Chapter 2: Member Eligibility and Benefit Coverage
### Chapter 2: Revision History

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## Revision History

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</tr>
</tbody>
</table>
# Chapter 2: Table of Contents

## Section 1: Member Identification .............................................................. 2-8

- Member Identification Number ....................................................... 2-8
- Member Identification Card – Hoosier Health Card ......................... 2-8
- General Information about the Card ................................................ 2-9
- Member Identification Card – Healthy Indiana Plan ......................... 2-9

## Section 2: Member Eligibility ................................................................ 2-12

- General Information ........................................................................ 2-12
- Indiana Health Coverage Programs .................................................. 2-12
- Eligibility Verification ..................................................................... 2-12
  - Importance of Verifying Eligibility ............................................... 2-12
  - Proof of Eligibility Verification .................................................... 2-13
  - How to Verify Member Eligibility .................................................. 2-14
  - Health Plan Eligibility ................................................................. 2-14

## Section 3: Hoosier Healthwise Program ............................................. 2-15

- Member Eligibility and Coverage ................................................... 2-15
- Hoosier Healthwise Open Enrollment .............................................. 2-16
- Hoosier Healthwise Package A: Standard Plan .................................. 2-16
  - Member Eligibility and Coverage .................................................. 2-16
- Hoosier Healthwise Package C: Children’s Health Plan ..................... 2-17
  - Member Eligibility and Coverage .................................................. 2-17
  - Wraparound Services .................................................................. 2-19
- Package P: Presumptive Eligibility for Pregnant Women .................... 2-20
  - Member Eligibility and Coverage .................................................. 2-20
  - Enrollment Process ...................................................................... 2-20
- Hoosier Healthwise Program Comparison ........................................ 2-21

## Section 4: Traditional Medicaid Program ........................................... 2-31

- Member Eligibility and Coverage ................................................... 2-31
- Medicaid and the Medicare Prescription Drug Coverage Program .... 2-31
- Delivery System ............................................................................. 2-32
- Waiver Liability .............................................................................. 2-32
  - Automation of Spend-down .......................................................... 2-33
  - Eligibility Verification System ...................................................... 2-33
  - Medicare Part D and IHCP Waiver Liability .................................... 2-33
- Medicare Savings Program – (QMB, SLMB, QI, QDWI) ................. 2-34
  - QMB-Also with Waiver Liability and Eligibility Verification ........... 2-35
  - Waiver ......................................................................................... 2-36
- 1915 (i) Home and Community-Based Services ............................... 2-36
This program offers one service, BPHC, and consists of the coordination of healthcare services to manage the healthcare needs of eligible members. This service includes logistical support, advocacy, and education to assist individuals in navigating the healthcare system and activities that help members gain access to physical and behavioral health services needed to manage their health conditions. ................................................ 2-37
- Care Select ..................................................................................... 2-37
- Package E: Emergency Services Only .............................................. 2-37
  - Member Eligibility and Coverage .................................................. 2-37
- Family Planning Services for Women and Men ................................ 2-38
  - Member Eligibility and Coverage .................................................. 2-38
  - Description of Service .................................................................. 2-39
  - Reimbursement Requirements ...................................................... 2-40
Member Eligibility ................................................................. 2-40
Hospital Presumptive Eligibility ........................................ 2-40

Section 5: Care Select .......................................................... 2-41
Overview ............................................................................... 2-41
Member Eligibility and Coverage ...................................... 2-41

Section 6: 590 Program ......................................................... 2-44
Member Eligibility and Coverage ...................................... 2-44
Delivery System .................................................................. 2-44

Section 7: Healthy Indiana Plan ........................................... 2-45
Overview ............................................................................... 2-45
Enhanced Services Plan ...................................................... 2-45
Member Eligibility ............................................................... 2-46
Eligibility Verification System .............................................. 2-46
Personal Wellness and Responsibility Account .................. 2-46
Billing Procedures for Providers ......................................... 2-47
Covered Services ................................................................. 2-47
Prior Authorization .............................................................. 2-48

Section 8: Program for All-Inclusive Care to the Elderly (PACE) ...... 2-49
Overview ............................................................................... 2-49
Covered Services ................................................................. 2-49

Section 9: Medical Review Team ......................................... 2-50
Overview ............................................................................... 2-50
Eligibility Determinations .................................................... 2-50
Billing Procedures ................................................................. 2-50
Member Eligibility ............................................................... 2-51

Section 10: Right Choices Program ....................................... 2-52
Overview ............................................................................... 2-52

Section 11: Traditional Medicaid, Hoosier Healthwise Package A, and Healthy Indiana Plan Member Copayment Policies ................. 2-53
Overview ............................................................................... 2-53
Copayment Policies ............................................................. 2-53
Federal Guidelines ............................................................... 2-53
Transportation Services ...................................................... 2-53
Pharmacy Services .............................................................. 2-54
Nonemergency Services Rendered in the Emergency Department 2-54
Nonemergency Services for Care Select Members ............... 2-54

Section 12: Hoosier Healthwise Package C Member Copayment Policies2-56
General Information ........................................................... 2-56
Copayment Policies ............................................................. 2-56
Transportation Services ...................................................... 2-56
Emergency Department Services ....................................... 2-56

Section 13: Retroactive Member Eligibility .......................... 2-57
Traditional Medicaid, Care Select, and Hoosier Healthwise Packages A ......................................................... 2-57
Hoosier Healthwise Package C Members .............................. 2-58

Section 14: 12-Month Monitoring Cycle .............................. 2-59
Overview ............................................................................... 2-59
Member Appeal Process ..................................................... 2-59
Section 1: Member Identification

Member Identification Number

Each Indiana Health Coverage Programs (IHCP) member is issued a 12-digit identification number that is referred to as the member or recipient identification number (RID). The RID is assigned by the Family and Social Services Administration (FSSA) Division of Family Resources (DFR) through the automated Indiana Client Eligibility System (ICES).

Member Identification Card – Hoosier Health Card

The IHCP member identification card, called the Hoosier Health Card, is used to identify eligibility for medical services. See Figure 2-1. Healthy Indiana Plan (HIP) members do not receive a Hoosier Health Card. HIP members receive member ID cards from the health plans. The card is a permanent plastic identification card the member is expected to retain for his or her lifetime. The Hoosier Health Card contains the following information:

- Member name
- Gender
- Date of birth
- Member identification number

Providers are required to verify eligibility on the date of service. Providers that fail to verify eligibility are at risk of claims being denied due to member ineligibility or coverage limitations. See Chapter 3: Electronic Solutions for additional information about eligibility verification.

If a member does not have a Hoosier Health Card at the time of service, a provider can still verify eligibility if the provider has the member’s RID, Medicare number, or Social Security number. The provider can also verify eligibility by using the member’s full name and date of birth on Health Insurance Portability and Accountability Act (HIPAA)-compliant devices, such as Web InterChange and Automated Voice Response (AVR) system. See Chapter 3: Electronic Solutions for more information about these Eligibility Verification System (EVS) options.
General Information about the Card

- Cards are issued upon program enrollment.
- The DFR determines eligibility, and cards are then generated and mailed within five business days of the action updating IndianaAIM. The member must allow five business days plus mailing time to receive the card. A letter to inform the member of eligibility status is system-generated within 24 hours of eligibility determination.
- Members should retain their cards even if eligibility lapses, in case eligibility is reinstated at a later date. Members may contact their local DFR county office or call toll-free 1-800-403-0864 to request a replacement card.
- Each family member covered by the IHCP receives an ID card specific to that member.
- Cards are not available at the local DFR county offices.
- Providers may photocopy cards.

Member Identification Card – Healthy Indiana Plan

HIP members are given member ID cards through the health plans, Managed Health Services (MHS), Anthem, or MDwise. Examples of HIP cards are provided in Figures 2.2 through 2.5. Although HIP eligibility information is available through the plans, limited information will also be available in the IHCP EVS. Member numbers are located in the indicated areas on the HIP cards shown in Figures 2.2 through 2.5. This information can be used in any of the EVS options to verify HIP eligibility.
Note: State ID is the RID used by pharmacies to process the prescription benefits. The number is located on the back of the card.

Figure 2.2 – Sample MDwise HIP Member Card

Figure 2.3 – Sample Anthem HIP Member Card with Dentalvision

Figure 2.4 – Sample Anthem HIP Member Card without Dentalvision
Figure 2.5 – Sample MHS HIP Member Card
Section 2: Member Eligibility

General Information

Providers should refer people interested in applying for Indiana Health Coverage Programs (IHCP) benefits to contact the Division of Family Resources (DFR) call center at 1-800-403-0864, apply at their local DFR office, or apply online at in.gov/fssa/dfr/2999.htm.

The Family and Social Services Administration (FSSA) provides general information about program eligibility and application on the FSSA website at in.gov.

Member eligibility for the 590 Program is initiated by the institution where the member resides.

Indiana Health Coverage Programs

The FSSA has categorized all covered IHCP into distinct subprograms that include the following:

- Hoosier Healthwise
- Traditional Medicaid
- Care Select
- 590 Program
- Healthy Indiana Plan (HIP)
- Family Planning Eligibility Program for women and men
- Presumptive Eligibility for Pregnant Women (PEPW)
- Hospital Presumptive Eligibility (HPE)

Eligibility Verification

Importance of Verifying Eligibility

It is important that providers verify member eligibility on the date of service. Viewing a Hoosier Health Card alone does not ensure member eligibility. If a provider fails to verify eligibility on the date of service, the provider risks claim denial. Claim denial could result if the member was not eligible on the date of service, or if the service provided was outside the member’s scope of coverage.

If the member is not eligible on the date of service, the member can be billed for services. However, it is important to remember that if retroactive eligibility is later established, the provider must bill the IHCP and refund any payment made to the provider by the member.

The DFR authorizes and initiates actions that affect member eligibility. The Eligibility Verification System (EVS) is updated daily with member eligibility information transmitted from the Indiana Client Eligibility System (ICES). The timing of the process (with the exception of Friday’s activity) is as follows:

1. Information from ICES is downloaded from all counties daily after the close of business.
2. This file is passed electronically to IndianaAIM between midnight and 5 a.m. the next day.
3. IndianaAIM completes file processing by 9 a.m. the same day it receives the file.
4. The EVS is updated around 11 p.m. the day the file was processed. In the case of Friday’s activity, the EVS is not updated until 11 p.m. Sunday.

The entire process takes two days to complete with the exception of Friday’s activity, which takes three days to complete. For example, if a DFR worker makes changes on Monday and the changes are transmitted to IndianaAIM Tuesday morning, between midnight and 5 a.m., IndianaAIM completes processing of Monday’s file by 9 a.m. Tuesday. The EVS is updated by 11 p.m. Tuesday.

Regardless of the method used to verify eligibility, the following guidelines apply:

- If the member has a primary medical provider (PMP), the physician identified must be contacted to determine whether a referral is needed.
- If the member is a risk-based managed care (RBMC) member, the managed care entity (MCE) identified in the response must be contacted for more specific program information.
- If the member is a Care Select member, the care management organization (CMO) identified in the response must be contacted for more specific program information.
- Benefit limits reflect only claims that process and pay in IndianaAIM.

**Proof of Eligibility Verification**

Providers must document the verification number provided by the Automated Voice Response (AVR) system and record it for future reference. This verification number serves as proof that member eligibility was verified. In the event that a discrepancy exists between the verification information obtained on the date of service and eligibility information on file, the verification number can be used to resolve the matter for claim processing.

Web interChange contains a time and date stamp used for proof of timely verification. In this instance, the provider must send a screen print from Web interChange to the HP Written Correspondence Unit with a completed claim form. Chapter 8: Billing Instructions provides additional information about written correspondence policies.

Note: Most denied claims are denied due to missing or incorrect information that should have been verified through one of the EVS options.

The following list gives reasons providers should always check member eligibility before rendering services:

- To avoid claim denials if the member is not eligible
- To determine whether the member is included in any of the IHCP programs or subprograms
- To determine, for a member who resides in a long-term care facility, how much liability to collect from the member
- To determine whether a member is enrolled in a hospice benefit program
- To determine whether the member has waiver Level of Care (LOC) services
- To determine whether the member is restricted to a designated pharmacy, hospital, or physician
- To determine whether the member’s coverage is limited to pregnancy and related care services only
- To determine whether the member is eligible for emergency services only
- To determine whether the member has a waiver liability or end-stage renal disease (ESRD) patient liability
• To determine whether the member is eligible for services only as a Qualified Medicare Beneficiary (QMB)
• To determine whether the member has other third-party liability (TPL) insurance coverage that takes precedence
• To determine whether a member is enrolled with any of the MCEs, HIP health plans, or CMOs
• To verify whether member benefit limitations have been reached
• To determine whether the member’s coverage is limited to family planning services only

How to Verify Member Eligibility

Providers can verify eligibility by using one of the following eligibility verification methods:
• Web interChange
• Approved vendor software for the 270/271 batch or interactive eligibility benefit transactions
• AVR

All eligibility verification applications can be used to verify the eligibility status of a member for dates of service greater than one year in the past. Eligibility inquiries are limited to one calendar month date span.

The EVS restricts providers from accessing member eligibility information for dates of service that are not within an active IHCP provider’s program eligibility segment. Providers may verify eligibility for members for any date of service that is within the provider’s program eligibility segment. If providers enter a date span, each day in the date span must be within the provider’s program eligibility segment. For example, if provider program eligibility date segment is 11/1/12 to 5/15/14, and an eligibility inquiry is entered for a date span of 4/15/14 to 5/20/14, the 5/16, 5/17, 5/18, 5/19, and 5/20 all fall outside the provider’s program eligibility segment. Even though there are some days that fall within the date range, because there are some days that fall outside, the inquiry on eligibility verification will not be allowed. Additional information about the EVS can be found in Chapter 3: Electronic Solutions of this manual.

