (IHCP) eligibility or managed care eligibility for more than two months are processed as new members for auto-assignment purposes—that is, they are given 14 days to choose their MCE. If a plan selection is not made at that time, the member is auto-assigned according to the auto-assignment criteria effective 2011.

Members who have gaps in IHCP eligibility or managed care eligibility for less than two months and have 90 days or more until the end of their 12-month open enrollment period are auto-assigned back to their MCE. These members are not given another 30-day free-change period. Before mid-2011, members who moved from one county to another were systematically terminated from their MCE, then reassigned after a gap in managed care coverage. The system maintains members’ MCE assignments when they move across counties or regions to prevent gaps in managed care coverage, as long as the members don’t have gaps in their Medicaid eligibility.

MCEs may assist and direct members to resources regarding the redetermination process. MCEs must offer the same level of assistance to all members (for which the redetermination date is provided) equally. Members are ultimately responsible for completing redetermination materials, signing the redetermination form, and submitting these materials to the DFR by the required deadline.

1. MCEs receive notification of members who have an upcoming redetermination from the State’s fiscal agent. The fiscal agent runs a monthly query for members with redetermination dates in the following month.

2. MCEs must be prepared to accept calls from members requesting assistance with redetermination and must provide direction to appropriate resources to answer any questions members may have.
   • MCEs may assist members in the redetermination process. Permissible examples of MCEs assisting members in the redetermination process include: Conducting outreach calls or sending letters to members reminding them to renew their eligibility in Hoosier Healthwise. All written materials and call scripts must be approved by the State before distribution.
   • Directing members to applicable resources to seek further assistance with their application (for example, in.gov/fssa and FSSA/DFR Service Center).

3. In providing assistance during redetermination, MCEs must not do any of the following:
Section 17: Redetermination

• Discriminate against members, particularly high-cost members.
• Provide any indication as to whether the member is redetermined eligible for Hoosier Healthwise (this decision must be made by the DFR).
• Talk to members about changing MCEs (if the member has questions, the MCE must refer the member to the enrollment broker).
• Provide incentives to members to complete or disregard their application.
• Engage in or support fraudulent activity in association with helping the member complete the redetermination process.
• Sign the member’s redetermination form.

4. MCEs must provide redetermination assistance equally across the membership for which redetermination dates are provided and be able to demonstrate that redetermination procedures are applied consistently for each member.

5. Members bear the ultimate responsibility for completing redetermination materials, signing the redetermination form, and submitting it to the DFR by the required deadline.

6. DFR makes the final redetermination decision.

Healthy Indiana Plan Eligibility Redetermination

The DFR uses the same process to verify information contained in redetermination forms as it does for original applications. Although MCEs are permitted to assist members in the redetermination process, the DFR must make all final redetermination decisions. After receiving a member’s completed redetermination materials, the DFR determines whether the member is eligible for HIP for another coverage term.

If a member does not submit the redetermination materials 45 days before the end of the member’s coverage term, the member is terminated from HIP effective the end of the member’s coverage term. If the DFR receives incomplete redetermination materials, it follows up with the member to obtain the missing information. If members fail to submit the missing information within the time frame required by the DFR, they are found ineligible to participate in HIP for the subsequent coverage term.

Note the following procedures when members are approved or fail redetermination.

Application Approved

If the DFR determines that a member is eligible to participate in HIP for another coverage term, the DFR recalculates the member’s POWER Account contribution to account for any changes in income or family circumstances. The new POWER Account contribution becomes effective in the subsequent coverage term. The DFR must send a notice to members of their renewed eligibility in HIP and their new annual POWER Account contributions. The DFR also informs the member that if there is a remaining balance in his or her POWER Account, the POWER Account is appropriately credited 120 days after all provider claims for the previous year have been received. See HIP Billing and Collection Services for more information.

The State fiscal agent notifies the MCEs of the results of the redetermination process via the 834 transaction, as well as the amount of the recalculated POWER Account contribution, when a member is approved for renewal. The State fiscal agent also provides any available data on total claims paid for the member in the member’s lifetime via the 834 transaction.
If a member’s redetermination is delayed, the member remains assigned to the HIP plan. The benefit period is not reported until the DFR processes the member’s eligibility. CoreMMIS, however, generates a provisional State POWER Account amount to the MCE in the same amount as the prior benefit period. After the redetermination is processed, the provisional POWER Account is recouped, and the new POWER Account amount is issued to the MCE.

**Application Denied**

If the DFR determines that a member is not eligible to participate in HIP in the subsequent coverage term, or if a member does not complete the redetermination process by the due date, the DFR notifies the individual that his or her HIP eligibility will terminate effective the end of the member’s current coverage term. This notice includes, at minimum, the following:

- The eligibility termination date from HIP.
- A description of the member’s right to appeal the decision by requesting a State fair hearing.
- An explanation that the member is restricted from participating in HIP for a period of six months (if applicable), as well as a detailed explanation of the lock-out exemptions.
- An explanation that the member may reapply if his or her circumstances change (if applicable).
- An explanation that the member’s pro rata share of his or her POWER Account balance (if any) is refunded by their MCE within 120 days of the end of the member’s coverage term, and that he or she may be responsible for claims that are received after this payout period.

MCEs are notified of the member’s termination from HIP via the 834 transaction, which includes the eligibility termination date. Policies governing termination of POWER Accounts apply.

If a member loses HIP eligibility at redetermination, MCEs must refund the member’s pro rata share of any remaining POWER Account balance within 120 days. If a member renews HIP eligibility at redetermination, MCEs must roll over the member’s POWER Account balance. Rollover occurs at the end of the 120-day reconciliation period. For further direction on how to reconcile a member’s POWER Account at redetermination, see [POWER Account Reconciliation](#).

**Eligibility Notice Not Received by End of HIP Coverage Term**

If ICES has not notified the MCEs of an eligibility decision and new POWER Account contribution amount before the first contribution is due, members must be billed using the contribution amount from the previous benefit period. MCEs must then reconcile any overpayments or underpayments made by the member as a result of using the contribution amount from the previous coverage term. This reconciliation can occur in future contribution bills, but must occur within 30 days of notification by ICES of the member’s recalculated contribution amount for the new benefit period.

If the member is ultimately determined ineligible for the program, MCEs must close the POWER Account according to the POWER Account closure procedures. If in month 13, there is no redetermination decision, the State will provide the MCE with a provisional POWER Account contribution, in addition to all required capitation payments. The amount of the provisional payment for the subsequent benefit year is the same amount as the prior benefit period.

**Member Appeals Ineligibility Decision at Redetermination**

A member may appeal a determination of ineligibility. The member has 33 days following the effective date of a notice of discontinuance of coverage to file the appeal with the Division of Hearings and Appeals. However, if the member would like to maintain coverage without change until the administrative law judge issues a decision, the appeal must be filed before his or her coverage...
terminates. If the appeal is filed before the member’s coverage terminates, the MCE must continue to provide coverage for the member through the pendency of the appeal. If a member was terminated for nonpayment before being denied eligibility, the appeal would be of the nonpayment termination. In these cases, the member does not qualify for continued benefits coverage during the appeal, even if the member appeals before his or her coverage termination date.

**Timely Appeal**

If a member timely appeals, a new eligibility period is established for the member until a determination can be made regarding the member’s appeal; therefore, a member who timely appeals is given a new 12-month benefit period. This eligibility period could be modified after the administrative law judge (ALJ) decision is rendered to comply with the ALJ’s decision. If the appeal decision has not been made before the member’s benefit period ends, the member is required to complete his or her redetermination. A member who timely appeals discontinuance because of not paying his or her POWER Account contribution is not entitled to a continuation of benefits pending appeal.

The MCE receives an 834 from the State fiscal agent that shows the member as eligible for 12 additional months of eligibility. This benefit period runs subsequent to the terminated benefit period.

The MCE establishes a new POWER Account for the member’s new Benefit Period. The MCE needs to complete rollover calculations as normal at the 120-day mark for the previous benefit period. The State makes its contribution to the new POWER Account via the State fiscal agent. The State fiscal agent continues to pay capitation to the MCE for each month the member is fully eligible in appeals.

During appeals, the member needs to continue to make POWER Account contributions to remain eligible for HIP Plus or HIP State Plan Plus, as applicable. The MCE continues to bill the member. If the member has 60 days of nonpayment, the MCE submits a nonpayment trigger to ICES and the member is terminated from HIP, or transferred to HIP Basic or HIP State Plan Basic, as applicable.

All routine member communications and services (for example, preventive services reminders, redetermination packets, billing, claims payment, and so forth) continue.

If the member’s timely appeal is granted:

- The member’s new or appealed benefit period continues. The MCE does not receive any additional information on the 834.
- The MCE needs to reconcile any debt or penalty that was charged to the member, as the member has continued to pay his or her monthly contributions, and the termination was made in error. No penalty or debt can be applied.

If the member’s timely appeal is denied:

- The member’s benefit period is terminated at the end of the month of the ALJ’s resolution and the member is liable for any claims paid on his or her behalf by the MCE during the appeals period. As the member must not have had coverage during the appeals period, the MCE may recoup any payments made to providers on behalf of the member while the member was in appeals. It is then be the provider's responsibility to pursue payment from the member.
- The MCE completes the termination calculations (including debt and penalty, if applicable) and reports them to the State fiscal agent on the POWER Reconciliation File (PRF), in accordance with Policy and Procedure.
Untimely Appeal

If a member does not appeal the eligibility determination by the time his or her current eligibility period is completed, the member is not given a new benefit period while in appeals. The MCE receives a termination notice via the 834 and must process it according to standard operating procedures.

If the member’s untimely appeal is granted:

- The MCE receives an 834 with a retroactive eligibility period (similar to MCEs transfers).
- A new 12-month benefit period is established that begins at the time the termination occurred.
- The MCE receives capitation payments for all months that are reinstated.
- All claims for HIP covered services that the member incurred during this time frame may be resubmitted by the provider for payment.
- The member must pay the remaining portion of his or her individual required contribution in equal installments throughout the remainder of the member’s current benefit period. If the member fails to make these installments or becomes 60 days delinquent in payments, the member is terminated for nonpayment, or transferred to HIP Basic or HIP State Plan Basic, as applicable.
- The MCE needs to reconcile any debt or penalty that was charged to the member, as the member has continued to pay his or her monthly contributions, and the termination was made in error. No penalty or debt can be applied. The member’s remaining balance may be adjusted in lieu of refunding money.

If the member’s untimely appeal is denied:

- The member’s termination is final, and the MCEs complete the 60 and 120 days calculations as with any termination. Penalty and debt may apply to these situations.

Changing Managed Care Entities without Cause at the End of a Coverage Term

The HIP member has an opportunity to change MCEs every 12 months during the redetermination process. At least 90 days before the end of the coverage term, the DFR sends HIP member’s a notice to the member about redetermination and the member’s right to change MCEs during redetermination. The notice includes a statement that the request must be received by the enrollment broker 45 days before the end of the coverage term. This notice also includes the enrollment broker’s contact information and an explanation that all requests to change MCEs must go to the enrollment broker. The enrollment broker can provide counseling regarding MCE changes.

If the member does not contact the enrollment broker to change MCEs 45 days before the end of his or her coverage term, the member is assigned to his or her original MCE. The enrollment broker will not process member requests to change MCEs without cause received less than 45 days before the end of the member’s coverage term.

If the member contacts the enrollment broker and selects a new MCE, the enrollment broker must notify CoreMMIS, according to established procedure. CoreMMIS processes the disenrollment with MCE #1 and enrollment with MCE #2, effective the first day of the member’s new coverage term. MCE #1 must continue to provide coverage for the member until the end of the coverage term.

During the member transfer, MCE #1 and MCE #2 must provide for continuity of care. During and after the member transfer, MCE #2 (the new MCE) is responsible for answering any questions the member may have about the transfer. MCE #2 is also responsible for resolving any transition issues that may arise.
For HIP members, MCE #1 must still notify the State fiscal agent of the rollover amount (even if it is zero) that the member qualifies for after the conclusion of the 120-day reconciliation period. This notice must also detail any amounts to be refunded to the State. The member’s rollover amount is moved by the State fiscal agent from MCE #1 to MCE #2.
Section 18: Provider Enrollment and Network Development

Overview

Managed care entities (MCEs) contracting with the Family and Social Services Administration (FSSA) to administer the Hoosier Healthwise and Healthy Indiana Plan (HIP) programs are required to develop and maintain a comprehensive provider network for the provision of covered services to their members. MCEs must also be enrolled in CoreMMIS. In addition to supporting capitation and claims processing functions, MCE enrollment in CoreMMIS allows the MCE to submit, through the Portal, the Indiana Health Coverage Programs (IHCP)-enrolled primary care providers participating in the MCEs’ Hoosier Healthwise and HIP programs.

Managed Care Entity Enrollment in CoreMMIS

MCEs are required to complete the MCE Enrollment Form and submit it to the fiscal agent’s Managed Care director. The form includes the MCE name, address, contact name, telephone number, electronic funds transfer (EFT) information, and MCE contact information. If this information changes after enrollment, the MCE must complete the MCE Enrollment Update Form and submit it to the fiscal agent.

If the MCE has network contracts in Hoosier Healthwise, the MCE is required to complete Hoosier Healthwise MCE Enrollment Addendums for each region and submit them to the State for approval. The State forwards the network information to the fiscal agent.

The MCE Enrollment Form, MCE Enrollment Update Form, and the Hoosier Healthwise MCE Enrollment Addendum can be found on the MCO Question and Answer page at indianamedicaid.com.

When the required information is verified, the fiscal agent enrolls the MCE in CoreMMIS and sends confirmation letters to the FSSA and the MCE. MCEs are enrolled statewide, and the confirmation letters contain the MCE’s unique 10-digit identification number (9999999999). The 10th digit denotes the region of the state in which the MCE is enrolled. The numeric region identifiers for Hoosier Healthwise are listed in the following table.

Table 18.1 – Hoosier Healthwise Region Identifiers

<table>
<thead>
<tr>
<th>Region Identifier</th>
<th>Region Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Northwest</td>
</tr>
<tr>
<td>2</td>
<td>North Central</td>
</tr>
<tr>
<td>3</td>
<td>Northeast</td>
</tr>
<tr>
<td>4</td>
<td>West Central</td>
</tr>
<tr>
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<td>6</td>
<td>East Central</td>
</tr>
<tr>
<td>7</td>
<td>Southwest</td>
</tr>
<tr>
<td>8</td>
<td>Southeast</td>
</tr>
<tr>
<td>9</td>
<td>Out of State/FSSA</td>
</tr>
</tbody>
</table>

HIP has one statewide region designation in CoreMMIS. The HIP region identifier is H.
Managed Care Entity Provider Network Requirements

The MCE must ensure that its provider network

• Is supported by written provider agreements;
• Is available and geographically accessible; and
• Provides adequate numbers of facilities, physicians, ancillary providers, service locations, and personnel for the provision of high-quality covered services for its members, in accordance with 42 CFR 438.206.

The MCE must also ensure that all its contracted providers are IHCP providers and can respond to the cultural, racial, and linguistic needs of its member populations. The network must be able to handle the unique needs of its members, particularly those with special healthcare needs. The MCE is required to participate in any State efforts to promote the delivery of covered services in a culturally competent manner.

In some cases, members may receive out-of-network services. To receive reimbursement from the MCE, out-of-network providers must be IHCP providers. The MCE must encourage out-of-network providers, particularly emergency services providers, as well as providers based in non-traditional urgent health care settings such as retail clinics, to enroll in the IHCP. An out-of-network provider must be enrolled in the IHCP to receive payment from the MCE.

Network Development

The State requires the MCE to develop and maintain a comprehensive network to provide services to its Hoosier Healthwise and HIP members. The network must include providers serving special needs populations. For its Hoosier Healthwise population, the network must include providers serving children with special healthcare needs.

The MCE must develop a comprehensive network before the effective date of the contract. The MCE shall establish written agreements with all network providers. The MCE is required to have an open network and accept any IHCP provider acting within his or her scope of practice until the MCE demonstrates that it meets the access requirements. The State reserves the right to delay initial member enrollment in the MCE’s plan if the MCE fails to demonstrate a complete and comprehensive network.

With approval from the State, MCEs that can demonstrate that they have met all access, availability, and network composition requirements may require members to use in-network providers, with the exception of certain self-referral providers. The MCE must provide ninety (90) calendar day advance notice to the State of changes to the network that may affect access, availability, and network composition. The FSSA regularly and routinely monitors network access, availability, and adequacy. The State may impose the remedies set forth in Exhibits 3 and 4 to the contract, or require the MCE to maintain an open network, if the MCE fails to meet the following network composition requirements:

• The anticipated enrollment;
• The expected utilization of services, taking into consideration the characteristics and healthcare needs of the MCE’s Hoosier Healthwise and HIP members;
• The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;
• The numbers of network providers that are not accepting new members; and
• The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.
The State will assess liquidated damages and impose other authorized remedies, such as requiring the MCE to maintain an open network, for MCEs’ noncompliance with the requirements for network development and composition.

The MCE must contract with its specialist and ancillary provider network before receiving enrollments. The State reserves the right to implement corrective actions and assesses liquidated damages, as described in Exhibits 3 and 4 of the contract, if the MCE fails to meet and maintain the specialist and ancillary provider network access standards. The State’s corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the MCE until the MCE’s specialist and ancillary provider network is in place. The State monitors the MCE’s specialist and ancillary provider network to confirm the MCE is maintaining the required level of access to specialty care. The State reserves the right to increase the number or types of required specialty providers at any time.

**Network Composition Requirements**

In compliance with 42 CFR 438.207, the MCE must:

- Serve the expected enrollment;
- Offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled; and
- Maintain a sufficient number, mix, and geographic distribution of providers.

At the beginning of its contract with the State, the MCE must submit regular network access reports, as directed by the State. After the MCE demonstrates compliance with the State’s access standards, the MCE must submit network access reports annually and any time the provider network changes substantially (such as the MCE no longer meets the network access standards). The State reserves the right to expand or revise the network requirements, as it deems appropriate. The MCE must not discriminate with respect to participation, reimbursement, or indemnification as to any provider that is acting within the scope of the provider’s license or certification under applicable State law, solely on the basis of such license or certification, as stated in 42 CFR 438.12. If the MCE declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This requirement does not require the MCE to contract with providers beyond the number necessary to serve the members’ needs. The MCE is not precluded from establishing any measure designed to maintain quality and control costs consistent with the MCE’s responsibilities.

As required under 42 CFR 438.206, the MCE must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the MCE also serves commercial members. The MCE must also make covered services available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. In meeting these requirements, the MCE must:

- Establish mechanisms to ensure compliance by providers;
- Monitor providers regularly to determine compliance;
- Take corrective action if there is a failure to comply; and
- Provide the State written notice at least 90 calendar days in advance of the MCE’s inability to maintain a sufficient network in any county.

For purposes of the following subsections, “urban areas” are counties not designated by the FSSA and approved by the CMS as rural counties. “Rural areas” are those areas designated by the FSSA and approved by the CMS as rural counties.
Acute Care Hospital Facilities

The MCE must provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. The transport distance to a hospital from the member’s home shall be the usual and customary, not to exceed 30 miles in urban areas and 60 miles in rural areas. Exceptions must be justified and documented to the State on the basis of community standards for accessing care. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

Primary Medical Provider (PMP) Requirements

Providers may contract as a PMP with one or multiple MCEs. A PMP may also participate as a specialist with another MCE. The PMP may maintain a patient base of non-Hoosier Healthwise and HIP members (such as commercial, traditional Medicaid or Hoosier Care Connect members). An MCE may not prevent the PMP from contracting with other MCEs.

The MCE must ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member’s needs. PMPs must coordinate each member’s physical and behavioral healthcare and make any necessary referrals. In Hoosier Healthwise (but not HIP), a referral from the member’s PMP is required when the member receives physician services from any provider other than his or her PMP, unless the service is a self-referral service.

The State requires the MCE to provide access to PMPs within at least thirty (30) miles of the member’s residence. Providers who may serve as PMPs include the following:

- Internal medicine physicians
- General practitioners
- Family medicine physicians
- Pediatricians
- Obstetricians
- Gynecologists
- Endocrinologists (if primarily engaged in internal medicine)
- Advance practice nurses

The MCE’s PMP contract must state the PMP panel size limits, and the MCE must assess the PMP’s non-Hoosier Healthwise and HIP practice when assessing the PMP’s capacity to serve the MCEs members. The fiscal agent maintains a separate panel for PMPs contracted with more than one MCE. The State monitors the MCE’s PMP network to evaluate its member-to-PMP ratio. The MCE must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services 24 hours a day, seven days a week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP’s qualified clinical staff person, through a toll-free telephone number 24 hours a day, seven days a week.

Each PMP must be available to see members at least three days per week for a minimum of 20 hours per week. The MCE must also assess the PMP’s non-Hoosier Healthwise and HIP practice to ensure that the PMP’s Hoosier Healthwise and HIP population is receiving accessible services on an equal basis with the PMP’s non-Hoosier Healthwise and HIP population.

An important State goal is to ensure members have quality access to their PMPs. In the past, a restriction limited PMP enrollment to no more than two locations. This was managed via a system limitation on the Portal which limited PMP enrollments to two service locations although the PMP
could be contracted with all three MCEs. As PMPs use network extenders more often and in more locations, the State understands service locations may now be broadened without sacrificing quality service and access. In response, the State removed the Portal restriction to two service locations per MCE. The State continues to expect that access, quality, and clinical outcomes are monitored to substantiate this.

This does not reduce the plans’ responsibility for provider enrollment, but will increase each plan’s ability to independently manage its network up to the contract limit.

The MCE must ensure that the PMP provides live-voice coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The MCE must ensure that members have telephone access to their PMP (or appropriate designate, such as a covering physician) in English and Spanish 24 hours a day, seven days a week.

The MCE must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the applicable Provider Reference modules, according to practice type. The MCE must monitor medical care standards to evaluate access to care and quality of services provided to members, and to evaluate providers regarding their practice patterns.

**Specialist and Ancillary Provider Network Requirements**

In addition to maintaining a network of PMPs, the MCE must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers.

As with PMPs, specialist and ancillary providers are not limited to serve in only one MCE network. In addition, physicians contracted as a PMP with one MCE may contract as a specialist with other MCEs.

The MCE must ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the applicable Provider Reference modules, according to practice type. The State requires the MCE to monitor medical care standards to evaluate access to care and quality of services provided to members, and to evaluate providers regarding their practice patterns.

The State requires the MCE to develop and maintain the following comprehensive network of specialty providers. For providers identified with an asterisk (*), the MCE must provide, at a minimum, two specialty providers within 60 miles of the member’s residence. For providers identified with two asterisks (**), the MCE must provide, at a minimum, one specialty provider within 90 miles of the member’s residence.

**Table 18.2 – Network Specialty Providers**

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Ancillary Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anesthesiologists*</td>
<td>• Diagnostic testing*</td>
</tr>
<tr>
<td>• Cardiologists*</td>
<td>• Durable Medical Equipment providers</td>
</tr>
<tr>
<td>• Cardiothoracic surgeons**</td>
<td>• Home Health</td>
</tr>
<tr>
<td>• Dentists/Oral Surgeons (HIP only)**</td>
<td>• Prosthetic suppliers**</td>
</tr>
<tr>
<td>• Dermatologists**</td>
<td></td>
</tr>
<tr>
<td>• Endocrinologists*</td>
<td></td>
</tr>
<tr>
<td>• Gastroenterologists*</td>
<td></td>
</tr>
<tr>
<td>• General surgeons*</td>
<td></td>
</tr>
</tbody>
</table>
### Specialties

- Hematologists
- Infectious disease specialists**
- Interventional radiologists**
- Nephrologists*
- Neurologists*
- Neurosurgeons**
- Nonhospital-based anesthesiologist (such as pain medicine)**
- OB/GYNs*
- Occupational therapists*
- Oncologists*
- Ophthalmologists*
- Optometrists*
- Orthopedic surgeons*
- Orthopedists
- Otolaryngologists
- Pathologists**
- Physical therapists*
- Psychiatrists*
- Pulmonologists*
- Radiation oncologists**
- Rheumatologists**
- Speech therapists*
- Urologists*

### Ancillary Providers

The State requires that the MCE maintain different network access standards for the listed ancillary providers as follows:

- Two (2) durable medical equipment providers must be available to provide services to the MCE’s members in each county or contiguous county.
- Two (2) home health providers must be available to provide services to the MCE’s members in each county or contiguous county.

In addition, the MCE must demonstrate the availability of providers with training, expertise, and experience in providing tobacco dependence treatment, especially to pregnant women. Evidence that providers are trained to provide tobacco dependence treatment must be available during the State’s monthly on-site visits.

The MCE must contract with the Indiana Hemophilia and Thrombosis Center or a similar State-approved, federally recognized treatment center. This requirement is based on findings of the Centers for Disease Control and Prevention (CDC), which illustrate that persons affected by a bleeding
disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience fewer bleeding episodes, and experience a 40% reduction in morbidity and mortality.

The MCE must arrange for laboratory services only through IHCP-enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

**Full-panel Add Requests**

When an MCE receives a full-panel add request for a member who is not on its 834 file, the MCE must deny the request. The denial must be sent with a message indicating that the full-panel add submitted cannot be processed because the MCE does not have this member on file. If the member is enrolled in another MCE or showing traditional Medicaid, the member must be instructed to contact the enrollment broker to pursue additional education and information on how to change MCEs, if applicable. If the member is eligible to change MCEs, the PMP may pursue sending the full-panel add with the MCE at that time. The MCEs must have a procedure in place for processing the full-panel add after the member joins the MCE via the 834 file.

The State nor the enrollment broker accepts or processes any paperwork from the PMP or the MCEs requesting a member be added to a full panel. The enrollment broker handles calls from members requesting a plan change if the member qualifies for one. If the member does not, the request is handled via the normal just cause change process, with a referral back to the MCE. Additionally, when a PMP changes MCEs, members are allowed to follow their PMP if they choose. The enrollment broker accepts and processes a member’s request to change MCEs because of the member’s PMP change. This change is allowed regardless of whether the member is now in an open enrollment status, and there is no referral back to the MCE. The enrollment broker confirms that the PMP did change plans before allowing the change. There is a just cause reason code (PMP changed plans) for these type changes, which applies to Hoosier Healthwise and HIP members.

The MCEs are responsible for letting the PMP know that the full-panel add request cannot be processed, because the member is not connected to that MCE. The enrollment broker no longer has that responsibility.

**Pharmacies**

MCEs must establish a network of pharmacies. The MCE or its pharmacy benefit manager (PBM) must provide at least two pharmacy providers within 30 miles or 30 minutes from a member’s residence in each county, as well as at least two durable medical equipment providers in each county or contiguous county.

**Non-psychiatrist Behavioral Health Providers**

MCEs must establish a network that includes psychiatrists and other behavioral health providers, addressing both mental health and addiction. The MCE is encouraged to contract with all Division of Mental Health and Addiction (DMHA)-certified community mental health centers (CMHCs). If all CMHCs are not included in the provider network, the MCE must demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services. Further, the MCE must, at a minimum, establish referral agreements and liaisons with contracted and non-contracted CMHCs, and must provide physical health and other medical information to the appropriate CMHC for every member.

The DMHA conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in the CMHCs. In addition to the regular oversight that the MCE provides for contracted
CMHCs, the MCEs must use the results of the DMHA’s review to inform contracting decisions, to monitor contracted CMHCs, and to develop improvement plans with contracted CMHCs.

The MCE must meet the following network composition requirements for non-psychiatrist behavioral health providers:

- In urban areas, the MCE must provide at least one behavioral health provider within 30 minutes or 30 miles from the member’s home.
- In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles. The availability of professionals will vary, but access problems may be especially acute in rural areas. The MCE must provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas.

The MCE also must monitor utilization in rural and urban areas to ensure equality of service access and availability. The following list represents behavioral health providers that must be available in the MCE’s network:

- Outpatient mental health and addiction clinics
- Community mental health centers
- Psychologists
- Certified psychologists
- Health services providers in psychology (HSPPs)
- Certified social workers
- Licensed clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under IC 25-23-1-1(1)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Marital and family therapists
- Licensed mental health counselors

All services covered under the clinic option must be delivered by licensed psychiatrists and HSPPs, or an advanced practice nurse or person holding a master’s degree in social work, marital and family therapy, or mental health counseling.

**Inpatient Psychiatric Facilities**

The MCE must provide a sufficient number and geographic distribution of inpatient psychiatric facilities to serve the expected enrollment. The transport distance to an inpatient psychiatric facility from the member’s home must be the usual and customary distance, not to exceed 60 miles. Exceptions must be justified and documented to the State on the basis of community standards for accessing care.

**Dental Providers**

The MCE shall ensure the availability of a dentist practicing in general or family dentistry within 30 miles of the member’s residence. Specialty dentists such as orthodontists and dental surgeons shall be available within 60 miles of the member’s residence.
Urgent Care Clinics

The MCE must affiliate or contract with urgent care clinics. Urgent care clinics must be made available no less than 11 hours each day, Monday through Friday, and no less than five hours each day on the weekend. In addition, the State strongly encourages the MCE to affiliate or contract with nontraditional urgent care clinics, including retail clinics. The State will continue to monitor the MCE’s access to primary and urgent care.

Provider Education and Outreach Activities

The MCE must provide ongoing education to its provider network on the Hoosier Healthwise and HIP programs, as well as MCE-specific policies and procedures. In addition to developing its own provider education and outreach materials, the MCE shall be required to coordinate with the FSSA-sponsored provider outreach activities on request. The MCE must educate its contracted providers, including behavioral health providers, about provider requirements and responsibilities, the MCE’s prior authorization policies and procedures, clinical protocols, member’s rights and responsibilities, claim submission processes, claim dispute-resolution processes, pay-for-performance programs, and any other information relevant to improving services.

All provider communications must be preapproved by the State. The MCE must submit all provider communications (that is, promotional, training, educational, and outreach materials) to the State for review and approval at least 30 calendar days before using and distributing the information. The MCE must also submit any material changes to previously approved provider communications to the FSSA for review and approval at least 30 calendar days before use and distribution. The MCE must develop and include an MCE-designated inventory control number on all provider materials with a date issued or date revised clearly marked to facilitate the State’s review and approval process. With the State’s approval, the MCE may distribute provider materials to the provider community.

All State-approved provider communications must be available on the MCE’s provider website within three business days of distribution. The provider communication materials must be organized online in a user-friendly, searchable format by communication type and subject.

Provider Policy and Procedure Manual

The MCE will develop and maintain a Provider Policies and Procedures Manual for use by the MCE’s network of Hoosier Healthwise and HIP providers. The Provider Policies and Procedures Manual must be available both electronically and in hard copy (on request) to all network providers, without cost, when providers are initially enrolled; when there are any changes in policies and procedures; and upon a provider’s request. The Provider Policies and Procedures Manual must include, at minimum, the following information, separately stated for the Hoosier Healthwise and HIP lines of business, as appropriate:

• Benefits and limitations of coverage
• Claims filing instructions
• Criteria and process to use when requesting prior authorizations
• Definition and requirements pertaining to urgent and emergent care
• Participants’ rights
• Providers’ rights for advising or advocating on behalf of his or her patient
• Provider nondiscrimination information
• Policies and procedures for grievances and appeals, in accordance with 42 CFR 438.414
• Frequently asked questions and answers
• MCE and the FSSA contact information, such as addresses and telephone numbers

The MCE must offer Provider Policies and Procedures Manual training to all network providers when they are initially enrolled in the network; whenever policies or procedures change; and upon a provider’s request. Updates or changes in operation that require revisions to the Provider Policies and Procedures Manual shall be submitted to the FSSA for review and approval.

**HIP-Specific Provider Education**

For its HIP providers, the MCE must provide education and outreach about the different HIP benefit plans, including the separate PDL for the HIP State Plan and the formulary for HIP Plus and HIP Basic benefits; medically frail policies and procedures; POWER Accounts, including preventive care and roll over; copayments for emergency room services; copayments for HIP Basic and HIP State Plan Basic services; and the POWER Account debit card and payment procedures.

The MCE must also educate its HIP providers about its pregnancy-related services and policies. Such education must emphasize that women may choose to stay in their existing HIP benefit plan or may transfer to MAGP coverage during their pregnancy. The MCE must prepare written materials about the differences between the two programs, including covered services and provider reimbursement.

Provider education must also include information about member cost-sharing, including the 5% cap on cost-sharing and the requirement that providers reduce or waive member copayments if notified by the MCE or the State that the member’s family has exceeded the 5% cap on member cost-sharing. Any notification to providers shall identify the time period during which the copayments must be reduced or waived.

**Provider Agreements**

The MCE must have a process in place to review and authorize all network provider contracts. The MCE must submit a model or sample contract of each type of provider agreement to State for review and approval at least 60 calendar days before the MCE’s intended use. Sample contracts must also be submitted in each bidder’s response to the Request for Services (RFS). If the bidder is awarded the contract, the bidder must notify the State of any changes to the sample contracts within three weeks of the contract award date.

The MCE must include in all its provider agreements provisions to ensure continuation of benefits. The MCE must identify and incorporate the applicable terms of its contract with the State and any incorporated documents, including the RFS. Under the terms of the provider services agreement, the provider must agree that the applicable terms and conditions set out in the RFS, the contract, any incorporated documents, and all applicable State and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The requirement that subcontracts indemnify and hold harmless the state of Indiana do not extend to the contractual obligations and agreements between the MCE and healthcare providers or other ancillary medical providers that have contracted with the MCE.

