Member Eligibility and Benefit Coverage
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<tr>
<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 Published: July 19, 2016</td>
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<td>FSSA and HPE</td>
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| 1.1     | Policies and procedures as of September 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: June 20, 2017 | Semiannual update:  
- Edited and reorganized text throughout for clarity  
- Changed RID references to Member ID  
- Changed IndianaAIM references to CoreMMIS  
- Changed Web interChange references to Provider Healthcare Portal  
- Changed AVR references to IVR  
- Removed references to the Care Select program throughout the module  
- Added references to the HIP Employer Link, Inpatient Hospital Services Only, and PASRR programs as needed throughout the module  
- Updated benefit plan names and eligibility verification instructions throughout the module to reflect new Portal and IVR processes  
- Added Table 1 – IHCP Programs and Associated Benefit Plans  
- Updated the Member Identification section as follows:  
  - Added CareSource as an MCE for HIP and Hoosier Healthwise (effective January 1, 2017)  
  - Removed MDwise from Hoosier Care Connect MCEs (effective April 1, 2017)  
  - Added HIP Employer Link member card | FSSA and HPE |
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<td>• Updated information in the <em>Traditional Medicaid</em> section</td>
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<td>• Removed HIP exception from the <em>Indiana Breast and Cervical Cancer Program</em> section</td>
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<td>• Updated information in the <em>Eligibility Verification for QMB Also and SLMB Also Members with Liability</em> section</td>
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<td>• Updated information in the <em>Healthy Indiana Plan</em> section and its subsections, including adding information about Fast Track payments and adding nonemergency transportation services to <em>HIP State Plan</em> coverage information</td>
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<td>• Updated <em>Table 5 – Comparing Hoosier Healthwise Benefit Packages A and C</em></td>
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<td>• Updated information in the <em>Presumptive Eligibility Processes</em> section and its subsections</td>
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<td>• Added the <em>Copayment Limitations and Exemptions</em> section</td>
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Section 1: Member Eligibility Overview

The Family and Social Services Administration (FSSA) offers a number of different programs and services under the Indiana Health Coverage Programs (IHCP) umbrella. Program and service options are available to Hoosiers based on established eligibility criteria.

Providers should advise people interested in applying for 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. Member eligibility for the 590 Program is initiated by the institution where the member resides. The FSSA provides general information about program eligibility and application on the IHCP member website at indianamedicaid.com.

The IHCP reimburses participating providers for necessary and reasonable medical services provided to individuals who are enrolled in the IHCP and who are eligible for the benefit at the time service is provided. The member is free to select the provider of services, unless the member is restricted to a specific provider through the Right Choices Program (RCP) or through a managed care program.

IHCP Programs and Benefit Plans

Generally, program and service options are categorized either under the fee-for-service (FFS) delivery system or the managed care delivery system. Some services may cross delivery systems based on specific circumstances of individual members.

Programs and services provided through the FFS delivery system are delivered by enrolled IHCP providers and reimbursed directly through the IHCP fiscal agent, Hewlett Packard Enterprise. FFS programs include:

- Traditional Medicaid
- Medicare Savings Programs
- Emergency Services Only
- Family Planning Eligibility Program
- 590 Program
- HIP Employer Link
- Inpatient Hospital Services Only (for inmates)

Programs and services provided through the managed care delivery system are delivered by enrolled IHCP providers participating in managed care networks. Services are reimbursed by managed care entities (MCEs) contracted by the State to manage the care for their members. Managed care programs include:

- Healthy Indiana Plan (HIP)
- Hoosier Care Connect
- Hoosier Healthwise
- Program of All-Inclusive Care for the Elderly (PACE)
Table 1 lists the specific IHCP benefit plans associated with each program. See the *Fee-for-Service Programs and Benefits* section of this document for information about FFS programs as well as certain benefit plans that are delivered as FFS regardless of whether the member is enrolled in an FFS or managed care program. See the *Managed Care Programs* section of this document for information about the IHCP managed care programs and benefit plans. See the *Special Programs and Processes* section of this document for information about special programs and benefits, including coverage for presumptively eligible individuals.