Note: Customer Assistance representatives do not provide eligibility verification information.

Health Plan Eligibility

The EVS provides health plan information if the member is assigned to an MCE, HIP, or CMO health plan for the time period of the eligibility request. The MCE, HIP, or CMO is an organization that participates in an FSSA health plan program, by provision of health plan services or through a program administrator.

If a member is assigned to a health plan program, the following information is included in the eligibility response on Web interChange and AVR:
• Type of managed care member (RBMC, Care Select, or HIP)
• MCE, HIP, or CMO name and telephone number
• PMP name and telephone number
• PMP assignment by date of service
  – If the member has been assigned to multiple PMPs during the time period of the eligibility request, the eligibility response includes each PMP and the PMP-MCE information with the date segments that the member was assigned to the PMP.
Section 3: Hoosier Healthwise Program

Member Eligibility and Coverage

The Hoosier Healthwise program provides coverage for children, pregnant women, and transitional low-income parents and caretakers. Enrollment in Hoosier Healthwise is mandatory for aid categories that include children, pregnant women, and children who are eligible for the Children’s Health Insurance Program (CHIP) unless they are a member of an exempted group. The specific eligibility aid category determines the benefit package.

The following Indiana Health Coverage Programs (IHCP) enrollees are excluded from mandatory participation in Hoosier Healthwise managed care:

- Individuals in nursing homes and other institutions, such as intermediate care facilities for individuals with intellectual disability (ICFs/IID)
- Immigrants who do not have documentation or whose status is unverified.
- Individuals receiving waiver or hospice services
- Members with waiver liability or end-stage renal disease (ESRD) patient liability
- Members eligible for Family Planning Services for Women and Men

Table 2.1 explains the Hoosier Healthwise benefit packages.

<table>
<thead>
<tr>
<th>Benefit Package</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package A Standard Plan</td>
<td>Full coverage for children, transitional low-income parents or caretakers (package also covers Care Select). Full coverage for pregnant women effective January 1, 2014.</td>
</tr>
<tr>
<td>Package C – Children’s Health Plan</td>
<td>Preventive, primary, and acute care services for some children under 19 years old.</td>
</tr>
<tr>
<td>Package P – Presumptive Eligibility</td>
<td>Presumptive eligibility for pregnant women.</td>
</tr>
</tbody>
</table>

As part of the Hoosier Healthwise enrollment process, managed care entities (MCEs) are responsible for making primary medical provider (PMP) assignments. Members must select an MCE or health plan that will assist with selection of a PMP. Members who do not make a voluntary MCE selection will be auto-assigned to a health plan through an automated assignment process. Auto-assignment is a federal requirement. The following provider specialties are eligible to enroll as a PMP:

- Family practice (type 31, specialty 316)
- General practice (type 31, specialty 318)
- Internal medicine (type 31, specialty 344)
- Obstetrics/gynecology (type 31, specialty 328)
- General Pediatrics (type 31, specialty 345)

Note: Member enrollment in managed care is effective on the first or 15th calendar day of a month and may be confirmed by any of the Eligibility Verification System (EVS) options described in Chapter 3: Electronic Solutions of this manual.
Unlike Hoosier Healthwise, Presumptive Eligibility for Pregnant Women (PEPW) members must select their health plan through the enrollment broker or their Presumptive Eligibility coverage will not start. Enrollment for newborns whose mothers are enrolled in Package A with an MCE on the date of delivery is retroactive with the mother’s MCE to the newborn’s date of birth. PMP changes that are outside the member’s current MCE will require an MCE change prior to the PMP change. MCE changes are completed by the enrollment broker during a member’s Open Enrollment period or as a just cause. MCE changes are effective on the first of the month whereas MCE enrollment for new members (excluding newborns/PEPW) may occur on the first or the 15th.

Hoosier Healthwise Open Enrollment

The Division of Family Resources (DFR) determines when an applicant is approved for eligibility in Hoosier Healthwise. After the DFR approves an applicant’s eligibility, the member has 14 days in which to select an MCE if the member has not selected a PMP on the application. If the member does not make an MCE selection after 14 days, an MCE is selected for the member (known as auto-assignment) based on the member’s prior participation or family member assignment.

Upon enrollment with an MCE, the member begins a 90-day free change period. During the free change period, the member may change from one MCE to another for any reason. When the free change period ends, the member remains with his or her chosen MCE for nine months and may not move to another MCE except for reasons that meet the standard of just cause. Just cause reasons include:

- Lack of access to medically necessary services covered under the MCE’s contract with the State
- Service not covered by the MCE for moral or religious objections
- Related services required to be performed at the same time
  - 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
- Lack of access to providers experienced in dealing with the member’s healthcare needs
- Concerns over quality of care
  - Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers.
- Member’s PMP disenrollment from member’s current MCE
  - If a member’s PMP disenrolls from the member’s current MCE and reenrolls into a new MCE, the member can change plans to follow his or her PMP to the new MCE.

Under Open Enrollment, members may choose a different PMP within their selected MCE.

Hoosier Healthwise Package A: Standard Plan

Member Eligibility and Coverage

Standard Plan coverage encompasses the full array of IHCP benefits for children, transitional low-income parents and caretakers, and pregnant women enrolled in the Hoosier Healthwise Program.
Indiana Breast and Cervical Cancer Program

Patients diagnosed with breast or cervical cancer through the Indiana Breast and Cervical Cancer Program (BCCP) of the Indiana State Department of Health (ISDH) are also eligible for Hoosier Healthwise Package A coverage during the course of treatment. These members are in the fee-for-service (FFS) delivery system only. To be eligible, a woman must meet the following criteria:

- Must be younger than 65 years old.
- Must not be eligible for another Medicaid category.
- Must not be covered by any other insurance that includes breast or cervical cancer treatment.
- Alternatively, a woman can receive coverage for treatment under the BCCP program if she was diagnosed with breast or cervical cancer, but not screened through BCCP if:
  - She is between the ages of 18 and 65.
  - She has income at or below 200% of the FPL.
  - She is not eligible for Medicaid under any other category.
  - She has no health insurance that will cover her treatment.

Hoosier Healthwise Package C: Children’s Health Plan

Member Eligibility and Coverage

To be eligible, a child must meet the following criteria:

- The child must be younger than 19 years old.
- The child’s family income must be between 158% and 250% of the federal poverty level.
- The child must not have minimum essential coverage at any time during the waiting period lasting no longer than 90 days.
- The child’s family must satisfy all cost-sharing requirements.

Enrollment Process and Cost-Sharing Requirements

The Indiana Application for Health Coverage is used for Medicaid, HIP, and CHIP. A child determined eligible for Package C is made conditionally eligible pending a premium payment. The child’s family must pay a monthly premium, as shown in Table 2.2. After the premium is paid, eligibility information is transferred to IndianaAIM.

Table 2.2 – Hoosier Healthwise Premium Comparison

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income (As a Percentage of the Federal Poverty Level)</strong></td>
<td><strong>One Child</strong></td>
</tr>
<tr>
<td>158 to 175%</td>
<td>$22.00</td>
</tr>
<tr>
<td>175 to 200%</td>
<td>$33.00</td>
</tr>
<tr>
<td>200 to 225%</td>
<td>$42.00</td>
</tr>
<tr>
<td>225 to 250%</td>
<td>$53.00</td>
</tr>
</tbody>
</table>
Enrollment continues as long as premium payments are received and the child continues to meet all eligibility requirements. Enrollment is terminated for nonpayment of premiums after a 60-day grace period.

The child’s family may also be required to make copayments for some services. Providers are responsible for collecting copayments, and the copayment amount is deducted from the claim. Specific information about Package C member copayments is included in this chapter.

Package C members do not have retroactive eligibility. Package C members may be eligible for coverage no earlier than the first day of the month of the Indiana Application for Health Coverage.

Hoosier Healthwise Package C provides preventive, primary, and acute healthcare coverage to children younger than 19 years old.

Children enrolled in Package C are eligible for the following benefits:

- Ambulance transportation
- Chiropractic services
- Clinic services
- Dental services
- Early intervention services
- Home health services
- Hospital services
- Inpatient rehabilitative services
- Laboratory and radiology services
- Medical supplies and equipment
- Mental health and substance abuse services
- Physicians’ surgical and medical services
- Podiatry
- Prescription drugs
- Therapies
- Vision services

The following services have coverage limitations and policies under Hoosier Healthwise Package C that differ from those limitations required by Hoosier Healthwise Package A:

- **Emergency Ambulance Transportation:** Package C is covered for emergency ambulance transportation subject to the prudent layperson standard as defined in 407 IAC 1-1-6. This service is subject to a $10 copayment.

- **Nonemergency Ambulance Transport:** Ambulance service for nonemergencies between medical facilities is covered when requested by a participating physician. A $10 copayment applies. All other nonemergency transportation is not covered for Package C.

- **Chiropractic services:** Coverage is limited to five visits and 14 therapeutic physical medicine treatments per member per rolling 12-month period. An additional 36 treatments may be covered if prior authorization (PA) is obtained based on medical necessity.

- **Early intervention services:** Package C covers immunizations and initial and periodic screenings according to the HealthWatch Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
periodicity and screening schedule. Coverage of referral and treatment services is subject to the Package C benefit limitations.

- **Inpatient rehabilitative services:** Coverage is available for a maximum of 50 days per calendar year.
- **Medical supplies and equipment:** Coverage is available for a maximum benefit of $2,000 per year and $5,000 per lifetime per member.
- **Podiatry services:** Surgical procedures involving the foot, which may include laboratory or X-ray services, and hospital stays are covered when medically necessary.
- **Prescription drugs:** The pharmacists provide a brand name drug only when the prescribing physician writes **Brand Medically Necessary, or words of similar meaning**, on the written or orally communicated prescription. The generic equivalent of a brand name drug will be substituted if one is available and the substitution results in a lower price. The medication should be dispensed as written; the pharmacist must dispense the drug prescribed. Pharmacy copayments for members enrolled in Hoosier Healthwise Package C continue to be $3 for generic drugs and $10 for brand name drugs.
- **Therapies:** Physical, speech, occupational, and respiratory therapy are covered for a maximum of 50 visits per rolling 12 months per type of therapy.

Note: The MCEs may have different PA requirements and should be contacted for specific information.

**Wraparound Services**

Enrolled children, including children enrolled in Hoosier Healthwise Package C, may be eligible for additional health coverage from the following programs:

- **Indiana First Steps:** This program provides early intervention services including:
  - Screenings and assessments
  - Planning and service coordination
  - Therapeutic services
  - Support services
  - Information and communication to infants and toddlers who have disabilities or who are developmentally vulnerable

- **Children’s Special Health Care Services at ISDH (CSHCS):** The CSHCS program provides healthcare services for children through age 21 who have a severe chronic medical condition that:
  - Has lasted or is expected to last at least two years
  - Will produce disability, disfigurement, or limits on function
  - Requires a special diet or devices
  - Would produce a chronic disabling condition without treatment

Both programs require the assistance of healthcare professionals to identify children for assessment and diagnostic evaluations, and to provide diagnoses and referrals. Additional information about the programs may be obtained by calling First Steps at 1-800-441-STEP (7837) option 1 or accessing the First Steps website at in.gov/fssa and by calling CSHCS at 1-800-475-1355 or accessing the CSHCS website at in.gov/isdh.

Note: The billing procedures for Hoosier Healthwise Package C are the same as those for the other Hoosier Healthwise benefit packages.
Even though children enrolled in Hoosier Healthwise Package C should not have other minimal essential coverage, providers are required to bill all other insurance carriers prior to billing the IHCP if additional insurance coverage is discovered.

**Package P: Presumptive Eligibility for Pregnant Women**

### Member Eligibility and Coverage

The aid category, Presumptive Eligibility for Pregnant Women (PEPW), allows pregnant women to receive earlier coverage of prenatal care while their Indiana Application for Health Coverage is in process.

To be eligible for PEPW, a pregnant woman must meet the following eligibility requirements:

- Be pregnant as self-attested.
- Not be a current IHCP member.
- Be an Indiana resident.
- Be a U.S. citizen or qualified noncitizen.
- Not be currently incarcerated.
- Have a family income level less than 213% of the federal poverty level (FPL).

**Note:** A 5% income disregard is applied if the member is found ineligible at a 213% FPL, but would be income eligible with the disregard.

Package P covers only pregnancy-related ambulatory services including:

- Doctor visits for prenatal care
- Lab work related to pregnancy
- Immunizations
- Outpatient services
- Prescriptions related to pregnancy
- Dental services (covered fee-for-service)
- Transportation for pregnancy- or emergency-related care
- Mental health
- Home health

Package P does not cover hospice, long-term care, inpatient care, labor and delivery services, abortion services, postpartum services, sterilization, and services unrelated to the pregnancy or birth outcome. These services, if determined to be pregnancy-related, may be covered if the woman is later determined to be fully eligible for IHCP benefits.

### Enrollment Process

**Presumptive Eligibility for Pregnant Women**

The Presumptive Eligibility for Pregnant Women (PEPW) process allows qualified providers (QPs) to make presumptive eligibility determinations for pregnant women so they can receive earlier coverage
of prenatal care while their official IHCP applications are in process. Providers that may be qualified under the PEPW process include medical clinics, family planning clinics, health departments, and some hospitals. For more information, see the Presumptive Eligibility for Pregnant Women Qualified Provider Manual.