In addition to the applicable requirements for subcontracts in Section 2.7 of the Contractor Scope of Work in the MCE’s contract with the State, the provider agreements must meet the following requirements:
• Describe a written provider claim dispute resolution process.
• Require each provider to maintain a current IHCP provider agreement, and to be duly licensed in accordance with the appropriate State licensing board and remain in good standing with said board.
• Require each provider to submit all claims that do not involve a third-party payer for services rendered to the MCE’s members within 90 calendar days or fewer from the date of service. The MCE must waive the timely filing requirement in the case of claims for members with retroactive coverage, such as PE pregnant women and newborns.

• Require each provider to use the Indiana Health Coverage Program Prior Authorization Request Form, available at indianamedicaid.com, for submission of prior authorization requests to the MCE.

• Include a termination clause stipulating that the MCE must terminate its contractual relationship with the provider as soon as the MCE has knowledge that the provider’s license or IHCP provider agreement has terminated.

• Terminate the provider’s agreement to serve the MCE’s Hoosier Healthwise and HIP members at the end of the contract with the State.

• Monitor providers and apply corrective actions for those who are out of compliance with the State’s or the MCE’s standards.

• Obligate the terminating provider to submit all encounter claims for services rendered to the MCE’s members while serving as the MCE’s network provider, and provide or reference the MCE’s technical specifications for the submission of such encounter data.

• Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other State contractors.

• Provide the PMP with the option to terminate the agreement without cause with advance notice to the MCE. Said advance notice must not have to be more than 90 calendar days.

• Provide a copy of a member’s medical record at no charge on reasonable request by the member, and facilitate the transfer of the member’s medical record to another provider at the member’s request.

• Require each provider to agree that it must not seek payment from the State for any service rendered to a Hoosier Healthwise or HIP member under the agreement.

• For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment before discharge. This treatment must be provided within seven (7) calendar days from the date of the member’s discharge.

• For HIP providers, require each provider to agree to use best commercial efforts to collect required copayments for services rendered to HIP Basic and HIP State Plan Basic members.

The MCE must have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

**Provider Credentialing and Recredentialing Policies and Procedures**

The MCE must have written credentialing and recredentialing policies and procedures for ensuring quality of care is maintained or improved, and assuring that all contracted providers hold current State licensure and enrollment in the IHCP. The MCE’s credentialing and recredentialing process for all contracted providers must meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards must apply across Hoosier Healthwise and HIP programs.

The MCE must use the State’s standard provider credentialing form during the credentialing process. The Provider Enrollment Form and the Credentialing Form can be found on the [IHCP Provider Enrollment Transactions page](https://indianamedicaid.com). The MCE must ensure that providers agree to
meet all the State’s and the MCE’s standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with State recordkeeping requirements
- The State’s access and availability standards
- Other quality improvement program standards

As provided in 42 CFR 438.214(c), the MCE’s provider credentialing and selection policies must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCE must not employ or contract with providers that have been excluded from participating in federal healthcare programs under Section 1128 or Section 1128A of the Social Security Act. The MCE must notify the State of any credentialing applications that are denied because of program integrity-related issues.

**Credentialing**

The MCE must have written policies and procedures for credentialing healthcare professionals it employs and with whom it contracts. The MCE must have documented plans to periodically review and revise policies and procedures. If the MCE contracts with a hospital that conducts the MCE’s credentialing activity, the MCE must have access to the hospital’s credentialing files. At minimum, the MCE must obtain and verify the following:

- A current valid license to practice.
- Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility.
- Current and valid Drug Enforcement Administration (DEA) or controlled-substance registration (CSR) certificate, as applicable (DEA certificates are not applicable to chiropractic settings).
- Proof of graduation from medical school and completion of a residency, or board certification for doctors of medicine (MDs) and doctors of osteopathy (DOs), as applicable, since the last time the provider was credentialed or recredentialed.
- Proof of graduation from a chiropractic college for doctors of chiropractic medicine (DC).
- Proof of graduation from podiatry school and completion of residency program for doctors of podiatric medicine (DPMs).
- Work history that includes a minimum of five years on the curriculum vitae (the MCE is not required to verify work histories).
- Current, adequate malpractice insurance, according to the MCE’s policies.
- History detailing any pending professional liability claims and claims resulting in settlements or judgments paid by or on behalf of the practitioner.
- Proof of board certification, if the practitioner states he or she is board certified.
- Verification of IHCP enrollment.
- For a group enrollment, verify that the provider is linked appropriately to the group, and that the provider is enrolled at the appropriate service locations.
- Verification that the provider, or an agent or managing employee of the provider, is not debarred, suspended, or otherwise excluded by Federal agencies or from participating in any contract paid with Federal funds.

The credentialing policies and procedures must specify the professional criteria required to participate in the MCE. Each practitioner’s file must contain sufficient documentation to demonstrate that these
criteria are evaluated. Primary sources used by the MCE to verify credentialing information must be included in its policies and can include using external agencies, such as county medical societies, hospital associations, or private verification services.

The MCE shall process all credentialing applications within 30 calendar days of receipt of a complete application. If the MCE delegates credentialing functions to a delegated credentialing agency, the MCE shall ensure that all credentialed providers are loaded into the MCE’s provider files and claims system within 15 calendar days of receipt from the delegated entity.

**Mechanisms for Credentialing and Recredentialing**

The MCE must document the mechanism for credentialing and recredentialing MDs, DOs, DPMs, and DCs that fall under the MCE’s scope of authority and action, and with whom it contracts or employs to treat members outside the inpatient setting. This documentation includes, but is not limited to, the following:

- Scope of practitioners covered.
- Criteria and the primary source verification of information used to meet these criteria.
- Process used to make decisions.
- Extent of any delegated credentialing or recredentialing arrangements.

Policies and procedures must specify the requirements and processes used to evaluate practitioners. Selection decisions must be based on the network needs of the MCE and on practitioners’ qualifications. Selection decisions cannot be based solely on a practitioner’s membership in another organization, such as a hospital or medical group.

Policies and procedures must include specific details regarding the physicians and other licensed independent practitioners who are subject to these policies, and criteria to reach a decision.

The MCE must have a process in place for receiving advice from participating practitioners in credentialing and recredentialing to ensure that procedures are followed consistently. MCEs must seek practitioner expertise on current practice in the medical community and advice on modifying the criteria, as appropriate. This expertise can be obtained from a committee with participating practitioner representation or from consultation with participating practitioners.

Participating practitioners must complete applications for membership on such a committee. Through the application process, the practitioner discloses information about health status and history of issues with licensure or privileges that may require additional follow-up. A signed attestation statement on the application ensures that the practitioner has completed it in good faith.

Before making a credentialing decision, the MCE must have the following information about the practitioner:

- Information from the National Practitioner Data Bank (NPDB). NPDB is not applicable to chiropractors and podiatrists.
- Information about sanctions or limitations on licensure from the State Board of Medical Examiners, Federation of State Medical Boards, or the Department of Professional Regulations, if available.
- Information from the State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards.
- Information from the State Board of Podiatric Examiners.
- Previous sanction activity by Medicare and the IHCP.
Evidence indicating that the MCE has obtained information from the previously designated organizations must be included in the credentialing file.

**Credentialing – Initial Visit**

NCQA no longer requires initial provider credentialing visits for certain provider types. However, the State continues to require that the MCE credentialing process includes an initial visit to the offices of all potential primary medical providers (PMPs), including all obstetricians and gynecologists (OB/GYNs). There must be a structured review that evaluates the site against the MCE standards. The initial site visit must also document evaluation of the medical recordkeeping practices at each site to ensure conformity with the maintenance of medical records. See [Member Services](#) for additional information.

**Recredentialing**

The MCE must have a formal recredentialing process that verifies credentialing information subject to change over time. The recredentialing process must be organized to verify the information through a primary source on the current standing of items listed in this section, such as member complaints, quality reviews, utilization management, and member satisfaction. The description of the recredentialing process must include data from at least three of the following six sources:

- Member complaints
- Quality reviews (practice-specific)
- Utilization management (profile of utilization)
- Member satisfaction (practice-specific)
- Medical record review
- Practice site reviews

The recredentialing process must use this data as objective evidence when reappraising professional performance, judgment, and clinical competence. There must be evidence that the MCE has taken action based on the data. Examples of action taken include continuation in the MCE, required supervision or participation in continuing education, evidence that the MCE has drawn up a clear plan for the practitioner’s improvement, evidence of changes in the scope of practice, or termination of the practitioner from the MCE.

**Recredentialing Practice Site Visit**

The MCE must conduct an on-site visit at the time of recredentialing to determine if there have been changes in the facility, equipment, staffing, or medical recordkeeping practices that would affect the quality of care or services provided to members of the MCE. Primary medical providers, OB/GYNs, and other high-volume specialists must be included in this site visit. The MCE is responsible for determining which high-volume specialists are subject to this visit, based on its own experience with the specialist.

**Altering Conditions of Provider Participation**

MCEs must have plans for developing and implementing policies and procedures for altering conditions of a provider’s participation with the MCE because of quality of care and service issues. These policies and procedures need to specify actions the MCE may take before terminating the provider’s participation with the MCE. Policies and procedures must have mechanisms in place for
reporting serious quality deficiencies to the State that could result in a provider’s suspension or termination. These policies and procedures must specify how reporting occurs and the individual staff members responsible for reporting deficiencies.

The policies and procedures must include a well-defined appeals process for instances in which the MCE decides to alter the provider’s condition of participation because of quality of care or service issues. The MCE must ensure that providers are aware of the appeals process. Policies and procedures must include mechanisms to ensure that providers are treated fairly and uniformly.

**Credentialing Provider Healthcare Delivery Organizations**

The MCE must have policies and procedures for credentialing healthcare delivery organizations, including, but not limited to, hospitals, home health agencies, freestanding surgical centers, laboratories, and subcontracted networks of providers.

Every three years after the initial contract, the MCE must confirm the following:

- The organizations are in good standing with State and federal regulatory bodies.
- The organizations have been reviewed and approved by an accreditation body before contracting with the MCE.
- The organizations conform to the previously mentioned requirements.

The MCE must also develop standards of participation and assess these providers accordingly if the provider has not received accreditation.

**Clinical Laboratory Improvement Amendments**

MCEs must arrange for laboratory services only through laboratories with current CLIA certificates.

**Provider Service Locations**

MCEs must verify that the physician is IHCP-enrolled before submitting a PMP enrollment via the Portal. PMPs participating with an MCE can have service locations in any Indiana county that the MCE’s State contract allows. Physicians can download the IHCP application from indianamedicaid.com.

**Out-of-State Providers**

To enhance access to primary care in areas with an inadequate number of PMPs, the State permits out-of-state PMPs to enroll in the program in areas where limited access has been identified. Concurrent with the implementation of the program statewide effective July 1996, the State developed criteria to determine which areas would most benefit from additional PMPs with out-of-state locations, permitting these enrollments on a case-by-case basis according to predetermined access measures. PMPs with out-of-state service locations are available for voluntary selection by members.

The FSSA out-of-state designations are defined in 405 IAC 5-5-2 and are delineated as cities that reside outside the state of Indiana, that are excluded from out-of-state prior authorization (PA) requirements, and that are required to follow in-state PA requirements. The cities defined as IFSSA out-of-state designations are as follows:

- Danville, Illinois
Residency Programs

To promote long-term relationships for managed care members, physicians practicing in group residency programs are not eligible to enroll as PMPs in the Hoosier Healthwise or HIP programs. The frequent turnover of physicians in a residency program disrupts the continuity of care essential to a managed care program. Residents can provide care to Hoosier Healthwise or HIP members only if the residency program’s faculty physicians are participating PMPs and are enrolled in CoreMMIS in the same billing group as the resident physicians. The PMP or faculty physician retains responsibility for the care provided to patients and must provide oversight to the resident physician consistent with the residency program’s stated procedures.

Physician Extenders

Physician extenders are healthcare professionals who are licensed to practice medicine under the supervision of a physician. Physician extenders can perform some of the services that physicians provide, such as physical exams, preventive healthcare, and education. Some can also assist in surgery and write prescriptions.

Appropriate use of physician extenders can have a positive influence on cost, quality, and access. Physician extenders can perform routine or straightforward services at a lower cost than a physician, allowing physicians to focus on more complicated patient problems. Physician extenders also allow patients to be seen promptly for preventive visits or less complicated health problems, which improves access to care and may allow more Medicaid patients to be seen.

The following physician extenders are licensed to provide care in the State:

- Advanced practice nurses, including nurse practitioners, nurse midwives, and clinical nurse specialists;
- Physician assistants; and
- Certified registered nurse anesthetists

The MCE shall implement initiatives to encourage providers to use physician extenders. Examples of these types of initiatives include, but are not limited to:

- Educate providers about reimbursement policies for physician extenders.
- Offer financial or nonfinancial incentives to providers who increase their use of physician extenders. Any financial incentives must be positive, not punitive.
- Collaborate with physician-extender training programs in Indiana. Collaboration could include providing internships or practicum for physician extenders, expanding the number of training slots for physician extenders, and so forth.
State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with 42 CFR 441.22. Members are allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the MCE’s network. If nurse practitioner services are available through the MCE, the MCE must inform the member that nurse practitioner services are available.

**Presumptive Eligibility Qualified Provider Enrollment**

Information regarding the PE program and QP enrollment can be found in the Presumptive Eligibility section in this manual. Specific QP enrollment processes are outlined in the Presumptive Eligibility and Presumptive Eligibility for Pregnant Women modules on the Provider Reference Materials page at indianamedicaid.com.

**School-based Clinics**

Some Hoosier Healthwise members are eligible for and receive medical services in a school-based clinic. These clinics typically have funding sources other than the IHCP, and do not bill the IHCP for the services they provide. For school-based clinics to bill for services provided to Hoosier Healthwise enrollees, the clinics must be IHCP-enrolled providers. Clinics that expect reimbursement from an MCE in the Hoosier Healthwise program must be IHCP-enrolled providers and must obtain MCE authorization before providing services. Services provided in a school-based clinic are usually limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), immunizations, or other primary care and preventive services.

School corporations can also provide IHCP-covered services to students as part of an individualized education plan (IEP). All claims for services provided to Hoosier Healthwise members as part of an IEP that are billed by provider specialty 120 – school corporation are carved out of the MCE capitation rate and adjudicated as fee-for-service (FFS) claims by the fiscal agent. The provider must send these claims to the fiscal agent, not to the MCE.

The State strongly encourages MCEs to collaborate with school-based programs in the delivery of care to their members and to encourage their PMPs to assist in the coordination of medical services.

**Pre-enrollment Provider Education**

The MCEs can educate physicians interested in becoming PMPs about the Hoosier Healthwise and HIP programs through face-to-face training sessions, brochures, and videos. The State must pre-approve all education and outreach materials designed for distribution to physicians interested in becoming PMPs.

Before enrolling PMPs in the MCE program, MCEs are encouraged to educate providers about the following:

- Hoosier Healthwise and HIP program goals.
- Member PMP selection and the PMP change process within their plans and programs.
- Practice requirements of a PMP include 24-hour access standards
- Provider disenrollment.
- Preventive health standards and requirements.
- Referral standards (for example, referrals for continuity of care).
- Quality improvement requirements (including EPSDT).
• Self-referral services.
• Billing and reimbursement practices.
• Covered and excluded services and referral practices for Hoosier Healthwise and HIP.
• Other relevant MCE-specific information.

Note: All prospective PMPs must first be enrolled in the IHCP at the service location at which they want to be enrolled as PMPs. MCEs must verify IHCP enrollment with prospective PMPs before enrolling them using the Portal. If the prospective PMP is not IHCP-enrolled, the MCE must tell the physician to contact the fiscal agent for an enrollment application, or the physician (or physician’s group) can download the appropriate application from indianamedicaid.com.

Post-Enrollment Provider Education

As part of the enrollment process for health plan PMPs, the MCE must educate PMPs about the following:
• How PMPs are notified about panels – MCEs provide member enrollment roster information to their contracted network PMPs.
• Universally accepted standards of preventive and other care – These standards are determined by the MCE. MCEs are strongly encouraged to employ the Practice Standards. Practice standards are updated as needed.
• Medical records retention and availability – This information is described in Maintenance of Medical Records.
• PMP authorization requirements – This information is described in Authorization of Services and Notice of Actions.
• IHCP-covered but MCE-excluded services – This information is described in IHCP-Covered Services Excluded from Hoosier Healthwise.
• HIP benefit plans, including information about the specific covered services and exclusions of each, as well as the recommended preventive care guidelines for HIP members.
• HIP POWER Accounts and cards.
• HIP Basic and HIP State Plan Basic copayment requirements.
• Provider claims dispute – These procedures are developed by the MCE. Minimum requirements are described in Provider Dispute Procedures.
• Provider helpline – MCEs must offer a toll-free telephone helpline to providers. The MCE must report provider help-line performance statistics, as described in the Hoosier Healthwise/HIP Reporting Manual. The MCE help-line staff must be prepared to respond to provider concerns including, but not limited to, the following:
  • Enrollment and disenrollment from the MCE
  • Provider grievances and claim disputes
  • Covered services
  • Self-referral services
  • Provider network development as described in this section
  • Quality improvement requirements as described in the Quality Improvement and Utilization Management section of this manual
  • Billing requirements
• Eligibility issues
• Preventive health standards and requirements (including EPSDT)
• Encounter data requirements as described in the Information Systems section of this manual

• Reassignment of a member to another PMP – This process, as initiated by the provider, is described in the Member Enrollment section of this manual.

Provider Enrollment

The MCE components of Hoosier Healthwise and HIP are subprograms of the IHCP in CoreMMIS. As such, participating providers must be IHCP-enrolled. The MCE is responsible for ensuring that all its providers are IHCP-enrolled at the service location where they wish to participate as a PMP. The MCE is also responsible for ensuring that there are sufficient providers to adequately serve enrolled members.

Provider enrollment activities are governed by the following criteria:

• MCE provider outreach personnel assume responsibility for education of providers enrolled in the MCE. State-contracted provider personnel from the enrollment broker or the fiscal agent can also provide general information about the Hoosier Healthwise and HIP programs.
• After enrolled in the IHCP, PMPs contract with the MCEs. PMPs are allowed to enroll with multiple MCEs and maintain member enrollment in each MCE and program.
• PMPs determine the maximum panel limits of Hoosier Healthwise or HIP members for each MCE. The State monitors each MCE’s PMP network to evaluate its member-to-PMP ratio on at least a quarterly basis.
• If a PMP disenrolls from Hoosier Healthwise or HIP, or disenrolls as an IHCP provider entirely, MCEs must ensure that members continue to receive care for a minimum of thirty (30) calendar days or until another PMP is chosen or assigned.
• When a PMP disenrolls from the Hoosier Healthwise or HIP program, the MCE is responsible for assisting the members assigned to that PMP in selecting a new PMP within the MCE’s network. If the member does not select another PMP within a reasonable amount of time, the MCE must assign the member to another PMP in the MCE’s network before the original PMP disenrollment is effective.
• The MCE must make a good faith effort to provide written notice of a provider’s disenrollment to any member who has received primary care services from that provider or otherwise sees the provider on a regular basis. Notice must be provided within 15 calendar days of the MCE’s receipt or issuance of the provider’s termination notice.

Indiana Health Coverage Programs Provider Enrollment Processing

To participate as a PMP or specialist in the Hoosier Healthwise program, a provider must be enrolled as an IHCP provider. A provider is enrolled in the IHCP when all the following conditions have been met:

• The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to State or federal law, or otherwise authorized by the FSSA.
• The provider has completed, signed, and returned an IHCP Provider Agreement and any other forms required by the IHCP.
• The provider has been assigned a provider identification number.
• Physicians must be actively enrolled at the service location where they wish to practice as a PMP before enrolling as a PMP at that location.
There are two types of IHCP providers:

Billing providers (sole proprietorship, group)

- A sole proprietorship is a provider that owns a practice location where he or she is the sole practitioner performing services with an unshared tax ID number.

- A group is a business entity that owns one or more service locations where providers are employed or contracted to perform professional services on behalf of the business entity.

Group members (rendering providers)

- A group member is a rendering provider that is employed or contracted to render services to IHCP members. Group members cannot have a billing service location in CoreMMIS. All services are billed using the group’s ID number.

The IHCP provider enrollment procedures are designed to ensure timely, accurate, and efficient processing of provider enrollment applications. This procedural base is the focus of provider participation and is critical for accurate claims processing. It is the MCE’s responsibility to ensure that any network providers delivering services to members in the Hoosier Healthwise and HIP programs are enrolled as IHCP providers. Providers enroll initially by completing the Indiana Health Coverage Programs Provider Agreement and mailing it to:

DXC Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Detailed information about compiling the provider enrollment application and agreement is found in the IHCP Provider Enrollment Module on the Provider Reference Materials page at indianamedicaid.com. Providers may also contact the fiscal agent’s Provider Enrollment by telephone at 1-877-707-5750 to request enrollment applications and to get answers to questions about IHCP provider enrollment.

Managed Care Entity Preferred Medical Provider Enrollments and Updates

MCEs can submit individual PMP enrollments for their Hoosier Healthwise and HIP plans through the Portal. MCEs can also update the existing PMP’s scope of practice, network, panel-hold status, and panel-size information. Panel size and network updates require effective dates that are the day after data entry or a future date. Updates to the panel size are viewable the day after data entry or when the change becomes effective. Updates to the panel-hold and scope-of-practice information are processed the day the update is completed in PMP Update using the Portal. Panel-hold and panel-full provider status affect member assignment processing in CoreMMIS through 2010. MCEs are responsible for assigning members as of 2011. Panel hold and full status are used for information purposes in CoreMMIS and are viewable in the Portal > Provider Profile.

Providers may access the from the IHCP website. All MCEs must enroll in the Portal as group administrators and establish user IDs and passwords to access the Portal. MCE group administrators can assign users and enable them with appropriate access to the Portal.

When users log on to the Portal, they must click the Provider Profile link. Then they have the option to view the provider profile, enroll a PMP, update PMP information, view a list of the fiscal agent’s provider field consultants, and download the PMP enrollment, update, and other program enrollment forms. Only users who are assigned access to the PMP Enrollment Membership task see the Enroll a PMP, Update PMP, or the PMP Enrollment and Update Forms section on the provider profile menu. Users also can access help text to assist them with PMP enrollments and updates. As of 2011, the MCEs can enroll HIP PMPs. The MCE must log in as the MCE ID of the program where they intend
to enroll the PMP so that CoreMMIS can differentiate between the two programs when establishing the PMP service location.

MCEs must complete the selection process by entering the IHCP group or billing ID, selecting a service location and, if a group provider, selecting the applicable rendering provider. After the selection process is finished, the MCE must enter the 24-hour telephone number, scope-of-practice information, panel size, and network information, if applicable. After the MCE’s data entry is complete and has passed the system cross-editing, the MCE must click Submit. A confirmation web page appears, stating that the PMP enrollment has been successfully processed. The window also includes the submission date, enrollment date, MCE name, provider ID number, group number, and alpha service location ID. MCEs can print the confirmation web page for PMP enrollment tracking purposes.

The following sections outline the paper enrollment process that can be used if system issues prevent web PMP enrollment.

**Linking Preferred Medical Providers to Managed Care Entity Networks**

As of April 2011, all MCEs have the capability to establish PMP networks for the Hoosier Healthwise and HIP programs, and enroll their PMPs accordingly in the Portal. MCEs also have the ability to disenroll their PMPs from networks using the Portal.

To create an MCE network, the MCE completes the following forms, as applicable:

- **Hoosier Healthwise MCE Network Enrollment Addendum**
- **Healthy Indiana Plan (HIP) MCE Network Enrollment Addendum**

These forms are accessible from the *MCO Question and Answer* page at indianamedicaid.com. Completed forms are submitted to the fiscal agent Managed Care Unit. MCEs specify the network’s name, effective dates, and four-digit ID. After the fiscal agent enters the networks under the applicable MCE and region in CoreMMIS, MCEs can see the networks that are available in the region for the PMP service location being enrolled in the lower portion of the enrollment window. The following PMP-network functions are available:

- Link an existing PMP service location to a network
- Link a PMP service location to a network as part of the initial enrollment
- End-date a network affiliation for a PMP service location

PMP-network effective and end-dates must be greater than or equal to the processing date. The PMP’s network name, when applicable for the date of service, appears in eligibility verification responses after the MCE name and telephone number.

**Paper File Submission**

MCEs are encouraged to use the Portal for submitting enrollments. If the MCE is unable to access the web, they may submit forms to the State fiscal agent at the following address or faxed to the attention of Managed Care enrollment at (317) 488-5020. MCEs must use this option only when the Portal access is not available for more than 24 hours Monday – Friday, or other extenuating circumstances agreed to by the fiscal agent and the State. The form for enrolling a PMP in the MCE may be found in the *Portal > PMP Enrollment*, and at the *MCO Question and Answer* page at indianamedicaid.com.

**DXC Provider Enrollment Unit**

P.O. Box 7263
Indianapolis, IN 46207-7263
The following procedure for manual enrollment submissions readily identifies submissions as belonging to an MCE and confirms to MCEs that the enrollments have been processed:

1. The PMP enrollment requests must be sent with a cover letter containing the MCE’s name, the signature of the MCE provider representative, MCE fax number, and an itemized list of the enrollment forms submitted. The itemization must include fields for the following information:
   - PMP name
   - Provider identification number
   - Effective date

2. The MCE must complete the PMP name and provider identification number.

3. On receipt of the MCE’s PMP enrollment forms, the PMP enrollment coordinator enters the data into CoreMMIS, verifying the following information:
   - Valid IHCP numbers
   - IHCP eligibility
   - Valid PMP provider type and specialty
   - Valid IHCP service location
   - Valid group and individual relationships
   - Number of PMP service locations
   - Acceptable panel size

4. The PMP enrollment coordinator annotates the MCE cover letter to indicate the effective date or the reason the enrollment could not be processed.

5. The PMP enrollment coordinator confirms the disposition of the enrollments by sending an email confirmation to the submitter.

Because PMP enrollment in the MCE is a manual process, no exception reports are generated.

**Changes to Preferred Medical Provider Scope of Practice**

PMPs may request changes to their scope-of-practice information by contacting their affiliated MCEs. The scope of information includes the following:

- Admit Privileges – Options: Relationship or Privileges
- Delivery Privileges – Options: Yes or No
- Age Restrictions – Options: None, 0-2 years of age, 0-12 years of age, 0-17 years of age, 0-20 years of age, 13-17 years of age, 13-20 years of age, 21 years of age and older, 3 years of age and older, 17 years of age and older, 13 years of age and older
- 24-Hour Telephone Number and Extension
- Accept Obstetrics – Options: Yes or No
- Accepts All Women – Options: Yes or No
- Panel Size
- Panel Size Hold
- Panel Size Hold Removal
- Gender – Options: Male, Female, Male/Female
Scope-of-practice information listed previously is specific to the Hoosier Healthwise program. PMP enrollment in CoreMMIS for HIP providers began in 2011. HIP leverages the Hoosier Healthwise scope of practice forms even though some of the PMP provider types and age ranges may not be a match for HIP members.

On receipt of a change request from a PMP, the MCE can perform a change through the Portal > Provider Profile: Update a PMP. If the Portal is not available, the MCE can submit the MCE Network PMP Panel Size/Panel Hold Request Form to the fiscal agent PMP enrollment specialist, who updates the PMP’s record in CoreMMIS.

Provider Disenrollment

A PMP can be disenrolled from the Hoosier Healthwise or HIP programs for various reasons. MCEs are responsible for reassigning members assigned to PMPs disenrolling from their plan. MCEs must have a policy and procedure in place to identify these members and ensure that they are enrolled in a new PMP in a timely manner. MCEs are required to end-date disenrolling Hoosier Healthwise and HIP PMP service locations in CoreMMIS, so this information is available for reporting and available for the enrollment broker.

As of 2011, MCEs disenroll their own PMP service locations using the Portal. Access is similar to the procedure used by the MCEs to enroll PMP service locations. MCEs must enroll in the Portal as group administrators and establish user IDs and passwords to access the Portal. MCE group administrators can assign users and enable them with appropriate access. A flowchart of this process is available on the MCO Question and Answer page at indianamedicaid.com.

Steps for Disenrolling a Preferred Medical Provider

• Access the Portal. Click Provider Profile. A new selection appears under the Managed Care section, titled Disenroll a PMP.

• Click Disenroll a PMP. A new page appears, titled PMP Disenrollment. Search for the desired provider location by entering the PMP’s group or dual provider national provider identifier (NPI) or Provider ID and the MCE ID.

• Click Select Service Location. A new page appears; all service locations for the group are selected.

• Select the disenrolling location using the radio buttons.

• Type the effective date of disenrollment and choose the disenrollment reason from the drop-down list. Disenrollment reasons are as follows:
  – PMP no longer practices at this location
  – PMP no longer contracted with MCE
  – PMP no longer in managed care at this location
  – PMP deceased

• The date must be the current date or a future date except for death of PMP. Web editing prevents entry of a past date except when the reason code is PMP Deceased. Click Save and Close to complete the process.

IHCP Disenrollment and Preferred Medical Provider Disenrollment

Immediate PMP terminations (such as a PMP’s death) that are the result of IHCP terminations are carried out by the fiscal agent’s Provider Enrollment Unit. The fiscal agent’s Provider Enrollment Unit notifies the MCE when one of the MCE’s PMPs has been disenrolled. PMPs terminated by the fiscal agent are disenrolled using the reason code, IHCP termed.
With the exception of an emergency event, such as the PMP’s death, the fiscal agent’s Provider Enrollment Unit notifies the MCE that the MCE has five business days to disenroll the PMP through the Portal. If the PMP is not disenrolled after five days, the Provider Enrollment Unit disenrolls the PMP and notifies the PMP’s MCE. MCEs use the PMP disenrollment reason codes available to them through the Portal disenrollment process (reason codes listed previously in step 5).

The Provider Enrollment Unit team members have the ability to retroactively end-date a PMP’s eligibility with an MCE, with the approval of the fiscal agent’s Managed Care Unit. An example of a retroactive end date is a PMP’s date of death when received by Provider Enrollment Unit one week after the PMP actually died.

**Maintenance of Medical Records**

The MCE must ensure that its participating providers maintain medical and other records of all medical services provided to enrollees by the MCE and its providers for seven years, in accordance with Indiana Code (IC) 16-39-7-1. The MCE medical records standards must be consistent, to the extent feasible, with NCQA accreditation standards for medical records. The records must at least be legible and must include the following:

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Personal biographical data
- Entry date
- Date on which the service was rendered
- Provider identification, and if applicable, the identity and position of the provider’s employee rendering the service
- Diagnosis of the medical condition of the individual to whom service was rendered, and a detailed statement describing services rendered
- The location at which services were rendered
- Written evidence of physician involvement and personal patient evaluation to document acute medical needs
- Allergies
- Past medical history
- Immunizations
- Medical information
- Consultations
- Referrals
- Medical conditions and health maintenance concerns
- Written instructions for living wills or durable power of attorney for healthcare when the patient is incapacitated and has such a document
- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care
- Diagnostic tests and findings
"Prescriptions for medications
Inpatient discharge summaries
Histories and physicals, including a list of smoking and chemical dependencies
EPSDT services
A current plan of treatment and progress notes as to the necessity and effectiveness of treatment must be attached to the prior authorization request and available for audit purposes.

Providers must maintain medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Health records must be legible, signed, dated, and maintained for at least seven years, as required by IC 16-39-7-1. Confidentiality of protected health information (PHI) must be maintained, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements, including but not limited to 42 CFR Part 2 specific to confidentiality of alcohol and drug abuse records.

The State (or MCE) must have access to medical records for medical record reviews. In accordance with Indiana Administrative Code (IAC) 405 IAC 1-5-1, the PMP must retain all records relating to the provision of MCE services for at least seven years from the date of record creation. The PMP must transfer, at the request of the State or the MCE, a summary or copy of a member’s medical records to another PMP if the member is reassigned.

Any physician receiving payments from the IHCP for rendered services may not charge an IHCP member for medical record copying or transfers. Federal regulation 42 C.F.R. 447.15 states that providers participating in Medicaid must accept the State’s reimbursement as payment in full (except that providers may charge for deductibles, coinsurance, and copayments).

**Managed Care Entity Communications with Providers**

The MCE must establish policies and procedures to maintain frequent communications and provide information to its provider network. As required by the Code of Federal Regulations (CFR) 42 CFR 438.207(c), the MCE must notify the State of material changes that may affect a procedure at least 30 calendar days before notifying its provider network of the changes. The MCE must give providers at least 45 calendar days’ advance notice (per IC 12-15-13-6) of material changes that may affect the providers’ procedures. The MCE must post a notice of the changes on its website to inform both network and out-of-network providers, and must make payment policies available to non-contracted providers on request.

Because some pharmacy services are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation, MCEs must educate providers about which pharmacy services should be submitted to the State fiscal agent for reimbursement, and which should be submitted to the MCE. The MCE must also ensure that providers receive education about the different PDLs applicable to the various HIP benefit plans, and that they have readily available information regarding a member’s applicable PDL.