**Table 1 – IHCP Programs and Associated Benefit Plans**

<table>
<thead>
<tr>
<th>Fee-for-Service Program</th>
<th>Benefit Plan</th>
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<tbody>
<tr>
<td>Traditional Medicaid</td>
<td>Full Medicaid*</td>
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<tr>
<td></td>
<td>* With no managed care details – fee-for-service (FFS)</td>
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<td></td>
<td>Package A – Standard Plan*</td>
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<td></td>
<td>* With no managed care details – fee-for-service (FFS)</td>
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<tr>
<td>Medicare Savings Programs</td>
<td>Qualified Disabled Working Individual (QDWI)</td>
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<td></td>
<td>Qualified Individual</td>
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<td></td>
<td>Qualified Medicare Beneficiary</td>
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<td>Specified Low Income Medicare Beneficiary</td>
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<td>Emergency Services Only</td>
<td>Package E - Emergency Services Only</td>
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<tr>
<td>Family Planning Eligibility Program</td>
<td>Family Planning Eligibility Program</td>
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<td>590 Program</td>
<td>590 Program</td>
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<tr>
<td>HIP Employer Link</td>
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<tr>
<td>Medicaid Inpatient Hospital Services Only (for inmates)</td>
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<tr>
<th>Fee-for-Service Benefit Option</th>
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<tr>
<td>1915(i) Home and Community-Based Services (HCBS)</td>
<td>Adult Mental Health Habilitation</td>
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<td>Children's Mental Health Wraparound</td>
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<td></td>
<td>Behavioral and Primary Healthcare Coordination</td>
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<tr>
<td>1915(c) HCBS Waiver</td>
<td>Aged and Disabled HCBS Waiver</td>
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<td>Community Integration and Habilitation HCBS Waiver</td>
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<td>Traumatic Brain Injury HCBS Waiver</td>
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<td>PRTF Transition Waiver</td>
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<tr>
<td>Money Follows the Person (MFP) Demonstration Grant</td>
<td>MFP Traumatic Brain Injury</td>
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<tr>
<td>Medicaid Rehabilitation Option (MRO)</td>
<td>Medicaid Rehabilitation Option</td>
</tr>
</tbody>
</table>
Section 1: Member Eligibility Overview

Managed Care Program | Benefit Plan
---------------------|------------------------
Hoosier Care Connect | Full Medicaid*  
* With managed care details  
Package A Standard Plan*  
* With managed care details
Healthy Indiana Plan | HIP 2.0 Basic  
HIP 2.0 Plus  
HIP 2.0 State Plan Basic  
HIP 2.0 State Plan Plus  
HIP 2.0 State Plan Plus Copay
Hoosier Healthwise | Package A Standard Plan  
Package C – Children’s Health Plan (SCHIP)
Program of All-Inclusive Care for the Elderly (PACE) | Program of All-Inclusive Care for the Elderly

Special Program or Process | Benefit Plan
--------------------------|------------------------
Medical Review Team (MRT) | Medical Review Team
Pre-Admission Screening and Resident Review (PASRR) | PASRR Individuals with Intellectual Disability  
PASRR Mental Illness (MI)
Presumptive Eligibility | Presumptive Eligibility – Adult  
Presumptive Eligibility Family Planning Services Only  
Presumptive Eligibility – Package A Standard Plan  
Presumptive Eligibility for Pregnant Women  
Medicaid Inpatient Hospital Services Only

*Note:  Full Medicaid and Package A – Standard Plan offer the same level of benefits.

Member Identification

Each IHCP member is issued a 12-digit identification number that is referred to as the Member ID (also known as RID). The Member ID is assigned by the FSSA DFR through the automated Indiana Client Eligibility System (ICES). Each member also receives a member identification card. The type of card received depends on the IHCP program in which the member is enrolled.