Hoosier Healthwise Program Comparison

Table 2.3 compares benefit packages of the Hoosier Healthwise program. The following items apply throughout Table 2.3:

- Medicaid-covered services and limitations in Package A are cited in Title 405, Article 5 of the Indiana Administrative Code (IAC): Package C covered services and limitations are cited in Title 407, Article 3 of the IAC. The IAC is available on the State’s website at in.gov/legislative/register.
- Reimbursed under RBMC – Services not reimbursed by MCEs are covered and reimbursed for the risk-based managed care (RBMC) members under Traditional Medicaid FFS benefits reimbursement, unless otherwise indicated in Package A and C.
- Service – In Care Select and Traditional Medicaid FFS benefits and services.
- Service – In RBMC: In general, all noncontracted out-of-network providers require PA. MCE contracted, in-network providers must contact the MCE to determine if PA is required.

Table 2.3 – Comparing Benefit Packages of the Hoosier Healthwise Program

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Reimbursed under RBMC</th>
<th>Package A Standard Plan</th>
<th>Package C Children’s Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management for Mentally Ill or</td>
<td>No</td>
<td>Noncovered as of July 1, 2011 Prior to July 1, 2011, targeted case management services</td>
<td>Noncovered as of July 1, 2011 Prior to July 1, 2011, targeted case management services limited to</td>
</tr>
<tr>
<td>Emotionally Disturbed (405 IAC 5-21)</td>
<td></td>
<td>limited to those provided by or under supervision of qualified mental health professionals who are employees of a provider agency approved by the Department of Mental Health and Addiction (DMHA).</td>
<td>those provided by or under supervision of qualified mental health professionals who are employees of a provider agency approved by the DMHA.</td>
</tr>
<tr>
<td>Case Management for Pregnant Women**</td>
<td>Yes</td>
<td>Noncovered as of July 1, 2011 Prior to July 1, 2011, limited to one initial assessment,</td>
<td>Noncovered</td>
</tr>
<tr>
<td>(405 IAC 5-11)</td>
<td></td>
<td>one reassessment per trimester, and one postpartum assessment.</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services* (405 IAC 5-12)</td>
<td>Yes (Self-referral)</td>
<td>Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 50 therapeutic physical medicine treatments per member, per year.</td>
<td>Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 14 therapeutic physical medicine treatments per member per rolling 12 months. An additional 36 treatments may be covered if prior approval is obtained based on medical necessity. There is a 50-treatment limit per calendar year.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed under RBMC</td>
<td>Package A Standard Plan</td>
<td>Package C Children’s Health Plan</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Yes</td>
<td>Coverage available to qualified members with chronic diseases such as congestive heart failure, diabetes, and asthma, to enhance, support, or train on self-management skills.</td>
<td>Coverage available to qualified members with chronic diseases such as congestive heart failure, diabetes, and asthma, to enhance, support, or train on self-management skills.</td>
</tr>
<tr>
<td>Dental Services (405 IAC 5-14)</td>
<td>No</td>
<td>In accordance with federal law, all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A. Effective November 5, 2011, there is no longer a benefit limit for members 21 years and older.</td>
<td>All medically necessary dental services are provided for children enrolled in Package C even if the service is not otherwise covered under CHIP.</td>
</tr>
<tr>
<td>Diabetes Self-Management Training Services* (405-IAC 5-36)</td>
<td>Yes</td>
<td>Limited to eight units per member, per year. Additional units may be prior authorized.</td>
<td>Limited to eight units per member, per year. Additional units may be prior authorized.</td>
</tr>
<tr>
<td>Drugs – Prescribed (Legend) (405 IAC 5-24)</td>
<td>No</td>
<td>IHCP covers legend drugs if the drug is:</td>
<td>IHCP covers legend drugs if the drug is:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Approved by the United States Food and Drug Administration.</td>
<td>• Approved by the United States Food and Drug Administration.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not designated by the Centers for Medicare &amp; Medicaid Services (CMS) as less than effective or identical, related, or similar to a less than effective drug or terminated.</td>
<td>• Not designated by the CMS as less than effective or identical, related, or similar to a less than effective drug or terminated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not specifically excluded from coverage by the IHCP.</td>
<td>• Not specifically excluded from coverage by the IHCP.</td>
</tr>
<tr>
<td>Drugs – Over-the-counter (Nonlegend)</td>
<td>No</td>
<td>IHCP covers nonlegend (over-the-counter) drugs on its formularies. Formularies are available under the Pharmacy Services quick link at indianamedicaid.com.</td>
<td>Not covered, except for insulin.</td>
</tr>
<tr>
<td>Early Intervention Services (EPSDT)</td>
<td>Yes</td>
<td>Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary healthcare services in accordance with the HealthWatch EPSDT periodicity and screening schedule.</td>
<td>Covers immunizations and initial and periodic screenings according to the HealthWatch EPSDT periodicity and screening schedule. Coverage of treatment services is subject to the Package C benefit package coverage limitations.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed under RBMC</td>
<td>Package A Standard Plan</td>
<td>Package C Children’s Health Plan</td>
</tr>
<tr>
<td>---------</td>
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<td>-------------------------</td>
<td>----------------------------------</td>
</tr>
</tbody>
</table>
| Emergency Services  
(405 IAC 12-15-12-15 and 405 IAC 12-15-12-17) | Yes  
(Self-referral) | Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered. | Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered. |
| Eye Care, Eyeglasses, and Vision Services  
(405 IAC 5-23) | Yes  
(Self-referral) | Coverage for the initial vision care examination is limited to one examination per year for a member under 21 years of age and one examination every two years for a member 21 years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, are limited to a maximum of one pair per year for members under 21 years of age and one pair every five years for members 21 years and older. Exceptions are when a specified minimum prescription change makes additional coverage medically necessary or the member’s lenses and/or frames are lost, stolen, or broken beyond repair. | Vision care examination is limited to one examination per year for a member under 21 years of age unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, is limited to a maximum of one pair per year for members under 21 years of age except when a specified minimum prescription change makes additional coverage medically necessary or the member’s lenses and/or frames are lost, stolen, or broken beyond repair. |
| Federally Qualified Health Centers  
(FQHCs) | Yes | Coverage is available for medically necessary services provided by licensed healthcare practitioners. | Coverage is available for medically necessary services provided by licensed healthcare practitioners. |
| Food Supplements, Nutritional Supplements, and Infant Formulas**  
(405 IAC 5-24-9) | Yes | Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs. | Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs. |
| Hospital Services – Inpatient*  
(405-IAC 5-17) | Yes | Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition. PA is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn stays will not require PA. | Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition. |
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Reimbursed under RBMC</th>
<th>Package A Standard Plan</th>
<th>Package C Children’s Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Services – Outpatient*</td>
<td>Yes</td>
<td>Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
<td>Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
</tr>
<tr>
<td>(405 IAC 5-17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Services**</td>
<td>Yes</td>
<td>Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.</td>
<td>Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.</td>
</tr>
<tr>
<td>(405 IAC 5-16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Services**</td>
<td>No</td>
<td>Hospice is available under Traditional Medicaid if the recipient is expected to die from illness within six months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days. Member must be disenrolled from Hoosier Healthwise before hospice benefit can begin.</td>
<td>Noncovered</td>
</tr>
<tr>
<td>(405 IAC 5-34)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory and Radiology Services</td>
<td>Yes</td>
<td>Coverage is available for medically necessary services and must be ordered by a physician.</td>
<td>Coverage is available for medically necessary services and must be ordered by a physician.</td>
</tr>
<tr>
<td>(405 IAC 5-18 and 405-IAC 5-27)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Acute Care Hospitalization **</td>
<td>Yes</td>
<td>Long-term acute care services are covered. PA is required. An all-inclusive per diem rate is paid based on level of care.</td>
<td>Long-term acute care services are covered up to 50 days per calendar year. Prior authorization is required. An all-inclusive per diem rate is based on level of care.</td>
</tr>
<tr>
<td>(IHCP Provider Manual, Chapter 14: Long Term Care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed under RBMC</td>
<td>Package A Standard Plan</td>
<td>Package C Children’s Health Plan</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Medical Supplies and Equipment (includes prosthetic devices, implants,</td>
<td>Yes</td>
<td>Coverage is available for medical supplies, equipment, and appliances suitable for use in</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>hearing aids, dentures, and so forth)** (405 IAC 5-19)</td>
<td>(Except drug-related</td>
<td>the home when medically necessary. Incontinence supplies are covered for members 3 years</td>
<td>Maximum benefit of $2,000 per</td>
</tr>
<tr>
<td></td>
<td>medical supplies and</td>
<td>old or older. Incontinence, urological, and ostomy supplies are covered for one of two</td>
<td>year or $5,000 per lifetime for</td>
</tr>
<tr>
<td></td>
<td>devices, dentures</td>
<td>contracted vendors. A maximum allowable benefit of $1,950 per member, per rolling</td>
<td>durable medical equipment.</td>
</tr>
<tr>
<td></td>
<td>or dental devices,</td>
<td>calendar year for all incontinence supplies is assigned. Providers may only supply such</td>
<td>Equipment may be purchased or</td>
</tr>
<tr>
<td></td>
<td>dental products,</td>
<td>services to an IHCP member in 30-day increments. Certain procedures are limited to</td>
<td>leased, depending on which</td>
</tr>
<tr>
<td></td>
<td>and dental supplies)</td>
<td>15 months of continuous rental.</td>
<td>is more cost efficient.</td>
</tr>
<tr>
<td>Mental Health Services – Outpatient* (405 IAC 5-19)</td>
<td>Yes</td>
<td>Coverage includes mental health services provided by physicians, psychiatric wings of acute</td>
<td>Coverage includes mental health</td>
</tr>
<tr>
<td></td>
<td>(Except Medicaid</td>
<td>care hospitals, outpatient mental health facilities, and psychologists endorsed as health</td>
<td>services provided by physicians,</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation</td>
<td>services providers in psychology (HSPP).</td>
<td>psychiatric wings of acute care</td>
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<td></td>
<td>Option [MRO])</td>
<td></td>
<td>hospitals, outpatient mental</td>
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<td></td>
<td></td>
<td></td>
<td>health facilities, and</td>
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<td></td>
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<td>psychologists endorsed as</td>
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<td></td>
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<td></td>
<td>HSPP.</td>
</tr>
<tr>
<td>MRO – Community Mental Health Centers * (405 IAC 5-22-1)</td>
<td>No</td>
<td>Coverage includes outpatient mental health services, partial hospitalization (group activity</td>
<td>Coverage includes outpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>program), and case management.</td>
<td>mental health services, partial</td>
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<td></td>
<td></td>
<td></td>
<td>hospitalization (group activity</td>
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<tr>
<td></td>
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<td></td>
<td>program), and case management.</td>
</tr>
<tr>
<td>Mental Health Services – Inpatient** (Freestanding Psychiatric</td>
<td>Yes</td>
<td>Medicaid reimbursement is available for inpatient psychiatric services provided to an</td>
<td>Inpatient mental health/substru-</td>
</tr>
<tr>
<td>Facility) (405 IAC 5-20)</td>
<td></td>
<td>individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds</td>
<td>ct abuse services are covered</td>
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<td>or less.</td>
<td>when the services are medically</td>
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<td>necessary for the diagnosis or</td>
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<td>treatment of the member’s</td>
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<td>condition except when they are</td>
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<td>provided in an institution for</td>
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<td>treatment of mental diseases</td>
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<td></td>
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<td>with more than 16 beds.</td>
</tr>
<tr>
<td>Intermediate Care Facilities for Individuals with Intellectual</td>
<td>No</td>
<td>60 days maximum, pending and prior to level of care determination. Medicaid coverage is</td>
<td>60 days maximum, pending and</td>
</tr>
<tr>
<td>Disability (ICFs/IID) – Services ** (405 IAC 5-13-2, IHCP Provider</td>
<td></td>
<td>available with preadmission diagnosis and evaluation. Includes room and board, mental</td>
<td>prior to level of care</td>
</tr>
<tr>
<td>Manual Chapter 14: Long Term Care)</td>
<td></td>
<td>health services, dental, therapy and habilitation services, durable medical equipment,</td>
<td>determination. Medicaid</td>
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<td></td>
<td></td>
<td>medical supplies, pharmaceutical products, transportation, and optometric services. *</td>
<td>coverage is available with</td>
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<td></td>
<td>Member must be disenrolled from Hoosier Healthwise for the benefit to begin.</td>
<td>preadmission diagnosis and</td>
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<td>evaluation. Includes room and</td>
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<td>board, mental health services,</td>
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<td>dental, therapy and habilitation</td>
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<td>services, durable medical</td>
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<td>equipment, medical supplies,</td>
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<td>pharmaceutical products,</td>
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<td>transportation, and optometric</td>
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<td>services. Member must be</td>
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<td>disenrolled from Hoosier Health-</td>
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<td>wise for the benefit to begin.</td>
</tr>
</tbody>
</table>