In accordance with 42 CFR 438.102, the MCE must not prohibit or otherwise restrict a healthcare professional from acting within the lawful scope of practice, including advising or advocating on behalf of a member. The MCE must develop and maintain a user-friendly website for network and out-of-network providers within six (6) months of the effective date of the MCE’s contract with the State. The State must pre-approve the information and graphic presentations on the MCE’s website. The MCE may choose to develop a separate provider website or incorporate it into the home page of the member website.
To minimize download and wait times, the website must avoid techniques or tools that require significant memory or disk resources, or require special intervention on the user side to install plug-ins or additional software. The MCE must date each web page, change the date with each revision, and enable users to print the information.

The provider website may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- MCE’s contact information.
- MCE provider policy and procedure manual and necessary forms.
- MCE bulletins or newsletters issued not fewer than four times a year that provide updates related to provider services, and updated policies and procedures specific to the Hoosier Healthwise population.
- All provider communication materials, organized online in a user-friendly, searchable format by communication type and topic
- Claim submission information – For example, but not limited to, MCE submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists, and frequently asked questions.
- Claims dispute resolution procedures for contracted and out-of-network providers.
- Prior authorization procedures, including a complete list of services that require prior authorization
- Appeal procedures
- Entire network provider listings
- Links to the State’s website for general IHCP, Hoosier Healthwise, and HIP information
- A link to the State’s Preferred Drug List (Hoosier Healthwise only)
- Information about the MCE’s chronic disease management program
- HIPAA and 42 CFR Part 2 privacy policy and procedures

The MCE must maintain a toll-free telephone helpline for all providers with questions, concerns, or complaints. The MCE must staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a 12-hour business day, Monday through Friday, from 8 a.m. to 8 p.m., except for the following holidays during which the provider helpline may be closed:

- New Year’s Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day (July 4th)
- Labor Day
- Thanksgiving
- Christmas

The MCE must maintain a system for tracking and reporting the number and type of providers’ calls and inquiries. The MCE must monitor its provider helpline and report its telephone service performance to the State, as described in the Hoosier Healthwise/HIP Reporting Manual.
The fiscal agent sponsors quarterly workshops throughout the State and an annual seminar for all IHCP providers. The MCE must participate in the annual provider seminar and in quarterly regional workshops in its service areas.

During the workshops, the MCE must have appropriate representatives available to make formal presentations and respond to questions during scheduled times. The State also encourages MCEs to set up information booths with representatives available during the annual seminar.

**Provider Dispute Procedures**

The MCE must promptly respond to provider complaints and appeals. The MCE must clearly document and maintain policies and procedures for registering and responding to complaints, and must clearly communicate this information to all providers enrolled in the MCE. These policies and procedures must describe in detail the mechanism the MCE uses to track and respond to provider complaints and grievances, and provide detailed descriptions of positions responsible for performing each task. These processes must include specific time frames and resources, including but not limited to electronic or manual reports, logs, and any other documentation used to track grievances and complaints. The MCE must also provide the State with detailed descriptions of its written policies and procedures for handling provider grievances. The policies and procedures must follow the requirements set forth in 405 IAC 1-1.6.

In its quarterly report to the State, the MCE must provide the number of provider grievances, resolved and unresolved, by type and number. Provider grievances must be recorded according to the framework established by the State.

Denial notices to providers must include explanations of specific criteria supporting decisions. If payment for a service is denied, the notice must cite not only the applicable rule provision, but also an explanation of how it fits the particular provision. For example, denials for nonemergency services must restate the definition of emergency services, and explain how the specific case fails to meet the criteria.

**Practice Standards**

**Universally Accepted Practice Standards**

There must be evidence that the MCE further enhances quality of service to its Hoosier Healthwise and HIP members by requiring PMPs to adhere to nationally accepted standards or guidelines for preventive care for pregnant women, infants, children, adolescents, and adults.

The MCE must use or develop preventive health guidelines based on reasonable medical evidence and national guidelines. Guidelines adopted by the MCE must include those endorsed by the following:

- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- American Society of Internal Medicine (ASIM)
- American College of Physicians (ACP)
- American College of Obstetrics and Gynecology (ACOG)
- U.S. Preventive Services Task Force
- American College of Surgeons
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- National Cancer Institute (NCI)
- American Cancer Society

The MCE must provide evidence that it reviews the guidelines and scientific literature incorporated into the MCE’s preventive health guidelines. Guidelines must be shared with the MCE’s Quality Improvement Committee (QIC) and subcommittees, if any, and must include provider participation. The QIC and subcommittees must have opportunities to review, comment, and make modifications reasonable for local practices.

The guidelines must be appropriate for the full spectrum of the Hoosier Healthwise and HIP populations enrolled in the MCE. Primary and secondary prevention must be addressed for populations identified as high risk. Practice guidelines must include areas of study, methodology, indicators, analysis, plans for corrective action, follow-up, and assessment of effectiveness.

The MCE must provide evidence that supports how it shares preventive health guidelines with MCE providers, including new and existing providers. There must also be evidence that the MCE has plans for sharing new and revised guidelines. Communications can include provider newsletters, mailings, and provider modules.

The MCE must establish mechanisms to monitor and review provider compliance and consistency in following preventive care guidelines. Barriers must be identified.

MCEs must publicize to members the availability of preventive health services, guidelines for these services, and the recommended frequency or conditions under which prevention activities are required. MCEs may inform members through member newsletters, member orientation packets, member handbooks, and targeted mailings.

Note: Additional evidence-based clinical practice guideline information is available at the National Clinical Guidelines website.

Early and Periodic Screening, Diagnosis, and Treatment Program

The federally established EPSDT program, known as HealthWatch in Indiana, is part of the IHCP and was established in 1967. The HealthWatch program is a children’s preventive healthcare program providing initial and periodic examinations and medically necessary follow-up care. The program objectives are to improve the overall health of infants, children, and adolescents through early detection and treatment of medical conditions. These efforts can reduce the risk of more costly treatment or hospitalization that can occur when detection of medical problems is delayed.

This program is available on a voluntary basis to eligible children from birth through 20 years. Any medical provider enrolled in the IHCP is eligible to offer HealthWatch screenings for IHCP-enrolled infants, children, and adolescents. Medical providers can offer EPSDT services to new and existing IHCP patients. If the provider participates in the Hoosier Healthwise program as a PMP, the provider must participate in HealthWatch, and offer or arrange for the full range of EPSDT screenings, recommended immunizations, and follow-up care for members in the applicable age ranges.

To meet standards for preventive child healthcare, the State requires adherence to guidelines developed by the AAP. The AAP publishes a schedule of recommendations for screening components, screening frequency, and immunizations started in infancy. There is also an accelerated screening and immunization schedule for children older than two years old who have not already received the recommended screenings or immunizations. For additional information, see the HealthWatch Recommended Screening Techniques and Referral Standards in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch module, which is available on the Provider Reference Materials page at indianamedicaid.com.
MCEs are responsible for ensuring that members receive EPSDT services. The State conducts ongoing studies for this focus area to measure results and monitor MCE compliance with this area of critical importance to Hoosier Healthwise program members. MCEs are required to report EPSDT compliance through submission of encounter data, as described in the Management Information Systems section.

**Prenatal and Pregnancy-Related Care**

The State has implemented pregnancy-related standards of care that are applied to members in all Indiana Health Coverage Programs. MCEs must consider these as minimum standards for their Hoosier Healthwise and HIP enrollees. These standards of care are based on the American Congress of Obstetricians and Gynecologists (ACOG)-recommended policies that include prenatal, delivery, and postpartum care. In general, the IHCP provides coverage for 14 prenatal and two postpartum care visits, which ideally occur throughout a low-risk pregnancy as follows:

- First trimester – Three visits
- Second trimester – Three visits
- Third trimester – Eight visits
- Postpartum – Two visits within eight weeks of delivery

The program does not place limits on the number of prenatal visits reimbursed for members with complicating conditions that designate the member medically high-risk. The IHCP reimburses for appropriate laboratory tests and screenings during the pregnancy and two postpartum visits.

These standards, including diagnoses designated as high-risk and recommended laboratory tests and screenings, are described in detail in the Obstetrical and Gynecological Services module.

Members who enroll with an MCE, either voluntarily or by auto-assignment, in the third trimester of pregnancy must receive particular attention regarding continuity of prenatal care. MCEs must make financial arrangements with out-of-network providers to continue care through pregnancy if members do not wish to change doctors in the late stages of pregnancy.

**Future Standards**

MCEs are expected to add detailed practice standards for other patient conditions including the following:

- Breast cancer and mammography
- Cervical cancer and pap smears
- Human immunodeficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)
- Asthma
- Diabetes
- Hypertension
- Sexually transmitted diseases
- Cholesterol screening
- Prevention of influenza
- Smoking prevention and cessation
- Immunizations
• Domestic violence

These standards are developed by the State’s QIC, based on consultation with and recommendations from the following:

• IHCP physician providers
• Indiana medical community at large
• External Quality Review Organization (EQRO) and the Healthcare Effectiveness Data and Information Set (HEDIS)
• Federal Agency of Health Care Policy and Research (AHCPR)
• Centers for Disease Control and Prevention (CDC)
• IHCP Coordinated Care Technical Assistance Group (TAG)
• Other Department of Health and Human Services (DHHS) collaborative TAG committees.

A medical director and one other person knowledgeable about managed care, quality improvement, and data analysis represents MCEs on the QIC committee. MCEs must have practice standards in place for any of the previously listed or other conditions, and must make these standards available to Hoosier Healthwise and HIP enrollees after review and approval by the State.

Billing and Reimbursement Policies and Procedures

The MCEs and providers in their networks negotiate billing and reimbursement arrangements. These arrangements must support the MCE’s general encounter data, utilization, and other reporting requirements described in Information Systems.

The MCE must pay providers for covered medically necessary services rendered to the MCE’s members in accordance with standards set forth in IC 12-15-13-1.6 and IC 12-15-13-1.7, unless the MCE and provider agree to an alternate payment schedule and method. The MCE must also abide by the specifications of 42 CFR 447.45(d)(5) and (d)(6), which require the MCE to ensure that the date of receipt is the date the MCE receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date the check or other form of payment.

The MCE must pay or deny electronically filed clean claims within 21 calendar days of receipt and clean paper claims within 30 calendar days of receipt. If the MCE fails to pay or deny a clean claim within these time frames, but subsequently pays the claim, the MCE must also pay the provider interest, as required under IC 12-15-13-1.7(d). A definition of a clean claim is set forth in IC 12-15-13-0.6. These standards apply to out-of-network claims for which the MCE is responsible and to any other claims submitted by providers that have not agreed to alternate payment arrangements.

While the MCE may choose to subcontract claims processing functions, or portions of those functions, with a State-approved subcontractor, the MCE must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral services, and does not result in confusion in the provider community about where to submit claims for payments. For example, the MCE may elect to establish one post office box for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, the MCE must ensure that the subcontracting organizations forward claims to the appropriate processing entity. Use of a method such as this does not lengthen the timeliness standards discussed in this section. In this example, the definition of date of receipt is the date of a claim’s receipt at the post office box.
Interest Payments to Non-contracted Providers

As of January 1, 1997, MCEs are financially responsible for interest payments on clean claims billed by noncontracted providers. The requirement ensures timely payment of claims for services provided to Hoosier Healthwise enrollees. Interest is payable in accordance with provisions set forth in IC 12-15-13. Claims for services rendered by providers contracted with the MCE are not subject to this provision.

Billing and Balance Billing IHCP Enrollees

IHCP and federal regulations specifically prohibit providers from charging IHCP enrollees for covered services, except in specific, limited circumstances. IHCP-enrolled providers are required to accept the IHCP’s determination of payment for covered services as payment in full, except for copayments and any other patient liability payment as authorized by law. The provider must maintain documentation that the member voluntarily chose to receive the service, knowing it was not covered by the program.

The Provider and Member Utilization Review Module contains detailed information about billing IHCP members. Generally, IHCP-enrolled providers can bill members only under the following conditions:

• The service is not covered under the IHCP (for example, cosmetic procedures).
• The member has exceeded the program limitation for a particular service.
• The member understands that the IHCP does not cover the service and accepts financial responsibility before receiving a service that is not covered by the program.
• The services provided are covered or non-covered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or non-covered.
• The provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of IHCP eligibility before the one-year claim-filing limitation.

MCE contracted providers, as IHCP-enrolled, are subject to the same policy outlined previously. While the State and the Centers for Medicare & Medicaid Services (CMS) recognize that there may be circumstances unique to the managed care environment in which billing members may be appropriate, the State discourages this practice. If an MCE elects to permit its contracted providers to bill members under any circumstance, the MCE must do all the following:

• Develop sufficient safeguards to ensure that members are able to access medically necessary services.
• Ensure that members are not subject to any coercive practices.
• Ensure that members are informed of their right to file grievances.

The MCE can permit a provider to bill members for services that require authorization, but for which authorization is denied, if certain safeguards are in place and are followed by the provider. MCEs must establish, communicate, and monitor compliance with procedures that include at least the following:

1. The provider must establish that authorization has been requested and denied before rendering the service.
2. The provider can request MCE review of the authorization decision. The MCE must inform providers of the contact person, the means for contact, the information required to complete the review, and procedures for expedited review, if necessary.
3. If the MCE maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied. If the provider is out-of-network, the provider must also explain that covered services may be available without cost in-network if authorization is provided.

4. The member must be informed of the right to contact the MCE to file an appeal if the member disagrees with the decision to deny authorization.

5. The providers must inform members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.

If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:

- The waiver is signed only after the member receives the appropriate notification stated in requirements 3 and 4.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- Providers must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
- The waiver must specify the date the services are provided and the services that fall under the waiver’s application.
- The provider must have the right to appeal any denial of payment by the MCE for denial of authorization.

Nothing on this list should be interpreted as preventing payment of covered services for HIP members with POWER Account funds before the member’s deductible is met. However, if the MCE permits providers to bill members for services that require authorization, but for which authorization has been denied (as outlined previously), the POWER Account funds cannot be used to reimburse the provider for the noncovered services.

**Disclosure of Physician Incentive Plan**

The MCE may implement a physician incentive plan (PIP) only if:

- The MCE makes no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee.
- The MCE meets requirements for stop-loss protection, member survey, and disclosure requirements under 42 CFR 438.6.

Federal regulations 42 CFR 438.6, 42 CFR 422.208, and 42 CFR 422.210 provide information about physician incentive plans, and the CMS provides guidance on its website. The MCE must comply with all federal regulations regarding PIPs and supply to the State information on its PIP, as required in the regulations and with sufficient detail to permit the State to determine whether the incentive plan complies with the federal requirements. The MCE must provide information about its PIP, on request, to its members and in any marketing materials, in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.
School-based Healthcare Services for Hoosier Healthwise Members

MCEs must plan for, develop, and enhance relationships with school-based health centers (SBHCs) with the goal of providing accessible quality preventive and primary healthcare services to school-aged Hoosier Healthwise members.

An SBHC is a health center located in a school or on school grounds that provides on-site comprehensive preventive and primary health services, including behavioral health, oral health, ancillary, and enabling services. These services may include a wide variety of preventive services, including general health screening or assessments, EPSDT screenings, laboratory and diagnostic screenings, immunizations, first aid, family planning counseling and services, prenatal and postpartum care, dental services, behavioral health services, drug and alcohol abuse counseling, patient education, and other services based on the student’s need and on the philosophy of the school administration.

On-site healthcare providers at SBHCs generally include a nurse practitioner or physician assistant who operates under the standing orders of a physician, a consultant physician, and a clinically trained behavioral health practitioner.

SBHCs have varying capacities and resources to deliver healthcare. For purposes of this procurement, SBHCs are not permitted to serve as PMPs. However, MCEs are encouraged to be creative in their approaches to collaborating with SBHCs, and to begin to develop affiliations with SBHCs with the potential of expanding those affiliations and the scope of services available in SBHCs in the future.

The following are some examples of the types and levels of services acceptable in SBHCs:

- The SBHC coordinates care with the child’s PMP, who assumes responsibility for care whenever the SBHC closes. The SBHC can deliver preventive and primary medical care, but may rely on its partner for year-round accessibility and 24-hour-a-day coverage.

- The SBHC provides a limited range of services. For example, the SBHC may be able to provide services such as preventive medical care, health education, reproductive healthcare, behavioral health services, dental services, and immunizations, and may also have limited hours of operation.

- The SBHC refers the child back to their PMP for the majority of their primary care.

MCEs’ relationships with SBHCs vary, depending on the resources available in MCEs’ area. The following list includes examples of possible MCE relationships with Indiana SBHCs, not requirements for the Hoosier Healthwise program:

- FQHCs, health systems, or other organizations contracted with an MCE may sponsor an SBHC. The MCE reimburses the sponsoring organization, which reimburses the SBHC for care provided to members enrolled in the MCE.

- An MCE can include SBHCs in its provider network. The MCE reimburses the SBHC for care provided to members enrolled in the MCE.

- MCEs may allow members to self-refer to an SBHC; for example, for a prescribed set of acute care visits, MCEs can reimburse SBHCs on a fee-for-service basis. The primary care functions and reimbursement stay with the child’s PMP, but the SBHC serves as an acute care provider.

- The SBHC can function as a satellite office for existing contracted providers.

- MCEs can reimburse an SBHC for care provided to enrolled members as an out-of-network provider.

To avoid duplicate services, promote continuity of care, and develop strong relationships between SBHCs and PMPs, the SBHC must coordinate care and refer children to their PMPs for follow-up.
Section 19: Quality Improvement and Utilization Management

Overview

The managed care entity (MCE) must monitor, evaluate, and take effective action to identify and address any needed improvements in the quality of care delivered to members in the Hoosier Healthwise and Healthy Indiana Plan (HIP) programs by all providers in all types of settings. In compliance with State and federal regulations, the MCE must submit quality improvement data, including data that meets Healthcare Effectiveness Data and Information Set (HEDIS) standards for reporting and measuring outcomes, to the State that includes the status and results of performance improvement projects. Additionally, the MCE must submit information requested by the State to complete the State’s Annual Quality Strategy Plan to the Centers for Medicare & Medicaid Services (CMS).

For purposes of this section, the following definitions apply. A “performance improvement project” means a plan to remediate an identified program deficiency in response to a sanction or action by the State. A “quality improvement project” is a planned strategy for program improvement and is incorporated into the MCE’s Quality Management and Improvement Program Work Plan.

The MCE’s medical director must be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program must have objectives that are measurable, realistic, and supported by consensus among the MCE’s medical and quality improvement staff. Through the Quality Management and Improvement Program, the MCE must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its Quality Management and Improvement Program, the MCE will develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of healthcare resources and improving health outcomes of Hoosier Healthwise and HIP members. The MCE may establish different provider and member incentives for its Hoosier Healthwise and HIP populations.

As a part of the MCE’s Quality Management and Improvement Program, the MCE must participate in the State’s annual performance improvement program.

Communication and activities between the MCEs and the FSSA include, but are not limited to the following:

• Meetings
• Reports
• Quality improvement measures and studies

The MCE must meet the requirements of 42 CFR 438 subpart D and the National Committee for Quality Assurance (NCQA), including but not limited to the following requirements, in developing its quality management program. The quality management program must ensure that it addresses the following:

• Assess quality and appropriateness of care provided to members with special needs, including all medically frail HIP members.
• Complete performance improvement projects in a reasonable time, so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects.
• Produce new information and reports on quality of care at least annually.

The MCE’s Quality Management and Improvement Program must:

• Include developing and maintaining an annual Quality Management and Improvement Program Work Plan, which sets goals, establishes specific objectives, identifies strategies and activities, monitors results, and assesses progress toward goals. Specific requirements for the Quality Management and Improvement Program Work Plan are outlined in the Hoosier Healthwise and HIP Reporting Manual.

• Have in effect mechanisms to detect both underutilization and overutilization of services. The actions the MCE takes to address underutilization and overutilization must be documented.

• Have written policies and procedures for quality improvement. Policies and procedures must include methods, time lines, and the name of departments responsible for completing each task.

• Incorporate an internal system for monitoring services, including clinically appropriate data collection and management for clinical studies, internal quality improvement activities, assessment of the special needs population, and other quality improvement activities requested by the State.

• Participate appropriately in clinical studies, and use HEDIS rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members. In assessing the quality and appropriateness of care provided to members under 21 years of age, the MCE must act in accordance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or HealthWatch requirements.

• Collect measurement indicator data related to areas of clinical priority and quality of care. The State establishes areas of clinical priority and indicators of care. These areas may vary from one year to the next and from program to program. The areas will reflect the needs of the Hoosier Healthwise and HIP populations. Examples of areas of clinical priority include:

  HIV and Hepatitis C Care
  • Behavioral health and physical healthcare coordination
  • Immunization rates
  • EPSDT services
  • Prenatal care
  • Blood lead testing (for Hoosier Healthwise only)
  • Emergency room utilization
  • Access to care
  • Special needs care coordination and utilization
  • Asthma
  • Obesity, especially childhood obesity
  • Smoking cessation, especially for pregnant women
  • Inpatient and emergency department follow-up
  • Timely follow-up and notification of results from preventive care and/or biopsies
  • Integrated medical and behavioral health utilization

• Report any national performance measures developed by the CMS. The MCE must develop an approach for meeting the performance levels established by the CMS on release of the national performance measures, in accordance with 42 CFR 438.240(a)(2), which allows the CMS to specify measures and topics for performance improvement projects.

• Establish procedures for collecting and ensuring accuracy, validity, and reliability of performance measures that are consistent with protocols developed in the public or private sector. The CMS website contains an example of available protocols.

• Develop and maintain a physician incentive program.

• Develop a member incentive program to encourage members to be personally accountable for their own healthcare and health outcomes. Targeted areas of performance could include the appropriate
use of emergency room services; keeping appointments and scheduling appointments for routine and preventive services, such as prenatal care; disease screenings; compliance with behavioral health drug therapy; compliance with diabetes treatment, and well-child visits.

- Participate in any State-sponsored prenatal care coordination programs.

- Contract for an NCQA-accredited HEDIS audit and report HEDIS rates. A separate HEDIS audit is required for Hoosier Healthwise and HIP lines of business. The HEDIS audit and report must be based on the NCQA methodology for sampling of HEDIS data.

- Conduct a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and report results to the State annually. A separate CAHPS is required for Hoosier Healthwise and HIP lines of business and must be based upon the NCQA methodology for sampling CAHPS data.

- Include a provider relations project annually

- Participate in other quality improvement activities, including External Quality Reviews, to be determined by the State.

**Work Plan Requirements for the Quality Management and Improvement Program**

The MCE’s Quality Management and Improvement Committee, in collaboration with the MCE’s medical and pharmacy directors, must develop, approve, monitor and evaluate an annual *Quality Management and Improvement Program Work Plan*. The plan must identify the MCE’s quality management goals and objectives and include a time line of activities and assessments of progress toward meeting the goals. The MCE may submit one plan for both lines of business, but the plan must include sections that are specific to each program. The plan must meet HEDIS standards for reporting and measuring outcomes. The plan must incorporate any quality improvement projects identified for the HIP program.

The MCE must submit its *Quality Management and Improvement Program Work Plan* to the State annually with quarterly progress updates and must be prepared to periodically report on its quality management activities to the State’s Quality Strategy Committee.

The MCE must prepare the annual *Quality Management and Improvement Program Work Plan* using standardized reporting templates provided by the State, in compliance with the *Hoosier Healthwise/HIP Reporting Manual*. Further, the MCE must also:

- Establish program goals and objectives specific to the Hoosier Healthwise and HIP populations to improve the MCE’s functioning, improve the delivery of healthcare services, and improve health outcomes.

- Identify specific tasks, individuals responsible, and time lines for each activity.

- Demonstrate an effort toward implementing enrollee-targeted or PMP-targeted programs that result from areas for improvement identified through readiness reviews, focused studies, and internal quality improvement efforts.

- Demonstrate that its quality improvement program is integrated throughout the organization, and through any of its subcontractors when appropriate, for the purposes of assessment, evaluation, and implementation of modifications and changes.

The *Hoosier Healthwise and HIP Reporting Manuals* contain more information about the annual *Quality Management and Improvement Work Plan*. 
External Quality Review

Pursuant to federal regulation, the State must arrange for an annual, external independent review of each MCE’s quality of, timeliness of, and access to healthcare services. The MCEs will cooperate with and participate in the External Quality Review (EQR), including providing all information required for the review in a time frame and form requested by the external quality review organization. Subsequently, the MCE’s Quality Management and Improvement Program must incorporate and address findings from all external quality reviews.

Incentive Programs

The State requires MCEs to participate in a pay-for- outcomes program that focuses on rewarding MCEs’ efforts to improve quality and outcomes for Hoosier Healthwise and HIP members. The State will provide, at minimum, financial performance incentives to MCEs based on performance targets in priority areas established by the State.

The State reserves the right to revise measures on an annual basis and will notify the MCE of changes to incentive measures. The measures for 2015 targeted the following services:

- Ambulatory Care
- Preventive care
- Follow up after hospitalization for mental illness
- Pregnancy and post partum
- Well care
- Emergency utilization
- Completion of the health needs screening and comprehensive health assessment

Provider Incentive Programs

MCEs must establish a performance-based incentive system for its providers. Different provider incentives may be established for the MCE’s Hoosier Healthwise and HIP providers. The MCE will determine its own methodology for incentivizing providers. The MCE must obtain the State approval before implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs.

If the MCE offers financial incentives to providers, these payments must be above and beyond the standard Medicaid fee-for-service fee schedule (for Hoosier Healthwise) and Medicare fee schedule (for HIP).

Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.6(n), 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans. The MCE must comply with all federal regulations regarding the physician incentive plan and supply to the State information on its plan as required in the regulations and with sufficient detail to permit the State to determine whether the incentive plan complies with the federal requirements. The MCE must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

Physician incentive plans must comply with the following requirements:
• The MCE will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member.

• The MCE meets requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.6(n).

**Member Incentive Programs**

MCEs must establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or nonfinancial. The MCE will determine its own methodology for incenting members. For example, the MCE may offer member incentives for:

• Attending all prenatal visits
• Obtaining recommended preventive care
• Completing the expected number of EPSDT visits
• Complying with treatment in a disease management, case management or care management program
• Making healthy lifestyle decisions such as quitting smoking or losing weight
• Completing a health screening

The MCE may not offer gifts or incentives greater than $10 for each individual and $50 per year per individual. The MCE may petition the State for authorization to offer items or incentives greater than $10 for each individual and $50 per year per individual if the items are intended to promote the delivery of certain preventive care services, as defined in 42 CFR 1003.101. Such incentives may not be disproportionate to the value of the preventive care service provided, as determined by the State. For Hoosier Healthwise, allowable preventive care services include well baby and well child visits, prenatal and postnatal care, and clinical services described in the current *U.S. Preventive Service Task Force’s Guide to Clinical Preventive Services*. HIP has its own preventive care services as established each year. The State will review the preventive care services every year and notify the MCEs as needed. The incentives offered to beneficiaries must be proportionate to the value of care provided. The State will not approve raffles as these are regulated activities subject to Indiana gaming law. All programs not tied to preventive care will remain subject to the $10 individual and $50 annual limits.

Member incentive programs may not be advertised to non-members. The State will not approve any mass marketing materials that describe member incentive programs. MCEs must only advertise incentives to current members through mediums such as the member handbook or letters or telephone calls directed to current membership.

To obtain approval for any member incentive programs and all enhanced services proposals, MCEs must use the Enhanced Services Program Review and Approval form to facilitate the State’s review. The MCE is responsible for describing the goals of the program, time frame, target population, program criteria, outreach methodology, incentives proposed and monitoring and evaluation methods. Additionally, the MCE must demonstrate that the incentive proposed does not surpass the value of the preventive care service provided. Petitions to provide enhanced incentives for preventive care are reviewed on a case-by-case basis, and the State retains full discretion in determining whether the enhanced incentives is approved.

In any member incentive program, the incentives must be tied to appropriate utilization of health services and/or health-promoting behavior. For example, the member incentive programs can encourage responsible emergency room use or preventive care utilization. MCEs must develop member incentives designed to encourage appropriate utilization of healthcare services, increase adherence to keeping medical appointments, and encourage the receipt of healthcare services in the
appropriate treatment setting. Additionally, the MCE must comply with all marketing provisions in the 42 CFR 438.104, as well as federal and State regulations regarding inducements. Examples of appropriate rewards include:

- Gift certificates for groceries
- Telephone cards
- Gifts such as diaper bags or new baby welcome kits

The MCE must obtain the State approval before implementing its member incentive program and before making any changes thereto.

### Notification of Pregnancy Incentives

The State implemented the Notification of Pregnancy (NOP) process to encourage MCEs and providers to complete a comprehensive risk assessment (such as an NOP form) for pregnant members. NOP requirements and conditions for payment are set forth in the Presumptive Eligibility and Notification of Pregnancy sections of this manual. Because pregnant women have been enrolled in HIP since 2015, NOP requirements also apply to HIP. Only one assessment should be completed per member, per pregnancy, regardless of whether the member receives pregnancy services through the Hoosier Healthwise or HIP program (or both during the course of her pregnancy).

The provider is responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The MCE receiving the NOP must contact the member to complete a comprehensive pregnancy health risk assessment within 21 calendar days of receiving a completed NOP form from the provider.

To be eligible for the provider incentive payment, the Notification of Pregnancy form must be submitted by providers via the Portal within five calendar days of the visit during which the NOP form was completed. The State reimburses the MCE for NOP forms submitted according to the standards in the NOP chapter. This reimbursement amount must be passed on to the provider that completed the NOP form. An additional amount is transferred to a bonus pool. The MCE is eligible to receive bonus pool funds based on achievement of certain maternity-related targets as outlined in the MCE contract with the State.

The MCE must have systems and procedures in place to accept NOP data from the State fiscal agent, assign pregnant members to a risk level and, when indicated based on the member’s assessment and risk level, enroll the member in a prenatal case management program. The MCE will assign pregnant members to a risk level and enter the risk level information into the Portal within 12 calendar days of receiving NOP data from the State fiscal agent.

### Utilization Management Program

The MCE must operate and maintain its own utilization management program. The MCE may limit coverage based on medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. The MCE is prohibited from arbitrarily denying or reducing the amount, duration, or scope of required services, solely because of diagnosis, type of illness, or condition.

The MCE must establish and maintain medical management criteria and practice guidelines, in accordance with federal and State regulations, based on valid and reliable clinical evidence or consensus among clinical professionals. The MCE must consider the needs of its members. The MCE may accept a nationally recognized set of guidelines, including but not limited to Milliman Care Guidelines or InterQual. If the MCE chooses to use separate guidelines for physical health and
behavioral health services, the MCE must demonstrate that using separate guidelines would have no negative impact on members and would not otherwise violate the MCE’s requirements under the MHPAEA. Pursuant to 42 CFR 438.210(b), the MCE must consult with contracting healthcare professionals in developing practice guidelines; the MCE must also have mechanisms in place to ensure consistent application of review criteria for authorization decisions and must consult with the provider that requested the services, when appropriate.

The MCE must have sufficient staff with clinical expertise and training to interpret and apply utilization management criteria and practice guidelines to providers’ requests for healthcare or service authorizations. The guidelines must be reviewed and updated periodically, distributed to providers, and available to members on request. MCEs must publish their prior authorization procedures on the MCE website at least 45 days before the effective date. Any updates must be published at least 45 days before the effective date. These procedures must include all information necessary for a provider to submit a prior authorization (PA) request.

The State may waive certain administrative requirements, including prior authorization, to the extent that such waivers are allowed by law and are consistent with policy objectives. The MCE may be required to comply with such waivers and are provided with prior notice by the State.

Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines. The MCE must be prepared to provide a written training plan, which must include dates and subject matter, as well as training materials, upon request by the State.

The MCE must maintain an efficient utilization management program that integrates with other functional units and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures in place that:

• Identify over- and underutilization of emergency room and other healthcare services;
• Identify aberrant provider practice patterns (especially related to emergency room visits, inpatient services, transportation, drug utilization, preventive care, and screening);
• Ensure active participation of a utilization review committee;
• Evaluate efficiency and appropriateness of service delivery;
• Incorporate subcontractors’ performance data;
• Facilitate program management and long-term quality;
• Identify critical quality-of-care issues; and
• Monitor pharmacy utilization.

The MCE must monitor utilization through retrospective reviews and identify areas of high and low utilization and identify key reasons for the utilization patterns. The MCE must identify those members who are high users of emergency room services and/or other services and perform the necessary outreach and screening to ensure the member’s services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services. The MCE must also use this data to identify additional disease management programs that are needed. Any member with emergency room utilization at least three standard deviations outside the mean for the population group must be referred to case management or care management.

The MCE must define service authorizations in a manner that at least includes members’ requests for services. The MCE’s utilization management policies and procedures must meet all NCQA standards and include appropriate time frames for the following:

• Completing initial requests for prior authorization of services.
• Completing initial determinations of medical necessity.
• Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity.
• Notifying providers and members of the MCE’s decisions on initial prior authorization requests and determinations of medical necessity.
• Notifying providers and members of the MCE’s decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity.

The MCE’s utilization management program must link members to disease management, case management, and care management. The MCEs utilization management program must also encourage health literacy and informed, responsible medical decision making. For example, MCEs must develop member incentives designed to encourage appropriate utilization of healthcare services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting. MCEs are also responsible for identifying and addressing social barriers that may prohibit a member’s ability to obtain preventive care.