Hoosier Health Card

The IHCP member identification card, called the Hoosier Health Card, is used to identify enrollment in IHCP FFS programs, including Traditional Medicaid, Emergency Services Only, Medicare Savings Programs, and the Family Planning Eligibility Program. Each family member covered by the IHCP receives an ID card specific to that member. The Hoosier Health Card contains the following information about the member:

- Name
- Gender
- Date of birth
- Member ID
Member Eligibility and Benefit Coverage

Section 1: Member Eligibility Overview

Hoosier Health Cards are issued upon program enrollment. After the DFR determines eligibility, cards are then generated and mailed within five business days of the action updating the IHCPCore Medicaid Management Information System (CoreMMIS). 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.

The card is a permanent plastic identification card the member is expected to retain for his or her lifetime. 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 Hoosier Health Card.

Cards are not available at the local DFR county offices. Providers may photocopy cards.

**Healthy Indiana Plan Member Card**

Note: CareSource was contracted as an MCE for HIP and Hoosier Healthwise effective January 1, 2017.

HIP members receive member ID cards from their individual health plans: Anthem, CareSource, Managed Health Services (MHS), or MDwise. Members enrolled in HIP Employer Link receive a member card specific to that program. Examples of HIP cards are provided in Figures 2 through 7. Member identification numbers are located in the indicated areas on the HIP cards shown in the figures.
### Section 1: Member Eligibility Overview

**Member Eligibility and Benefit Coverage**

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**Figure 2 – Sample Anthem HIP Member Card with Dental and Vision**

![Image of the Sample Anthem HIP Member Card with Dental and Vision]

**Figure 3 – Sample Anthem HIP Member Card without Dental and Vision**

![Image of the Sample Anthem HIP Member Card without Dental and Vision]

**Figure 4 – Sample MHS HIP Member Card**

![Image of the Sample MHS HIP Member Card]

**Figure 5 – Sample MDwise HIP Member Card**

![Image of the Sample MDwise HIP Member Card]

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**Member Name:**
First Name M.I. Last Name

Log on to the myMDwise portal at MDwise.org to check eligibility and Primary Medical Provider (PMP).

MDwise Customer Service for Members and Providers:
1-800-356-1204, Local 317-630-2831, TTY/TDD: 1-800-743-3333

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EMERGENCIES: Call 911 or go to the nearest emergency room.
Emergency room visit may result in copay.

NURSEon call: 800-356-1204 or 317-630-2831 if you are in the Indianapolis area, option #1 then option #4

Pharmacy Services Helpline: 1-844-336-2677
Pharmacy Prior Authorization Fax Line: 858-790-7100

Claims Address:
MDwise, P.O. Box 830120, Birmingham, AL 35283-0120

Rx Bin: 003585 RxGRP MDW Claims payer ID:
Rx PCN ASPR0D1 Refer to MDwise.org

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Library Reference Number: PROMOD00009
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(CoreMMIS updates as of February 13, 2017)
Version: 1.1
Figure 6 – Sample CareSource HIP Member Card

Member Eligibility and Benefit Coverage

Section 1: Member Eligibility Overview

Effective April 1, 2017, MDwise is no longer an MCE option for Hoosier Care Connect.

Hoosier Care Connect members receive member ID cards from their individual health plans: Anthem or MHS. Examples of Hoosier Healthwise member cards are provided in Figures 8 through 9. Member identification numbers are located in the indicated areas.

Figure 7 – Sample HIP Employer Link Member Card

Hoosier Care Connect Member Card

Note: Effective April 1, 2017, MDwise is no longer an MCE option for Hoosier Care Connect.

Figure 8 – Sample Anthem Hoosier Care Connect Member Card
Hoosier Healthwise Member Card

Note: CareSource was contracted as an MCE for HIP and Hoosier Healthwise effective January 1, 2017.