** (405 IAC 5-19)**

* (405 IAC 5-22-1)
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Reimbursed under RBMC</th>
<th>Package A Standard Plan</th>
<th>Package C Children’s Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Midwife <em>(405 IAC 5-22-3)</em></td>
<td>Yes</td>
<td>Coverage is available for medically necessary services or preventative healthcare services provided by a licensed, certified nurse-midwife within the scope of the applicable license and certification.</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioners <em>(405 IAC 5-22-4)</em></td>
<td>Yes</td>
<td>Coverage is available for medically necessary services or preventative healthcare services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Services ** <em>(Long-term)</em> <em>(405 IAC 5-31-1, IHCP Provider Manual, Chapter 14: Long Term Care)</em></td>
<td>No</td>
<td>Requires pre-admission screening for level of care determination and disenrollment from Hoosier Healthwise. RBMC coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation for a maximum of 60 days and prior to level of care determination. Noncovered</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Services ** <em>(Short-term)</em> Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID) – Services ** <em>(405 IAC 5-31-1)</em></td>
<td>No</td>
<td>The MCE may obtain services for its members in a nursing facility setting on a short-term basis, up to 60 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 can negotiate rates for reimbursing the nursing facilities for these short-term stays. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board, mental health services, dental, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services. Member must be disenrolled from Hoosier Healthwise for the benefit to begin. Noncovered</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed under RBMC</td>
<td>Package A Standard Plan</td>
<td>Package C Children’s Health Plan</td>
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</tr>
<tr>
<td>Nursing Facility Services (Short-term) <em>(405 IAC 5-31-1)</em></td>
<td>Yes</td>
<td>The MCE may obtain services for its members in a nursing facility setting on a short-term basis, up to 60 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 can negotiate rates for reimbursing the nursing facilities for these short-term stays.</td>
<td>Noncovered</td>
</tr>
<tr>
<td>Occupational Therapy** <em>(405 IAC 5-22)</em></td>
<td>Yes</td>
<td>Services must be ordered by a doctor of medicine (MD) or doctor of osteopathy (DO) and provided by a qualified therapist or assistant. PA is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge. Any combination of therapies ordered cannot exceed 30 units in 30 calendar days without PA. Effective for dates of service on or after June 30, 2011, PA is required for all members age 21 or older.</td>
<td>Services must be ordered by an MD or DO and provided by a qualified therapist or assistant. Maximum of 50 visits per rolling 12-month period <em>(407 IAC 3-8-2)</em>, per type of therapy.</td>
</tr>
<tr>
<td>Organ Transplants** <em>(405 IAC 5-3-13)</em></td>
<td>Yes</td>
<td>Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.</td>
<td>Noncovered</td>
</tr>
<tr>
<td>Orthodontics** <em>(IHCP Provider Manual, Chapter 8: Billing Instructions)</em></td>
<td>No</td>
<td>No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.</td>
<td>No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.</td>
</tr>
<tr>
<td>Out-of-state Medical Services** <em>(405 IAC 5-5)</em></td>
<td>Yes</td>
<td>Medicaid reimbursement is available for the following services provided outside Indiana: acute hospital care, physician services, dental services, pharmacy services, transportation services, therapy services, podiatry services, chiropractic services, and durable medical equipment and supplies. All out-of-state services are subject to the same limitations as in-state services.</td>
<td>Covers acute, general hospital care, physician services, dental services, pharmacy services, transportation services, therapy services, podiatry services, chiropractic services, durable medical equipment, and supplies. Coverage is subject to any limitations included in the CHIP benefit package.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed under RBMC</td>
<td>Package A Standard Plan</td>
<td>Package C Children’s Health Plan</td>
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</tr>
<tr>
<td>Physician Surgical and Medical Services* <em>(405 IAC 5-25)</em></td>
<td>Yes</td>
<td>Coverage includes reasonable services provided by an MD or DO for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within scope of practice. PMP office visits are limited to a maximum of four per month or 20 per year, per member without PA.</td>
<td>Coverage includes reasonable services provided by an MD or DO for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within scope of practice. PMP office visits are limited to a maximum of 30 per rolling 12-month period per member without PA.</td>
</tr>
<tr>
<td>Physical Therapy* <em>(405 IAC 5-22-6)</em></td>
<td>Yes</td>
<td>Services must be ordered by an MD or DO and provided by a qualified therapist or assistant. PA is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge. Any combination of therapies ordered cannot exceed 30 units in 30 calendar days without PA. Effective for dates of service on or after June 30, 2011, PA is required for all members age 21 or older.</td>
<td>Services must be ordered by an MD or DO and provided by a qualified therapist or assistant. Maximum of 50 visits per rolling 12-month period, per type of therapy.</td>
</tr>
<tr>
<td>Podiatric Services <em>(405 IAC 5-26)</em></td>
<td>Yes (Self-referral)</td>
<td>Surgical procedures involving the foot, laboratory, X-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.</td>
<td>Surgical procedures involving the foot, laboratory, X-ray services, and hospital stays are covered when medically necessary. Routine foot care services are not covered.</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility (PRTF) ** <em>(405 IAC 5-20-3.1)</em></td>
<td>No</td>
<td>Reimbursement is available for medically necessary services provided to children younger than 21 years old in a PRTF. Reimbursement is also available for children younger than 22 years old who began receiving PRTF services immediately before their 21st birthday. All services require PA. The FSSA will notify the MCE when an MCE’s member is admitted to a PRTF. The MCE is required to provide case management and utilization management during the member’s stay. The MCE is not at financial risk for PRTF services.</td>
<td>Reimbursement is available for medically necessary services provided to children younger than 21 years old in a PRTF. Reimbursement is also available for children younger than 22 years old who began receiving PRTF services immediately before their 21st birthday. All services require PA. The FSSA will notify the MCE when an MCE’s member is admitted to a PRTF. The MCE is required to provide case management and utilization management during the member’s stay. The MCE is not at financial risk for PRTF services.</td>
</tr>
<tr>
<td>Rehabilitation Unit Services – Inpatient** <em>(405 IAC 5-32)</em></td>
<td>Yes</td>
<td>The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function, or self-care activities.</td>
<td>Covered up to 50 calendar days per calendar year.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed under RBMC</td>
<td>Package A Standard Plan</td>
<td>Package C Children’s Health Plan</td>
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<tr>
<td>Respiratory Therapy* (405 IAC 5-22)</td>
<td>Yes</td>
<td>Services must be ordered by an MD or DO and provided by a qualified therapist or assistant. PA is not required for inpatient or outpatient hospital, emergency, and oxygen in a nursing facility. 30 calendar days following discharge from hospital when ordered by physician prior to discharge.</td>
<td>Services must be ordered by an MD or DO and provided by a qualified therapist or assistant. Maximum of 50 visits per rolling year (407 IAC 3-8-2), per type of therapy.</td>
</tr>
<tr>
<td>Rural Health Clinics (RHCs)</td>
<td>Yes</td>
<td>Coverage is available for services provided by a physician; nurse practitioner; or appropriately licensed, certified, or registered therapist employed by the rural health clinic.</td>
<td>Coverage is available for services provided by a physician; physician assistant; nurse practitioner; or appropriately licensed, certified, or registered therapist employed by the rural health clinic.</td>
</tr>
<tr>
<td>Smoking Cessation Services (405 IAC 5-37)</td>
<td>Yes (Except pharmacy benefits)</td>
<td>Reimbursement is available for one 12-week course of treatment per member, per calendar year. One or more modalities may be included in any combination of treatment.</td>
<td>Reimbursement is available for one 12-week course of treatment per member, per calendar year. One or more modalities may be prescribed and counseling may be included in any combination of treatment.</td>
</tr>
<tr>
<td>Speech, Hearing and Language Disorders* (405 IAC 5-22)</td>
<td>Yes</td>
<td>Services must be ordered by an MD or DO and provided by a qualified therapist or assistant. PA is not required for initial evaluations or for services provided within 30 calendar days following discharge from a hospital when ordered by physician prior to discharge. Effective for dates of service on or after June 30, 2011, PA is required for all members age 21 or older.</td>
<td>Services must be ordered by an MD or DO and provided by a qualified therapist or assistant. Maximum of 50 visits per rolling year, per type of therapy.</td>
</tr>
<tr>
<td>Substance Abuse Services – Inpatient (Freestanding Psychiatric Facility) ** (405 IAC 5-20-3)</td>
<td>Yes</td>
<td>Inpatient mental health/substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the member’s condition except when they are provided in an institution for treatment of mental diseases with more than 16 beds for children under 21 years of age. Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less.</td>
<td>Inpatient mental health/substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the member’s condition except when they are provided in an institution for treatment of mental diseases with more than 16 beds.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed under RBMC</td>
<td>Package A Standard Plan</td>
<td>Package C Children’s Health Plan</td>
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</tr>
<tr>
<td>Substance Abuse Services – Outpatient * <em>(405 IAC 5-20-8)</em></td>
<td>Yes, except MRO services</td>
<td>Coverage includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as HSPP.</td>
<td>Coverage includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as HSPP.</td>
</tr>
<tr>
<td>Transportation – Emergency* <em>(405 IAC 5-30)</em></td>
<td>Yes</td>
<td>Coverage has no limit or prior approval for emergency ambulance or trips to or from a hospital for inpatient admission or discharge, subject to the prudent layperson standard.</td>
<td>Covers emergency ambulance transportation using the prudent layperson standard as defined in 407 IAC 1-1-6. A $10 copayment applies.</td>
</tr>
<tr>
<td>Transportation – Nonemergent <em>(405 IAC 5-30)</em></td>
<td>Yes</td>
<td>Nonemergent travel is available for up to 20 one-way trips of less than 50 miles per year without PA.</td>
<td>Ambulance services for nonemergencies between medical facilities are covered when requested by a participating physician; a $10 copayment applies. Any other nonemergent transportation is not covered.</td>
</tr>
</tbody>
</table>
Section 4: Traditional Medicaid Program

Member Eligibility and Coverage

The Traditional Medicaid program provides coverage for healthcare services rendered to the following eligibility groups:

- Persons in long-term care facilities and other institutions, such as an intermediate care facility for individuals with intellectual disability (ICF/IID)
- Immigrants who do not have documentation or unable to verify immigration status
- Persons receiving waiver or hospice services
- Persons with both Medicare and Medicaid (duals)
- Persons with waiver liability or end-stage renal disease (ESRD) patient liability
- Persons with breast and cervical cancer
- Refugees who do not qualify for any other aid category
- Wards of the State
- Foster children

The benefit packages associated with Traditional Medicaid are as follows:

- Standard plan
- Medicare Savings Program – QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-Income Beneficiary), QI (Qualified Individual), or QDWI (Qualified Disabled Working Individual) – with and without a waiver liability or ESRD patient liability
- Waiver
- Emergency services only
- Family Planning Services only

Medicaid and the Medicare Prescription Drug Coverage Program

With implementation of the Medicare Modernization Act (MMA) and Medicare Part D prescription drug coverage program (Medicare Part D), the Indiana Health Coverage Programs (IHCP) can no longer pay for Medicare-covered prescription drugs. Medicaid covers excluded Medicare Part D drugs that are listed on the IHCP Over-the-Counter Drug (OTC) Formulary, benzodiazepines, and barbiturates. Enrollment in Medicare Part D prescription drug coverage is voluntary.

Effective January 1, 2013, Medicare revised coverage of Part D drugs to include the following:

- Barbiturates when used for the medical indications of epilepsy, cancer, or chronic mental health disorders
- Benzodiazepines

As a result, the IHCP discontinued covering these drugs for IHCP members who are also eligible for Medicare Part D prescription drug coverage for prescriptions with dates of service on or after January 1, 2013.
The IHCP continues to cover barbiturates that are excluded from coverage by Medicare Part D when they are used for other medically accepted indications (for example, the combination product butalbital/aspirin/caffeine, indicated for headaches).

Medicaid members who receive full Medicaid benefits and who are enrolled in Medicare Part A or Part B do not have coverage for Medicare Part D-covered drugs unless they join or are auto-enrolled by Medicare into a Medicare prescription drug plan (PDP). Medicaid does not pay for Medicare Part D covered drugs for people who are enrolled in Medicare or who decline the Medicare Part D coverage or disenroll from the Medicare PDP.

Compounded drug products containing a Medicare Part D-covered drug product will not be covered by the IHCP for dually eligible members. This change applies to dates of service on or after November 1, 2014.

The Medicare Low-Income Subsidy (LIS), also known as “Extra Help,” is a federal subsidy provided by Medicare that helps members pay for their Medicare PDP premiums, copay, and deductibles. Members need to apply for this assistance program through Social Security at 1-800-722-1213 or access help online at the Social Security website at socialsecurity.gov. If the member chooses a Medicare PDP with higher premiums than the amount that Medicare will subsidize, he or she will have to pay the difference. Assistance can also be obtained through any of the local Social Security offices in the member’s area.

Questions about Medicare prescription drug coverage can be directed to Medicare at 1-800-Medicare (1-800-633-4227), TTY users 1-877-486-2048, or the Medicare website at medicare.gov. Members can contact Medicare or State Health Insurance Assistance Program (SHIP) at 1-800-452-4800 for help choosing a Medicare prescription drug plan or applying for the “Extra Help.”

Delivery System

Traditional Medicaid is a fee-for-service (FFS) delivery system. See Chapter 1: General Information of this manual for detailed information about the FFS delivery system.

The following table provides detailed information about each of the benefit packages under the Traditional Medicaid program.