As part of its utilization review, the MCE must monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards such as those published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology and the State’s recommended preventive care guidelines (for HIP). The MCE must develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

The MCE must also monitor the pharmacy utilization of all its members, including its Hoosier Healthwise members, even though the MCE is not responsible for paying or reimbursing the pharmacy claims of its Hoosier Healthwise members.

To monitor under- or overutilization of behavioral health services, the State requires MCEs to provide separate utilization reports for behavioral health services; report specifications are outlined in the Hoosier Healthwise and HIP Reporting Manual. MCEs can contact their OMPP quality analyst for access to this manual. In particular, the MCE must monitor use of services for its members with special needs and those with diagnoses of severe mental illness or substance abuse. The behavioral health services report must also separately identify the utilization of HIP members designated as medically frail.

The Right Choices Program

The Right Choices Program (RCP) identifies members who use covered services more extensively than their peers. The program, set forth in 405 IAC 1-1-2(c) and 405 IAC 5-6, is designed to monitor member utilization, and when appropriate, implement restrictions for those members who would benefit from increased care coordination. The MCE provides appropriate disease management, care management, or complex case management services to RCP members. Program policies, set forth by the State for RCP, are delineated in the Right Choices Program module. The MCE must comply with the program policies set forth in the Right Choices Program module.

The MCE is responsible for RCP duties, as outlined in the Right Choices Program Policy module, including, but not limited to, the following:
• Evaluate claims (including medical and pharmacy claims), medical information, referrals, and data to identify members to be enrolled in RCP—before enrolling a member in RCP, the MCE must ensure a physician, pharmacist, or nurse confirms the appropriateness of the enrollment.
• Enroll members in RCP.
• Provide written notification of RCP status to such members and their assigned primary physicians, pharmacies, and/or hospitals.
Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management, and care coordination with the goal of modifying member behavior.

Provide appropriate customer service to providers and members.

Evaluate and monitor the member’s compliance with his or her treatment plan to determine continuation or termination of RCP restrictions. The State must make available utilization data about the MCE’s RCP members to assist the MCE in its monitoring duties.

Notify the State of members who are being reported to the Family and Social Services Administration (FSSA) Bureau of Investigation for suspected or alleged fraudulent activities.

Provide ad-hoc reports about RCP to the State upon request.

Cooperate with the State in evaluation activities of the program by providing data and/or feedback when requested by the State.

Meet with the State about RCP implementation as requested by the State.

Develop, obtain the State approval of, and implement internal policies and procedures regarding the MCE’s RCP administration.

The State monitors the MCE’s compliance with RCP duties set forth in the Right Choices Program module through its monthly on-site visits and/or external quality review activities. The MCE may be subject to noncompliance remedies if the MCE fails to comply with RCP duties set forth in the MCE’s contract with the State and the Right Choices Program module. The State reserves the right to review all data and utilization figures for the MCE’s RCP membership, including the number of RCP members who have had more than one emergency room visit in a 30-calendar day period, in assessing the effectiveness of the MCE’s RCP program administration.

Authorization of Service and Notice of Action

Professionals with clinical expertise in the treatment of a member’s condition must make all decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Only licensed physicians and nurses may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested. The MCE must not provide incentives to utilization management staff for denying, limiting, or discontinuing medically necessary services.

As part of utilization management, the MCE must facilitate its PMPs’ requests for authorizing primary and preventive care and must assist PMPs in providing referrals for specialty services. In accordance with federal regulations, the process for authorizing services must comply with the following requirements:

- Second Opinions—In accordance with 42 CFR 438.206(b)(3), the MCE must comply with all member requests for second opinions from qualified professionals. If the provider network does not include a provider that is qualified to give a second opinion, the MCE must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

- Special Needs—In accordance with 42 CFR 438.208(c), the MCE must allow members with special needs who require courses of treatment or regular care monitoring to directly access specialists for treatment via established mechanisms, such as standing referrals from the members’ PMPs or an approved number of visits. Treatment provided by specialists must be appropriate for the member’s condition and needs.

- Women’s Health—In accordance with 42 CFR 438.206(b)(2), the MCE must provide female members with direct access to a women’s health specialist within the network to provide women’s covered routine and preventive healthcare services. This is in addition to female members’ designated sources of primary care (if those sources are not women’s health specialists). The MCE
must have an established mechanism, such as standing referrals from members’ PMPs or an approved number of visits, to permit female members direct access.

- The MCE must notify the requesting provider and provide written notice to members of any decisions to deny service authorization requests, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must be given within the time frames required in this section and in 42 CFR 438.404. Notification must be made to the member by the last day of the decision time frame if a decision is still pending.

- The MCE must submit all PA notification form letters to the State through the document review process. The letters must meet the requirements of 42 CFR 438.10(c) and (d) and 2 of the request for service (RFS) regarding language, oral interpretation, and format for member materials, and must clearly explain the following:
  - The action the MCE or its subcontractor has taken or intends to take
  - The reasons for the action
  - The member’s or the provider’s right to file an appeal with the MCE and the process for doing so
  - If the member has exhausted the MCE’s appeal process, the member’s right to request an FSSA hearing and the process for doing so
  - Circumstances under which expedited resolution is available and how to request it
  - The member’s right to have benefits continue until the resolution of the appeal, how to request continued benefits, and the circumstances under which the member may have to pay the costs of these services

The MCE must notify members of standard authorization decisions as expeditiously as required by the member’s health condition, not to exceed seven calendar days after the request for services. An extension of as many as 14 calendar days is permitted if the member or provider requests an extension, or if the MCE justifies to the State a need for more information and explains how the extension is in the member’s best interest. Extensions require written notice to members and must include the reason for the extension and the member’s right to file an appeal.

Unless otherwise provided in 405 IAC 5-3-14 (Hoosier Healthwise) or 405 IAC 10-7-12 (HIP), if the MCE fails to respond to a member’s prior authorization request within seven calendar days of receiving all necessary documentation, the authorization is deemed to be granted.

For situations in which a provider indicates, or the MCE determines, that following the standard time frame could seriously jeopardize the member’s life or health, or ability to attain, maintain, or regain maximum function, the MCE must expedite the authorization decision and provide notice as quickly as the member’s condition requires and no later than three working days after receiving the request. The MCE may extend the three working days to as many as 14 calendar days if the member requests an extension, or if the MCE justifies a need for additional information and how the extension is in the member’s best interest.

The MCE must notify the member of a decision to deny payment on the date of the MCE’s decision if the member is liable for payment.

The MCE must notify members of decisions to terminate, suspend, or reduce previously authorized covered services, including decisions to transfer members between HIP benefit plans that result in changes to covered services, at least 10 calendar days before the date of action, with the following exceptions:

- Notice is shortened to five calendar days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General.

- Notice may occur no later than the date of the action if any of the following occurs:
  - The member dies.
– The MCE receives a signed, written statement from the member requesting termination of service or giving information requiring termination or reduction of services (the member must understand the result of supplying this information).
– The member is admitted to an institution and is consequentially ineligible for further services.
– The member’s address is unknown, and there is no forwarding address.
– The member is accepted for Medicaid services by another jurisdiction.
– The member’s physician prescribes a change in the level of medical care.
– An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions, or the safety or health of individuals in the facility would be endangered; the member’s health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the member’s urgent medical needs; or a member has not resided in the nursing facility for 30 days (applies only to adverse actions for nursing facility transfers).

Requirements for Tracking Prior Authorization Requests

The MCE must track all prior authorization requests in their information system. All notes in the MCE’s prior authorization tracking system must be signed by clinical staff and include the appropriate suffix, such as registered nurse (RN), medical doctor (MD), and so forth. For prior authorization approvals, the MCE must provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the MCE’s information system:
• Name of caller
• Title of caller
• Date and time of call
• Prior authorization number

For all denials of prior authorization requests, the MCE must maintain a record of the following information, at a minimum, in the MCE’s information system:
• Name of caller
• Title of caller
• Date and time of call
• Clinical synopsis inclusive of:
  – Time frame of illness or condition
  – Diagnosis
  – Treatment plan
• Clinical guidelines or other rational supporting the denial (such as insufficient documentation)

Objection on Moral or Religious Grounds

If the MCE elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows, in accordance with 42 CFR 438.102(b):
• To the State with its response to the RFS
• To the State if it adopts the policy during the term of the contract
• To potential members before and during enrollment
• To members within 90 calendar days after adopting the policy with respect to any particular service, but at least 30 calendar days before the effective date.

Utilization Management Committee

The MCE must have a utilization management committee directed by the MCE’s medical director. The same committee must be responsible for the MCE’s Hoosier Healthwise and HIP lines of business. The committee is responsible for the following:

• Monitoring providers’ requests for rendering healthcare services to its members.
• Monitoring the medical appropriateness and necessity of healthcare services provided to its members.
• Reviewing the effectiveness of the utilization review process and making changes to the process as needed.
• Writing policies and procedures for utilization management that conform to industry standards, including methods, time lines, and individuals responsible for completing each task.
• Confirming that the MCE has an effective mechanism in place to respond within one hour to all emergency room providers, 24 hours a day, seven days a week.

Program Integrity Plan

Pursuant to 42 CFR 438.608, which sets program integrity requirements, the MCE must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan shall serve as MCE’s compliance plan. The Program Integrity Plan shall be submitted annually and upon request by the OMPP PI Unit, and updated quarterly, or more frequently if required by the OMPP Program Integrity (PI) Unit, and be submitted to the OMPP. The PI Plan and/or updates to the PI Plan shall be submitted through the reporting process to the OMPP, who shall forward to the OMPP PI Unit, 10 business days before scheduled meetings discussing the Plan. The Plan shall include in its PI Plan provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of MCE’s providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers, vision, transportation, dental) and MCE itself, including:

• Written policies, procedures and standards of conduct that articulate the organization’s commitment to comply with all applicable state and federal standards.
• The designation of a Special Investigation Unit Manager, a Compliance Officer and a Compliance Committee. The Plan should document that the Compliance Officer and SIU Manager shall meet with the OMPP PI Unit at a minimum of quarterly and as directed by the FSSA PI Unit.
• The type and frequency of training and education for the Special Investigation Unit manager, compliance officer, and the organization’s employees who will be provided to detect fraud. Training must be annual and address the False Claims Act, Indiana laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other Federal and state laws governing Medicaid provider participation and payment as directed by the CMS and FSSA. Training should also focus on recent changes in rules.
• A risk assessment of the MCE’s various fraud and abuse/program integrity processes. A risk assessment shall also be submitted on an ‘as needed’ basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines), is issued on a provider with concerns of fraud and abuse. The MCE shall inform the OMPP PI Unit of such action and provide details of such financial action. The assessment shall also include a listing of the MCE’s top three vulnerable areas and shall outline action plans mitigating such risks.
• An organizational chart and communication plan highlighting lines of communication between the Special Investigation Unit manager, the compliance officer and the organization’s employees.

• Provision for internal monitoring and auditing.

• Procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this contract.

• A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to a list of:
  o Automated pre-payment claims edits
  o Automated post-payment claims edits
  o Types of desk audits on post-processing review of claims
  o Reports for provider profiling and credentialing used to aid program and payment integrity reviews
  o Surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services
  o Provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials
  o References in provider and member material regarding fraud and abuse referrals
  o Provisions for the confidential reporting of PI Plan violations to the designated person
  o Provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports

• Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.

• Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.

• Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under state or federal law to the OMPP PI Unit and pursuant to the Program Integrity Operations section of this manual.

• Assurances that no individual who reports MCE’s potential violations or suspected fraud and abuse is retaliated against.

• Policies and procedures for conducting announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

• Provisions for prompt response to detected offenses, and for development of corrective action initiatives.

• Program integrity-related goals, objectives and planned activities for the upcoming year.

Additional Program Integrity Requirements

The Indiana Office of the Attorney General, Medicaid Fraud Control Unit is the state agency responsible for the investigation of provider fraud in the Indiana Medicaid program.

The OMPP Program Integrity Unit (OMPP PI), is responsible for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of Medicaid-eligible beneficiaries, and referring cases of suspected fraud to the MFCU for investigation. The OMPP PI Unit identifies and recovers Medicaid waste and abuse. The FSSA Bureau of Investigations evaluates and investigates reports of suspected fraud by recipients of assistance programs and both government and contract employees.
The MCE, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting, including business transaction disclosure reporting (42 CFR 455.105) and the full ownership and control information (42 CFR 455.104) and shall further provide any additional information necessary for the FSSAS to perform exclusion status checks pursuant to 42 CFR 455.436. All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and the terms of the Contract, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three years, and at any time upon request.

Program Integrity Operations

- The MCE shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use of Medicaid
- The MCE shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities
- MCE shall have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud and abuse issues of MCE’s providers, vendors, and subcontractors (including pharmacy benefits managers) and MCE itself
- MCE is required to conduct and maintain at a minimum the following operations and capabilities. MCE shall conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud and abuse
- The Special Investigation Unit within the MCE’s structure shall have the ability to make referrals to the OMPP PI Unit, and accept referrals from a variety of sources including: directly from providers (either provider self-referrals or from other providers), members, law enforcement, government agencies, and so forth
- The MCE shall also have effective procedures for timely reviewing, investigating, and processing such referrals.
  - Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation
  - Provider profiling and peer comparisons of all of MCE’s provider types and specialties – at a minimum annually - to identify aberrant service and billing patterns warranting further review/audit
  - Onsite Audit capability and protocols identifying how and when the Special Investigation Unit shall conduct such onsite audits of providers
  - Medical claim audit capabilities sufficient to enable the Special Investigation Unit to audit any payment issued to any provider. This includes utilizing medical record reviewers, clinicians, coding specialists, accountants, and investigators needed for review of payments to any provider/provider type
  - Member service utilization analytics to identify members that may be abusing services.
- MCE shall submit to FSSA for approval the criteria utilized for its review of its members and the referral of members to the Right Choices Program.

Program Integrity Reporting

The MCE, and all subcontractors, shall cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP PI Unit, in investigating fraud and abuse. The MCE shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21).
Reporting Waste, Fraud, and Abuse

The MCE shall immediately report all suspected or confirmed instances of waste, fraud and abuse to the OMPP and the PI Unit.

- The MCE shall use the Reporting Forms provided by the OMPP for all such reporting or such other form as may be deemed satisfactory
- The MCE shall be subject to non-compliance remedies under this Contract identified in Exhibit 3 and 4 of the contract for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/members, or applicants to the OMPP PI Unit as appropriate
- All confirmed or suspected cases of waste, fraud, and abuse shall be discussed at the Managed Care-Program Integrity coordination meeting following the OMPP PI Unit’s receipt of the report unless otherwise directed by the OMPP PI Unit

Investigation of Waste, Fraud, and Abuse

The MCE shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCE shall not take any of the following actions as they specifically relate to Indiana claims:

- Contact the subject of the investigation about any matters related to the investigation
- Enter into or attempt to negotiate any settlement or agreement regarding the incident
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident
- The MCE shall promptly provide the results of its preliminary investigation to the OMPP PI Unit or to another agency designated by the OMPP PI Unit
- The MCE shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCE employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

Credible Allegation of Fraud

The MCE shall comply with 42 C.F.R. § 455.23 by suspending all payments to a provider after the Agency determines that there is a credible allegation of fraud and has provided the MCE with notice of a payment suspension.

Audit Report

As directed by the OMPP PI Unit, the MCE shall submit a quarterly detailed Audit Report to the OMPP which outlines the MCE’s program integrity-related activities, as well as identifies the MCE’s progress in meeting program integrity-related goals and objectives. The Audit Report documents all provider and member-specific program integrity activities of MCE (for example, the specific application of Program Integrity Plan provisions to identify specific provider and member waste, fraud and abuse), as documented in the following.

- The Audit Report shall specify current audits, reviews, claim denials, and investigation activity of the unit, a summary of the reason for the audit/investigative activity, the disposition of any such completed activity (including detailed overpayment amounts identified or recouped), and projected upcoming activity for the following quarter.
• The Audit Report should also specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The quarterly progress report must identify recoupment totals for the reporting period. In accordance with the Affordable Care Act and FSSA policy and procedures, the MCE shall report overpayments made by FSSA to the MCE as well as overpayments made by the MCE to a provider and/or subcontractor.

• The Audit Report shall also identify projected upcoming activity, including the top 20 providers on MCE’s list for audit, and the types of audits envisioned.

• The OMPP PI Unit shall review and approve, approve with modifications, or reject the Audit Report and specify the grounds for rejection.

• Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the OMPP PI Unit) must also be submitted in the Audit Report.

HIPPA or Other Security Breach

The MCE shall notify the OMPP within one business day upon discovery of a HIPAA or other security breach.

Program Integrity Overpayment Recovery

The MCE has primary responsibility for the identification of all potential waste, fraud and abuse associated with services and billings generated as a result of this Contract. In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified and recovered by MCE.

In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Unit, the FSSA may recover any identified overpayment directly from the provider or may require MCE to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by MCE or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from MCE generates an investigation and/or corresponding legal action results in a monetary recovery to IHCP, the reporting MCE is entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Indiana. The MCE's share of recovery is as follows:

• From the recovery, the State (including the IMFCU) shall retain its costs of pursuing the action, including any costs associated with OMPP PI Unit operations associated with the investigation, and its actual documented loss (if any). The State will pay to the MCE the remainder of the recovery, not to exceed the MCE’s actual documented loss. Actual documented loss of the parties is determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.

• If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the MCE about potential settlement. The State may consider the MCE's preferences or opinions about acceptance, rejection or the terms of a settlement, but they are not binding on the State.

• If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the MCE shall survive expiration of the Contract and remain in effect until final resolution of a matter referred to the IMFCU by the MCE under this section.
If the State makes a recovery from a fraud investigation and/or corresponding legal action where the MCE has sustained a documented loss but the case did not result from a referral made by the MCE, the State shall not be obligated to repay any monies recovered to MCE, but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation/litigation, however, is shared with MCE as prescribed for funds recovered as a result of MCE’s fraud referral absent extenuating circumstances.

The MCE is prohibited from the repayment of state, federally, or MCE-recovered funds to any provider when the issues, services or claims upon which the repayment is based meets one or more of the following:

- The funds from the issues, services, or claims have been obtained by the State or federal governments, by the State or as part of a resolution of a state or federal audit, investigation, and/or lawsuit, including but not limited to false claims act cases
- When the issue, services, or claims that are the basis of the repayment have been or are currently being investigated by the OMPP PI Unit, the Federal Unified Program Integrity Contractor (UPIC), Indiana MFCU, or Assistant United State Attorney (AUSA), are the subject of pending federal or state litigation, or have been/are being audited by the State Recovery Audit MCE (RAC)

This prohibition described previously shall be limited to a specific providers, for specific dates, and for specific issues, services or claims. The MCE shall check with the OMPP PI Unit before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.

### 10.5 Auditing Program Integrity Operations

The OMPP PI Unit may conduct audits of MCE’s SI Unit activities to determine the effectiveness of MCE’s operations. Such audit activities may include conducting interviews of relevant staff, reviewing all documentation and systems used for Special Investigation Unit activities, and reviewing the SI Unit’s performance metrics. The OMPP PI Unit may issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State’s imposing liquidated damages up to the amount of overpayments recovered from MCE’s providers by OMPP PI Unit audits for the preceding calendar year, or imposing other non-compliance remedies including liquidated damages as outlined by Exhibit 3 and 4 of the contract.

### Medical Management Standard Compliance

The health plan also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the plan’s medical management standards.

The MCE must conduct periodic reviews of claims files and medical audits to determine the following:

- Treatment was consistent with diagnosis
- The treatment resulted in appropriate outcomes for participants with certain high-risk chronic or acute conditions (for example, asthma, hypertension, diabetes, otitis media, lead poisoning, drug dependency, and diseases preventable by routine immunization)
- The services provided emphasized preventive care and resulted in early detection
- The PMP appropriately referred members for specialty care
- Other compliance and appropriateness of services were provided
The State recommends that MCEs implement internal desk review procedures. Utilization review is emphasized particularly for outlier cases. MCEs are also required to provide the State with additional information to assist in investigation of outlier and other unusual cases.
Section 20: Information Systems

Overview

The managed care entity (MCE) must have a management information system (MIS) sufficient to support the Hoosier Healthwise and Healthy Indiana Plan (HIP) program requirements. For example, the MCE must be prepared to submit all required data and reports accurately and completely in the format specified by the OMPP. The MCE must maintain an information system with capabilities to perform the data receipt, transmission, integration, management, assessment, and system analysis tasks described in this manual and in the MCE’s contract with the State. The MCE’s information system must integrate: pharmacy data received from the State fiscal agent (Hoosier Healthwise only) for utilization analysis, care management activities, POWER Account activities, including roll-over, and HIP member benefit plan assignment, including any applicable medically frail designation or pregnancy diagnosis. The State must provide the MCE with pharmacy claims data on the MCE’s Hoosier Healthwise members on a weekly basis through the State fiscal agent. The State must also provide access to real-time pharmacy profiles of Hoosier Healthwise members via a web portal.

The MCE must have a plan for accessing and storing data files and records in a manner that is in keeping with Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 162 and 164 requirements for confidentiality when transmitting and maintaining medical data, including:

- Administrative procedures
- Physical safeguards
- Technical safeguards

The Contractor’s information system (IS) must support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier (NPI) requirements, and Privacy and Security Rule standards. The Contractor’s electronic mail encryption software for HIPAA security purposes shall be the same as the State’s. If the State’s technical requirements require a contract amendment, the State will work with MCEs in establishing the new technical requirements. The MCE must be capable of adapting to any new technical requirements established by the State, and the State may require the MCE to agree in writing to the new requirements. After the MCE has agreed in writing to a new technical requirement, any MCE-initiated change must be approved by the State and the State may require the MCE to pay for additional costs incurred by the State to implement the MCE-initiated change.

The Contractor’s IS plans for privacy and security shall include, but be not limited to:

- Administrative procedures and safeguards (45 CFR 164.308)
- Physical safeguards (45 CFR 164.312)
- Technical safeguards (45 CFR 164.312)

The MCE must make all collected information available to the State and, on request, to the Centers for Medicare & Medicaid Services (CMS). In accordance with the Code of Federal Regulations (CFR) at 42 CFR 438, subpart H, the MCE must submit all data with the signatures of its financial officer and executive leadership (for example, president, chief executive officer, or executive director), certifying the accuracy, truthfulness, and completeness of the MCE’s data.

The MCE must comply with all Indiana Office of Technology (IOT) standards, policies, and guidelines. All hardware, software, and services provided to or purchased by the State are compatible.
with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d) and Indiana Code (IC) 4-13.1.3. Any deviation from these architecture requirements must be approved in advance and in writing by IOT. In addition to the IOT policies, the MCE must comply with all FSSA Application Security Policies. Any deviation from the policies must be approved in writing from the State.

The MCE must develop processes for development, testing, and promotion of system changes and maintenance. The MCE must notify the State at least 30 calendar days before the installation or implementation of minor software and hardware changes, upgrades, modifications or replacements. The MCE must notify the OMPP at least 90 calendar days before the installation or implementation of major software or hardware changes, upgrades, modifications, or replacements. “Major” changes, upgrades, modifications, or replacements are those that impact “mission-critical” business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting the MCE’s capability to interface with the State or the State’s contractors. The MCE must ensure that system changes or system upgrades are accompanied by a plan that includes a timeline, milestones, and adequate testing to be completed before implementation. The MCE must notify and provide such plans to the FSSA upon request, in the time frame and manner specified by the State.

Disaster Recovery Plans

Information system contingency planning must be developed in accordance with the MCE’s contract with the State, as well as 45 CFR 164.308. Contingency plans must include: data backup plans, disaster recovery plans, and emergency mode of operations plans. For purposes of this policy, disaster means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the MCE’s or its subcontracting entities’ information system, or claims processing system; or that affects the performance, functionality, efficiency, accessibility, reliability, or security of the system. Application and data criticality analysis, along with testing and revisions procedures must also be addressed in the MCE’s contingency plan documents. The MCE is responsible for executing all activities needed to recover and restore operation of information systems, data, and software at an existing or alternative location under emergency conditions within 24 hours of identifying a disaster. The MCE must protect against hardware, software, and human error. The MCE must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file backups, and disaster recovery.

The MCE must maintain full and complete backup copies of data and software, and must proficiently back up tapes or optical disks and store data in an approved off-site location approved by the State. The MCE must maintain or otherwise arrange for an alternate site for its system operations in a catastrophe or other serious disaster.

The MCE must take the steps necessary to recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the MCE jointly determine when unscheduled system downtime is elevated to disaster status. Disasters may include natural disasters, human error, computer virus, or malfunctioning hardware or electrical supply.

The MCE must notify the State, at minimum, within two hours of discovery of a disaster or other disruptions in its normal business operations. Such notification must include a detailed explanation of the impact of the disaster, particularly related to mission-critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, encounter data management, and any other processing affecting the MCE’s capability to interface with the State or the State’s contractors. Depending on the anticipated length of disruption, the State, at its discretion, may require the MCE to provide the State with a detailed plan for resuming operations. In case of a catastrophic or natural disaster (including, but not limited to, fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist
activities), the MCE must resume normal business functions at the earliest possible time, not to exceed 30 calendar days. If deemed appropriate by the State, the MCE must coordinate with the State fiscal agent to restore the processing of claims by CoreMMIS (or the Indiana CoreMMIS, as applicable) if the claims processing capacity cannot be restored within the MCE’s system. In case of other disasters or system unavailability caused by the failure of systems and technologies within the MCE’s span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment, or electrical supply), the MCE must resume normal business functioning at the earliest possible time, not to exceed 10 calendar days.

The MCE’s responsibilities include, but are not limited to:

• Supporting immediate restoration and recovery of lost or corrupted data or software.

• Establishing and maintaining, in an electronic format, a daily and weekly backup that is adequate and secure for all computer software and operating programs; database tables; files; and system, operations, and user documentation.

• Demonstrating an ability to meet backup requirements by submitting and maintaining a Disaster Recovery Plan that addresses:
  – Checkpoint and restart capabilities;
  – Retention and storage of backup files and software;
  – Hardware backup for the servers;
  – Hardware backup for data entry equipment; and
  – Network backup for telecommunications.

• Coordinating required system operations with the State and its contractors, including backups of information sent or accepted, to ensure continuous eligibility, enrollment, and delivery of services.

• Providing the State with annually updated business resumption documents, such as:
  – Disaster recovery plans
  – Business continuity and contingency plans
  – Facility plans
  – Other related documents as identified by the State

**Member Enrollment, Capitation, and POWER Account Data Exchange**

The MCE is required to accept enrollment data in the HIPAA-compliant 834 electronic format. See the 834MCE Benefit Enrollment and Maintenance Transaction companion guide maintained by the State fiscal agent for details on the enrollment data exchanges specific to those programs. The MCE is responsible for loading the eligibility information into its claims system within five calendar days of receipt. The State fiscal agent produces enrollment roster change records seven days per week. Audit files generate twice a month for Hoosier Healthwise, on the 1st and 15th. Audit files for HIP and hospital PE generate on the first day of each month. Audit files provide a snapshot of the plans’ enrollment for a given report date, whereas the change records provide daily updates to member enrollment. MCEs are notified via email if there are systematic delays with the enrollment roster reporting. Emails generate to the same email addresses that receive the file transfer notices.

The MCE is required to accept capitation and State Personal Wellness and Responsibility (POWER) Account payment data in the HIPAA-compliant 820 electronic premium payment format. See the 820 MCE Capitation Payment Transaction companion guide or program-specific payment details.

Capitation and State POWER Account cycles run monthly for Hoosier Healthwise and HIP. The Hoosier Healthwise financial cycle for per member per month (PMPM) capitation payments begins the third Wednesday of each month, producing 820 detail reports on the following Saturday. Presumptive eligibility for pregnant women is processed as part of the Hoosier Healthwise cycle. Funds are then transferred via electronic funds transfer (EFT) to the MCE the middle of the following week after 820s are produced.
The Hoosier Healthwise 820 also encompasses capitation adjustments. A similar process occurs for HIP; except that that program’s financial cycle begins the second Wednesday of each month. The HIP cycle also includes the capitation payments made for Hospital PE Adult members. 820s are produced the subsequent Saturday, followed by the EFT by the middle of the next week. HIP PMPM capitation, State POWER Account payments, and any capitation or POWER Account adjustments are all included in the 820 process.

If recoupment adjustment dollar amounts exceed payments for a given cycle, any unfunded recoupments are stored until the next applicable financial cycle. For example, if Hoosier Healthwise capitation rate adjustments result in a greater dollar amount of recoupments than routine per-member, per-month payments, outgoing payments won’t generate until all the recoupments have been satisfied. Also note that HIP has two independent financial cycles for capitation and POWER Account payments. If, for example, PRF recoupments exceed State POWER Account payments, no State POWER Account dollars generate until all the recoupments have been satisfied. HIP capitation payments aren’t affected.

Capitation is always driven by MCE and PMP assignments. MCEs receive full- or half-month capitation for Hoosier Healthwise and PE members, depending on the number of days a member is assigned to the MCE for a given month. Full-month capitation is paid for 18 total days or more of a member’s assignment to the MCE. Half-month capitation is paid for 17 days or fewer. Days do not have to be consecutive, preventing multiple half-month capitation payments if a member has multiple assignments to an MCE in a given month. For example, if a member loses eligibility, then immediately regains eligibility, an assignment of 17 days or less results in a half-month capitation payment. The full-month rate is divided by two for the half-month rate. Capitation is not prorated by the exact number of days assigned.

HIP has no half-month capitation logic; capitation is always paid at a full month’s rate, regardless of when in the month the member’s assignment date falls.

For PEPW members, the two programs, PE and Hoosier Healthwise, must be considered separately. The MCE receives two capitation payments for all bisect members: one for PE and one for Hoosier Healthwise. Capitation is not driven by a program change; it is driven by the PMP assignment. The same applies for Hospital PE-Adults and HIP.

The MCE is responsible for verifying member eligibility and receipt of capitation and State POWER Account payments for each eligible member. The MCE must reconcile its eligibility and payment records monthly for HIP and Hoosier Healthwise. If the MCE discovers a discrepancy in eligibility, capitation, or State POWER Account information, the MCE must notify the State and the State fiscal agent within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after the State delivers the eligibility records. The MCE must return any capitation or POWER Account overpayments to the State within 45 calendar days of discovering the discrepancy. If the MCE receives enrollment information or capitation, and/or the State’s POWER Account contribution for a HIP member, the MCE is financially responsible for the member.

Enrollment may change at any time. For example, a Hoosier Healthwise or HIP member who is enrolled with an MCE on the 18th day of the month for an effective date on the first of the following month will appear on the MCE enrollment roster produced on or around the 18th. If the member loses eligibility before the eligibility can take effect, the deletion is reported on or around the same date the eligibility loss is reported to CoreMMIS from Indiana Client Eligibility System (ICES). Deleted records include an INS03 segment of 024.

**Capitation Adjustments – Systematic**

Capitation payments are subject to change even after they have been paid to the MCE. Most are performed systematically as in the case of retroactive capitation rates. The State may retroactively reset
Capitation rates for the MCEs. The State sends written notification to the fiscal agent’s managed care director. The notification includes the capitation categories, time period, newly calculated rate, and the affected MCE/region. Adjustments can apply to Hoosier Healthwise and HIP capitation rates. A flowchart of the capitation process is available on the MCO Question and Answer page at indiana Medicaid.com.

The State fiscal agent processes the rate changes in CoreMMIS. The systematic capitation reconciliation process then determines affected prior payments and creates recoupment adjustments. The corresponding payment adjustment is also created. All recoupment and payment adjustments are noted by reason codes that distinguish adjustment details from regular per member per month details in the MCE’s 820s. See applicable program capitation adjustment reason codes in Appendix A and Appendix B.

Capitation adjustments can also occur for eligibility-based scenarios:

- Member date of death reported retroactively (ICES)
- Member date of birth corrections (ICES)
- Retroactive member eligibility changes (aid category, level of care, benefit package)
- Retroactive MCE assignment changes

For example, a Hoosier Healthwise Package C member may become retroactively eligible for Package A. The capitation reconciliation process automatically detects the eligibility change and recoups the outdated rates, in addition to paying the updated rates.

**Capitation Adjustments – Manual**

Manual adjustments to monthly capitation payments are performed by the fiscal agent as required.

Manual adjustments are placed on hold status in CoreMMIS until reviewed and approved by the fiscal agent. Approved manual adjustments are activated before the capitation cycle.

**Hospital Assessment Fee – HIP 2.0**

The State increased certain hospital reimbursement rates to more closely reflect payment equivalent to the level of reimbursement, which would be paid under federal Medicare-allowed amounts. The State began to assess a hospital fee for two years for state fiscal year period beginning July 1, 2011, and ending June 30, 2013. The process was reinstated in 2014 to be effective retroactive from July 1, 2013, through June 30, 2015, and again reauthorized until 2017.

The CoreMMIS modification provides the capability to collect the fee, reconcile, and report the assessment fees obtained from the subset of hospital providers. Reimbursement methodology was modified for inpatient and outpatient hospital services provided by a hospital during the fee period to Medicaid members. This process applies to HIP 2.0, which in the aggregate will result in payments equivalent to the level of reimbursement that would be paid under federal Medicare payment principles during the reporting period.