Hoosier Healthwise members receive member ID cards from their individual health plans: Anthem, CareSource, MHS, and MDwise. Examples of Hoosier Healthwise member cards are provided in Figures 10 through 13. Member identification numbers are located in the indicated areas.
Eligibility Verification System

Providers are required to verify member 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. Viewing a member ID card alone does not ensure member eligibility.

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 that the member made to the provider.

How to Verify Member Eligibility

Providers can verify eligibility by using one of the following Eligibility Verification System (EVS) methods:

- Provider Healthcare Portal at indianamedicaid.com
- Approved vendor software for the 270/271 batch or interactive eligibility benefit transactions
- Interactive Voice Response (IVR) system at 1-800-457-4584

Note: Customer Assistance representatives do not provide eligibility verification information.
Providers can use information from a member’s health card to access eligibility information on the EVS. If a member does not have a member ID card at the time of service, a provider can still verify eligibility if the provider has one of the following:

- The member’s IHCP Member ID
- The member’s Social Security number and date of birth
- The member’s first and last name and date of birth

See the Provider Healthcare Portal, Electronic Data Interchange, and Interactive Voice Response System modules for details about using each EVS option to verify member eligibility.

| Note: | If the EVS indicates that the member is enrolled in a managed care program, the MCE identified must be contacted for more specific program information. |
|       | If the EVS indicates that the member has a PMP, the physician identified must be contacted to determine whether a referral is needed. |

**Importance of Verifying Eligibility**

It is important that providers verify member eligibility on the date of service. 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. Most denied claims are denied due to missing or incorrect information that should have been verified through one of the EVS options.

Before rendering services, providers should always check member eligibility to determine the following:

- Whether the member is eligible for the IHCP on the date of service
- Whether the member has other insurance coverage (known as third-party liability [TPL]) that takes precedence over the IHCP coverage
- What type of IHCP coverage the member has on the date of service (see Table 1 for a list of benefit plans associated with the various IHCP programs)

| Note: | When using the Provider Healthcare Portal to verify eligibility, users must click the benefit plan name in the Coverage column of the eligibility verification results to view the following details about the coverage. |

- Whether the member has a copayment responsibility for certain services
- Whether a member is enrolled through a managed care program and, if so, to which MCE and PMP the member is assigned
- Whether the member is restricted to a designated pharmacy, hospital, and physician (PMP) through the Right Choices Program
- What level of care (LOC) is assigned for long-term care (LTC) or hospice members as well as whether a member who resides in an LTC facility has a patient liability and, if so, how much liability to collect from the member
- Whether the member has a waiver liability or end-stage renal disease (ESRD) patient liability
- What services are authorized under the member’s Medicaid Rehabilitation Option (MRO) or 1915(i) home and community-based services (HCBS) plan (for applicable provider types only)
- Whether member benefit limitations have been reached
Health Plan Eligibility

MCEs are organizations that participate in an IHCP managed care program, by provision of health plan services or through a program administrator. Although health plan eligibility information is available through the MCEs, limited eligibility information for managed care members is also available through the IHCP EVS.

If a member is assigned to an MCE for the time period of the eligibility request, the following information is included in the eligibility response on the Provider Healthcare Portal and IVR system:

- Type of managed care program (HIP, Hoosier Care Connect, or Hoosier Healthwise)
- MCE 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.

Note: When using the Provider Healthcare Portal to verify eligibility, users must click the plan name in the Coverage column of the eligibility verification results to access the Managed Care Assignment Details panel, which contains information about the member’s managed care program, MCE, and PMP assignment.

EVS Update Schedule

The DFR authorizes and initiates actions that affect member eligibility. The EVS is updated daily with member eligibility information transmitted from the 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 CoreMMIS between midnight and 5 a.m. the next day.
3. CoreMMIS 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 CoreMMIS Tuesday morning, between midnight and 5 a.m., CoreMMIS completes processing of Monday’s file by 9 a.m. Tuesday. The EVS is updated by 11 p.m. Tuesday.