<table>
<thead>
<tr>
<th>Benefit Package</th>
<th>Coverage</th>
</tr>
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<tbody>
<tr>
<td>Package A - Standard Plan</td>
<td>Members enrolled in the Traditional Medicaid Standard Plan are eligible for full coverage.</td>
</tr>
<tr>
<td></td>
<td>Hospital presumptive eligibility for infants, children, low income parents and caretakers, and former foster children.</td>
</tr>
<tr>
<td>Package P – Hospital Presumptive Eligibility</td>
<td>Hospital presumptive eligibility for pregnant women</td>
</tr>
<tr>
<td>Family Planning Eligibility Program</td>
<td>Services and supplies intended to prevent or delay pregnancy</td>
</tr>
</tbody>
</table>

Waiver Liability

Some members with income in excess of the Traditional Medicaid threshold are enrolled under the waiver liability provision. These members are enrolled in Traditional Medicaid with a waiver liability. Waiver liability is similar to a deductible. Members must incur medical expenses in the amount of their excess income each month before becoming eligible for Traditional Medicaid. It is the member’s
responsibility to provide nonclaim verification of incurred medical expenses to the Division of Family Resources (DFR). The member becomes eligible at the beginning of the month, but payments are subject to reduction based on the amount of waiver liability remaining for the month. The spend-down provision was eliminated effective 6-1-14 when the State made a transition to its Traditional Medicaid program under the 1634 provisions. However, the ESRD liability and waiver liability use very similar processes as the former spend-down provision. Also, the functionality for spend-down in the claims systems still remains as there will still be claims that need to be adjudicated for spend-down prior to 6-1-14. The same system functionality is used for ESRD liability and waiver liability as was for the spend-down provision.

**Automation of Spend-down**

Medicaid provider responsibilities to members enrolled under the spend-down provision are published in 405 IAC 1-1-3.1.

A provider may bill a member for the amount listed on the Remittance Advice (RA) under Patient Responsible. The IHCP does not require the member to pay the provider until the member receives the Medicaid Spend-Down Summary Notice, with the exception of point-of-sale (POS) pharmacy claims. The IHCP notifies pharmacists of the amount the member owes at the time the POS claim adjudicates so that the pharmacists can collect from the members at the time of service. The IHCP permits the provider to bill a member after the second business day of the month following the month the claim was adjudicated. The provider may not apply a more restrictive collection policy to spend-down members than to other patients or customers. If the provider has a general policy to refuse service to a patient or customer with an unpaid bill, that policy may not be applied to a spend-down member before the member receives the Medicaid Spend-Down/HCBS Waiver Liability Summary Notice. Providers must bill their usual and customary charge to Medicaid. The maximum amount a provider can bill a member is the lesser of the spend-down obligation remaining at the time the claim adjudicates or the usual and customary charge.

**Eligibility Verification System**

When a provider verifies member eligibility if the member has a spend-down or waiver liability, the Eligibility Verification System (EVS) displays the dollar amount of the remaining spend-down or waiver liability obligation for the month. Providers can use the enhanced spend-down or waiver liability information to assist members with financial planning for payment of the spend-down or waiver liability. When a provider verifies member eligibility for a member who has a spend-down or waiver liability, the EVS displays the dollar amount of the remaining spend-down or waiver liability obligation for the month. Providers may not collect the spend-down or waiver liability obligation from the member at the time of service. Providers may bill the member for the amount credited to spend-down or waiver liability after the claim is adjudicated and after the second business day of the following month.

**Medicare Part D and IHCP Waiver Liability**

When a member qualifies for the Medicare LIS, Medicare considers the member qualified for the remainder of the calendar year. If the member qualifies for the Medicare LIS after the first half of the current calendar year, Medicare considers the member qualified until the end of the next calendar year. When qualified, Medicare Part D members are able to receive prescription drug coverage from Medicare every month without waiting to meet the monthly IHCP waiver liability.

Members must meet their monthly IHCP waiver liability requirements prior to receiving Medicaid benefits. Although members may not meet IHCP waiver liability requirements as quickly, other medical expenses, Medicare copayments, and Medicare-excluded drugs covered by the IHCP still
count toward the IHCP waiver liability. Until IHCP waiver liability is met, members are responsible for the provider’s usual and customary charges (UCCs) for IHCP-covered drugs and other IHCP-covered health services. Providers are not required to dispense IHCP-covered drugs if the member’s waiver liability has not been met.

**Medicare Savings Program – (QMB, SLMB, QI, QDWI)**

Federal law requires that state Medicaid programs pay Medicare coinsurance or copayment, deductibles, and/or premiums for certain elderly and disabled people through a program called the Medicare Savings Program. These people are designated as QMB, SLMB, QI, or QDWI and must meet the following eligibility criteria to receive assistance with Medicare-related costs:

- Entitled to Medicare
- Low income
- Age 65 years or older, or younger than 65 years old and entitled to Medicare
- Few personal resources

QMB, SLMB, QI, and QDWI coverage falls into the following categories:

- **QMB-Only coverage:** The member’s benefits are limited to payment of the member’s Medicare Part A (if member is not entitled to free Part A) and Part B premiums as well as deductibles and coinsurance or copayment for Medicare-covered services only. **Claims for services not covered by Medicare are denied as Medicaid noncovered services.** The member must make payment in full for medical supplies, equipment, and other services not offered by Medicare, such as routine physicals, dental care, hearing aids, and eyeglasses. Providers should tell the member that the service is not a Traditional Medicaid-covered service for a QMB who has “Only” coverage. If the member still wants the service, the member is responsible for payment. See Chapter 4: Provider Enrollment, Eligibility, and Responsibilities in this manual for additional information about billing an IHCP member for noncovered services. When the EVS shows a member is a QMB-Only, the provider should contact Medicare to confirm medical coverage. Failure to confirm coverage may result in a claim denial because Medicare benefits may have been discontinued or recently denied.

- **QMB-Also coverage without HCBS waiver liability:** The member’s benefits include payment of the member’s Medicare premiums, deductibles, and coinsurance or copayment on Medicare-covered services in addition to Traditional Medicaid benefits throughout each month of eligibility. **For these members, Medicaid claims for services not covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.**

- **QMB-Also coverage with HCBS waiver liability:** The member’s benefits include payment of the member’s Medicare premiums, deductibles, and coinsurance or copayment for Medicare-covered services in addition to Traditional Medicaid benefits after the member’s monthly waiver liability is met. After the waiver liability is met, the member becomes eligible for the full benefits covered by the Traditional Medicaid program, excluding prescription drug coverage, as stated in the Medicaid and the Medicare Prescription Drug Coverage Program section. Claims may process toward the member’s waiver liability amount; however, until the spend-down or waiver liability is satisfied, the member’s benefits are limited to payment of Medicare deductibles and coinsurance or copayment for Medicare-covered services.

- **SLMB-Only coverage:** The member’s benefits are limited to payment of the member’s Medicare Part B premium only. Providers should tell the member that the service is not a Traditional Medicaid-covered service for an SLMB who has “Only” coverage. **The provider should contact Medicare to confirm medical coverage.** Failure to confirm coverage may result in a claim denial because Medicare benefits may have been discontinued or recently denied. If the member still wants the service, the member is responsible for payment.
• **SLMB-Also coverage without waiver liability or ESRD patient liability:** The member’s benefits include payment of the member’s Medicare Part B premium in addition to Traditional Medicaid benefits throughout each month of eligibility.

• **SLMB-Also coverage waiver liability or ESRD patient liability:** The member’s benefits include payment of the member’s Medicare Part B premium in addition to Traditional Medicaid benefits after his or her monthly waiver liability or ESRD patient liability is met. After the waiver liability is met, the member becomes eligible for the full benefits covered by the Traditional Medicaid program excluding prescription drug coverage as stated in the *Medicaid and the Medicare Prescription Drug Coverage Program* section. Claims may process toward the member’s waiver liability or ESRD patient liability amount; however, until the waiver liability or ESRD patient liability is satisfied, the member’s benefits are limited to payment of the Medicare Part B premium.

• **QI coverage** – The member’s benefit is payment of the member’s Medicare Part B premium.

• **QDWI coverage** – The member’s benefit is payment of the member’s Medicare Part A premium.

• **All QMBs**

For all QMBs, the IHCP pays the Medicare Part B premiums and Medicare Part A (as necessary), as well as Medicare deductibles and coinsurance or copayment for Medicare-covered services when the Medicare payment amount is less than the IHCP-allowed reimbursement amount. The member is never responsible for the amount disallowed (paid at zero) when Medicare paid more than the IHCP-allowed amount for the service.

**QMB-Also with Waiver Liability and Eligibility Verification**

The IHCP EVS is designed to inform a provider of a member’s Traditional Medicaid and QMB dual eligibility status when waiver liability has not been met for the month. The EVS maintains all historical waiver liability information. The EVS displays the dollar amount of the remaining waiver liability obligation for the month. Providers may not collect the waiver liability obligation from the member until the claim is adjudicated showing the member waiver liability has been applied to the provider claim.

**Automated Voice Response**

• **QMB-Also with Spend-down or Waiver Liability** – Automated Voice Response (AVR) System Response: Using the AVR system, the provider receives the following responses about spend-down or waiver liability and QMB members:
  – If the member is a QMB, the message is “The member is a Qualified Medicare Beneficiary and is eligible for coverage of Medicare deductible and coinsurance only.”
  – If the member is a QMB with spend-down or waiver liability and spend-down or waiver liability is met, an additional message is, “The member is on spend-down/HCBS waiver liability.”

**Web interChange Response**

• **QMB-Also with Spend-down or Waiver Liability:** Using the Web interChange system, the provider receives the following responses about spend-down or waiver liability and QMB members:
  – If the member is a QMB, but does not have dual eligibility, the user sees “Medicare Coinsurance Deductible Only QMB: QMB-Only.”
  – If the member is a QMB with spend-down or waiver liability, the user sees “QMB: QMB-Also.” The user also sees the Spenddown/HCBS Waiver Liability indicator flagged with a Y.
Waiver

Waiver programs cover a variety of home and community-based services (HCBS) not otherwise reimbursed by the IHCP. Waiver programs are available to those IHCP-eligible members who require the Level of Care (LOC) services provided in a nursing facility (NF), hospital, or ICF/IID, but choose to remain in the home.

Eligibility for all waiver programs requires the following:

- The member must meet IHCP eligibility guidelines.
- The member would require institutionalization in the absence of the waiver or other home-based services.
- Providers must verify member eligibility and if a member is enrolled in managed care, the member must be disenrolled from managed care to participate in the HCBS waiver programs.

Members served under an HCBS waiver are ineligible for services under any other waiver. The HCBS waiver programs are not entitlement programs and can serve only a limited number of members.

Indiana offers five waiver programs that target specific groups:

- Two programs assist individuals who meet NF level of care:
  - Aged and Disabled Waiver
  - Traumatic Brain Injury Waiver
- Two programs assist individuals who meet ICF/IID level of care:
  - Community Integration and Habilitation Waiver
  - Family Supports Waiver
- One program assists children who meet Psychiatric Residential Treatment Facility (PRTF) level of care:
  - PRTF Transition Waiver

Waiver services allow members to live in a community setting and avoid institutional placement. To be eligible for any waiver program, you must meet Medicaid guidelines and waiver eligibility guidelines.

1915 (i) Home and Community-Based Services

Section 1915(i) of the Social Security Act (SSA) gives states the option to offer a wide range of home and community-based services (HCBS) to members through state Medicaid plans. Using this option, states can offer services and supports to a target group of individuals, including individuals with serious mental illness, emotional disturbance, and substance use disorders to help them remain in the community.

Indiana administers the following 1915(i) HCBS programs through the Family and Social Services Administration (FSSA), Division of Mental Health and Addiction (DMHA):

- Children’s Mental Health Wraparound (CMHW)
- Behavioral and Primary Healthcare Coordination (BPHC)
Children’s Mental Health Wraparound

The CMHW program delivers individualized services to children with serious emotional disturbances (SED). The focused nature of the CMHW program is intended to better address the special needs of children and youth with SED.

Behavioral and Primary Healthcare Coordination

This program offers one service, BPHC, and consists of the coordination of healthcare services to manage the healthcare needs of eligible members. This service includes logistical support, advocacy, and education to assist individuals in navigating the healthcare system and activities that help members gain access to physical and behavioral health services needed to manage their health conditions.

Care Select

The Care Select program is a disease management program. The Care Select program is focused on disease management for the following chronic conditions:

- Asthma
- Diabetes
- Congestive heart failure or coronary heart disease
- Hypertension
- Chronic kidney disease
- Severe mental illness (SMI)
- Serious emotional disturbance (SED)
- Depression

Eligible members with one of the previously listed conditions are automatically enrolled in the Care Select disease management program. Members who choose to opt out of the Care Select program, members that do not have one of the conditions, and HCBS waiver members will be enrolled in Traditional Medicaid. HCBS waiver individuals receive case management services through the waiver.

Package E: Emergency Services Only

Member Eligibility and Coverage

Health coverage for certain members is limited to treatment for medical emergency conditions. These members are in the FFS delivery system only. The Omnibus Budget Reconciliation Act (OBRA) of 1986 defines an emergency medical condition as:

A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member’s health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any organ or part.

In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions.

For emergency services rendered to members enrolled in this benefit package, providers must indicate emergency in the proper form locator on the claim form or 837P transaction. Table 2.5 provides
instructions for completing these locators for paper claims associated with services rendered to Package E members.