This policy change resulted in the need to increase the amounts paid to Medicaid hospitals through the Hoosier Healthwise program and HIP 2.0, and to properly report on the increased reimbursements in accordance with the Hospital Assessment Fee (HAF) structure established by the state of Indiana.

**Inpatient/Outpatient Hospital Assessment Fee (HAF) Application Process**

**Inpatient process**
In 2015, HIP inpatient claims were paid using MS-DRGs and Medicare payment principles, excluding Medicare disproportionate share hospitals (DSH) and Medicare GME. In 2016, HAF-eligible hospitals is paid by MCEs using APR-DRGs and Medicaid enhanced payment (HAF factors built into reimbursement). The 3% rate reduction is no longer included in the capitation rates for HIP members and therefore, should not be incorporated into the base payment when HAF is in place. When the HAF payment is made via a supplemental payment – for example, in Hoosier Healthwise and Hoosier Care Connect – the 3% is currently still in place. The HAF or enhanced rate has been included in the 2016 capitation rates for all the HIP population. The enhanced rates have an effective date of January 1, 2016, and is paid by the MCEs beginning in February 2016 to cover dates of service beginning January 1, 2016.

Any claims paid by the MCEs during the month of January under the old rate methodology for dates of service after December 31, 2015, were retro adjusted with the new enhanced rates in February 2016. Mass adjustments processed claims using the Medicaid APR-DRG or LOC, and accounted for the difference between the initial base reimbursement rate and the enhanced HAF-adjusted amount. The IHCP’s rate-setting contractor, Myers and Stauffer, developed a tool that guides MCEs how to configure their systems, and each MCE programs their system accordingly.

Plan reimbursement to hospitals reflected in the HIP 2.0 2016 capitation rates

Inpatient change applies to all HIP 2.0 populations (including Hospital Presumptive Eligibility)

- Expansion: enhanced (with HAF) Medicaid (directly paid to hospitals)
- Low-income parents and caretakers: enhanced (with HAF) Medicaid (directly paid to hospitals)

Hospital Details and Claims

- HAF-eligible hospitals only (list of eligible hospitals supplied by Myers and Stauffer)
- All non-HAF-eligible hospitals continue to be reimbursed at their current rates and methodologies for inpatient and outpatient services rendered to all HIP members.
- HAF applies only to claims billed on a UB-04 (institutional claim form); physician and professional services are excluded.

The current HAF factors to be used in this new distribution method are as follows:

- The adjustment factor for the inpatient DRG base rate is 2.1
- The adjustment factor for the inpatient rehabilitation LOC rate is 2.6
- The adjustment factor for the inpatient burn LOC rate is 1.0
- The adjustment factor for the inpatient psychiatric LOC rate is 2.2.

Outpatient process

The enhanced HAF rate was implemented March 1, 2016, for outpatient claims, requiring Milliman to make adjustments to the capitation rates. See the Hospital Assessment Fee module for more information. Until March 1, 2016, outpatient payments were made in the same manner as the current methodology in place, which will continue a supplemental/add-on for the low-income parents and caretakers population (details follow). Interim payments are based on reimbursement reflected in the current CY 2016 capitation rates.

The calculation for outpatient claims is the Medicaid reimbursement rate multiplied by the outpatient HAF factor of 2.7.

For HIP 2.0 enrollees, the plans have been directed to pay hospitals as follows:
• Before March 1, 2016 – Outpatient reimbursement differs by population:
  – Expansion: Medicare payment principles, but excluding Medicare GME or DSH
  – Low-income parents and caretakers: base Medicaid, without HAF factors, less 3%. For this population, the MCEs also receive a pass-through payment that they will send on to providers, representing the difference between enhanced and base Medicaid.
• March 1, 2016, and onward – Outpatient change applies to all HIP 2.0 populations:
  – Expansion: enhanced (with HAF) Medicaid (directly paid to hospitals)
  – Low-income parents and caretakers: enhanced (with HAF) Medicaid (directly paid to hospitals)

**Hospital Details and Bill Type**

• HAF-eligible hospitals only (list of eligible hospitals supplied by Myers and Stauffer)
• All non-HAF eligible hospitals continue to be reimbursed at their current rates and methodologies for inpatient and outpatient services rendered to all HIP members.
• HAF enhanced reimbursement does not apply to clinical laboratory services provided in an outpatient setting.
• HAF is applicable for the following bill types:
  – How to code bill type: If ‘110’<=bill_type<='129' then patient='INP' and if ‘130’<=bill_type<='149' or ‘850’<=bill_type<='859' then patient='OUT'.

**Individual Claim HAF Eligibility**

1. Using the Indiana Hospital Association (IHA) report:
   a. Determine claims and their HAF criteria eligibility (provides all the provider Medicaid IDs).
      i. Usually, there is only one NPI associated with each Medicaid ID; it is possible to have multiple IDs.
      ii. If there are multiple IDs, split the dollars out at the NPI level, not at the Medicaid ID level.
2. Filter down the claims that are serviced in the time period specified:
   b. Typically, July 1 through June 30 dates are used.
      i. For inpatient stays, use the admission date, not the service date, to ensure that the entire claim is kept together.
      ii. Remove any claims paid after the paid-date cutoff (often referred to as runout).

Traditionally, the paid-date cutoff is June 30th of the next year to allow a full year of runout.

In the report, the costs should be categorized as inpatient and outpatient using the bill type of the claim. Bill type was chosen because every facility claim should have one, and it is an industry standard.

If the bill type is between:
• Numbers 110 to 129 (Costs fall under Inpatient)
• Numbers 130 to 149 or 850 to 859 (Costs fall under Outpatient)

The claims should be summarized at the NPI level, and the report should contain the following fields:
• Indiana Medicaid Provider ID
• Provider Medicare ID
• NPI
• Provider address (provider’s city, state, Zip, Zip+4 (if available)
• Total paid inpatient claims
• Total paid outpatient claims

Lastly, the claim detail used to build the report should be kept in case the State has further questions about the submission.

Table 20.1 can be used to identify an inpatient or outpatient claim that would be eligible for HAF.

<table>
<thead>
<tr>
<th>Inpatient Claim</th>
<th>1st Digit Bill Type</th>
<th>2nd Digit Bill Type</th>
<th>3rd Digit Bill Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>0 – Nonpayment or Zero Claims</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>1 – Admit Through Discharge Claim</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>2 – Interim (First Claim)</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>3 – Interim (Continuing Claims)</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>4 – Interim (Last Claim)</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>5 – Late Charge Only</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>7 – Replacement of Prior Claim or Corrected Claim</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>8 – Void or Cancel of a Prior Claim</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>1 – Inpatient (Medicare Part A)</td>
<td>9 – Final Claim for a Home Health PPS Episode</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>0 – Nonpayment or Zero Claims</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>1 – Admit Through Discharge Claim</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>2 – Interim (First Claim)</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>3 – Interim (Continuing Claims)</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>4 – Interim (Last Claim)</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>5 – Late Charge Only</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>7 – Replacement of Prior Claim or Corrected Claim</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>8 – Void or Cancel of a Prior Claim</td>
<td></td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>2 – Inpatient (Medicare Part B)</td>
<td>9 – Final Claim for a Home Health PPS Episode</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Claim</th>
<th>1st Digit Bill Type</th>
<th>0 – Nonpayment or Zero Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Hospital</td>
<td>3 – Outpatient</td>
<td>1 – Admit Through Discharge Claim</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>3 – Outpatient</td>
<td>2 – Interim (First Claim)</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>3 – Outpatient</td>
<td>3 – Interim (Continuing Claims)</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>3 – Outpatient</td>
<td>4 – Interim (Last Claim)</td>
</tr>
<tr>
<td>1 – Hospital</td>
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</tr>
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<td>1 – Hospital</td>
<td>3 – Outpatient</td>
<td>9 – Final Claim for a Home Health PPS Episode</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>4 – Other (Medicare Part B)</td>
<td>0 – Nonpayment or Zero Claims</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>4 – Other (Medicare Part B)</td>
<td>1 – Admit Through Discharge Claim</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>4 – Other (Medicare Part B)</td>
<td>2 – Interim (First Claim)</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>4 – Other (Medicare Part B)</td>
<td>3 – Interim (Continuing Claims)</td>
</tr>
<tr>
<td>1 – Hospital</td>
<td>4 – Other (Medicare Part B)</td>
<td>4 – Interim (Last Claim)</td>
</tr>
</tbody>
</table>
Member counts used in the calculation of the HAF payments are considered a “snapshot” of enrollment figures for the day that the counts are captured. Members who receive a capitation payment with a capitation reason code of ‘PN’ – normal capitation payment, or ‘PR’ – retroactive capitation payment are used in the calculation as long as the capitation category is one of the codes listed in Table 20.2.

Table 20.2 – HAF Capitation Categories

<table>
<thead>
<tr>
<th>HAF Capitation Categories</th>
<th>HAF Capitation Categories</th>
<th>HAF Capitation Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>CN</td>
<td>UM</td>
</tr>
<tr>
<td>A6</td>
<td>NB</td>
<td>UN</td>
</tr>
<tr>
<td>AF</td>
<td>TN</td>
<td>UT</td>
</tr>
<tr>
<td>AM</td>
<td>U1</td>
<td></td>
</tr>
</tbody>
</table>
HAF Capitation Categories | HAF Capitation Categories | HAF Capitation Categories
--- | --- | ---
C1 | U6 |  
C6 | UF |  

All other capitation category codes are excluded from the HAF member counting process as are all other payment reasons. Members who have half-month capitation are also excluded. The HAF payment is as follows:

**HAF Rate x Member Count = HAF Expenditure Payment**

The expenditures are reported monthly on the 835. These expenditures are reported with a negative symbol in front of the expenditure amount. Per the *5010 835 Implementation Guide* the amounts are negative because of an increase in the payment. The two-digit adjustment reason code that is reported in the PLB segment of the 835 is LS (lump sum) for the HAF expenditure payments and IP (incentive premium) payment for the supplemental expenditures.

In 2014, the HAF reconciliation process was automated. This process handles retroactive HAF rates systematically, eliminating the manual process. The system has the ability to account for multiple expenditures or accounts receivables within the month. For example, if the HAF rate is adjusted multiple times, all expenditures or account receivables related to the month are accounted for in the reconciliation process.

**Affordable Care Act PCP payments**

One of the *Affordable Care Act* (ACA) initiatives implemented in 2013 was to increase reimbursement for primary care providers who provide services that are billed under specific E&M and vaccine administration codes. This program requires providers to self-attest to (1) being board certified or (2) having 60% of billed procedure codes during the past year being the qualifying procedure codes.

Myers and Stauffer determines the reimbursement calculations and transmits the information to CoreMMIS on a quarterly basis. Payments are then generated to the MCEs via the 820 premium payment transaction. Myers and Stauffer also posts reports for the MCEs, detailing the payment information.

| Table 20.3 – ACA expenditure and accounts receivable codes for MCEs |
|---|---|
| **ACA Expenditure Codes** | **ACA Accounts Receivable Codes** |
| 8396 System payment to an MCE for Evaluation and Management | 8579 AR setup because of an overpayment to an MCE for Evaluation and Management |
| 8397 Manual payment to an MCE for Evaluation and Management | 8580 AR setup because of an overpayment to an MCE for Vaccine Administration Codes |
| 8710 System payment to an MCE for Vaccine Administration Codes |  |
| 8711 Manual payment to an MCE for Vaccine Administration Codes |  |
POWER Account Systems – Healthy Indiana Plan

The MCE must have an information system that is capable of automating the required POWER Account transactions, including the 820, 834, and POWER Account Reconciliation File (PRF) transactions, in compliance with the data specifications set forth in the State fiscal agent’s companion guides. The MCE must provide real-time access to member POWER Account balances in a secure format.

The MCE must have policies, procedures, and mechanisms in place to support the POWER Account requirements set forth in this manual and the State fiscal agent’s companion guides. The MCE must have policies, procedures and mechanisms in place to support accuracy, security and privacy in the MCE’s administration of member POWER Accounts.

Supplemental HIP report definitions and layouts created to assist the MCEs with maintenance of the HIP program are included in Appendix K: Report Definitions for Fiscal Agent Generated HIP Reports. These are primarily member eligibility reports designed to help the MCEs reconcile member enrollment and POWER Account data in their systems.

IHCP Fee Schedule Information

The Indiana Health Coverage Programs (IHCP) fee schedule information provides information about all Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and American Dental Association (ADA) procedure codes that are currently recognized by the IHCP. The information provided on the IHCP fee schedule reflects the most current allowed rate for all procedure codes pertinent to CMS-1500, 837 professional, and dental billers. The IHCP fee schedule contains the following information:

• Procedure code
• Certain modifiers
• Taxonomy
• Program coverage indicator
• Program prior authorization (PA) indicator
• Pricing indicator
• Pricing effective date
• Pricing end date
• Fee schedule amount
• Anesthesia base units, if applicable

The IHCP fee schedule also contains ambulatory surgical center (ASC) rates that are used for paying outpatient surgery claims. The rates associated with each of the ASCs, along with specific ASC assignments by procedure code, are on the fee schedule. The fee schedule can be accessed using the quick links section on indianamedicaid.com.

The IHCP information and the ASC rates are on the IHCP website under the Fee Schedule section. The IHCP fee schedule information is updated monthly on the last Sunday of each month and promoted to the web on the following Tuesday.

CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association
Supplemental IHCP Rate Information

MCEs also have access to the following supplemental IHCP rate information through File Exchange. The supplemental rate files contain rate segments in effect as of January 1, 2007, and after. As rates change, the historical rate segments are maintained for rate files available through File Exchange. Rate updates occur with the monthly IHCP fee schedule update.

Supplemental rate information for inpatient pricing includes the following:

• Diagnosis-related group (DRG) base rates (universal base rates and provider specific base rates), weights and average lengths of stay.
• Provider-specific rates apply to certain children’s hospitals.
• Capital cost per diem for calculating capital cost payment for hospital inpatient claims.
• Provider-specific medical education rates to calculate the medical education payment for hospital inpatient claims.
• Medical education payments are given for hospitals that are classified as teaching facilities.
• Inpatient level-of-care rates including psychiatric, burn, and rehabilitation per diems.
• Provider-specific inpatient level-of-care rates including psychiatric, burn, and long-term acute care per diems.
• Provider-specific cost-to-charge ratios used to calculate cost outlier payments for hospital inpatient claims.
• Marginal cost factor percentage used to calculate cost outlier payments for hospital inpatient claims.
• Cost outlier threshold used to calculate cost outlier payments for hospital inpatient claims.
• Revenue flat-fee rates associated with treatment room revenue codes, add-on revenue codes, and stand-alone revenue codes for payment of outpatient claims.
• Max fee rates for technical component (modifier TC) of radiology services provided in outpatient hospital settings.
• Lab-fee rates that are used in payment of laboratory services performed in outpatient hospital settings.
• Max fee rates for chemotherapy administration in outpatient hospital settings.
• The supplemental IHCP rate information will also include nursing facility level-of-care rates used for reimbursement of long-term care claims.

Claims Processing

The MCE must have policies and procedures to audit and monitor providers’ encounter claim submissions for accuracy, completeness, and timeliness of claims information. The MCE must have policies and procedures regarding claims submissions and processing that integrate with and support the internal quality management and improvement plan.

Claims Processing Capability

The MCE must demonstrate and maintain the capability to process and pay provider claims for services rendered to the MCE’s members, in compliance with HIPAA, including NPI. The MCE must be able to price specific procedures or encounters (depending on the agreement between the providers and the MCE) and to maintain detailed records of remittances to providers. The State must preapprove the MCE’s delegation of any claims processing function to a subcontractor, and the MCE must notify
the State and secure the State’s approval of any change to subcontracting arrangements for claims processing.

The MCE must develop policies and procedures to monitor claims adjudication accuracy and must submit its policies and procedures for monitoring its claims adjudication accuracy to the State for review and approval. The MCE must also submit its policies and procedures for monitoring its claims adjudication accuracy against its own internal criteria. The State recommends that the MCE’s standards for accuracy of internal claims processing and financial accuracy be no less than 95%.

The out-of-network provider filing limit for submission of claims to the MCE is 12 months from the date of service. This conforms with the filing limit under the Medicaid state plan [42 CFR 447.45(d;)(4)]. The in-network provider filing limit is established in the MCE’s provider agreements pursuant to the guidelines set forth in Section 8.4 in the Scope of Work, which generally require in-network providers to submit claims within 90 calendar days from the date of service. MCEs have up to 15 months from the date of service to submit encounter data to the fiscal agent. Voids and replacements of previously paid encounter claims can be submitted up to two years from the “to” date of service on the claim.

The MCE must have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

Compliance with State and Federal Claims Processing Regulations

The MCE must also comply with State and federal claims processing regulations such as the following:

- The MCE must have a claims processing system to support electronic claims submission for in- and out-of-network providers.
- The MCE’s system must process all claim types, such as professional and institutional.
- The MCE must comply with claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, and any applicable federal regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information.
- The MCE must ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for providers.
- The MCE is prohibited from requiring out-of-network providers to establish an MCE-specific provider number to receive payment for claims submitted.

Claims Payment Timelines

The MCE must pay or deny electronically filed clean claims within 21 calendar days of receipt. (As set forth in IC 12-15-13.1.6, a clean claim is one in which all information required for processing the claim is on the claim form.) The MCE must pay or deny clean paper claims within 30 calendar days of receipt. If the MCE fails to pay or deny a clean claim within these time frames and subsequently reimburses for any services itemized within the claim, the MCE must also pay the provider interest, as required under IC 12-15-13-1.7(d). The MCE must pay interest on all clean claims paid late (for example, in- or out-of-network claims) for which the MCE is responsible, unless the MCE and provider have made alternate written payment arrangements. The State reserves the right to perform a random-sample audit of all claims, and expects the audited MCE to fully comply with the requirements of the audit by providing all requested documentation, including provider claims and encounters submissions.
**Encounter Data Submission**

The MCE must have policies, procedures, and mechanisms in place to support the following encounter data reporting process and in the State fiscal agent’s companion guides. MCEs must strictly adhere to the standards set forth in the State fiscal agent’s companion guides for professional and institutional claims, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by the State).

The MCE must submit institutional, pharmacy (for HIP only), dental, vision, transportation, and other professional encounter claims in an electronic format that adheres to the data specifications in the State fiscal agent’s *Companion Guides* and any other state or federally mandated electronic claims submission standards, or be subject to liquidated damages. A diagnosis code and DRG, as applicable, is a required data field and must be included on all encounter claims. The MCE’s encounter claims must include the National Drug Codes (NDCs) when an encounter involves products or services with NDCs, including medical and institutional claims where medications with NDCs are included and billed separately. An indication of claim payment status and an identification of claim type (for example, original, void, or replacement) is also required, in the form designated by the State fiscal agent. For HIP claims, the amount of POWER Account funds used to pay the claim must be designated on each encounter claim.

The MCE must submit an encounter claim to the State fiscal agent for every service rendered to a member for which the MCE either paid or denied reimbursement. Encounter data provides reports of individual patient encounters with the MCE’s healthcare network.

These claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers’ identification numbers, and other detailed claims data required for quality improvement monitoring and utilization analysis. See applicable sections for claims compliance and qualitative analysis.

Information about compliance with encounter claim submission follows. Payment of liquidated damages does not relieve the MCE of its responsibility to provide complete and accurate encounter claims as required under the contract.

**Note:** OptumRx is responsible for processing all pharmacy claims and data extracts for the Hoosier Healthwise program. Furthermore, legend and nonlegend drugs are covered by OptumRx under the pharmacy benefit.

**Weekly Batch Submission**

The MCE must submit via secure FTP at least one batch of encounter claims before 5 p.m. on Wednesday of each week, for paid and denied institutional, pharmacy, and professional claims, in accordance with the terms of the contract and scope of work. If, during any calendar month, the MCE fails to submit all encounter claims on a weekly basis when due, unless the delay is caused by technical difficulties of the office, the MCE pays liquidated damages in the amount of $4,850 for each claim type for which shadow and encounter claims were not submitted in a timely manner.

**Precycle Edits**

For each weekly encounter claim batch submission, the MCE must achieve no less than 98% compliance rate with pre-cycle edits. The State assesses pre-cycle edit compliance based on the average compliance rate of the weekly encounter claims batch submissions made during the calendar month. If the average compliance rate is less than 98%, the MCE pays liquidated damages in the amount of $4,850 per each claim type.
The MCE Technical Meeting provides a forum for MCE technical support staff to participate in the development of the data exchange process and ask questions related to data exchange issues, including encounter data transmission and reporting issues. The MCE must report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated State contract compliance analyst.

The State will use the encounter data to make tactical and strategic decisions related to the Hoosier Healthwise and HIP program, including primarily using encounter data to calculate MCE’s future capitation rates. It will also use encounter data to calculate incentive payments to the MCE, monitor quality, and assess the MCE’s contract compliance.

Additional requirements for encounter claims include the following:

- **Timeliness of Encounter Claims Submission to the State Fiscal Agent** – MCEs must submit all encounter claims within 15 months of the earliest date of service on the claim. Void/replacement claims for Hoosier Healthwise members must be submitted within two years from the date of service. In addition, MCEs must submit 100% of adjudicated claims within 30 calendar days of adjudication. The State will require the MCE to submit a corrective action plan to address timeliness issues and will assess liquidated damages if the MCE fails to comply with pre-cycle edits.

- **Compliance with Pre-cycle Edits** – The State fiscal agent will assess each encounter claim for compliance with pre-cycle edits. The MCE must correct and resubmit any encounter claims that do not pass the pre-cycle edits. The State will require MCEs to submit a corrective action plan to address noncompliance issues and will assess liquidated damages if the MCE fails to comply with pre-cycle edits.

- **Accuracy of Encounter Claims Detail** – MCEs must demonstrate that it implements policies and procedures to ensure that encounter claims represent the services provided and that the claims are accurately adjudicated according to the MCE’s internal standards and all State and federal requirements. The State reserves the right to monitor encounter claims for accuracy against the MCE’s internal criteria and its level of adjudication accuracy. The State will regularly monitor accuracy by reviewing the MCE’s compliance with its internal policies and procedures for ensuring accurate encounter claims submissions and by performing a random sample audit of all claims. The State expects MCEs to fully comply with the requirements of the review and audit and to provide all requested documentation, including provider and encounter claims submissions and medical records. The State will require MCEs to submit a corrective action plan to address noncompliance issues and will assess liquidated damages if the MCE fails to comply with encounter claims accuracy reporting standards.

- **Completeness of Encounter Claims Data** – MCEs must have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, for example, for every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions. MCEs must also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

- **Pharmacy Encounter Claims** – To facilitate the State’s collection of Medicaid drug rebates, the MCE must submit pharmacy encounter data to the State in a timely, accurate, and complete manner. At minimum, the following information must be provided: (i) the total number of units of each dosage form; (ii) strength and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to MCE members; and (iii) such other data that the Secretary of CMS determines necessary for the State to access rebates. If the MCE fails to provide required files for drug rebate purposes in a timely, accurate, and complete manner, the MCE shall be responsible for the loss of the rebate money and/or interest entitled to the State.

### Encounter Data Considerations for HIP
HIP MCEs currently submit encounter data to the fiscal agent. The claims data is then stored on tables in CoreMMIS. HIP encounters are not adjudicated like Hoosier Healthwise; for example, they are not subjected to further editing and auditing by CoreMMIS.

Claim Elements Unique to Hoosier Healthwise Encounter Data

Hoosier Healthwise encounter data mirrors fee-for-service (FFS) claims, ensuring the continuity of Medicaid data collected. HIP claims are adjudicated by MCEs at Medicare rates, plus the HIP has services unique to that program; therefore, HIP encounter claims are only minimally edited when submitted to CoreMMIS. Additional claim filing elements, unique to Hoosier Healthwise encounter data processing and submission, are described as follows:

The MCE Identification Number and Region Identifier is assigned to an MCE when it enrolls in Hoosier Healthwise. This 10-digit number’s 10th digit denotes the geographic region of the state where the MCE is contracted to provide services. The MCE ID and region identifier are required on all encounter-data submissions.

Value codes and value-code amounts are required on the electronic 837 institutional claim submission format to designate the MCE’s reimbursement and actual amount paid on the claim. Omission or incorrect data in the value-code fields causes the claim to adjudicate with a denied status for one of the following reasons:

• Value code missing
• Value-code amount missing
• Value-code amount invalid

The Z codes are located on table CD DSC VALUE and are specific to encounter data. These codes are located in the UB-editor and found that Value Code from Y5 – ZZ, is considered “Reserved for Assignment by the NUBC.” which means the following values are unique to Indiana. Their corresponding claim types are as follows:

• Z1 – Inpatient diagnosis-related grouping (DRG)
• Z2 – Level of care (LOC)
• Z3 – Inpatient per diem
• Z4 – Outpatient
• Z5 – Nursing home (NH) or long-term care (LTC) facility
• Z6 – Home

Coordination of Benefits Details

• MCEs must follow the 837 COB format and include their encounter data in the coordination of benefits (COB) loops of the transaction.
• MCEs format the 837 with their payment information in the first iteration of the COB loops before submitting encounter data.
• Encounter data is accepted only from MCEs and rejected from all others.
• MCEs send only claims that have been paid or denied at the claim and detail level in their systems.
• MCEs exclude claims that have not been finalized in their systems.
Additional claim elements that need to be included for Hoosier Healthwise encounter data can be found in the, 837P Health Care Claim: Professional Transaction and 837I: Health Care Claim: Institutional Transaction companion guides.

**Encounters for Units of Service over 9999**

CoreMMIS is limited to 9999 units of service on the front end processing. If a service is billed at the header level with units over 9999 limitation, the Hoosier Healthwise encounter will reject. To bypass the front end processing, the MCEs are required to submit encounters with the multiple details lines to break out the units under the 9999 limitation. The encounter is accepted into CoreMMIS for back end processing and available for reporting purposes. An example of this type of encounter would be for services related to blood factors.

**Encounters Voids for Services Payable as FFS**

The State fiscal agent redirects providers to the MCEs when providers are having claims deny because of duplicate encounters for FFS-payable services that are less than two years old. MCEs must then void the encounter claims so that providers can resubmit the services as FFS and bypass the duplicate claims editing.

For services more than two years old, the fiscal agent’s Provider Relations team will work with the provider and the MCE to verify common agreement that the claim, indeed, needs to be voided. After all parties agree, the Client Services team will submit a special batch request to the State Care Programs and Claims teams for their approval. The provider is notified after the approval is obtained, the void is completed, and the special batch claim is processed.

**Capitated Provider Encounters**

The MCEs must submit CMS-1500 claims that report services rendered under a Hoosier Healthwise provider-capitated arrangement by sending the LOOP 2320 Segment CAS with ARC code 24 and $0.00 as the billed amount.

**Fully Denied Hoosier Healthwise and HIP Claims**

Claims submitted as encounter data are those claims that the MCE has accepted for payment. If the MCE has a claim that contains denied and paid details, the claim is submitted as a paid encounter. MCEs must submit encounter data to report services rendered within the health plan that were included in the capitation paid to a particular provider.

MCEs are required to submit monthly data files of the denied professional and institutional Hoosier Healthwise encounter data to the State fiscal agent. MCEs are allowed to submit the denied encounters in their regular encounter files and the monthly denied encounter filing limit still applies.

Hoosier Healthwise fully denied professional and institutional encounter claims are indicated in the 837 transaction in one of the following manners:

- Loop 2300 HCP01 = 00 and HCP02 = 0
- All claim details contain SVD02 = 0 and CAS02 = ARC code requested by MCE to identify their MCE denied details.

HIP fully denied professional and institutional encounter claims are indicated in the 837 transaction at the detail only:

- All claim details contain SVD02 = 0 and CAS02 = ARC code requested by MCE to identify their MCE denied details.
The fully denied encounter claims are processed through the front end (EDI) editing bypassing the MCE ARC logic and applied edit 292. The denied encounter data is stored in a separate table with Claim ID beginning with 24 and is not viewable in CoreMMIS. The denied encounter data is used by the State for reporting purposes. The fiscal agent will not process these claims through CoreMMIS and will not be applying the back end claim edits and audits.

MCEs have up to 15 months from the date of service to submit denied Hoosier Healthwise encounter data to the fiscal agent. Voids and replacements of previously paid encounter claims can be submitted up to two years from the “to” date of service on the claim.

**Denied Encounters and Rejected Common Definitions**

Rejected claims must not be submitted as encounter data. A rejected claim is a claim that the MCE cannot accept into its inventory for future adjudication. Rejected claims include:

- Misdirected claims: A claim submitted to the wrong entity for processing (for example, claim submitted to the wrong MCE).
- Claims for members not currently enrolled.
- Claims for which the MCE or Managed Behavioral Healthcare Organization (MBHO) is not financially responsible (for example, a provider submits a claim to the MCE for an MBHO covered service).
- Unclean claims (a claim in which all the information required for processing is not present – per IC 12-15-13.0.6).

Claims that were rejected, or claims that were received and denied by the MCE because they did not pass HIPAA compliance edits must not be submitted as encounters. These rejected claims correlate with the fiscal agent’s electronic data interchange (EDI) Edit #132 (non-HIPAA Compliant transaction). They will not pass the fiscal agent’s pre-cycle edits. The MCE must conduct provider outreach and education to assist the provider with resubmitting a corrected claim to secure payment. Therefore, this subsequent submission would be available for utilization data as either a paid encounter or denied encounter from resubmission.

Denied encounters include all clean claims that do not fall into one of the aforementioned categories and must be submitted as encounter data. This includes all clean paid claims (partially paid and fully paid) and all clean fully denied claims. A clean claim is a claim submitted by a provider for payment that can be adjudicated without obtaining additional information from the provider of the service or a third party.

**HIPAA Adjustment Reason Codes**

The MCE Adjustment Reason Codes (ARCs) are used for denied details in the paid encounter processing. Each MCE is required to maintain and provide its applicable ARCs to the State fiscal agent. The MCE’s ARCs are utilized in the encounter claim processing at the detail level.

The fiscal agent EDI Solutions Unit coordinates with the MCEs and the fiscal agent Systems Unit to incorporate the new ARC into the MCE’s ARC tables. EDI sends an ARC Code Update form to the MCEs one week before January, April, July, and October. Each MCE completes the form, listing new ARC codes to indicate denied details for the encounter claim processing. The MCE can also designate if no updates. Email notification is sent to the fiscal agent EDI team.

ARC update forms must be emailed by the 10th of each month listed previously to the following address: INXIXElectronicSolution@dxc.com.
Delivery Capitation Payments

Providers are required to bill any inpatient stay that is fewer than 24 hours as an outpatient service. Therefore, when a member has an inpatient delivery stay of fewer than 24 hours, the inpatient stay must be billed as an outpatient service for dates of delivery before January 1, 2013. For dates of delivery after January 1, 2013, delivery capitation payments are included in the regular monthly capitation payment.

When an MCE becomes aware of a claim for an inpatient delivery stay that is fewer than 24 hours with a date of delivery in 2012 or before, the MCE must inform the fiscal agent of the inpatient stay. The MCE must notify the fiscal agent by downloading and completing the Delivery Capitation Request form from the MCO Question and Answer page at indianamedicaid.com.

The completed form must be sent by email to the contact names for the fiscal agent listed on the form. The fiscal agent then sends an email to the MCE confirming that the completed form has been received.

The fiscal agent must confirm the following before manually issuing payment:

1. An outpatient delivery encounter claim has adjudicated as paid through CoreMMIS.
2. There are no paid inpatient delivery encounter claims in CoreMMIS history for the member on the reported date of service.
3. There are no other delivery capitation payments made on behalf of the member within the last nine months.

After the fiscal agent has confirmed these items, the fiscal agent must execute the manual process to ensure that the MCE receives delivery capitation payment for the member. The fiscal agent ensures that the delivery capitation payment is issued during the capitation cycle following the verification process.

Encounter Data Edits and Audits

Hoosier Healthwise encounter data is subjected to appropriate system edits to ensure that data is valid. These edits fall into the following two broad categories:

- Electronic claim capture (ECC) pre-cycle edits
- Claim resolution edits and audits (also referred to as back-end edits)

Pre-cycle editing establishes the presence and validity of critical data elements before the claim’s acceptance into CoreMMIS. For example, to pass the pre-cycle edit, the Member ID field must contain a valid combination of numeric characters recognized by CoreMMIS. The pre-cycle editing process does not attempt to link the number to a specific member’s eligibility or other information. The ECC pre-cycle edits for encounter data are identical to those in FFS electronic claim submission (ECS) claims, except for the addition of two edits created for encounter data: MCE ID MISSING and MCE ID INVALID. The pre-cycle edits are described in the Companion Guide: Electronic Data Interchange Reports and Acknowledgements.

The EDI translator used by the fiscal agent is EDIFECS. Information about this initiative is available on the MCO Question and Answer page at indianamedicaid.com and is updated regularly.

Claim resolution editing and auditing validates information specific to a particular enrollee’s IHCP program eligibility, subprogram affiliation, and claim history. These edits and audits are designed to support benefit limits and conditions of payment in State and federal requirements and are described fully in the fiscal agent Claim Edits and Audits data file. For example, a claim with a Member ID...
accepted in CoreMMIS during pre-cycle editing may be denied during claim resolution editing if the member was ineligible for benefits on the date of service, or if the member’s name or Member ID on the claim did not match the name or Member ID on file in CoreMMIS.