Table 2.5 – Package E Billing Instructions

<table>
<thead>
<tr>
<th>Claim Form</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500 Claim Form</td>
<td>Field Number 24C: EMG&lt;br&gt;Enter Y for Yes for emergency services.</td>
</tr>
<tr>
<td>ADA 2006 Dental Claim Form</td>
<td>Field Number 2: If an emergency situation, include the word Emergency in field&lt;br&gt;Field Number 45: TREATMENT RESULTING FROM&lt;br&gt;Use this field to indicate if the treatment is a result of an occupational illness or injury, an auto accident, or other accident.</td>
</tr>
<tr>
<td>UB-04 Claim Form</td>
<td>Field Number 14: ADMISSION TYPE&lt;br&gt;Enter a type code of 1 for Inpatient or Long Term Care for an emergency admission.</td>
</tr>
<tr>
<td>Drug Claim Form</td>
<td>Field Number 03: EMERGENCY&lt;br&gt;Enter YES for emergency services.&lt;br&gt;Field Number 11: DAYS SUPPLY&lt;br&gt;Days supply must be less than 5 for emergency services.</td>
</tr>
<tr>
<td>Compounded Prescription Claim Form</td>
<td>Field Number 04: EMERGENCY&lt;br&gt;Enter YES for emergency services.&lt;br&gt;Field Number 13: DAYS SUPPLY&lt;br&gt;Days supply must be less than 5 for emergency services.</td>
</tr>
</tbody>
</table>

The IHCP does not cover nonemergency services furnished to individuals enrolled in Package E. The patient may be billed for these services if notified of noncoverage prior to rendering care. See Chapter 4: Provider Enrollment, Eligibility, and Responsibilities for information about billing an IHCP member for noncovered services.

Children born to Package E members are eligible for full coverage upon determination of eligibility through the DFR or an outreach location. Children who are not born in the United States are eligible only under Package E unless the child is a current U.S. citizen, a qualified alien, or a lawful permanent resident who has resided in the U.S. for 5 years or longer. These children are only eligible for emergency coverage, and are not covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Family Planning Services for Women and Men

**Member Eligibility and Coverage**

The IHCP implemented an aid category for family planning eligibility, which provides only family planning services to IHCP members who:

- Do not qualify for any other category of Medicaid.
- Are male or female of any age.
- Are not pregnant.
- Have not had a hysterectomy or sterilization.
• Have income that is at or below 141% of the federal poverty level.
• Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens.

**Description of Service**

The family planning services for women and men aid category provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy.

Services covered under the Family Planning Aid Category include:

• Annual family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods
• Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods
• Limited health history and physical (H&P) examinations
• Pap smears
• Initial diagnosis and treatment of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs), if medically indicated, including the provision of Food and Drug Administration (FDA)-approved anti-infective agents
• Follow-up care for complications associated with contraceptive methods issued by the family planning provider
• Providing FDA-approved oral contraceptives and contraceptive devices and supplies, including emergency contraceptives
• Screening, testing, counseling, and referral of members at risk for human immunodeficiency virus (HIV)
• Tubal ligations
• Hysteroscopic sterilization with an implant device
• Vasectomies

Services not covered under the Family Planning Aid Category include:

• Abortions
• Any drug or device intended to terminate fertilization
• Artificial insemination
• In vitro fertilization (IVF)
• Fertility counseling
• Fertility treatment
• Fertility drugs
• Inpatient hospital stays
• Reversal of tubal ligation and vasectomies
• Treatment for any chronic condition, including STDs or STIs that have advanced to chronic conditions
• Emergency room services
• Services unrelated to family planning
Reimbursement Requirements

IHCP reimbursement is available for Family Planning Eligibility Program-covered services rendered by IHCP-enrolled providers, including but not limited to physicians, certified nurse midwives, family planning clinics, and hospitals. Family Planning Eligibility Program services may be self-referred.

Member Eligibility

Providers must check for “Family Planning” eligibility before rendering services, via Web interChange or via one of the following EVS options:

• AVR
• Electronic Data Interchange (EDI) 270/271 – Eligibility Benefit Transaction

For more information on the Family Planning Eligibility Program, see Chapter 8: Billing Instructions.

Hospital Presumptive Eligibility

The Hospital Presumptive Eligibility (HPE) process allows acute care hospitals to enroll with the IHCP as HPE qualified providers (QPs) for the purpose of making presumptive eligibility determinations for IHCP. The eligibility groups that may be determined presumptively eligible under the HPE process include infants, children, pregnant women, parents and caretakers, former foster care children, and individuals seeking family planning services. For more information, see the Hospital Presumptive Eligibility Qualified Provider Manual.
Section 5: Care Select

Overview

To improve the quality of care and health outcomes for its Indiana Health Coverage Programs (IHCP) members, the Family and Social Services Administration (FSSA) initiated Care Select.

Care Select is designed to improve the member’s health status; enhance quality of life; improve client safety, client autonomy, and adherence to treatment plans; and control healthcare expenses. Through this optional program, the State focuses on the following goals:

- More effectively tailor benefits to the individual’s and population’s needs by using evidence-based medicine, best practices, and practice-based evidence to manage services by duration, scope, and severity.
- Improve the quality of care and health outcomes for the Indiana Care Select population.
- Manage the growth of healthcare costs for the Indiana Care Select population.
- Appropriately utilize community resources and reduce duplication of resources.
- Provide accessible and safe home environments.
- Provide appropriate and accessible healthcare.
- Increase understanding regarding medical conditions, treatments, and medications.
- Reduce emergency room (ER) visits and avoidable hospitalizations.
- Provide more effective and ongoing health promotion and disease prevention activities.
- Integrate the members and their families within the community.
- Provide cost savings.

Member Eligibility and Coverage

The Care Select program focuses on disease management, particularly for those with chronic conditions. Qualifying members have the option to participate in the disease management programs that the care management organizations (CMOs) provide for their chronic conditions. Members who meet the requirements for Care Select, but who opt out of Care Select, are placed in Traditional Medicaid.

Eligibility and coverage are based on the member’s aid category and disease state. Care Select is a statewide program serving these members:

- Aged members who are not dual-eligible for Medicare
- Blind
- Physically and mentally disabled
- Children receiving adoption services
- Wards of the court and foster children
- Children on adoption assistance

In addition, members must present with one or more of the following disease states to be eligible for Care Select:
• Asthma
• Diabetes
• Congestive heart failure
• Coronary artery disease
• Chronic obstructive pulmonary disease
• Hypertension
• Chronic kidney disease without dialysis
• Severe mental illness
• Serious emotional disturbance
• Depression
• Comorbidity of diabetes and hypertension
• Comorbidities and/or combinations of any of these disease states
• Other serious or chronic medical condition, as approved by FSSA

The following IHCP members are not eligible for the Care Select:
• Dual eligibles
• Individuals receiving Home and Community-Based Waiver Services
• Medicaid for Employees with Disabilities (M.E.D. Works) participants
• Individuals receiving room and board assistance
• Breast and Cervical Cancer Group
• Individuals with Qualified Medicare Beneficiaries (QMB) or Special Low-Income Medicare Beneficiaries (SLMB) only (not in combination with another aid category)
• Persons in nursing homes, intermediate care facilities for individuals with intellectual disability (ICF/IID) and state-operated facilities
• Persons receiving hospice services
• Members with a psychiatric residential treatment facility (PRTF) level of care

Upon eligibility for Care Select, and as part of the enrollment process, members may select a primary medical provider (PMP) within 60 days of their initial determination of eligibility. Members who do not choose a PMP are assigned to a PMP through an automated assignment process that links members with an appropriate PMP. Auto-assignment is a federal requirement.

General-care physicians as well as specialty physicians may enroll as PMPs for Care Select members; however, only physicians from the following specialties receive automated system assignments or auto assignments:
• Family practitioner (type 31, specialty 316)
• General practitioner (type 31, specialty 318)
• General internal medicine (type 31, specialty 344)
• General pediatrics (type 31, specialty 345)
• Obstetrics/gynecology (type 31, specialty 328)
Other physician specialties receive members only if a member actively chooses the physician as their PMP. See Chapter 4: Provider Enrollment, Eligibility, and Responsibilities of this manual for additional information about provider enrollment in the Care Select care management program.

Care Select members receive full coverage under the Standard Package A benefit package. Claims are reimbursed as fee-for-service (FFS), as with Traditional Medicaid.

Medicaid providers are able to contact the enrollment broker (EB), MAXIMUS, to report when a patient is diagnosed with a disease state that may qualify him or her for Care Select. Providers use the Indiana Care Select Disease Management Program – Provider Referral Form to notify the EB of the potentially eligible patient. Providers can fax the completed form to MAXIMUS at (317) 238-3120.

If a referred member meets the eligibility criteria (qualifying disease state and aid category) for Care Select, the EB reaches out to the member to determine whether the member wants to participate. If the member chooses to opt in to the Care Select program, the member is required to choose a Care Select PMP. If efforts are unsuccessful after 60 days’ outreach, the eligible Care Select member is auto-assigned to a Care Select PMP.
Section 6: 590 Program

Member Eligibility and Coverage

The 590 Program provides coverage for certain healthcare services provided to members who are residents of state-owned facilities. These facilities operate under the direction of the Family and Social Services Administration (FSSA), the Division of Mental Health and Addiction (DMHA), and the Indiana State Department of Health (ISDH). Incarcerated individuals residing in Department of Corrections (DOC) facilities are not covered by the 590 Program.

Members eligible for 590 claim payment must be enrolled as 590 members in IndianaAIM. Members enrolled in the 590 Program are eligible for the full array of benefits covered by the Indiana Health Coverage Programs (IHCP) with the exception of transportation services. Transportation services are provided by facility. Only 590-enrolled providers can render services to 590 members.

Services provided to members enrolled in the 590 Program are reimbursed per claim by the IHCP when the claim total is greater than $150. If the claim total is less than $150, the 590 facility is responsible for the cost of services. All services totaling $500 or more require prior authorization (PA). The 590 Program does not reimburse for transportation.

IHCP members enrolled in the 590 Program are not issued a Hoosier Health Card. The facility where the member resides should contact the provider to schedule appointments for medical services. Eligibility status for the 590 Program may be determined using the Eligibility Verification System (EVS). Information about EVS options can be found in Chapter 3: Electronic Solutions.

To receive reimbursement, any provider rendering services to 590 Program members must be enrolled in the IHCP as a 590 Program provider. Providers must check the appropriate box on the billing or rendering provider enrollment application and update form to become a 590 Program provider.

Claims for services rendered to 590 Program members under the jurisdiction of the DMHA or the ISDH must be billed to HP Enterprise Services. The billing address for 590 Program claims is located in Chapter 1: General Information of this manual.

Delivery System

The 590 Program is part of the fee-for-service (FFS) delivery system. See Chapter 1: General Information of this manual for detailed information about the FFS delivery system.

For further information about the 590 Program, obtain a copy of the 590 Program Provider Manual from the Manuals page at indianamedicaid.com or contact HP at the following telephone number:

HP Customer Assistance Unit
1-800-577-1278
Section 7: Healthy Indiana Plan

Overview

The Healthy Indiana Plan (HIP) is a program sponsored by the state of Indiana that provides more affordable healthcare choices to thousands of otherwise uninsured individuals throughout Indiana. HIP provides health insurance for uninsured adult Hoosiers between the ages of 19 and 64 whose income is at or under 133% of the federal poverty level (FPL), and who are not otherwise eligible for Medicaid. HIP consists of multiple benefit packages including HIP Plus, HIP Basic, and HIP State Plan. The HIP Plus program requires predictable and affordable monthly contributions to the individual Personal Wellness and Responsibility (POWER) Account. Members enrolled in HIP Plus receive a more generous benefit package including vision and dental services. Individuals who either choose not to make their POWER Account contribution or stop paying their contribution and are under 100% FPL will revert to HIP Basic. HIP Basic requires copayments for services received ranging from $4-$75. It also has more limited benefits including no vision or dental and less benefits at the pharmacy. The third benefit package is HIP State Plan. HIP State Plan – Plus requires the predictable and affordable monthly contributions while HIP State Plan – Basic requires copayments for services received. Although they have different payment mechanisms for services, the services for HIP State Plan – Plus and HIP State Plan – Basic are the same. The HIP State Plan benefit package is similar to the services provided in Package A.

HIP encourages uninsured Hoosiers to take responsibility for their health with a focus on prevention. The uninsured often do not obtain preventive healthcare and as a result, are most likely to be seen in a hospital emergency room or urgent care center.

Applicants may apply for the HIP at local FSSA, Division of Family Resources (DFR) offices or by calling enrollment centers. Applicants will complete the Indiana Application for Health Coverage, the same application individuals use to apply for all Indiana Health Coverage Programs (IHCP) plans. Applications are available from the HIP website at in.gov/fssa/hip or by calling 1-877-GET-HIP9. Applicants may select an insurer on the application or one will be auto-assigned. HIP applicants must also be assigned to a primary medical provider (PMP). The insurer will assist with the PMP assignment. Applicants will be able to change plans only before their first POWER Account contribution is made and will not be able to make changes after payment unless they have an unresolved just cause issue. Coverage for HIP Plus begins on the first day of the month in which receipt of the initial monthly contribution occurs. Individuals who choose not to make their initial contribution will remain conditionally eligible and will be unable to receive services while they are conditionally eligible. If the individual is under 100% FPL, they will revert to HIP Basic after 60 days. The individual will be eligible to receive HIP Basic services on the first day of the month in which the 60th day occurs.

Individuals that were enrolled in HIP and select Hoosier Healthwise populations were converted to the new HIP program effective February 1, 2015. The Hoosier Healthwise populations included low-income parents or caretakers and low-income 19- and 20-year-old dependents.

Enhanced Services Plan

On January 1, 2014, HIP ESP members transitioned into the HIP health plans managed by the managed care entities (MCEs): Managed Health Services (MHS), MDwise, and Anthem. HIP and HIP ESP members above the 100% FPL (105% with the income disregard) had the option of reapplying for HIP or seeking health coverage through the federal health insurance marketplace or through the private market.
The HIP Enhanced Services Plan (ESP) program was phased out and the members in this plan were absorbed by the other HIP plans. Anthem assumed responsibility for processing the HIP ESP claims run-out effective July 1, 2014.

Note: Due to problems with individuals accessing the federal health insurance marketplace during the initial open enrollment period, individuals who had HIP coverage on December 31, 2013, and would have been discontinued due to the change in the income standard effective January 1, 2014, had their HIP benefits extended through April 30, 2014, or until they obtained other health insurance coverage, whichever occurred sooner. Individuals continued to be required to pay their POWER Account contribution to maintain coverage during this transition period.

Member Eligibility

Eligibility in HIP is limited to uninsured Hoosiers between the ages of 19 and 64 whose family income is up to 133% of the FPL. A 5% income disregard is applied to determine eligibility if an individual is found ineligible at 133% FPL, but would be income eligible with the disregard. Other key eligibility requirements include, but are not limited to:

• A parent of a child enrolled in or eligible for Hoosier Healthwise may qualify.
• Does not have Medicare.

Pregnant women are now eligible to remain in HIP if they become pregnant while enrolled in the program. If a pregnant woman applies for HIP while pregnant, she will be enrolled in HIP Maternity which receives Hoosier Healthwise Package A services free of cost sharing. If a woman is already enrolled in HIP when she becomes pregnant, she will have all cost sharing suspended regardless of which benefit package she is enrolled in. Also, she will receive wrap-around benefits that mirror the services provided in Hoosier Healthwise Package A so there is no difference in coverage.

Eligibility Verification System

HIP members are given member ID cards through the health plans. Although HIP eligibility information is available through the plans, limited information is also available in the IHCP Eligibility Verification System (EVS). The EVS provides the following eligibility information for HIP members:

• Member’s eligibility for HIP
• Member’s insurer and telephone number
• Member’s emergency room copay amount

Personal Wellness and Responsibility Account

The POWER Account comprises a monthly member contribution plus a State contribution. Members pay a modest monthly contribution for HIP coverage. Contributions to POWER Accounts on or after January 1, 2014, will not exceed 2% of the family income. The maximum combined total annual amount of the POWER Account is $2,500 and is used to pay the initial eligible expenses or the deductible to participating providers. If a POWER Account is not fully funded, the plan is still required to pay all claims.
Billing Procedures for Providers

To be reimbursed for rendering services to HIP members, providers must be IHCP-enrolled providers and participating providers with the HIP plans. Providers bill the member’s HIP plan for services rendered to HIP members. Reimbursement is one of the following:

1. Not to be less than the federal Medicare reimbursement rate for the service provided
2. At a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate

Providers are encouraged to join with insurers to take part in this innovative program. Providers should contact the member’s plan for billing instructions. HIP contact information can be found on the IHCP Quick Reference Guide at indianamedicaid.com.

Covered Services

HIP coverage is focused on preventive services and covers essential medical services, similar to commercial plans. All preventive services set forth in federal regulations will be administered free of cost sharing and will not be debited from the POWER Account. If additional preventive services are offered, the first $500 of these services do not require member contributions from the POWER Account.

The services covered under HIP Basic include benefits in each of the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity services
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive care services
- Early and periodic screening, diagnosis, and treatment (EPSDT) services, as defined at 42 U.S.C. § 1396d(r), for 19- and 20-year-old members

The following services are not covered under HIP Basic:

- Services that are not medically necessary
- Dental services
- Vision services
- Nonemergency transportation services
- Any other services not approved by the Centers for Medicare & Medicaid Services (CMS) in the HIP Basic alternative benefit plan

The services covered under HIP Plus include benefits in each of the following categories:

- Ambulatory patient services
- Emergency services
• Hospitalization
• Maternity services
• Mental health and substance abuse services
• Prescription drugs
• Rehabilitative and habilitative services and devices
• Laboratory services
• Preventive care services
• Vision services
• Dental services
• EPSDT services, as defined in 42 U.S.C. § 1396d(r), for 19- and 20-year-old members

The following services are not covered under HIP Plus:
• Services that are not medically necessary
• Nonemergency transportation services
• Any other services not approved by the CMS in the HIP Plus alternative benefit plan

The services covered under HIP State Plan include benefits in the following categories that are equivalent to the Medicaid State Plan:
• Ambulatory patient services
• Emergency services
• Hospitalization
• Maternity services
• Mental health and substance abuse services
• Prescription drugs
• Rehabilitative and habilitative services and devices
• Laboratory services
• Preventive care services
• Vision services
• Dental services
• EPSDT services, as defined in 42 U.S.C. § 1396d(r), for 19- and 20-year-old members

The following services are not covered under HIP State Plan:
• Services that are not medically necessary
• Any other services not covered by the CMS approved Medicaid State Plan

Prior Authorization
Each health plan is responsible for processing medical service prior authorization (PA) requests. Additionally, the health plans are responsible for notifying members about PA decisions.
Section 8: Program for All-Inclusive Care to the Elderly (PACE)

Overview

The IHCP introduced a new program for all-inclusive care to the elderly (PACE), effective January 2015. The PACE program is a risk-based managed care Medicare and Medicaid program that services individuals who:

- Are 55 years old or older.
- Are certified by their state to need nursing home care.
- Are able to live safely in the community at the time of enrollment.
- Live in a PACE service area.

PACE participants are required to sign an enrollment agreement indicating they understand the PACE organization must be their sole service provider. Services must be preapproved or obtained from specified doctors, hospitals, pharmacies, and other healthcare providers that contract with the PACE organization. Before providing services to a member, IHCP providers should always check the member’s Medicare and IHCP card for a sticker indicating that they are a PACE participant. The IHCP will deny payment of fee-for-service claims submitted by non-PACE providers for PACE members.

Covered Services

PACE benefits include the following:

- Primary care
- Hospital care
- Medical specialty services
- Prescription drugs
- Nursing home care
- Emergency services
- Home care
- Physician, occupational, and recreational therapy
- Adult day care
- Meals
- Dentistry
- Nutritional counseling
- Social services
- Laboratory/X-ray services
- Social work counseling
- Transportation
Section 9: Medical Review Team

Overview

The Medical Review Team (MRT) determines whether an applicant meets the Medicaid disability definition based on medical information that is collected and provided to the MRT by the Division of Family Resources (DFR). Providers are reimbursed for MRT services in accordance with an established fee schedule.

Eligibility Determinations

To make timely determinations about an applicant’s alleged disability for coverage through Indiana Health Coverage Programs (IHCP), the MRT directs providers to include medical reports that substantiate level of severity and functionality. The following examples represent expected information for the four most common application diagnoses:

- **Back pain**
  - Associated surgeries for back pain
  - Medications that the applicant is taking
  - Details about the applicant’s level of functioning with the back pain
  - Any additional information about the applicant’s back pain

- **Depression**
  - Associated hospitalizations for depression
  - Medications the applicant is taking
  - Details about the applicant’s level of functioning with depression
  - Any additional information about the applicant’s depression

- **Diabetes**
  - Associated neuropathy, nephropathy, or retinopathy
  - Blood sugar levels, HgA1C levels, and other relative lab results
  - Medications the applicant is taking
  - Diabetes flow sheet
  - Details about the applicant’s level of functioning with diabetes
  - Additional information about the applicant’s diabetes

- **Hypertension**
  - Associated end organ damage due to hypertension
  - Medications the applicant is taking
  - Details about the applicant’s level of functioning with hypertension
  - Any additional information about the applicant’s hypertension

Billing Procedures

For providers to be reimbursed for Medicaid disability exams, the MRT directs providers to return all requested information to the local county office of the DFR within 20 days of the date of service. Failure to remit documentation in a timely manner may result in claim processing and reimbursement delays.
Member Eligibility

The DFR is responsible for determining initial and continuing eligibility for Medicaid disability. To meet the disability requirement, a person must have an impairment that is expected to last a minimum of 12 months. The MRT makes this determination and notifies the DFR of its decision. An individual that is receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) for his or her own disability automatically meets the State’s disability requirement without requiring a separate disability determination by MRT.
Section 10: Right Choices Program

Overview

The Right Choices Program (RCP) is designed to provide intensive member education, care coordination, and utilization management to eligible Hoosier Healthwise, Care Select, Healthy Indiana Plan (HIP), and Traditional Medicaid members identified as using services more extensively as their peers. The RCP member remains eligible to receive all medically necessary, covered services allowed by the Indiana Health Coverage Programs (IHCP). However, services are reimbursed only when rendered by the member’s assigned RCP providers and/or when rendered by a specialist who has received a valid, written referral from the primary RCP physician.

Because there are multiple vendors administering RCP services, providers must verify member eligibility to determine the appropriate member plan assignment. The Eligibility Verification System (EVS) that is available to the provider community presents specific information regarding the member’s managed care entity (MCE) assignment. RCP contact information can be found on the IHCP Quick Reference Guide at indianaicaid.com.

RCP members are initially placed on the program for two years, after which a utilization review will determine if more time on RCP is necessary. The RCP restricted provider types are the following:

- Hospitals
- Pharmacies
- Physicians

A member may be restricted to other provider types if such action is warranted. In addition to the RCP policy guidelines, providers must follow all other IHCP guidelines, such as prior authorization (PA) requirements.

The selected RCP providers are notified by mail of the selections and given a summary of responsibilities as an RCP provider. If the RCP member is currently under the care of a specialist, the PMP must make the referral to the specialist and send a copy of the referral to the RCP administrator. Providers added by the primary care physician’s written referral can confirm their status through eligibility verification. See Chapter 13: Utilization Review of this manual for details about the RCP.

When it is identified through eligibility verification that the member is on the RCP, the inquiring provider must contact the RCP administrator to verify the primary RCP provider from whom they must obtain the written approval. To determine which RCP administrator to contact, providers must verify eligibility for every RCP member on the date of service using one of the EVS options.

In summary, if no restrictions are listed, the member is not restricted to any specific provider. If restrictions are listed by any of the EVS options, the member is enrolled in the RCP and may only receive services from the specific providers indicated or from the providers to which the member has a valid referral.
Section 11: Traditional Medicaid, Hoosier Healthwise Package A, and Healthy Indiana Plan
Member Copayment Policies

Overview

Some Indiana Health Coverage Programs (IHCP) members are required to contribute a copayment for certain services. Chapter 8: Billing Instructions provides information about claim billing issues related to copayments. The copayment is made by the member and collected by the provider at the time the service is rendered.

The amount of the copayment is automatically deducted from the provider’s payment; therefore, the provider should not subtract the copayment from its submitted charge.

The following services require a copayment. Providers are advised to review the Indiana Administrative Code (IAC) for complete copayment narratives. The IAC sections that dictate the specific copayment policy are as follows:

- Nonemergency services provided in an emergency room setting (405 IAC 1-8-4)
- Pharmacy (405 IAC 5-24-7)
- Transportation (405 IAC 5-30-2)

Copayment Policies

Federal Guidelines

According to 42 CFR 447.15, providers may not deny services to any member due to the member’s inability to pay the copayment amount on the date of service. Pursuant to this federal requirement, this service guarantee does not apply to a member who is able to pay, nor does a member’s inability to pay eliminate his or her liability for the copayment. It is the member’s responsibility to inform the provider that he or she cannot afford to pay the copayment on the date of service. The provider may bill the member for copayments not paid on the date of service.

Transportation Services

Transportation providers may collect a copayment amount from the IHCP member equal to the information presented in Table 2.6.

<table>
<thead>
<tr>
<th>Copayment</th>
<th>Transportation Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.50 each one-way trip</td>
<td>Transportation services that pay $10 or less</td>
</tr>
<tr>
<td>$1 each one-way trip</td>
<td>Transportation services that pay $10.01 to $50</td>
</tr>
<tr>
<td>$2 each one-way trip</td>
<td>Transportation services that pay $50.01 or more</td>
</tr>
</tbody>
</table>

No copayment is required for accompanying a minor member or for an attendant.

The determination of the member’s copayment amount is to be based on the reimbursement for the base rate or loading fee only.
Copayment Exemptions for Transportation Services

The following transportation services are exempt from the copayment requirement:

- Emergency ambulance services
- Services furnished to members younger than 18 years old
- Services furnished to pregnant women
- Services furnished to members who are inpatients in hospitals, nursing facilities (NFs), intermediate care facilities for individuals with intellectual disability (ICFs/IID), or other medical institutions – including when a member is being transported for the purpose of admission or discharge
- Transportation services provided under a managed care entity (MCE) to its Hoosier Healthwise enrollees

Note: Package C members have a transportation copayment of $10 for ambulance transportation.

Pharmacy Services

For pharmacy services copayment information, see Chapter 9: IHCP Pharmacy Services Benefit of this manual.

Nonemergency Services Rendered in the Emergency Department

Any nonemergency service treated in an emergency department setting is subject to a copayment of $3. However, this policy does not apply to Care Select or Hoosier Healthwise members. HIP members have a copay of $3 – $25 for nonemergency services rendered in an emergency department setting. For HIP, these copays are set by tables based on age, sex, federal poverty level, and caretaker/noncaretaker status. The applicable charge should be listed on the member’s HIP card.

Nonemergency Services for Care Select Members

The program provides reimbursement to the emergency department physician for federally mandated emergency-screening exams using codes 99281, 99282, and 99283.