The State fiscal agent provides quarterly claim edit and audit information via File Exchange that includes the historical and current editing documentation as defined by the State and coded in CoreMMIS.

In IHCP’s FFS claims processing environment, generating system edits and audits causes claims to be suspended for review, pended to request additional information, or denied. In the encounter data environment, claims are subjected to the same edit and audit criteria for data collection, utilization, and program comparison. Because encounter data has been fully adjudicated by the MCE, it adjudicates in CoreMMIS as paid or denied.

The FFS edits and audits related to validity of data, member eligibility, provider enrollment, or duplicate claim submissions are also active for encounter data claims. FFS audits limiting duration or frequency of specific services, restricting place of service, or requiring prior authorization are inactive, or post and pay for encounter data. Claims that are potential (but not exact) duplicates adjudicate as paid, because the MCE has determined the validity of the paid claim before its submission as encounter data.

The disposition of each edit and audit applicable to encounter data is recommended by the fiscal agent managed care director or designee, and approved by the State managed care director or designee. MCEs can request a review of the disposition of a specific edit or audit by submitting a request to the State’s fiscal agent managed care director.

Generation of the FFS edits and audits in an encounter data processing environment causes claims to adjudicate with a paid or denied status in CoreMMIS, even though payments are not actually issued. Encounter data is not suspended or pended for review because it reports claims payments adjudicated by MCEs to their contracted and non-contracted providers.

**Encounter Data Output Documents**

CoreMMIS acknowledges each encounter submitted by the MCE. This acknowledgment includes the Submission Summary Report, an electronic Remittance Advice (RA) and the 835 Remittance Advice Transaction.

**Submission Summary Report**

The Submission Summary Report shows claims accepted in CoreMMIS for processing in addition to claims rejected in the pre-cycle editing process. Error code descriptions are in the 835 Health Care Claim Payment/Advice Transaction companion guide. The Submission Summary Report is the basis for the application of liquidated damages that may be applied, at the discretion of the State, if the acceptance rate falls below 98% for any single batch submission.

**Remittance Advice**

The 835 electronic remittance advice (RA) is generated for all claims accepted and adjudicated in CoreMMIS. Because encounter data is adjudicated with either a paid or denied disposition, the RA for these claims indicates the disposition.

The 835 is posted after the financial cycle is completed on the weekend, acknowledging the claims processed during the previous week’s claim cycle. It is then available on the File Exchange server or the dial-up server (depending upon how the trading partner is set up).
The 835s remain on the File Exchange server for 30 days unless the trading partner deletes them. It is very important that the plans download files in a timely manner. The files remain on the dial-up server until the trading partner downloads are complete. The cut-off time for claims to be included in the weekly financial cycle is Wednesday at 4 p.m.

The fiscal agent business objects reporting unit supplies the MCEs a weekly 835 supplemental file that provides detail descriptions of the back end edits that were applied to the adjudicated MCE’s paid and denied encounters. This file helps the MCEs reconcile their Hoosier Healthwise encounter claims errors.

**Encounter Data Corrections and Resubmissions**

MCEs must have a procedure in place to review the Submission Summary Reports and RA files previously described to identify claims denied in either the precycle or adjudication processes. The Submission Summary Reports references error codes contained in the 835 Health Care Claim Payment/Advice Transaction. The MCE may resubmit the corrected claim in the next batch submission.

CMS-1500 claims containing paid and denied details may be completely resubmitted or denied details only resubmitted. Resubmitted details on claims that adjudicated with a paid status deny as duplicates on the resubmission.

UB-04 claims are not adjudicated at the detail level, so denied elements must be corrected and the entire claim resubmitted.

MCEs may bring questions about any aspects of encounter data submission and adjudication to the monthly MCE Technical Meeting.

**Encounter Data Adjustments**

The void and replacement process through 837 Professional and Encounter Claim Transaction allows MCEs the ability to adjust or reverse an adjudicated Hoosier Healthwise claim with a paid status. Additional claim filing elements, unique to Hoosier Healthwise encounter data adjustments, are described as follows:

- The MCE ID, provider ID, and State region must appear on the replacement exactly as they appear on the claim being replaced. If the NPI is used on the claim, the taxonomy and service location ZIP Code+4 on the replacement must be identical to those on the claim being replaced.
- The MCE ID, provider ID, State region, and member information on a void must be identical to the same information on the claim being voided. If the NPI is used on the claim, the taxonomy and service location ZIP Code +4 on the void and on the claim being voided must be identical.
- The type of claim on the void or replacement must be the same type on the claim being voided or replaced.
- The void or replacement cannot be older than two years from the dates of service on the claim being voided or replaced.
- The void or replacement request must be completed against the most recent occurrence of the bill.
- The void or replacement request must be for an IHCP claim that is found in the database.
- A void cannot be processed against a claim that denied in CoreMMIS.
- A replacement request cannot be performed against a claim that denied because of a previous void request.
• Additional instructions for void and replacement, as well as information about file formats, are in the 837P Health Care Claim: Professional Transaction and 837I Health Care Claim: Institutional Transaction, companion guides.

Third-Party Liability (TPL)

If a member is also covered by another insurer, the MCE is fully responsible for coordinating benefits so as to maximize the utilization of third-party coverage. The MCE must share information regarding its members, especially those with special healthcare needs, with other payers as specified by the State and in accordance with 42 CFR 438.208(b). In the process of coordinating care, the MCE must protect each member’s privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164. The MCE is responsible for payment of the member's coinsurance, deductibles, copayments and other cost-sharing expenses, but the MCE's total liability must not exceed what the MCE would have paid in the absence of third party liability (TPL), after subtracting the amount paid by the primary payer.

The MCE must coordinate benefits and payments with the other insurer for services authorized by the MCE, but provided outside the MCE's plan. Such authorization may occur before provision of service, but any authorization requirements imposed on the member or provider of service by the MCE must not prevent or unduly delay a member from receiving medically necessary services. The MCE remains responsible for the costs incurred by the member with respect to care and services, which are included in the MCE's capitation rate, but which are not covered or payable under the other insurer's plan. MCEs must not deny claims for TPL for newborns less than 30 days old.

MCEs may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

TPL Coordination of Benefits

Coordination of benefits is covered for many of the MCE members. Each aid category must be treated appropriately in accordance with the State policy. Each MCE must have policies and procedures in place to ensure the appropriate application when coordinating benefits for its members.

HIP and Hoosier Healthwise Packages A, and P

If the HIP or Hoosier Healthwise member primary insurer is a commercial health maintenance organization (HMO) and the MCE cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the MCE's rules, the MCE may submit to the enrollment broker a written request for disenrollment. The request must provide the specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker will consult with the State and the request for disenrollment is considered and acted upon accordingly.

Hoosier Healthwise Package C

An individual is not eligible for Hoosier Healthwise Package C if they have other health insurance coverage. If the MCE discovers that a Hoosier Healthwise Package C member has other health insurance coverage, it is not required to coordinate benefits but must report the member’s coverage to the State. The MCE must assist the State in its efforts to terminate the member from Hoosier Healthwise Package C because of the existence of other health insurance.

The types of other insurance coverage the MCE must coordinate with include insurance such as worker’s compensation insurance and automobile insurance.
Third-Party Liability Data Sources

The State fiscal agent provides each MCE with a monthly list of known TPL resources for its enrolled Hoosier Healthwise and HIP members. The jobs that create the MCE TPL files run on the evening of the 20th of every month. The files are available for download from the File Exchange during the early morning hours of the 21st of each month. The TPL file layout is being expanded to include TPL-source code information. The TPL file layout is available on the MCO Question and Answer page at indianamedicaid.com under File Formats.

Medicare information is also provided to the MCEs for Hoosier Healthwise or HIP members who have overlapping Medicare. The Medicare extract file layout is available on the MCO Question and Answer page at indianamedicaid.com under File Formats. The extract runs monthly and is posted to File Exchange monthly.

The data on the monthly TPL file and TPL information accessed via the automated eligibility systems (IVR, 270/271 transaction, and the Portal are limited to the most current information on file with the fiscal agent.

The fiscal agent obtains TPL information for members from several sources, including the following:

- Member’s caseworker
- HMS, the fiscal agent’s subcontractor
- Other MCEs Portal
- Providers

The fiscal agent verifies for accuracy all TPL information received (except when the information comes from the caseworker). Any TPL information found for members can be submitted to the fiscal agent using the Provider TPL Referral Form. The completed form is mailed to the following address:

DXC TPL/Casualty Unit
P.O. Box 7262
Indianapolis, IN 46207-7262

The completed form may also be faxed to (317) 488-5217. TPL information can also be submitted via the Portal > Eligibility inquiry by selecting TPL Form.

Managed Care Entity Third Party Liability Responsibilities – Cost Avoidance and Coordination of Benefits

When the MCE is aware of health or casualty insurance coverage before paying for a healthcare service for a member, the MCE can reject a provider’s claim and direct that the claim be submitted first to the appropriate third party.

When the MCE becomes aware that an enrollee has instituted a legal cause of action for damages against a third party, the MCE sends written notification to the fiscal agent that includes the following:

- Enrollee’s name
- IHCP Member ID
- Date of accident or incident
- Nature of injury
- Name and address of enrollee’s legal representative
The MCE also provides the fiscal agent with copies of pleadings and any other documents in its possession related to the action.

If insurance coverage is not available, or if one of the exceptions to the cost-avoidance rule applies, then payment must be made and a claim made against the third party, if it is determined that the third party is or may be liable.

The MCE must ensure that its cost-avoidance efforts do not prevent an enrollee from receiving medically necessary services in a timely manner.

**Cost Avoidance Exceptions**

Cost avoidance exceptions in accordance with 42 CFR 433.139 include the following situations in which MCEs must first pay the provider and then coordinate with the liable third party:

- The claim is for prenatal care for a pregnant woman.
- The claim is for labor, delivery, and postpartum care, and does not involve hospital costs associated with the inpatient hospital stay.
- The claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program.
- The claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within 30 calendar days after the date of service.
- The claim is for services provided that were covered by a third party at the time services were rendered or reimbursed (for example, the MCE was not aware of the third-party coverage); the MCE must pursue reimbursement from potentially liable third parties.

**Third-Party Liability Collection and Reporting**

As an incentive to identify TPL and coordinate benefits, the MCE may retain a portion of TPL collections for their members. TPL collections must be reported in accordance with reporting requirements outlined in the Hoosier Healthwise/HIP Reporting Manual. In accordance with IC 12-15-8 and 405 IAC 1-1-15, the State has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. MCEs may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

The MCE may retain all TPL collections received on behalf of its HIP and Hoosier Healthwise Package A and P members.

For Hoosier Healthwise Package C members, the MCE may retain all TPL collections from any insurer or responsible party other than health insurers (such as automobile insurers, workers compensation, and so forth). In an effort to incentivize MCEs to investigate whether members have obtained health insurance that would exclude them from Hoosier Healthwise Package C eligibility, the MCE may keep 30% of the recovery collected from other health insurers but must transfer the remaining 70% to the State within 30 calendar days of collection.

**Health Information Technology and Data Sharing**

The MCE must develop, implement, and participate in healthcare information technology (HIT) and data-sharing initiatives to improve the quality, efficiency, and safety of healthcare in Indiana. The
MCE must also cooperate and participate in the development and implementation of future State-driven HIT initiatives. The State’s requirements for HIT and data sharing vary by resources available in each region.

MCEs are required to enter into data-sharing agreements with any health information technology entity that the State enters into data sharing agreements with.

The State reserves the right to require MCEs to establish personal health records (PHRs) for its members in the future. A PHR is an electronic health record of the member that is maintained by the MCE. PHRs typically include a summary of member health and medical history such as diagnoses, allergies, family history, lab results, vaccinations, surgeries, and so forth, and may also include claims information. If the State adopts a standard PHR format, the MCE is required to implement the State’s standard format. The MCE is also required to incorporate its member portal information and, for HIP members, POWER Account balance information into the PHR.

In addition to a PHR, the following are examples of HIT initiatives the MCE must consider developing:

- Electronic medical record (EMR) – An electronic medical record provides for electronic entry and storage of patients’ medical record data. Depending on the local information technology infrastructure, EMRs may also allow for electronic data transmission and data sharing. More complex EMRs can integrate computerized provider order entry and e-prescribing functions.

- Inpatient computerized provider order entry (CPOE) – CPOE refers to a computer-based system of ordering diagnostic and treatment services, including laboratory, radiology and medications. A basic CPOE system promotes legible and complete order entry and can provide basic clinical decision support such as suggestions for drug doses and frequencies. More advanced CPOE systems can integrate with an EMR for access to a patient’s medical history.

- Health information exchanges (including regional health information organizations – RHIOs) – These exchanges, such as the Indiana Health Information Exchange, allow participating providers to exchange clinical data electronically. The capacity of health information exchanges varies. Some initiatives provide electronic access only to lab or radiology results, while others offer access to shared fully integrated medical records.

- Benchmarking – Insurers can pool data from multiple providers and benchmark or compare metrics related to outcomes, utilization of services, and populations. Practice pattern analysis, with appropriate risk adjustment, can help to identify differences in treatment of patients and best practices. Information can be shared with insurers and providers to help them identify opportunities for improvement, or can be linked to pay for performance initiatives.

- Telemedicine – Telemedicine allows provider-to-provider and provider-to-member live interactions, and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of treating complex patients. Insurers are encouraged to develop reimbursement mechanisms to encourage appropriate use of telemedicine.

- Mobile and Self-Service Technology – The MCE is encouraged to use mobile and self-service technology in delivering services to members. This includes, but is not limited to, remote monitoring devices to enable members to record health measures for delivery to the MCE and/or physician practices and medication and appointment reminders through personalized voice or text messages.

To ensure interoperability among providers (including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health, and other providers), organizations at the national level, including the Health IT Standards Panel and the Certification Commission for Health IT, are working to develop standards. The MCE is encouraged to use these standards in developing its electronic data sharing initiatives, if any. These standards relate to:
• IT architecture
• Messaging
• Coding
• Privacy/security
• A certification process for technologies

Currently, resources and infrastructure for HIT vary widely throughout Indiana. There are multiple strategies and tactics that MCEs can adopt to participate directly and to incent providers to participate in HIT. Some examples include:

• Contract or affiliate with existing health information exchanges and information networks.
• Develop coalitions with other healthcare providers to develop health information exchanges and information networks.
• Develop proposals for health information exchanges and information networks, and apply for grants to support those proposals.
• Require providers to participate in one of Indiana’s established health data exchanges or information networks, in regions where those networks are currently established.
• Require high-volume prescribers to use some level of e-prescribing.
• Require high-volume providers to use EMRs.
• Identify providers that are and are not currently participating in information networks or using EMRs, e-prescribing, CPOE, or other HIT to focus incentives.
• Offer incentives to providers for adopting HIT, such as providing free or subsidized handheld devices to physicians for electronic prescribing, and/or providing financial or nonfinancial incentives to providers that adopt EMRs or electronic prescribing.
Section 21: Performance Reporting

Overview

Plans must submit required performance data in the form and manner specified by the State and consistent with the requirements of the Hoosier Healthwise and HIP MCE Reporting Manuals, and in accordance to the terms of the MCE’s contract with the State. Plans must have policies, procedures, and validation mechanisms in place to ensure that the financial and nonfinancial performance data submitted to the State and/or its subcontractors is accurate. Reports must be submitted under the signature of the plans’ financial officer or executive leadership (for example, president, chief executive officer, executive director), certifying the accuracy, truthfulness, and completeness of the data.

The required reports, format, and reporting calendar is produced by the State on an annual basis and compiled in the Hoosier Healthwise and HIP Reporting Manuals. However, the State may modify the frequency of reports and may require additional recurring reports with reasonable advance notice to the plans. For purposes of this policy, reasonable advance notice is defined as at least 30-calendar-days’ notice.

Performance reports must be submitted in the format specified by the State, using the most current version of supplied Report Templates, if applicable. Reports may be required for major subcontracted entities and/or separately by program. It is the responsibility of the plan to accurately, completely, and timely report all delegated performance data.

Reports may be due on an annual, semiannual, quarterly, monthly, or ad-hoc basis. Plans must submit performance reports by the dates due as indicated in the Hoosier Healthwise and HIP Reporting Manuals (or similar document), issued by the State each year. Plans must submit all performance reporting data electronically to the State’s reporting SharePoint site in the appropriate folders by the due date in the format and naming conventions described in the reporting manual. Plans may submit performance data earlier than the actual date the data is due. However, the State considers the performance data late if the State does not receive the performance data electronically in the designated location by 4 p.m. (Indianapolis time) on the date due. If the deadline falls on the weekend, it is due the first business day following the deadline.

Plans may occasionally encounter internal operational issues that prevent timely submissions of performance data. The State considers a plan’s request for a submission extension under the following conditions.

• The plan must submit its request for an extension at least one full business day before the data is due to the State.

• The plan must submit the request in writing via email directly to its assigned State policy analyst with a carbon copy to the contract compliance manager.

• The plan’s written request must be sent from the compliance officer or the officer’s alternate.

• The plan’s written request must explain why an extension is necessary and must suggest an alternative submission due date for the State to consider.

The State responds with a decision to the plan’s request via email. The State may consider the plan’s reporting submission as untimely if the request does not follow the prescribed protocol. Further, extensions are granted solely at the State’s discretion. If the extension request is denied, the State will consider the submission untimely if received passed the due date.
Plans must submit complete and accurate data. However, if the plan discovers that it has omitted some performance data during a reporting cycle or discovers errors in data submitted to the State, the plan must notify its designated State policy analyst upon discovery.

If the plan fails to provide performance data as required, the State may consider the plan noncompliant in its performance reporting and may assess liquidated damages or take corrective action as outlined in the Exhibits 3 and 4 of the Scope of Work.

As required to meet the deliverables in the Scope of Work or as requested by the State, a managed care entity (MCE) may be asked to submit ad hoc reports, data analysis, and/or material for the purpose of presentation to program stakeholders. If the State makes such a request, the MCE must submit such material within 30 calendar days or at an alternative date specified by the State (whichever comes sooner). The MCE must provide such reports to the State in the following format, unless directed otherwise by the State:

- **Cover Page**
  - MCE ID/Name
  - Program Name
  - Report Title
  - Report Description – The Report Description must outline its purpose, as well as what each of the rows and columns of the report represent; for example, a key as to how the report is to be read and interpreted
  - Data Period
  - Data Source
  - Date Run

- **Table of Contents (if appropriate for content)**

- **Executive Summary** – The Executive Summary must include, but is not limited to, a clear statement of the question at hand, the MCE’s high-level analysis of the data, its key findings, a clear statement of its recommendations and/or any action items, and the MCE staff responsible for each action item. It must not exceed two pages in length.

- **Component Reports as Directed by the State**

- **Definition of Terms/Terminology Used in the Report**

- The report is to be paginated in a sequential fashion, beginning to end, first page to last, and the Table of Contents (if applicable) is to match exactly to the pagination. The overall appearance of the report (for example, orientation of information [landscape vs. portrait] as it appears on the pages, how the report is bound) is not to vary substantially from iteration to iteration unless approved by the State. Each individual component report must have identifying information located in the margin that is unique to each report.

- The report is to be provided in electronic and hard copy format to the State.

- The electronic version of the report must be in a printer-friendly format requiring no manual manipulation to format print readiness.

- For presentations to stakeholders, the report must be the primary document to support the material presented and all attending MCE staff must be thoroughly conversant with the content of the entire report.

- The report must be submitted in the same font, preferably 12 point throughout.

The header and footer of the document must be defined across all pages of the report. The footer must include the MCE name, page number X of XX total pages, and date of the information. The title of the report must be included in the header or footer as appropriate for formatting of the document.
Appendix A: Hoosier Healthwise Code Tables

Overview

Monthly, the managed care entities (MCEs) access Hoosier Healthwise capitation data using the 820 MCE Capitation Payment Transaction. The following tables provide the codes applicable to the Hoosier Healthwise 820 transaction file.

The following tables list applicable MCE capitation rate cells, region codes, and reason codes related to capitation. This information is derived from the Managed Care subsystem in CoreMMIS.

Table A.1 – Hoosier Healthwise MCE Capitation Rate Cells

<table>
<thead>
<tr>
<th>Description</th>
<th>Capitation Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package A Preschool Ages 1 to 5</td>
<td>A1</td>
</tr>
<tr>
<td>Package A/B/P Child Ages 6 to 12</td>
<td>A6</td>
</tr>
<tr>
<td>Package A MA-U Female</td>
<td>UF</td>
</tr>
<tr>
<td>Package A MA-U Males</td>
<td>UM</td>
</tr>
<tr>
<td>Package A MA-U Preschool Ages 1 to 5</td>
<td>U1</td>
</tr>
<tr>
<td>Package A MA-U Child Ages 6 to 12</td>
<td>U6</td>
</tr>
<tr>
<td>Package A MA-U Teen Ages 13 to 20</td>
<td>UT</td>
</tr>
<tr>
<td>Package A MA-U Newborn</td>
<td>UN</td>
</tr>
<tr>
<td>Package C Preschool Ages 1 to 5</td>
<td>C1</td>
</tr>
<tr>
<td>Package C Child Ages 6 to 12</td>
<td>C6</td>
</tr>
<tr>
<td>Package A/P Adult Female</td>
<td>AF</td>
</tr>
<tr>
<td>Package A Adult Male</td>
<td>AM</td>
</tr>
<tr>
<td>Package A Newborn 0 to 12 Months</td>
<td>NB</td>
</tr>
<tr>
<td>Package A/P Teen</td>
<td>TN</td>
</tr>
<tr>
<td>Package C Teens Age 13 to 18</td>
<td>CT</td>
</tr>
<tr>
<td>Package C – Newborn 0 to 12 Months</td>
<td>CN</td>
</tr>
<tr>
<td>Package A/B – NOP Payment</td>
<td>NP</td>
</tr>
<tr>
<td>Package A MA-U – NOP Payment</td>
<td>UP</td>
</tr>
<tr>
<td>Package C – NOP Payment</td>
<td>CP</td>
</tr>
</tbody>
</table>
Table A.2 – Hoosier Healthwise MCE Region Codes

<table>
<thead>
<tr>
<th>Description</th>
<th>Region Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest</td>
<td>1</td>
</tr>
<tr>
<td>North Central</td>
<td>2</td>
</tr>
<tr>
<td>Northeast</td>
<td>3</td>
</tr>
<tr>
<td>West Central</td>
<td>4</td>
</tr>
<tr>
<td>Central</td>
<td>5</td>
</tr>
<tr>
<td>East Central</td>
<td>6</td>
</tr>
<tr>
<td>Southwest</td>
<td>7</td>
</tr>
<tr>
<td>Southeast</td>
<td>8</td>
</tr>
<tr>
<td>Out of State/IFSSA</td>
<td>9</td>
</tr>
</tbody>
</table>

Table A.3 – Hoosier Healthwise MCE Payment Reason Codes

<table>
<thead>
<tr>
<th>Description</th>
<th>Capitation Reason Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment – Half Month Normal</td>
<td>HN</td>
</tr>
<tr>
<td>Payment – Birth Month</td>
<td>PB</td>
</tr>
<tr>
<td>Payment – Half Month Retro</td>
<td>PH</td>
</tr>
<tr>
<td>Payment – Normal</td>
<td>PN</td>
</tr>
<tr>
<td>Payment – Retro</td>
<td>PR</td>
</tr>
<tr>
<td>Payment – Adjustment Payment</td>
<td>PA</td>
</tr>
<tr>
<td>Payment – Adjustment Recon Full Month</td>
<td>PC</td>
</tr>
<tr>
<td>Payment – Delivery Increase</td>
<td>PD</td>
</tr>
<tr>
<td>Payment – Adjustment Recon Half Month</td>
<td>PE</td>
</tr>
<tr>
<td>Payment – Adjustment Recon Birth Month</td>
<td>PG</td>
</tr>
<tr>
<td>Payment – Adjustment Increase</td>
<td>PI</td>
</tr>
<tr>
<td>Payment – Recipient Elig Adj</td>
<td>PJ</td>
</tr>
<tr>
<td>Payment – Retroactive Elig Between Programs</td>
<td>PK</td>
</tr>
<tr>
<td>Payment – Adjustment Auto-Recon Full Month</td>
<td>PL</td>
</tr>
<tr>
<td>Payment – Adjustment Auto-Recon Half Month</td>
<td>PM</td>
</tr>
<tr>
<td>Payment – Adjustment Auto-Recon Birth Month</td>
<td>PO</td>
</tr>
<tr>
<td>Recoupment – Delivery</td>
<td>RC</td>
</tr>
<tr>
<td>Recoupment – Death</td>
<td>RD</td>
</tr>
<tr>
<td>Recoupment – Recipient Elig Adj</td>
<td>RE</td>
</tr>
<tr>
<td>Recoupment – Adjustment Recovery Full</td>
<td>RF</td>
</tr>
<tr>
<td>Recoupment – Retroactive Elig Btwn Programs</td>
<td>RG</td>
</tr>
<tr>
<td>Recoupment – Adjustment Auto-Recon Half Month</td>
<td>RH</td>
</tr>
<tr>
<td>Recoupment – Adjustment Auto-Recon Full Month</td>
<td>RL</td>
</tr>
<tr>
<td>Recoupment – Adjustment Recovery Partial</td>
<td>RP</td>
</tr>
<tr>
<td>Recoupment – Delivery Systematic</td>
<td>RS</td>
</tr>
<tr>
<td>Recoupment – Normal Payment Notification of Pregnancy</td>
<td>NP</td>
</tr>
</tbody>
</table>
Appendix B: HIP Code Tables

Overview

Monthly, the managed care entities (MCEs) access HIP capitation data using the 820 MCE Capitation Payment Information Transaction companion guide. The following tables provide the codes applicable to the HIP 820 transaction file which are confirmed in the 820 MCE Capitation Payment Information Transaction companion guide.

The following tables list the capitation rate cells, reason codes, and Personal Wellness Responsibility (POWER) Account payment reason codes applicable to HIP. The HIP POWER Account process has only one category: PW.

Table B.1 – HIP MCE Capitation Rate Cells

<table>
<thead>
<tr>
<th>Description</th>
<th>Capitation Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male State Plan Plus 19 – 24</td>
<td>S1</td>
</tr>
<tr>
<td>Male State Plan Plus 25 – 34</td>
<td>S2</td>
</tr>
<tr>
<td>Male State Plan Plus 35 – 44</td>
<td>S3</td>
</tr>
<tr>
<td>Male State Plan Plus 45 – 54</td>
<td>S4</td>
</tr>
<tr>
<td>Male State Plan Plus 55 – 64</td>
<td>S5</td>
</tr>
<tr>
<td>Male State Plan Basic 19 – 24</td>
<td>B1</td>
</tr>
<tr>
<td>Male State Plan Basic 25 – 34</td>
<td>B2</td>
</tr>
<tr>
<td>Male State Plan Basic 35 – 44</td>
<td>B3</td>
</tr>
<tr>
<td>Male State Plan Basic 45 – 54</td>
<td>B4</td>
</tr>
<tr>
<td>Male State Plan Basic 55 – 64</td>
<td>B5</td>
</tr>
<tr>
<td>Female State Plan Plus 19 – 24</td>
<td>S6</td>
</tr>
<tr>
<td>Female State Plan Plus 25 – 34</td>
<td>S7</td>
</tr>
<tr>
<td>Female State Plan Plus 35 – 44</td>
<td>S8</td>
</tr>
<tr>
<td>Female State Plan Plus 45 – 54</td>
<td>S9</td>
</tr>
<tr>
<td>Female State Plan Plus 55 – 64</td>
<td>SX</td>
</tr>
<tr>
<td>Female State Plan Basic 19 – 24</td>
<td>B6</td>
</tr>
<tr>
<td>Female State Plan Basic 25 – 34</td>
<td>B7</td>
</tr>
<tr>
<td>Female State Plan Basic 35 – 44</td>
<td>B8</td>
</tr>
<tr>
<td>Female State Plan Basic 45 – 54</td>
<td>B9</td>
</tr>
<tr>
<td>Female State Plan Basic 55 – 64</td>
<td>BX</td>
</tr>
<tr>
<td>Male State Plan Plus 19 – 24</td>
<td>P1</td>
</tr>
<tr>
<td>Male State Plan Plus 25 – 34</td>
<td>P2</td>
</tr>
</tbody>
</table>
### Description | Capitation Categories
--- | ---
Male State Plan Plus 35 – 44 | P3
Male State Plan Plus 45 – 54 | P4
Male State Plan Plus 55 – 64 | P5
Male State Plan Basic 19 – 24 | R1
Male State Plan Basic 25 – 34 | R2
Male State Plan Basic 35 – 44 | R3
Male State Plan Basic 45 – 54 | R4
Male State Plan Basic 55 – 64 | R5
Female HIP Plan Plus 19 – 24 | P6
Female HIP Plan Plus 25 – 34 | P7
Female HIP Plan Plus 35 – 44 | P8
Female HIP Plan Plus 45 – 54 | P9
Female HIP Plan Plus 55 – 64 | PX
Female HIP Plan Basic 19 – 24 | R6
Female HIP Plan Basic 25 – 34 | R7
Female HIP Plan Basic 35 – 44 | R8
Female HIP Plan Basic 45 – 54 | R9
Female HIP Plan Basic 55 – 64 | RX
Medically Frail – Plus | FP
Medically Frail – Basic | FB
Pregnant Females – State Plan | PS
Pregnant Females – HIP | PR
Case Rate – State Plan | DS
Case Rate – HIP | DR
Hospital Presumptive Eligibility | AP

### Table B.2 – HIP/Hospital PE Capitation Payment Reason Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Payment Reason</th>
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</thead>
<tbody>
<tr>
<td>PN</td>
<td>Payment – Normal</td>
</tr>
<tr>
<td>PR</td>
<td>Payment – Retro</td>
</tr>
<tr>
<td>RD</td>
<td>Recoupment – Death</td>
</tr>
<tr>
<td>PT</td>
<td>Payment – Increase Adjustment</td>
</tr>
<tr>
<td>RT</td>
<td>Recoupment – Decrease Adjustment</td>
</tr>
</tbody>
</table>
### Table B.3 – HIP POWER Account Payment Reason Codes

<table>
<thead>
<tr>
<th>HIP Reason Code</th>
<th>HIP Reason Code Description</th>
<th>Payment type</th>
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<tbody>
<tr>
<td>MN</td>
<td>Member POWER Refund</td>
<td>POWER Account</td>
</tr>
<tr>
<td>NP</td>
<td>State POWER Refund</td>
<td>POWER Account</td>
</tr>
<tr>
<td>SC</td>
<td>State POWER Account</td>
<td>POWER Account</td>
</tr>
<tr>
<td>TR</td>
<td>Recoup – Termination</td>
<td>POWER Account</td>
</tr>
<tr>
<td>WR</td>
<td>State POWER Account Recoup</td>
<td>POWER Account</td>
</tr>
<tr>
<td>PM</td>
<td>Plan Change Recoup Remaining Member POWER</td>
<td>POWER Account</td>
</tr>
<tr>
<td>PS</td>
<td>Plan Change Recoup Remaining State POWER</td>
<td>POWER Account</td>
</tr>
<tr>
<td>RM</td>
<td>Recoup – Rollover Member Amount</td>
<td>POWER Account</td>
</tr>
<tr>
<td>RP</td>
<td>Recoup-Rollover Plan Amount</td>
<td>POWER Account</td>
</tr>
<tr>
<td>RS</td>
<td>Recoup – Rollover State Amount</td>
<td>POWER Account</td>
</tr>
<tr>
<td>SR</td>
<td>Payment – State POWER Rollover to Receiving Plan</td>
<td>POWER Account</td>
</tr>
<tr>
<td>SS</td>
<td>Payment – MemberPOWER Rollover to Receiving Plan</td>
<td>POWER Account</td>
</tr>
<tr>
<td>PP</td>
<td>Provisional POWER Account</td>
<td>POWER Account</td>
</tr>
<tr>
<td>RP</td>
<td>Recoupment Provisional POWER Account</td>
<td>POWER Account</td>
</tr>
<tr>
<td>AP</td>
<td>Manual Adjustment – Payment</td>
<td>POWER Account</td>
</tr>
<tr>
<td>AR</td>
<td>Manual Adjustment – Recoupment</td>
<td>POWER Account</td>
</tr>
<tr>
<td>EP</td>
<td>Eligibility Adjustment – Payment</td>
<td>POWER Account</td>
</tr>
<tr>
<td>ER</td>
<td>Eligibility Adjustment – Recoupment</td>
<td>POWER Account</td>
</tr>
<tr>
<td>TP</td>
<td>Termination Payment Due to Void Termination POWER Account Reconciliation Transaction</td>
<td>POWER Account</td>
</tr>
<tr>
<td>MP</td>
<td>Member Penalty</td>
<td>POWER Account</td>
</tr>
<tr>
<td>MR</td>
<td>Member Penalty Refund</td>
<td>POWER Account</td>
</tr>
<tr>
<td>TU</td>
<td>True Up Amount</td>
<td>POWER Account</td>
</tr>
</tbody>
</table>
Appendix C: State Data Request Form

Overview

The OMPP Data Request Form is used when data is needed for analysis or planning.