Because the IHCP does not cover a hospital charge for nonemergency services not authorized by the PMP, the amount of the copayment is deducted from physician claims for emergency department evaluations that do not contain an emergency diagnosis. The physician may collect the appropriate copay amount from the member for the Current Procedural Terminology (CPT®) code billed, as shown in Table 2.7.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>$1</td>
</tr>
<tr>
<td>99282</td>
<td>$1</td>
</tr>
<tr>
<td>99283</td>
<td>$2</td>
</tr>
</tbody>
</table>

CPT copyright 2013 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.
The copayment requirements are designed to encourage members to seek emergency department treatment only when it is appropriate. Thus, to the extent permitted by federal and state regulations, a copayment is charged when there is not an emergency, and the emergency department setting was chosen without the authorization of the PMP.

If the medical screening exam reveals that the patient’s condition is nonurgent or nonemergent, and the PMP denies authorization for further services, the member may choose to assume financial responsibility for those services beyond the physician’s screening exam. See Chapter 4: Provider Enrollment, Eligibility, and Responsibilities, Section 5 for further instruction on billing IHCP members.

**Note:** For policies regarding risk-based managed care (RBMC) members, providers must contact the appropriate MCE.

### Emergency Department Nonemergency Service Exemption from Copayments

The following categories of members and services are exempt from the copayment requirements:

- Emergency services provided under an MCE to its members
  - Contact the appropriate member’s MCE for further information about copayments on nonemergency services rendered in an emergency department.
- Family planning services
- Members who are inpatients in hospitals, NFs, ICFs/IID, or other medical institutions
- Package C members
- Services provided to children 18 years old and younger
- Services provided to pregnant women
- Services provided to Native Americans or Alaska Natives
Section 12: Hoosier Healthwise Package C Member Copayment Policies

General Information

Hoosier Healthwise Package C members’ families are required to satisfy cost-sharing requirements that include copayments for some services. Providers are responsible for collecting copayments, and the copayment amounts are systematically deducted from the claims.

Note: Hoosier Healthwise managed care entities (MCEs) may choose whether to impose copays for Package C members for the services (except pharmacy services) described in this section. Pharmacy services are billed to Catamaran and a copayment may be required. Please see Chapter 9: IHCP Pharmacy Services Benefit for more information on pharmacy billing.

Copayment Policies

Transportation Services

Hoosier Healthwise Package C members are eligible to receive emergency ambulance services, subject to the prudent layperson definition of emergency in 407 IAC 1-1-6, as shown in Table 2.8. Nonemergency ambulance transportation between medical facilities is a covered service when ordered by the treating physician.

Table 2.8 – Transportation Services Copayment for Hoosier Healthwise Package C

<table>
<thead>
<tr>
<th>Copayment</th>
<th>Transportation Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 each one-way trip</td>
<td>Ambulance transportation services</td>
</tr>
</tbody>
</table>

Emergency Department Services

No Hoosier Healthwise Package C member copayment is associated with emergency department services.
Section 13: Retroactive Member Eligibility

Traditional Medicaid, Care Select, and Hoosier Healthwise Packages A

Eligibility for Traditional Medicaid, Care Select, and Hoosier Healthwise Package A can be established retroactively up to three months prior to the member’s date of application. Providers rendering services to members during a period of retroactive eligibility are bound by the requirements that follow. This policy is mandatory only for providers enrolled in the Indiana Health Coverage Programs (IHCP) at the time the service was rendered.

Note: Except in the case of newborns, the member’s managed care primary medical provider (PMP) assignment is not retroactive to the date of enrollment. PMP assignments for newborns may be retroactive to the date of birth. All other managed care assignments to PMPs follow the managed care program assignments described in Sections 3 and 4 of this chapter.

When notified of member eligibility, the provider must refund to the member any payments made by the member for covered services (other than IHCP Package C copayments) rendered on or after the eligibility effective date.

If a provider’s office observes specific refund procedures, and those refund procedures apply to all customers, regardless of patient status, refunds to IHCP members may be handled in the manner dictated by normal office procedures. For example, an organization that routinely issues refunds at the end of the month and mails the refunds by check can apply the same process to IHCP members. The provider must then bill the IHCP for the covered service.

If the service was rendered more than one year ago and is past the filing limit, the provider must submit a paper claim with appropriate documentation requesting a filing limit waiver. Retroactive billing procedures are discussed in Chapter 10: Claims Processing Procedures. The filing limit is waived as long as the claim is filed within one year of the date when the member was notified of their retroactive enrollment.

If prior authorization (PA) is required for the covered service, such authorization may be requested retroactively up to one year from the date the member was enrolled. The provider must indicate on the PA form or with a cover letter that the reason for the untimely request was due to retroactive eligibility. Authorization is determined solely on the basis of medical necessity.

The following example illustrates retroactive enrollment:

An IHCP provider renders an IHCP-covered service on August 1, 2013, to a patient on a private-pay basis. On October 1, 2013, the patient is enrolled in the IHCP retroactively to May 1, 2013. The patient informs the provider and furnishes a member identification card. When the member informs the provider of the retroactive eligibility, the provider needs to verify program eligibility using one of the Eligibility Verification System (EVS) options. After member eligibility is verified, the provider must adhere to the refund policy and refund the full amount paid by the member for the services rendered on August 1, 2013. The provider must bill the IHCP within one year of the date the member was retroactively enrolled (October 1, 2013). Providers must return money paid by the IHCP member as soon as possible, according to normal office policy. See Chapter 5: Third Party Liability when there is also a third-party carrier involved.
Hoosier Healthwise Package C Members

Hoosier Healthwise Package C members are not eligible prior to the month in which they apply for benefits. However, the individual may be eligible for coverage under a different category or package for the retroactive months. Members become eligible for Hoosier Healthwise Package C benefits on the first day of the month in which they applied and paid the first month’s premium. For example, if an application was filed in June and was approved the 15th of June and the applicant’s first month’s premium was paid in full, eligibility would begin on the first day of June.

Eligibility for Traditional Medicaid and any other Hoosier Healthwise benefit package can be established retroactively up to three months prior to a member’s date of application. If it is determined that a Package C member is retroactively eligible for any other benefit package, providers that have rendered services to Package C members during a period of retroactive eligibility are bound by the following requirements:

- Payment for services not covered by Package C and paid for by the Package C member, but covered by the benefit package for which the member is now eligible, must be refunded to the member. However, if normal practice-management protocols specify standard refund procedures, and those refund procedures are applied to all refunds regardless of member status, refunds to IHCP members may be handled in the standard manner dictated by practice-management protocols.
- The provider must then bill the IHCP for the covered service.
- If PA is required for the covered service under the new benefit package, it may be requested retroactively up to one year from the date the member was enrolled.
Section 14: 12-Month Monitoring Cycle

Overview

Most Indiana Health Coverage Programs (IHCP) service limitations are monitored via a rolling 12-month period. However, some are monitored on a calendar-year basis.

During claim processing, IndianaAIM reviews the claim history to ensure services do not exceed established limitations. IndianaAIM compares the service date for a particular claim with service dates that are already paid. IndianaAIM looks back at service dates within the particular code’s established service limitation. If the number of services or dollars has been exceeded for a specific benefit limit, prior authorization (PA) may be required based on medical necessity. If PA is not obtained, IndianaAIM rejects the claim.

In summary, IndianaAIM generally rolls back one year from the service date and counts the number of units or dollars used. IndianaAIM calculates benefit limits on a service-date-specific basis for paid claims.

Example 1: This example illustrates a rolling 12-month monitoring cycle. IHCP members are authorized office visits at four per month, 30 per 12 rolling months. A member became eligible on February 1, 2014, and visited a physician the same day. The member used the four-per-month office visit maximum each month. The 30-office visit limitation is reached in August 2014. Without PA, the member is not authorized for another office visit until February 1, 2015. In this example of a 12-month limitation, the system restores one service following one year or 365 days from the previous service. In this illustration, if the member does not use another office visit until all services are restored, the full complement of 30 office visits per 12 rolling months would be totally restored in August 2015.

Example 2: This example illustrates a calendar year monitoring cycle. IHCP-eligible members of Package C, Chiropractic Services, are limited to 14 therapeutic physical medicine treatments per member, per calendar year. If the member is seen on February 1, 2014, and all units have been exhausted by December 1, 2014, the member would be eligible for the next 14 units as of February 1, 2015.

The following services are limited on a calendar-year basis:

- Inpatient rehabilitation
- Durable medical equipment (DME) and home medical equipment (HME)
- Chiropractic
- Vision

The following services are limited on a rolling 12-month basis:

- Office visits
- Mental health visits
- Transportation
- Incontinence supplies

Member Appeal Process

In response to changes to Indiana Administrative Code (Legislative Services Agency [LSA] Document #11-724), the Family and Social Services Administration (FSSA) is increasing the number of days a member has to appeal actions taken by the IHCP that deny or delay member services or benefits.
Before the rule change, the FSSA established a 30-day period during which an individual could file an appeal with the State. If the individual mailed the appeal, three additional days were allowed. The FSSA has simplified this process by allowing a 33-day appeal deadline for all appeals related to this rule.

This requirement applies to managed care and fee-for-service (FFS) members. This does not affect the grievance process used by the managed care entities (MCEs) or care management organizations (CMOs) before appeals to the State. Appeals must be submitted in writing. Guidance to members on how to submit an appeal is available from the indianamedicaid.com member website (Members Rights & Responsibilities > Appeals and Grievances).
Index

5
590 Program ............................................. 2-44

A
Anthem HIP member card with Dentalvision example ............................................. 2-10
Anthem HIP member card without Dentalvision example ............................................. 2-10

B
benefit package explanation ................. 2-15, 2-32
Breast and Cervical Cancer Program ....... 2-17

C
Care Select ................................................ 2-41
Children’s Health Plan .............................. 2-15
Children’s Special Health Care Services... 2-19
copayment ................................................. 2-53
ER nonemergency services .................... 2-54
exempt services ....................................... 2-55
exempt transportation services ............... 2-54
federal guidelines ..................................... 2-53
Hoosier Healthwise Package C ............... 2-56
policies .................................................. 2-53
transportation ........................................... 2-53
transportation services ............................ 2-53
transportation services for Hoosier Healthwise Package C ................... 2-56
CSHCS ...................................................... 2-19

E
eligibility
how to verify ............................................. 2-14
member .................................................... 2-12
retroactive .............................................. 2-57
verification .............................................. 2-12
verification methods .............................. 2-14
eligibility verification
proof ....................................................... 2-13
emergency .............................................. 2-37
Enhanced Services Plan ......................... 2-45
exempt from the copayment ................. 2-54, 2-55

F
fee-for-service ........................................... 2-32
FFS .................................................................. 2-32

H
health plan eligibility .............................. 2-14
Healthy Indiana Plan ............................... 2-45
HIP .......................................................... 2-45
Hoosier Health Card ................................... 2-8
Hoosier Healthwise
coverage .................................................. 2-15
member eligibility ..................................... 2-15
Open Enrollment ....................................... 2-16
Package A
standard plan ........................................... 2-16
Package C
member copayment policies ................. 2-56
transportation copayment ..................... 2-56
Package P
Presumptive Eligibility ............................ 2-20
premium comparison ............................. 2-17
program comparison ............................. 2-21
Hoosier Healthwise benefit package
explanation .............................................. 2-15
how to verify member eligibility ............. 2-14

I
ICES .......................................................... 2-8
Indiana Client Eligibility System ............. 2-8
Indiana Health Coverage Programs ........... 2-12
Indiana Hoosier Health Card ................. 2-8
example .................................................... 2-9
introduction .............................................. 2-8

L
limitations .................................................. 2-59

M
MDwise HIP member card example ........ 2-10
Medicaid Program
Traditional .............................................. 2-31
Medical Review Team ............................. 2-50
member eligibility ..................................... 2-12
member identification ............................. 2-8
member identification card .................... 2-8
member identification number ............... 2-8
MHS HIP member card
eample ..................................................... 2-11
monitoring cycle .................................2-59
rolling 12-month ..................................2-59
MRT ..................................................2-50

N
nonemergency
Care Select member ................................2-54
nonemergency services rendered in the emergency department ..............2-54

P
PACE ..................................................2-49
Package A ..........................................2-15, 2-32
Package C ..........................................2-15
children’s health plan ................................2-17
cost sharing ........................................2-17
enrollment ...........................................2-17
Package E
emergency services only .........................2-37
Package P
cost sharing ........................................2-20
enrollment ...........................................2-20
PEPW ..................................................2-15
PMP ......................................................2-15
premium comparison .............................2-17
Presumptive Eligibility ...........................2-15
primary medical provider (PMP) .................2-54
Program for All-Inclusive Care to the Elderly ...........................................2-49
proof of eligibility verification ......................2-13

Q
QDWI ...................................................2-34
QI ........................................................2-34
QMB .....................................................2-34
with spend-down or waiver liability ..............2-35
qualified Medicare beneficiaries .................2-34

R
RBMC members .....................................2-55
retroactive eligibility ..............................2-57
RID ......................................................2-8
Right Choices Program ..........................2-52
rolling 12-month monitoring cycle ...............2-59

S
service limitations ....................................2-59
SLMB ....................................................2-34
spend-down or waiver liability with QMB..........2-35
Standard Plan .......................................2-15, 2-32

T
Traditional Medicaid ................................2-31
Standard Plan .......................................2-32
Traditional Medicaid benefit package
explanation ...........................................2-32
transportation .......................................2-53
copayment ..........................................2-53
transportation services copayment ............2-53
Hoosier Healthwise Package C ..................2-56

V
verify member eligibility ..........................2-12

W
waiver ..................................................2-36
waiver liability .....................................2-32
wraparound services ................................2-19