![State Data Request Form](image)

**OMPP Data Request Form**

State of Indiana  
Office of Medicaid Policy & Planning  
Data Management & Analysis

402 W. Washington St. Room W574  
Indianapolis, IN 46204  
Phone: 317-232-4971  
DataManagement.Analysis@fssa.in.gov

**QR #**  
NOTE: Although data requests are processed as quickly as possible, it may take 1-2 weeks for most data requests. This is due to the complexity of the data request, the number of requests in-process, and the available resources. Complex data requests can take longer.

<table>
<thead>
<tr>
<th>Contact Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Title/ Organization</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>Email</td>
</tr>
</tbody>
</table>

**Description of Data Request**  
(please fill out white section and send to Data Management email address above)

**Background Information and/or Question**

**The items in the shaded area on the right are criteria options. Please type in the white space which ones apply.**

| Purpose | Grant application, Public Info, Presentation on ___ date, OTHER |
| Program |  |
| Sub-Program |  |
| Time Period | CY = Calendar Year (e.g., CY87 = 8103107/1210187)  
SPY = State Fiscal Year (e.g., SPY87 = 8301000100 - 86999987)  
FFY = Federal Fiscal Year (e.g., FFY87 = 10001000 - 10999987) |
| Geography | Statewide (aggregate), By County, Region, OTHER |
| Claim Forms | A = Dental (ADA forms)  
C = Admin/Eligitation  
D = Drug/Pharmacy  
H = CMS-1500 (Professional)  
U = UB-04 (Institutional)  
$ = Encounter Claims |
| Claim Date Basis | Paid Date, Date of Service (incurred) |
| Billing Provider | Billing Provider ID/Name, Provider Type, Provider Specialty |
| Procedure/Diagnosis | List codes as appropriate |
| Units to be displayed in the report | Enrollee Count  
Recipient Count  
Provider Count  
Claim Count  
Expenditures  
Age Group  
Gender  
Race/Ethnicity  
OTHER |
| OTHER NOTES |  |

**To Be Completed by Request Coordinator or Data Director**

| Date Assigned | Assign to: |
| Date Due | Reviewer: |
| Priority | Complexity: |
| Notes |  |
Appendix D: Health Risk Screening (Newborn – 17 Years)

Overview

This form is completed for all members from newborn to 17 years old to identify health risks and to provide the appropriate care.

Figure D.1 – Health Risk Screening Form (Newborn – 17 years old) 1 of 6

Children newborn to 13 years – complete pages 1-5 only;
14 to 17 years – complete pages 1-6

Questions pertain to the IHCP enrolled child (member)
Figure D.1 – Health Risk Screening Form (Newborn – 17 years old) 2 of 6

Indiana Office of Medicaid Policy and Planning
Indiana Health Coverage Programs Health Risk Screening
Children (newborn through 17 years of age) Members

Regular Doctor
1. A regular doctor is the one that your child would see if he/she needed a checkup, you want advice about a health problem, or your child gets sick or hurt. Do you have a regular doctor or clinic that you take your child to when he/she gets sick or hurt?
   □ Yes (Go to 1a/b) □ No (Go to 2)

   (For children birth through 23 months)
   1a. Has your child gone to see his/her regular doctor for a check-up in the last 3 months?
      □ Yes □ No

   (For children 2 yrs and older)
   1b. Has your child gone to see his/her regular doctor for a check-up in the last 3 months?
      □ Yes □ No

General Health
2. In general, compared to other children the same age as your child (the member), how would you describe his/her health?
   □ Excellent □ Very Good □ Good □ Fair □ Poor

3. During the past year, did your child (the member) miss more than 5 days of school because he/she was sick or hurt?
   □ Yes □ No □ Don’t Know

Hospitalization
4. In the past 6 months, has your child (the member) stayed overnight in a hospital? (Not including at birth)
   □ Once □ More than twice □ Not at all

Admitted to Intensive Care Nursery
5. When your baby was born, did he/she need to stay overnight or longer in the Intensive Care Nursery because of a problem?
   □ Yes (Go to 5a.) □ No (Go to 6)

   5a. Was your child born 6 or more weeks premature? □ Yes □ No □ Don’t Know

Emergency Room Use
6. In the past 6 months, has your child (the member) gone to a hospital emergency room about his/her health?
   □ Once □ More than twice □ Not at all

Special Needs
7. Does your child (the member) currently need or use medicine from their doctor (other than vitamins)?
   □ Yes (Go to 7a.) □ No (Go to 8)

   7a. Is this a problem that has lasted or you think will last for at least 12 months?
      □ Yes □ No □ Don’t Know

FINAL 8/2010 2
Figure D.1 – Health Risk Screening Form (Newborn – 17 years old) 3 of 6

Indiana Office of Medicaid Policy and Planning
Indiana Health Coverage Programs Health Risk Screening

Children (newborn through 17 years of age) Members

8. Many families tell us that it is difficult to give children medicines every day or at the same time every day. In the last 7 days, has your child (the member) missed taking a dose of his/her medications? [ ] Yes [ ] No

9. When you think about other children the same age as your child (the member), does your child have trouble doing any of these things?

[ ] Eating/Feeding [ ] Walking [ ] Dressing [ ] Bathing
[ ] Toileting [ ] Talking [ ] Playing
[ ] Not able to do any of these things

Early Intervention Services
(For children birth through 3 years old)

10. Does your child (the member) receive services from a program called First Steps? (Your child might have an Individualized Family Service Plan (IFSP) and you might meet with a Service Coordinator. Most times, children get speech therapy, physical therapy, developmental therapy or occupational therapy at home.)

[ ] Yes [ ] No [ ] Don’t Know

(For children 4 years and older)

10. Does your child (the member) receive services from a program called Special Educational Services through your school district? (Children receiving these services often have an Individualized Education Plan (IEP). Special Education is any kind of special school, classes or tutoring.)

[ ] Yes [ ] No [ ] Don’t Know

Emotional Health

11. Does your child (the member) have any trouble with emotions, behaving, learning, focusing or getting along with others? [ ] Yes [ ] No

12. Does he/she see a doctor or clinic for problems with emotions, learning or their behavior? [ ] Yes [ ] No

13. Has he/she experienced physical or sexual abuse, neglect, or been exposed to violent behavior? [ ] Yes [ ] No [ ] Don’t Know

14. Does he/she exhibit unusual or uncontrollable behavior? [ ] Yes [ ] No [ ] Don’t Know

15. Has he/she been sent to Juvenile Detention or Jail? (For children 10 years and older) [ ] Yes [ ] No

Immunizations (Shot record)

16. Are your child’s (the member’s) shots up-to-date? [ ] Yes [ ] No [ ] Don’t Know

FINAL 8/2010
Appendix D: Health Risk Screening

Indiana Office of Medicaid Policy and Planning
Indiana Health Coverage Programs Health Risk Screening
Children (newborn through 17 years of age) Members

Lead Poisoning (Screen should be completed at 9 months to 12 months and again at 24 months)
17. Has your child (the member) ever been tested for lead poisoning?  □ Yes  □ No
18. Have you ever been told your child (the member) has lead poisoning?  □ Yes  □ No

Durable Medical Equipment
19. Does your child (the member) use special equipment, such as:
   □ Cane  □ Wheelchair  □ Breathing Machine/Nebulizer
   □ Special bed  □ Special telephone  □ Sleeping machine/Annea monitor
   □ Other

Health Conditions
20. Has your child’s (the member’s) doctor or clinic ever told you that he/she had any of the following:
   □ ADHD – attention and learning problems  □ Yes  □ No
   □ Alcohol or drug problems  □ Yes  □ No
   □ Anxiety  □ Yes  □ No
   □ Depression  □ Yes  □ No
   □ Mental retardation  □ Yes  □ No
   □ Schizophrenia or Bipolar Disorder  □ Yes  □ No
   □ Breathing problems like asthma or bronchitis  □ Yes  □ No
   □ Diabetes  □ Yes  □ No
   □ Kidney problems, like need for dialysis  □ Yes  □ No
   □ Blood disorders like Hemophilia or Sickle Cell Disease  □ Yes  □ No
   □ Digestive or stomach problems like ulcers, chronic diarrhea, Crohn’s  □ Yes  □ No
   □ Cancer, type:  □ Yes  □ No
   □ Cystic Fibrosis  □ Yes  □ No
   □ Autism or autism spectrum disorder  □ Yes  □ No
   □ Birth Defects  □ Yes  □ No
   □ Cerebral palsy  □ Yes  □ No
   □ Down syndrome  □ Yes  □ No
   □ Paraplegia/Quadriplegia  □ Yes  □ No
   □ Epilepsy/Seizure disorder  □ Yes  □ No
   □ Hearing problems like deafness, hearing aids  □ Yes  □ No
   □ Vision problems like blindness, glasses or contact lenses  □ Yes  □ No
   □ HIV/AIDS  □ Yes  □ No
   □ Infectious problems, like Hepatitis or TB  □ Yes  □ No

Dental Use (For children over 6 months old)
21. Has your child (the member) ever been to a dentist? (Include all types of dentists, such as
Figure D.1 – Health Risk Screening Form (Newborn – 17 years old) 5 of 6

Indiana Office of Medicaid Policy and Planning
Indiana Health Coverage Programs Health Risk Screening
Children (newborn through 17 years of age) Members
orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists).
☐ Never  ☐ Less than 1 year ago  ☐ More than 1 year ago

Household nicotine
22. Do you or anyone in the home smoke or use tobacco products?
☐ Yes (Go to 22a)  ☐ No (Go to 23)

22a. Are you (he/she) interested or willing to quit smoking?
☐ Not considering  ☐ Thinking about quitting  ☐ Planning to quit soon (Refer to 1-800-QUIT–NOW/1-877-784-8669)

Alcohol Use
23. Does your child (the member) drink alcohol?  ☐ Yes  ☐ No  ☐ Don’t Know
24. Has he/she received treatment for alcohol use?  ☐ Yes  ☐ No  ☐ Don’t Know

The following questions are about YOU (the person completing this form)
25. In general and compared to other people your age, how would you rate YOUR physical health?
☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor

26. In general and compared to other people your age, how would you rate YOUR mental health?
☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor
(Follow-up needed if Good, Fair or Poor box is checked)

27. Have you (the parent) been pregnant in the last 12 months?
☐ Yes (Go to 27a-e)  ☐ No (Go to 28)

27a. In the past two weeks, how often have you blamed yourself unnecessarily when things went wrong?
☐ Yes, most of the time  ☐ Yes, some of the time  ☐ Not very often  ☐ No, not at all

27b. In the past two weeks, have you been anxious or worried for no good reason?
☐ No, not at all  ☐ Hardly ever  ☐ Yes, sometimes  ☐ Yes, very often

27c. In the past two weeks, have you felt scared or panicky for no good reason?
☐ Yes, quite a lot  ☐ Yes, sometimes  ☐ No, not much  ☐ No, not at all

Transportation
28. There are many reasons people delay getting medical care. Have you ever delayed getting care for your child (the member) because you did not have a ride to the doctor or clinic?
☐ Yes  ☐ No

Homelessness
29. How many different addresses has your child (the member) had in the last year?
☐ Only 1 address in the last year  ☐ 2-3 addresses in the last year
Appendix D: Health Risk Screening

Hoosier Healthwise and Healthy Indiana Plan
MCE Policies and Procedures Manual

Figure D.1 – Health Risk Screening Form (Newborn – 17 years old) 6 of 6

Indiana Office of Medicaid Policy and Planning
Indiana Health Coverage Programs Health Risk Screening
Children (newborn through 17 years of age) Members

☐ More than 3 addresses in the last year ☐ I am homeless right now

To be completed for 14 through 17 years members ONLY
(Follow up needed if combined scores for 36, 37, and 32 is 3 or above)

Mental Health
To be completed for members 14-17 years only
30. Over the last week, how often have you (the member) had feelings of worthlessness, hopelessness, like you were letting people down, or not being a good person?
   ☐ 0 = Hardly ever ☐ 1 = Much of the time ☐ 2 = Most of the time ☐ 3 = All the time

To be completed for members 14-17 years only
31. Over the last week, how often have you (the member) been feeling tired, low in energy, hard to get motivated, have to push to get things done, or want to rest/lie down a lot?
   ☐ 0 = Hardly ever ☐ 1 = Much of the time ☐ 2 = Most of the time ☐ 3 = All the time

To be completed for members 14-17 years only
32. Over the last week, how often have you (the member) been feeling that life is not very much fun, not feeling good when usually (before getting sick) you would feel good, not having as much fun when you do fun things (before getting sick).
   ☐ 0 = Hardly ever ☐ 1 = Much of the time ☐ 2 = Most of the time ☐ 3 = All the time

Young Women’s Health - To be completed for members 14-17 years only

Pregnancy
33. Are you (the member) currently pregnant?
   ☐ Yes ☐ No (Go to 34)
   ☐ Yes ☐ No (Go to 33a.)

33a. If yes, have you (the member) seen a doctor for this pregnancy?
   ☐ Yes ☐ No
   ☐ Yes ☐ No

34. Have you (the member) been pregnant in the last 12 months?
   ☐ Yes (Go to 34a-c) ☐ No

34a. In the past two weeks, how often have you blamed yourself unnecessarily when things went wrong?
   ☐ Yes, most of the time ☐ Yes, some of the time ☐ Not very often ☐ No, not at all

34b. In the past two weeks, have you been anxious or worried for no good reason?
   ☐ Yes, quite a lot ☐ Yes, sometimes ☐ No, not much ☐ No, not at all

34c. In the past two weeks, have you felt scared or panic for no good reason?
   ☐ Yes, quite a lot ☐ Yes, sometimes ☐ No, not much ☐ No, not at all

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Appendix E: Health Risk Screening (Ages 18 years and older)

Overview

This form is completed for all members 18 years old and older to identify health risks and to provide the appropriate care.

Figure E.1 – Health Risk Screening Form (18 years old and older) 1 of 4

<table>
<thead>
<tr>
<th>Indiana Office of Medicaid Policy and Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana Health Coverage Programs Health Risk Screening</td>
</tr>
<tr>
<td>Adult (18 years and older) Members</td>
</tr>
</tbody>
</table>

**Background Information**

- Member’s name: 
- Medicaid ID: 
- Male 
- Female 
- DOB: (MM/DD/YYYY)

- Member’s address: 
- Primary Contact Phone Number: 
- Cell Phone Number: 
- City: 
- ZIP: 
- E-mail address: 
- Alternate Phone Number: 

If the member is not completing this form, what is the name and phone number of the person completing this form?

*Name: 
Phone number: 

Relationship: 
- Spouse 
- Domestic partner 
- Father/mother 
- Son/daughter 
- Brother/sister 
- Other:

Why is someone other than the member completing this? 
- Member is cognitively impaired or intellectually disabled 
- Member has emotional or behavioral problems 
- Member is hospitalized (acute care, psychiatric, etc.)

Primary language preference: 
- English 
- Spanish 
- Other: 

Do you speak and understand English well? 
- Yes 
- No

Race/Ethnicity of the Member: 
- Non-Hispanic Black 
- Non-Hispanic White 
- American Indian 
- Asian 
- Hispanic Black 
- Hispanic White 
- Other

Care Coordination/Case Management/Disease Management

- Case Manager: 
- Yes 
- No 
- Name: 
- Phone: 
- Mental Health Case Manager: 
- Yes 
- No 
- Name: 
- Phone: 
- Other Case Coordinator: 
- Yes 
- No 
- Name: 
- Phone: 

Is member enrolled in one of the following waiver programs: 
- Aged and Disabled Waiver 
- Autism Waiver 
- Developmentally Disabled Waiver 
- Support Services Waiver 
- Traumatic Brain Injury Waiver 
- Waiver waiting list (not currently on a waiver):

Is member currently receiving any of the following services? Please check all that apply: 
- Area Agency on Aging (AAA) 
- Rehabilitation 
- Substance Abuse 
- Home Health Agency Services 
- Special Education Services 
- Physical Therapy 
- Occupational Therapy 
- Behavioral/Mental Health Services 
- Developmental Therapy 
- Speech Therapy 
- Dialysis 
- Chemotherapy/Radiation Therapy 
- 24-hour supports from a Medicaid Waiver Provider

Regular Doctor or Clinic

1. A regular doctor or clinic is the one you would go to if you need a checkup, want advice about a health problem, or get sick or hurt. Do you (the member) have a regular doctor or clinic?

- Yes (Go to 1a.) 
- No (Go to 2.) 
- Don’t Know (Go to 2.)

1

Library Reference Number: MC10009
Published: February 8, 2018
Policies and Procedures as of March 1, 2017
Version: 7.1
Appendix E: Health Risk Screening
Hoosier Healthwise and Healthy Indiana Plan
(Ages 18 years and older)
MCE Policies and Procedures Manual

Figure E.1 – Health Risk Screening Form (18 years old and older) 2 of 4

Indiana Office of Medicaid Policy and Planning
Indiana Health Coverage Programs Health Risk Screening
Adult (18 years and older) Members

1a. Have you been to your regular doctor/clinic for a check-up in the last 12 months?
☐ Yes  ☐ No  ☐ Don’t Know

Hospitalization
2. In the last 6 months, were you (the member) sick enough to go to the emergency room?
☐ Once  ☐ More than twice  ☐ Not at all

3. In the last 6 months, were you (the member) sick enough to stay the night in the hospital?
☐ Once  ☐ More than twice  ☐ Not at all

Durable Medical Equipment
4. Do you (the member) use any of the following medical equipment or supplies?
☐ Oxygen  ☐ Feeding Pump  ☐ Specialty Bed  ☐ Wheelchair
☐ Breathing Machine (CPAP, BiPAP, Ventilator)  ☐ Wound Supplies
☐ Mechanical Lift (Hoist Lift)  ☐ Other

Medicine Use
5. Does your (the member’s) doctor or clinic prescribe or give you (him/her) pills or medicine that is taken every day? (other than vitamins)?
☐ Yes  ☐ No  ☐ Don’t Know

6. Many people tell us that it’s difficult to take their medications at the same time every day. Have you (the member) missed or stopped taking any pills or medicine and NOT told the doctor?
☐ Yes  ☐ No  ☐ Don’t Know

Home Health
7. During the past year, did you (the member) receive care AT HOME from a nurse or other health care professional?
☐ Yes  ☐ No  ☐ Don’t Know

Transportation
8. There are many reasons people delay getting medical care. Have you (the member) delayed getting care because you (he/she) didn’t have a ride to the doctor or clinic?
☐ Yes  ☐ No

Health Status

Pregnancy: Women Members Only (Male members, skip to #11)
9. Are you (the member) currently pregnant?
☐ Yes  ☐ No (Go to 10)
   What is the estimated due date? __________________________
   (Go to 9a.)

9a. If yes, have you (the member) seen a doctor for this pregnancy?
☐ Yes  ☐ No
   What was the date of the first visit? _______________________

10. Have you (the member) been pregnant in the last 12 months?
☐ Yes (Go to 10a-c)  ☐ No (Go to 11)

10a. In the past two weeks, how often have you (the member) blamed yourself unnecessarily when things went wrong?
☐ Yes, most of the time  ☐ Yes, some of the time  ☐ Not very often  ☐ No, not at all

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Figure E.1 – Health Risk Screening Form (18 years old and older) 3 of 4

<table>
<thead>
<tr>
<th>Health Conditions</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol or drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental problems like Bipolar (Manic Depressive), Schizophrenia, or PTSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathing problems like Asthma difficulty breathing, COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure problems like Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Problems like chest pain, heart attacks, Congestive Heart Failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney problems like dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Blood disorders like Hemophilia, or Sickle Cell Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone joint problems like arthritis, amputation, chronic low back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel and Stomach problems like ulcers, or chronic diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Cancer, (specify type)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Transplant (specify type)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing problems, like deafness or hearing aids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nerve/Brain problems, like Stroke, Multiple Sclerosis, or Spinal Cord Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision problems, like blindness, glasses or contact lens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious problems, like Hepatitis or TB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(*Refer to HIP ESP drop down listing for specific types)

General Health

12. In general, compared to other people your (the member’s) age, how would you say your (the member) health is? (Follow-up needed if Good, Fair or Poor box is checked)

- Excellent (Go to 13)
- Very Good (Go to 13)
- Good (Go to 12a/b)
- Fair (Go to 12a/b)
- Poor (Go to 12a/b)

12a. During the past 4 weeks, how much did physical health problems limit your (his/her) usual physical activities (such as walking or climbing stairs)?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do physical activities

12b. During the past 4 weeks, how much did your (his/her) physical health or emotional problems limit your (his/her) usual social activities with family or friends?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do physical activities

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Figure E.1 – Health Risk Screening Form (18 years old and older) 4 of 4

Indiana Office of Medicaid Policy and Planning
Indiana Health Coverage Programs Health Risk Screening
Adult (18 years and older) Members

Pain
15. During the past 4 weeks, how much did pain interfere with your (the member) normal work, including both work outside the home and housework?
☐ Extremely  ☐ Quite a bit  ☐ Moderately  ☐ Slightly  ☐ Not at all

Dental
14. About how long has it been since you (the member) last saw a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienist?
☐ Never  ☐ Less than 1 year  ☐ More than 1 year

Functioning
Activities of Daily Living
15. During the past four weeks, have you (the member) been able to eat, bathe, dress and use the toilet without difficulty?
☐ Yes  ☐ No

16. In the last 3 months, it is harder for me (the member) to speak, think, or remember things.
☐ Yes  ☐ No

Mental Health & Substance Use
General Utilization
17. In general, compared to other people your (the member's) age, how would you say your mental health is?
☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor

18. Have you gone to a doctor or clinic for mood, stress, or mental problems?
☐ Yes  ☐ No

General Depression
19. Over the past two weeks, how often have you (he/she) had little interest or pleasure in doing things?
☐ 0 = Not at all  ☐ 1 = Several days  ☐ 2 = More than half the days  ☐ 3 = Nearly every day

20. Over the past two weeks, how often have you (he/she) felt down, depressed, or hopeless?
☐ 0 = Not at all  ☐ 1 = Several days  ☐ 2 = More than half the days  ☐ 3 = Nearly every day

Smoking  (Follow up needed if member is planning to quit or wants help)
21. Do you (the member) or anyone in the home smoke or use tobacco products?
☐ Yes (Go to 21a.)  ☐ No (Go to 22.)

21a. Are you (he/she) interested or willing to quit smoking?
☐ Not considering
☐ Thinking about quitting
☐ Planning to quit soon (1-800-QUIT -NOW/1-877-784-8669)
☐ Want help (1-800-QUIT -NOW/1-877-784-8669)

Alcohol and Substance Use
22. How many times in the last month did you (the member) have more than 4-5 drinks (alcohol) at once?
☐ Number of times  ☐ None

23. Have you (the member) gone to a doctor or clinic for drug or alcohol problems?
☐ Yes  ☐ No (Go to 23a.)

23a. Do you think you (the member) need to?
☐ Yes  ☐ No

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# Appendix F: Subcontract Approval Checklist

## Overview

This form is used when the managed care entity (MCE) chooses to subcontract a service to another vendor. This form must be completed and sent to the State for approval.

### Figure F.1 – Subcontract Approval Checklist

<table>
<thead>
<tr>
<th>FOR OMPP REVIEW: MCE SUBCONTRACT CHECKLIST</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MCE Name:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCE Contact:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCE Plan Contact:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>OMPP Plan Contact:</td>
<td></td>
<td></td>
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<tr>
<td>MCE to complete</td>
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<tr>
<td>OMPP to complete</td>
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</tr>
<tr>
<td>For any event subcontract</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Describes amount, duration and scope of services to be performed</td>
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</tr>
<tr>
<td>2. Describes monitoring and oversight procedures, provides option for revoking delegation or imposing other sanctions for inadequate performance</td>
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</tr>
<tr>
<td>3. Allows OMPP to evaluate through inspection or other means, quality, appropriateness and timeliness of services performed</td>
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</tr>
<tr>
<td>4. Allows inspection of any records pertinent to the contract by state and federal officials</td>
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<tr>
<td>5. Requires adequate record system for recording services, charges and dates, etc. for services rendered to members</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Allows participation in internal/external quality assurance, utilization review, peer review and/or grievance procedures</td>
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<tr>
<td>7. Indemnifies the State</td>
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</tr>
<tr>
<td>8. Identifies and incorporates the applicable terms of the State/MCE contract</td>
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<tr>
<td>9. Term of contract does not extend beyond the State/MCE contract term</td>
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<tr>
<td>In addition, for any subcontractor rendering health care services:</td>
<td></td>
<td></td>
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<tr>
<td>10. A written provider claim dispute resolution procedure</td>
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<tr>
<td>In addition, for all PBM agreements:</td>
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<tr>
<td>11. Provision allowing PBM to terminate the agreement for any reason upon 90-day written notice to the MCE</td>
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</tr>
<tr>
<td>12. For all subcontractors which transfer &gt;5% of MCE’s financial risk to the subcontractor:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requires submission of quarterly and annual financial info</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Notes/Comments:
Overview

The following are guidelines to use when completing a health risk assessment. These guidelines help evaluate the answers given by the member or prospective member.

Figure G.1 – Health Risk Screener Response Guidelines 1 of 2

Indiana Office of Medicaid Policy and Planning
IHCP Health Risk Screener Response Guidelines

When reporting member responses for the Adult or Child Health Risk Screener, the following guidelines must be adhered to for accuracy in data collection:

- ALL screener questions are REQUIRED to be asked of all members, dependent on question related rules (i.e. gender specific, age range, follow-up based on response)
- Valid responses are noted on the screener form in a check box format.
  - Yes
  - No
  - Don’t know
  - Free form text
  - Topic specific (i.e. PHQ-2, Edinburgh Depression Scale, menu of options)

Member refusal – MR must be reported when member does NOT answer the question.
- Telephone: Refusal can be verbal or non-verbal.
- Mailed documents: member skips a question, leaves it blank and/or does not mark an answer.

Not Applicable – N/A must be reported when a question does not apply to the member:
- Age specific
- Gender specific
- Prior response my indicate that the next question is not applicable (i.e. If Yes go to #1a, if No go to #2)

*Even though N/A was added to all the questions as a viable response, N/A is only appropriate in the above listed scenarios.
If Health Risk Screener is mailed to members:
- MCE has option to revise format and customize form, as long as ALL questions are included (i.e. change the order of the questions);
Figure G.1 – Health Risk Screener Response Guidelines 2 of 2

- If MCE chooses to reorganize content of the HRS, it is the responsibility of the MCE to submit form through the document review process;
- MCE is the responsible for submitting member responses, accurately paired to corresponding questions, regardless of the order of the questions on a paper-mailed form.
- MCEs should follow-up with member when responses indicate potential for high risk behaviors or conditions: OMPP does not dictate the follow-up assessment questions.

The HRS was developed to detect actionable health risk indicators for ongoing healthcare. Much of the content was pulled together from individual assessment tools to provide the health plans with an opportunity to recognize the need for further assessment. OMPP expects the health plans to act on the results when high risk behaviors and conditions are revealed. Follow-up may include:

- Conducting additional in-depth assessment of a specific health concern
- Contacting member for more information about a health concern
- Asking additional questions, such as “What challenges have you experienced when you try to …”
Appendix H: Third Party Liability Verification and Change Report

Overview

This form is used by the managed care entities (MCEs) to report any additions or revisions to the Healthy Indiana Plan (HIP) member’s third-party health insurance coverage.

Figure H.1 – Third Party Liability Verification and Change Report Form
Appendix I: Report Definitions for Fiscal Agent-Generated Healthy Indiana Plan Reports

Overview

This appendix identifies the Healthy Indiana Plan (HIP) reports generated by the fiscal agent. The source for all reports listed is Business Objects. Each report detail table describes the report and specifications.

- HIP Denied Conditional Weekly Roster
- Member Weekly Roster
- HIP Overdue POWER Account Reconciliation File (PRF)
- HIP Member Over Age 65
- HIP Member Under Age 19
- Provisional HIP Members
- Open Conditional Member Weekly Roster
- HIP Rollover and Summary

Table I.1 – Healthy Indiana Plan Denied Conditional Weekly Roster Report

<table>
<thead>
<tr>
<th>Healthy Indiana Plan Denied Conditional Weekly Roster Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
</tr>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Specifications:</td>
</tr>
</tbody>
</table>

Table I.2 – Member Weekly Roster Report

<table>
<thead>
<tr>
<th>Member Weekly Roster Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
</tr>
<tr>
<td>Frequency</td>
</tr>
</tbody>
</table>
### Member Weekly Roster Report

**Specifications:**
- MCE ID
- Last Name
- First Name
- Medicaid ID
- Benefit Period
  - Effective Date
  - End Date
- HIP Assignment
  - Effective Date
  - End Date
- HIP Start Reason
  - Reason Code
  - Reason Code Description
- HIP Stop Reason
  - Reason Code
  - Reason Code Description
- POWER Account
  - Effective Date
  - End Date
  - Member Amount
  - State Amount

### Table I.3 – HIP Overdue POWER Account Reconciliation File (PRF) Report

**Description:**
The State uses this report to identify POWER Account Reconciliation file (PRF) transactions that were not submitted by the MCE in the required time frame. It allows the State to monitor overdue PRF activity for the MCE.

**Criteria**
This report is run on a monthly basis, showing:

- **a.** Members whose member benefit period and assignment date is end-dated. The fiscal agent has not processed a transaction type T from the member’s HIP plan by the 186th day of the benefit period end date. This designates the member was terminated from the HIP program.

- **b.** Members who are given a new benefit period, whose assignment date remains active, and for whom the fiscal agent has not processed a transaction type R from the members HIP plan by the 186th day of the benefit period end date. This designates the member as successfully redetermined for a new benefit period in the HIP program.

- **c.** The member benefit period remains open member assigned consecutively with two different plans. The fiscal agent has not processed a transaction type P from the member’s prior HIP plan by the 31st day of the member’s end date with the prior plan. This designates the member as transferred to another HIP plan within the benefit period.

Distributed to each of the MCEs. State receives a summary of the three plans. Media: Business Objects produces the report in Excel format and places copies on File Exchange.

**Frequency**
Monthly

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Each month, MCEs go to File Exchange to retrieve their copies of the report.</td>
</tr>
<tr>
<td>2</td>
<td>The MCEs review their report and are required to report their findings and the status of the PRFs listed on the report, including</td>
</tr>
<tr>
<td></td>
<td>Submitted and accepted by fiscal agent</td>
</tr>
<tr>
<td></td>
<td>Submission not accepted by fiscal agent</td>
</tr>
</tbody>
</table>
HIP Overdue POWER Account Reconciliation File (PRF) Report

- Will be resubmitted by mm/dd/yy
- Not submitted.

(If a PRF has not been submitted to the fiscal agent, a reason needs to be given, and these reasons are listed as separate status types.)

3 By 4 p.m. on the fifth day of the following month, a status update including a list of RIDs and their correlating statuses and a summary total of the status types is sent to the applicable State Care Programs analyst.

4 If an MCE is having an issue with the previous steps, the FSSA expects that this issue is brought to the attention of the State’s fiscal agent and the State Care Programs technical analyst as needed.

5 After the status update is received, the Care Programs technical analyst reviews it and follows up with any questions to the MCEs.

Expectation
- Any PRFs that have not been submitted to and accepted by the State’s fiscal agent is submitted as soon as possible.
- The number of overdue PRFs on each monthly report decreases each reporting cycle until only a minimal number ever appear on the report.
- Each MCE works toward an efficiently managed PRF submission process that eventually results in no or minimal PRFs being overdue.

Specifications:
- MCE ID – The 10-digit identification number to the Healthy Indiana Plan when it enrolls in the HIP program. The MCE ID is required on encounter-data submissions.
- Member Last Name – The member’s last name.
- Member First Name – The member’s first name.
- Medicaid ID – The member’s Indiana Health Coverage program identification number, as assigned by ICES.
- HIP Benefit Period – The benefit period for the member.
  Effective Date – The effective date of the benefit period.
  End Date – The end date of the benefit period.
- HIP Assignment – The dates the member is assigned to the HIP plan.
  Effective Date – The effective date of the assignment.
  End Date – The end date of the assignment.
- PRF Transaction Type – The PRF transaction type that should have been sent by the HIP plan: P = plan change, T = term, R = rollover
- Days Overdue – The number of days the PRF transaction is overdue.

Table I.4 – HIP Member Over Age 65 Report

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>This report provides the State with a monthly list of members who are under the age of 65 years and one month who technically no longer qualify for HIP membership. MCEs receive their lists from the State and notify the members listed to end their HIP membership and join Medicare. Business Objects produces this report in Excel format and places copies on File Exchange.</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Specifications:</td>
<td>MCE ID</td>
</tr>
<tr>
<td></td>
<td>Member Last Name</td>
</tr>
<tr>
<td></td>
<td>Member First Name</td>
</tr>
<tr>
<td></td>
<td>Medicaid ID</td>
</tr>
</tbody>
</table>
### HIP Member Over Age 65 Report

- HIP Benefit
  - Effective Date
- HIP Benefit
  - End Date
- HIP Assignment
  - Effective Date
- HIP Assignment
  - End Date
- Date of Birth
- Months over 65 + 1 month

### Table I.5 – HIP Member Under Age 19 Report

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>This report provides the State with a monthly list of members who are under the age of 18 years and 11 months who technically do not qualify for HIP membership.</td>
</tr>
</tbody>
</table>

Business Objects produces the report in Excel format and places copies on File Exchange for the State to pick up.

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCE ID</td>
</tr>
<tr>
<td>Member Last Name</td>
</tr>
<tr>
<td>Member First Name</td>
</tr>
<tr>
<td>Medicaid ID</td>
</tr>
<tr>
<td>HIP Benefit</td>
</tr>
</tbody>
</table>
  - Effective Date
| HIP Benefit     |
  - End Date
| HIP Assignment  |
  - Effective Date
| HIP Assignment  |
  - End Date
| Date of Birth   |
| Months under 18 – 11 Months |

### Table I.6 – Provisional HIP Members Report

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>This report provides a list of active HIP members who have not completed the redetermination process in a timely manner. The fiscal agent generates a State POWER Account payment to the plan.</td>
</tr>
</tbody>
</table>

Business Objects produces this report in Excel format and places copies on File Exchange for each plan.

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
</tr>
<tr>
<td>Member First Name</td>
</tr>
<tr>
<td>Member Last Name</td>
</tr>
<tr>
<td>Medicaid ID</td>
</tr>
<tr>
<td>HIP Benefit</td>
</tr>
</tbody>
</table>
  - Effective Date
| HIP Benefit     |

Agent-Generated Healthy Indiana Plan Reports

Provisional HIP Members Report

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provisional HIP Members Report</td>
</tr>
<tr>
<td>- End Date</td>
</tr>
<tr>
<td>- HIP Assignment</td>
</tr>
<tr>
<td>- Effective Date</td>
</tr>
<tr>
<td>- HIP Assignment</td>
</tr>
<tr>
<td>- End Date</td>
</tr>
<tr>
<td>- POWER Account</td>
</tr>
<tr>
<td>- Member Amount</td>
</tr>
<tr>
<td>- State Amount</td>
</tr>
</tbody>
</table>

Table I.7 – Open Conditional Member Weekly Roster Report

<table>
<thead>
<tr>
<th>Description</th>
<th>Open Conditional Member Weekly Roster Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>This report provides the MCEs with a weekly roster of open conditional members. The report is used to verify conditional members, or HIP members with an open conditional record and a Code Status of “C” for conditional or “P” for pending. Because these are conditional members, some do not have an MCE assignment and will not be reported to an MCE. Also, conditional members with a High Risk Indicator = ‘Y’ belong to the ESP MCE and are reported to that MCE and not to any other MCE chosen on the application. Any conditional members with a High Risk Indicator = ‘N’ or are eligible for enrollment in the HIP Program and are not reported to any MCE. The policy requires that a conditional HIP member must meet their POWER Account obligation or, failing payment, their conditional membership must end. Business Objects produces this report in Excel format and places copies on File Exchange for each plan.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Weekly, Sunday through Saturday</td>
</tr>
<tr>
<td>Specifications:</td>
<td>- MCE ID</td>
</tr>
<tr>
<td></td>
<td>- Last Name</td>
</tr>
<tr>
<td></td>
<td>- First Name</td>
</tr>
<tr>
<td></td>
<td>- Medicaid ID</td>
</tr>
<tr>
<td></td>
<td>- POWER Account</td>
</tr>
<tr>
<td></td>
<td>- Member amount</td>
</tr>
<tr>
<td></td>
<td>- State Amount</td>
</tr>
<tr>
<td></td>
<td>- Assign Reason</td>
</tr>
<tr>
<td></td>
<td>- Code AG status</td>
</tr>
<tr>
<td></td>
<td>- DSC Status Ag</td>
</tr>
<tr>
<td></td>
<td>- Code Status</td>
</tr>
<tr>
<td></td>
<td>- Dsc Status HIP</td>
</tr>
<tr>
<td></td>
<td>- Date DFR Received</td>
</tr>
<tr>
<td></td>
<td>- Date ICES Authorized</td>
</tr>
<tr>
<td></td>
<td>- Date End</td>
</tr>
<tr>
<td></td>
<td>75 + Days (calculated field showing days conditional record is open past 75)</td>
</tr>
</tbody>
</table>

Table I.8 – HIP Rollover and Summary Report

<table>
<thead>
<tr>
<th>Description:</th>
<th>HIP Rollover and Summary Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>This report provides member POWER Account Reconciliation Rollover information related to the member’s successful redetermination to the Healthy Indiana Program. The State uses this report to track the number and dollar amount related to a member’s rollover of a POWER Account for a benefit period.</td>
</tr>
</tbody>
</table>
Distributed to the FSSA HIP analyst from Business Objects, in Excel format. This report is also called *The Governor’s Report* and the *Redetermination Report*.

**Frequency**  
Monthly  
Uses member effective date and PRF transactions reported to the fiscal agent on a 12-month rolling basis. The State must provide the report to State leadership by the 15th of each month. The State requires the fiscal agent to generate report by the fifth day of the month.

**Specifications: (First Tab)**
- 12-Month Rolling POWER Account Analysis
- Member’s Federal Poverty Level (FPL)
- Members Effective as of MM/DD/CCYY (Add header as each month progresses)
- YTD Rolling Total
- Column Heading Information
- Total Members Eligible for Rollover
- Total Members Who Received Required Preventive Services
- Percentage of Members Who Received Required Preventive Services
- Total Members With Available Rollover Balance
- Total Members With Available Rollover Balance Who Received Preventive Services
- Percentage of Members With Available Rollover Balance Who Received Preventive Services (denominator: members w/rollover balance)
- Total Members Who Had A Rollover Balance But Did Not Receive Required Preventive Services
- Percentage of Members Who Had A Rollover Balance But Did Not Receive Required Preventive Services
- Average Member Rollover Available, Greater Than $0
- Average State Refund Available, Greater Than $0
- Average Member Rollover Available To Members Who Did Not Receive Preventive Services, Greater Than $0
- Average Rollover Returned to The State For Members Who Did Not Receive Preventive Services, Greater Than $0
- Total Members With No Available Rollover Balance
- Percentage Of Members With No Available Rollover Balance

**Specifications: (Second Tab)**
- First Chart – Bar Chart Percentages representing the number of members who received Preventive Services information.  
  - Total Members eligible for Rollover in Month report.  
  - Members who received Preventive Services  
  - Percentage of members who received Preventive Services.

- Second Chart – Bar Chart Percentages representing the Members who received preventive services and had available rollover based on their FPL.  
  - Total members eligible for rollover in reporting monthly.  
  - Members who received Preventive services and had available rollover.
Appendix J: Interface Schedule

Overview

This appendix provides the schedule of the various extracts that are provided to the managed care entities (MCEs) and exceptions to the schedule.

Figure J.1 – Interface Schedule – Input to Fiscal Agent

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>I/O</th>
<th>Entity</th>
<th>Frequency</th>
<th>When expected</th>
<th>Holiday Exceptions/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMP Assignments</td>
<td></td>
<td>MCE</td>
<td>D</td>
<td></td>
<td>Files received past cut-off will not be processed. Only one file per day M-F should be submitted. The job will succeed without receiving a file. The jobs will run if files are received, regardless of holidays.</td>
</tr>
<tr>
<td>HIP/HHW PMP Assignments</td>
<td>Input</td>
<td>MCE</td>
<td>D</td>
<td>Mon-Fri 6pm</td>
<td>HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.</td>
</tr>
<tr>
<td>Eligibility</td>
<td></td>
<td>ICES</td>
<td>D</td>
<td>Mon-Fri</td>
<td>HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.</td>
</tr>
<tr>
<td>HIP Pending (GDE462FA)</td>
<td>Input</td>
<td>ICES</td>
<td>D</td>
<td>Mon-Fri</td>
<td>HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.</td>
</tr>
<tr>
<td>HIP Conditional (GDE462FB)</td>
<td>Input</td>
<td>ICES</td>
<td>D</td>
<td>Mon-Fri</td>
<td>HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.</td>
</tr>
<tr>
<td>Recipient Eligibility (GDE429FA)</td>
<td>Input</td>
<td>ICES</td>
<td>D</td>
<td>Mon-Fri</td>
<td>HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.</td>
</tr>
<tr>
<td>Companion Case ID (GDEW084FA)</td>
<td>Input</td>
<td>ICES</td>
<td>D</td>
<td>Mon-Fri</td>
<td>HPE begins processing as soon as received from ICES. ICES files do not run on OMPP holidays.</td>
</tr>
<tr>
<td>HIP Eligibility</td>
<td></td>
<td>MCE</td>
<td>D</td>
<td>Mon-Fri 5pm</td>
<td>Files received past cut-off will not be processed. Only one file per day M-F should be submitted. The job will succeed without receiving a file. HPE does not process files on days ICES doesn’t run (OMPP holidays).</td>
</tr>
<tr>
<td>HIP Pay/No Pay Data</td>
<td>Input</td>
<td>HIP MCE</td>
<td>D</td>
<td>Mon-Fri</td>
<td>Files received past the adverse action cut-off date will not be processed.</td>
</tr>
<tr>
<td>HIP Pay/No Pay Data</td>
<td>Input</td>
<td>HIP MCE</td>
<td>M</td>
<td>Each month by the 10th at 5pm</td>
<td>ICES files do not run on OMPP holidays. The combined file response from HPE is therefore impacted by OMPP holidays.</td>
</tr>
<tr>
<td>HIP Pay/No Pay Data ICES Response (GDE422FB)</td>
<td>Input</td>
<td>ICES</td>
<td>D/M</td>
<td>In response to D/M files passed by the MCEs via HPE</td>
<td>ICES files do not run on OMPP holidays. The combined file response from HPE is therefore impacted by OMPP holidays.</td>
</tr>
<tr>
<td>Interface with Enrollment Broker</td>
<td></td>
<td>Maximus</td>
<td>D</td>
<td>Mon-Sat 6pm</td>
<td>Files received past cut-off will not be processed. Only one file per day M-S should be submitted.</td>
</tr>
</tbody>
</table>
# Appendix J: Interface Schedule

## Hoosier Healthwise and Healthy Indiana Plan

**MCE Policies and Procedures Manual**

---

### Figure J.2 – Interface Schedule – Output from Fiscal Agent (1 of 2)

<table>
<thead>
<tr>
<th>OUTPUTS</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>File</strong></td>
<td><strong>I/O</strong></td>
<td><strong>Receiving Entity</strong></td>
<td><strong>Frequency</strong></td>
<td><strong>When generated</strong></td>
</tr>
<tr>
<td>Provider Enrollment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPI Reference</td>
<td>Output</td>
<td>MCE</td>
<td>D</td>
<td>Mon-Fri</td>
</tr>
<tr>
<td>CPR Provider File</td>
<td>Output</td>
<td>MCE</td>
<td>W</td>
<td>Friday</td>
</tr>
<tr>
<td>Provider Profile</td>
<td>Output</td>
<td>MCE</td>
<td>M</td>
<td>1st day of each month</td>
</tr>
<tr>
<td>DMP Assignments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIP/HHW PMP Response File</td>
<td>Output</td>
<td>MCE</td>
<td>D</td>
<td>Mon-Fri</td>
</tr>
<tr>
<td>HIP/HHW PMP History</td>
<td>Output</td>
<td>MCE</td>
<td>D</td>
<td>Sun-Fri evening</td>
</tr>
<tr>
<td>HIP Eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIP 834 Conditional</td>
<td>Output</td>
<td>MCE</td>
<td>D</td>
<td>Tues-Sat early morning</td>
</tr>
<tr>
<td>HIP 834 Fully Eligible</td>
<td>Output</td>
<td>MCE</td>
<td>D</td>
<td>Tues-Sat early morning</td>
</tr>
<tr>
<td>HIP 834 Monthly Audit</td>
<td>Output</td>
<td>MCE</td>
<td>M</td>
<td>1st day of each month</td>
</tr>
<tr>
<td>HIP Pay/No Pay Response File</td>
<td>Output</td>
<td>HIP MCE</td>
<td>D/W</td>
<td>Corresponds to the MCE submitting a file</td>
</tr>
<tr>
<td>HIP Medicare Extract</td>
<td>Output</td>
<td>HIP MCE</td>
<td>M</td>
<td>20th of each month</td>
</tr>
<tr>
<td>HIP Member TPL Information</td>
<td>Output</td>
<td>HIP MCE</td>
<td>M</td>
<td>20th of each month</td>
</tr>
<tr>
<td>HHW Eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHW 834 Fully Eligible</td>
<td>Output</td>
<td>MCE</td>
<td>D</td>
<td>Tues-Sat early morning</td>
</tr>
<tr>
<td>HHW 834 Audit</td>
<td>Output</td>
<td>MCE</td>
<td>2xM</td>
<td>1st and 15th of each month</td>
</tr>
<tr>
<td>HHW Medicare Extract</td>
<td>Output</td>
<td>HHW MCE</td>
<td>M</td>
<td>20th of each month</td>
</tr>
<tr>
<td>HHW Member TPL Information</td>
<td>Output</td>
<td>HHW MCE</td>
<td>M</td>
<td>20th of each month</td>
</tr>
<tr>
<td>Presumptive Eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved CPTs by file transfer protocol (FTP)</td>
<td>Output</td>
<td>HHW MCE</td>
<td>D</td>
<td>Mon-Fri</td>
</tr>
<tr>
<td>Interface with Enrollment Broker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recipient Assignment Transaction (HASSIGN)</td>
<td>Output</td>
<td>EB</td>
<td>D</td>
<td>Mon-Sat</td>
</tr>
</tbody>
</table>
## Figure J.2 – Interface Schedule – Output from Fiscal Agent (2 of 2)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Frequency</th>
<th>Schedule</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Recipient Update</td>
<td>Output</td>
<td>EB D</td>
<td>Mon-Sat</td>
</tr>
<tr>
<td>HIP Recipient Update</td>
<td>Output</td>
<td>EB D</td>
<td>Mon-Sat</td>
</tr>
<tr>
<td>MCE Providers</td>
<td>Output</td>
<td>EB D</td>
<td>Mon-Sat</td>
</tr>
<tr>
<td>HIP Members on RCP</td>
<td>Output</td>
<td>EB D</td>
<td>Mon-Sat</td>
</tr>
<tr>
<td>MRO Reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRO Member Report</td>
<td>Output</td>
<td>MCE M</td>
<td>2nd Mon of each month</td>
</tr>
<tr>
<td>MRO Claims Report</td>
<td>Output</td>
<td>MCE M</td>
<td>2nd Mon of each month</td>
</tr>
<tr>
<td>HIP Capitation and POWER Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIP 820 Payment Transactions</td>
<td>Output</td>
<td>MCE M</td>
<td>Saturday after the 2nd Wed of each month</td>
</tr>
<tr>
<td>HIP Electronic Funds Transfers</td>
<td>Output</td>
<td>MCE M</td>
<td>Following Wed after the HIP payment cycle</td>
</tr>
<tr>
<td>HHW Capitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHW 820 Payment Transactions</td>
<td>Output</td>
<td>MCE M</td>
<td>Saturday after the 3rd Wed of each month</td>
</tr>
<tr>
<td>HHW Electronic Funds Transfers</td>
<td>Output</td>
<td>MCE M</td>
<td>Following Wed after the HHW payment cycle</td>
</tr>
</tbody>
</table>

*Does not run on OMPP holidays*  
*Not affected by holidays*
Appendix K: Preferred Medical Provider Assignments from the Managed Care Entities

Overview

Managed care entities (MCEs) assign their members to primary medical providers (PMPs) and must report the assignment information to CoreMMIS. The following are information supplements about the interface specifications.

File Data

Input fields sent to the fiscal agent by the Hoosier Healthwise and the Healthy Indiana Plan (HIP) MCEs include the following:

- Members’ ID – Required, 12 numeric characters
- Member’s start date – Required, eight characters (CCYYMMDD)
- Member’s start reason – From Assignment Reasons Tab
  Auto-assigned previous PMP
  Auto-assigned case ID PMP
  Auto-assigned PMP in previous group
  Auto-assigned case ID in previous group
  Default auto assignment
  PMP disenrolled
  Member request
  PMP initiated
- Member’s end date – Required, eight characters (CCYYMMDD)
- Member’s stop reason – From Assignment Reasons Tab
- PMP’s Medicaid Provider ID – Required, nine numeric characters
- PMP’s Medicaid location, individual or group – Required, one alpha character
- Member’s health program – R (RBMC) or H (HIP)
- PMP’s Medicaid group Provider ID – If present, nine numeric characters
- MCE ID – Required, nine numeric characters
- PMP’s region code – Required for RBMC; null for HIP
- Transaction type – A (add), C (change or termination), or D (deleted = terminated before effective date because of an error in eligibility)
- Member’s first name – 13 characters
- Member’s middle initial – One character
- Member’s last name – 15 characters

Output fields sent by the fiscal agent to the Hoosier Healthwise and HIP MCEs include the following:

- Members’ ID – Required, 12 numeric characters
- Member’s start date – Required, eight characters (CCYYMMDD)
Appendix K: Preferred Medical Provider Assignments

from the Managed Care Entities

Hoosier Healthwise and Healthy Indiana Plan

MCE Policies and Procedures Manual

- Member’s start reason – From Assignment Reasons Tab
- Member’s end date – Required, eight characters (CCYYMMDD)
- Member’s stop reason – From Assignment Reasons Tab
- PMP’s Medicaid Provider ID – Required, nine numeric characters
- PMP’s Medicaid location, individual or group – Required, one alpha character
- Member’s health program – R (RBMC) or H (HIP)
- PMP’s Medicaid group Provider ID – If present, nine numeric characters
- MCE ID – Required, nine numeric characters
- PMP’s region code – Required for RBMC; null for HIP
- Transaction ID – 12 characters
- Transaction type – A (add), C (change or termination), or D (deleted = terminated before effective date because of error in eligibility)
- Error Reasons one through 10 – Three characters each

Process notes

- MCEs can delete a member’s PMP assignment. MCEs must use the one character “D” value for the Transaction type. The assignment must be future dated for the MCE to use this transaction.
- If the MCE submits a member assignment with overlapping start and end dates, the system overwrites the member’s new PMP assignment over the old assignment. CoreMMIS windows reflect the new PMP information, including new start and stop dates, and PMP start and stop reasons.
- MCEs must not use the one character “T” value for the Transaction type. This code is reserved for use by the Enrollment Broker.
- MCEs can submit future-dated PMP assignments if the member is currently linked to his or her MCE.
- HIP members in ESP are not part of this PMP assignment process.
- Hoosier Care Connect member process is not affected by these Hoosier Healthwise and HIP linking assignment changes.
- PMP assignment end-dates are now adjusted to coincide with the Indiana Health Coverage Programs (IHCP) eligibility end-date, if the submitted end-date is > the Medicaid end-date.
- MCEs are not prevented from submitting an end-date on the PMP assignment input file if they’re aware the member is terminating in the future.
- MCEs do not receive an error response if CoreMMIS adjusts the member’s PMP assignment end-date, compared to what was submitted on the assignment input file.
Transaction Codes and Their Use

Table K.1 – Transaction Codes and Their Usage

<table>
<thead>
<tr>
<th>TXN Type</th>
<th>Usage</th>
<th>Date Effective</th>
<th>Date End</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Used by the MCEs to replace a placeholder assignment, or to change a PMP assignment</td>
<td>Effective date of the PMP assignment</td>
<td>End date of the PMP assignment</td>
<td>Primary transaction used by the MCEs. Effective date must be current or future date. If &lt; the run date, CoreMMIS resets the effective date to the run date. MCEs do not need to send a corresponding Term or Change transaction. PMP assignment end-dates are adjusted to coincide with the IHCP eligibility end-date, if the submitted end-date is &gt; the Medicaid end-date.</td>
</tr>
<tr>
<td>C</td>
<td>Used by the MCEs when they want to end an assignment but don’t have a PMP replacement yet</td>
<td>Effective date of the PMP assignment that’s being ended</td>
<td>End date of the PMP assignment</td>
<td>CoreMMIS creates the PMP placeholder assignment effective the day after the PMP assignment end-date. PMP assignment end-dates are adjusted to coincide with the IHCP eligibility end-date, if the submitted end-date is &gt; the Medicaid end-date.</td>
</tr>
<tr>
<td>D</td>
<td>Used by the MCEs when they want to delete a future-dated PMP assignment</td>
<td>Effective date of the PMP assignment that’s being deleted</td>
<td>End date of the PMP assignment that’s being deleted</td>
<td>An assignment cannot be deleted if it’s already taken effect.</td>
</tr>
<tr>
<td>T</td>
<td>Not for use by MCEs; reserved for the enrollment broker</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</table>

Table K.2 – PMP Assignment and Eligibility Scenarios

<table>
<thead>
<tr>
<th>ID</th>
<th>Scenario</th>
<th>Effect on Submissions</th>
<th>Effect on Current Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hoosier Healthwise member maintains his or her eligibility.</td>
<td>No effect. MCEs are able to make changes.</td>
<td>No effect; the assignment remains on file.</td>
</tr>
<tr>
<td>2</td>
<td>Hoosier Healthwise member loses his or her eligibility; member is not reopened.</td>
<td>MCEs are not able to submit PMP assignments beyond the IHCP eligibility end-date.</td>
<td>The PMP assignment is systematically end-dated in conjunction with the IHCP eligibility end-date. 834 term record is sent to the MCE.</td>
</tr>
<tr>
<td>ID</td>
<td>Scenario</td>
<td>Effect on Submissions</td>
<td>Effect on Current Assignments</td>
</tr>
<tr>
<td>----</td>
<td>----------</td>
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<td>------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>Hoosier Healthwise member loses his or her eligibility; member is reopened without a break in coverage.</td>
<td>The original PMP assignment reopens; therefore, the MCE does not have to resend the PMP assignment.</td>
<td>The original PMP assignment is dated in conjunction with the IHCP eligibility end-date. An 834 term record is sent to the MCE. When eligibility is reopened, the member’s PMP assignment also reopens as if it was never closed, as long as the stop reason on file is a 99 (open) or 81 (eligibility end). An 834 change record generates, indicating a change in eligibility dates.</td>
</tr>
<tr>
<td>4</td>
<td>Hoosier Healthwise member loses his or her eligibility; member is reopened after a break in coverage.</td>
<td>MCEs have to submit a PMP assignment after the member is reopened.</td>
<td>The original PMP assignment is dated in conjunction with the IHCP eligibility end-date. An 834 term record is sent to the MCE. When eligibility is reopened, the member is assigned prospectively back to the MCE with a PMP placeholder assignment. Effective date of the placeholder is either the 1st or the 15th of the month, depending on what date ICES reopens the eligibility.</td>
</tr>
<tr>
<td>5</td>
<td>HIP member maintains his or her eligibility.—</td>
<td>No effect. MCEs are able to make changes.</td>
<td>No effect; the assignment remains on file.</td>
</tr>
<tr>
<td>6</td>
<td>HIP member loses his or her eligibility; member is not reopened.</td>
<td>MCEs are not able to submit PMP assignments beyond the HIP eligibility end-date.</td>
<td>The PMP assignment is systematically dated in conjunction with the eligibility end-date. An 834 term record is sent to the MCE.</td>
</tr>
<tr>
<td>7</td>
<td>HIP member loses his or her eligibility; member is reopened without a break in coverage.</td>
<td>The original PMP assignment reopens; therefore, the MCE does not have to resend the PMP assignment.</td>
<td>The original PMP assignment is dated in conjunction with the IHCP eligibility end-date. An 834 term record is sent to the MCE. When eligibility is reopened, the member’s PMP assignment also reopens as if it was never closed. An 834 change record generates, indicating a change in eligibility dates.</td>
</tr>
<tr>
<td>8</td>
<td>HIP member loses his or her eligibility; member is reopened after a break in coverage.</td>
<td>MCEs have to submit a PMP assignment after the member is reopened.</td>
<td>The original PMP assignment is dated in conjunction with the IHCP eligibility end-date. An 834 term record is sent to the MCE. When eligibility is reopened, the member is assigned retroactively back to the MCE placeholder. HIP members do not have fee-for-service (FFS) periods.</td>
</tr>
</tbody>
</table>
Appendix L: Auto-Assignment Reason Codes

Overview

Applicants have the option to preselect their managed care entity (MCE) when applying for the Hoosier Healthwise or the Healthy Indiana Plan (HIP) programs. This information is transmitted from the Indiana Client Eligibility System (ICES) to CoreMMIS after the member is determined fully eligible. If there is no MCE preslection, the member record is held for 14 days so the enrollment broker can outreach to the member and assist with the MCE selection. If after 14 days, the member is not assigned to an MCE, CoreMMIS auto-assignment logic assigns the member to a Hoosier Healthwise or HIP plan, based on their eligibility. Flowcharts for the auto-assignment process are available on the MCO Question and Answer page at indianamedicaid.com.

- MCE Assignment – Hoosier Healthwise and Healthy Indiana Plan
- Post-MCE Assignment – Hoosier Healthwise and Healthy Indiana Plan
- Post-PMP Assignment – Hoosier Healthwise and Healthy Indiana Plan
- PMP Disenrollment – Hoosier Healthwise and Healthy Indiana Plan

The following are exceptions to the 14-day wait period and members are assigned immediately:

- Members previously enrolled in the Right Choices Program (RCP)
- Hoosier Healthwise members with less than a two-month gap and more than 90 days from annual open enrollment period. Open enrollment as defined for Hoosier Healthwise does not apply to HIP.
- Hoosier Healthwise members whose psychiatric residential treatment facility (PRTF) level-of-care (LOC) has ended.
- HIP members who transfer to Hoosier Healthwise

The following table provides the auto-assignment reason codes and descriptions used for the various care programs.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Auto Assigned – Case ID</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>23</td>
<td>Auto Assigned – Default</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>3A</td>
<td>Auto Assigned – Previous MCE</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>3B</td>
<td>Auto Assigned – Companion Case ID</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>3C</td>
<td>Auto Assigned – Previous RCP</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>3D</td>
<td>Auto Assigned – Spouse (HIP)</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>3F</td>
<td>Auto Assigned – Newborn (Mom MCE)</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>3G</td>
<td>Auto Assigned – Member Choice</td>
<td>Hoosier Healthwise</td>
</tr>
<tr>
<td>A1</td>
<td>MCE Auto Assigned – Previous PMP</td>
<td>Hoosier Healthwise/HIP</td>
</tr>
<tr>
<td>A2</td>
<td>MCE Auto Assigned – Case ID PMP</td>
<td>Hoosier Healthwise/HIP</td>
</tr>
<tr>
<td>A5</td>
<td>Default Auto Assignment</td>
<td>Hoosier Healthwise/HIP</td>
</tr>
<tr>
<td>AA</td>
<td>Auto Assign – Default</td>
<td>HIP</td>
</tr>
<tr>
<td>ID</td>
<td>Description</td>
<td>Program</td>
</tr>
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<td>----</td>
<td>--------------------------------------------------</td>
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</tr>
<tr>
<td>AB</td>
<td>Auto Assign – Previous Insurer HIP</td>
<td>HIP</td>
</tr>
<tr>
<td>AC</td>
<td>Auto Assign – Previous Insurer Hoosier Healthwise</td>
<td>HIP</td>
</tr>
<tr>
<td>AD</td>
<td>Auto Assign – Spouse HIP</td>
<td>HIP</td>
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<tr>
<td>AG</td>
<td>Auto Assign – Case Hoosier Healthwise</td>
<td>HIP</td>
</tr>
<tr>
<td>AH</td>
<td>Auto Assign – Companion Case Hoosier Healthwise</td>
<td>HIP</td>
</tr>
<tr>
<td>AP</td>
<td>Auto Assigned – Previous Insurer</td>
<td>HIP</td>
</tr>
<tr>
<td>AR</td>
<td>Auto Assigned – Rotation</td>
<td>HIP</td>
</tr>
<tr>
<td>AS</td>
<td>Auto Assigned – Spouse</td>
<td>HIP</td>
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# Appendix M: PRF Timing, Rollovers, Scenarios, and Process Flow

## Table M.1 – PRF System Timing

<table>
<thead>
<tr>
<th>Scenario Type</th>
<th>End of HEF Assignment</th>
<th>End of HEF Assignment</th>
<th>End of HEF Assignment</th>
<th>MCE 2 Note: that the member transferred to</th>
<th>HEF Change Reason</th>
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<tbody>
<tr>
<td>AF Initial Transfer (This member is not a member of any MCO, HEF, or whether the item was assigned to another MCO, HEF, or whether the item was transferred in or out of the MCO)</td>
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</table>
Table M.2 – PRF Rollover Process (1 of 2)

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Initiate process</td>
</tr>
<tr>
<td>2.</td>
<td>Check eligibility criteria</td>
</tr>
<tr>
<td>3.</td>
<td>Process application for eligibility criteria</td>
</tr>
<tr>
<td>4.</td>
<td>Determine if eligible for rollover</td>
</tr>
<tr>
<td>5.</td>
<td>If eligible, proceed to next step; otherwise, return to step 1.</td>
</tr>
<tr>
<td>6.</td>
<td>Calculate the amount to be rolled over</td>
</tr>
<tr>
<td>7.</td>
<td>Communicate the amount to the member</td>
</tr>
<tr>
<td>8.</td>
<td>Process the rollover transaction</td>
</tr>
<tr>
<td>9.</td>
<td>Update member's account information</td>
</tr>
<tr>
<td>10.</td>
<td>Notify the member of the successful rollover</td>
</tr>
<tr>
<td>11.</td>
<td>End process</td>
</tr>
</tbody>
</table>

Diagram: [Diagram of the PRF Rollover Process]
Table M.2 – PRF Rollover Process (2 of 2)
## Table M.3 – Rollover Scenarios

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Rollover Calculated Based on Member Status as of Month 12 of the RF</th>
<th>Member Dollars Remaining</th>
<th>Qualifies for Basic % Rollover Discount (e.g., received preventive care)</th>
<th>Member Status When Rollover Applied (1st RF)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Plus</td>
<td>Yes</td>
<td>N/A</td>
<td>Plus</td>
<td>Member and state rollover dollars applied as credit on account. PACs owed in future months can be deducted from the rollover amount. If enough to cover more than just prospective months, member current year payments may be refunded.</td>
</tr>
<tr>
<td>2</td>
<td>Plus</td>
<td>Yes</td>
<td>N/A</td>
<td>Basic</td>
<td>Member goes potential plus. If there is enough rollover to cover at least one month's PAC, the MCE sends pac file. Member invoice should show that they got rollover and that this was applied and they owe $0 for Plus coverage. Otherwise the member gets an invoice showing their one month PAC discount.</td>
</tr>
<tr>
<td>3</td>
<td>Basic</td>
<td>Yes</td>
<td>Yes</td>
<td>Plus</td>
<td>Percent discount from basic rollover is applied to PAC and member rollover dollars apply to PAC. Percent discount applies to the entire Plus period, not just prospectively. PACs are not retroactively adjusted, but if the member owed $10 in the first 4 months and qualifies for a 10% discount, then the member should get a $4 credit and a 10% discount on each subsequent PAC. Member dollars, less the 25% penalty, are applied as a credit on the account and PACs owed in future months can be deducted from the rollover amount.</td>
</tr>
<tr>
<td>4</td>
<td>Basic</td>
<td>Yes</td>
<td>No</td>
<td>Plus</td>
<td>Member dollars, less the 25% penalty, are applied as credit on the account and reduce the member’s PAC.</td>
</tr>
<tr>
<td>5</td>
<td>Basic</td>
<td>Yes</td>
<td>Yes</td>
<td>Basic</td>
<td>Percent discount from basic rollover is applied to current year PAC and member dollars apply to first month’s PAC. Since member is in Basic, percent discount only applies going forward, even if member had a prior month of plus coverage in the benefit period. Member dollars, less the 25% penalty, are applied as credit on the account. If there are enough member dollars to pay for at least one month of PAC the MCE sends pac file and the member moves to HIP Plus. Remaining member dollars can be applied to remaining year’s PACs. If there are not enough member dollars to put the member into HIP Plus then the dollars are applied to the current month’s contribution and the member receives an invoice for the balance.</td>
</tr>
<tr>
<td>6</td>
<td>Basic</td>
<td>Yes</td>
<td>No</td>
<td>Basic</td>
<td>Member dollars, less the 25% penalty, are applied as a credit on the account. If there are enough member dollars to pay for at least one month of PAC the MCE sends pac file and the member moves to HIP Plus. Remaining member dollars can be applied to remaining year’s PAC. If there are not enough member dollars to move the member into HIP Plus then the dollars are applied to the current month’s PAC and the member receives an invoice for the balance.</td>
</tr>
<tr>
<td>7</td>
<td>Basic</td>
<td>No</td>
<td>Yes</td>
<td>Plus</td>
<td>Discount applied to member PAC. Percent discount applies to the entire Plus period, not just prospectively. PACs are not retroactively adjusted, but if the member owed $10 in the first 4 months and qualifies for a 10% discount, then the member should get a $4 credit and a 10% discount on each subsequent PAC. Member remains in Plus but gets their Basic discount off of their PAC and a credit for the discount on the first 4 months of coverage.</td>
</tr>
<tr>
<td>8</td>
<td>Basic</td>
<td>No</td>
<td>Yes</td>
<td>Basic</td>
<td>Member goes Potential Plus and receives discount applied to PAC owed. Since member is in Basic, discount only applies prospectively.</td>
</tr>
</tbody>
</table>
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