Verifying Eligibility for a Specific Date of Service

All eligibility verification applications can be used to verify the eligibility status of a member for dates of service up to 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 the provider program eligibility date segment is 11/1/14 to 5/15/16, and an eligibility inquiry is entered for a date span of 4/15/16 to 5/20/16, the dates of 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 options can be found in the Electronic Data Interchange, Interactive Voice Response System, and Provider Healthcare Portal modules.

**Proof of Eligibility Verification**

Providers must retain proof that member eligibility was verified. For verification conducted via the IVR system, providers must document the verification number provided by the IVR system and record it for future reference. 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.

The Provider Healthcare Portal contains a time-and-date stamp used for proof of timely eligibility verification. If a provider is required to prove timely eligibility verification, the provider must send a screen print from the Provider Healthcare Portal to the Written Correspondence Unit with a completed claim. The Claim Submission and Processing module provides additional information about written correspondence policies.
Section 2: Fee-for-Service Programs and Benefits

Indiana Health Coverage Programs (IHCP) members enrolled in programs that are delivered as fee-for-service (FFS) are not enrolled with a managed care health plan and are not required to choose a primary medical provider, unless they are assigned to the Right Choices Program. See the Introduction to the IHCP module for detailed information about the FFS delivery system.

The programs associated with the FFS delivery system include:

- Traditional Medicaid (identified in the IHCP Eligibility Verification System [EVS] as Full Medicaid or Package A – Standard Plan coverage with no managed care details)
- Medicare Savings Programs
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low Income Medicare Beneficiary (SLMB)
  - Qualified Individual (QI)
  - Qualified Disabled Working Individual (QDWI)

  **Note:** Members identified in the EVS as having both Qualified Medicare Beneficiary coverage and also Full Medicaid or Package A coverage are known as QMB Also. Members identified as having both Specified Low Income Medicare Beneficiary coverage and also Full Medicaid or Package A coverage are known as SLMB Also. Members who have only QMB coverage or only SLMB coverage (not in conjunction with Full Medicaid or Package A) are known as QMB Only or SLMB Only. See Medicare Savings Programs – QMB, SLMB, QI, QDWI for details.

- Emergency Services Only (Package E)
- Family Planning Eligibility Program
- 590 Program
- HIP Employer Link

See Fee-for-Service Benefits for information about additional benefit options that are available on an FFS basis.

**Traditional Medicaid**

The Traditional Medicaid program provides coverage for healthcare services rendered to individuals in the following groups who meet eligibility criteria, such as specific income guidelines:

- Persons in long-term care (LTC) facilities and other institutions, such as a nursing facility (NF) or an intermediate care facility for individuals with intellectual disability (ICF/IID)
- Persons receiving hospice services in nursing facilities
- Persons receiving home and community-based waiver services, including those with a waiver liability
- Persons with both Medicare and Medicaid (dual eligibility)
- Persons with end-stage renal disease (ESRD), including those with a patient liability
• Persons enrolled in the breast or cervical cancer treatment program
• Refugees who do not qualify for any other aid category
• Wards of the State who opt out of Hoosier Care Connect
• Current and former foster children who opt out of Hoosier Care Connect

Traditional Medicaid members are eligible for full coverage of Medicaid services, as described in the Indiana State Plan. In conjunction with Full Medicaid/Package A – Standard Plan benefits, Traditional Medicaid members may, under certain circumstances, also be eligible for additional services, including 1915(c) Home and Community-Based Services (HCBS) Waiver services, 1915(i) home and community-based services, Medicaid Rehabilitation Option (MRO) services, ESRD services, hospice services, and long-term care (LTC) services. These additional services are also delivered on an FFS basis. Providers must consult the EVS to determine the member’s eligibility status and coverage details.

**Indiana Breast and Cervical Cancer Program**

Women diagnosed with breast or cervical cancer through the Indiana Breast and Cervical Cancer Program (BCCP) of the Indiana State Department of Health (ISDH) are eligible for Traditional Medicaid coverage during the course of treatment. These members are in the 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 federal poverty level (FPL).
• She is not eligible for Medicaid under any other category.
• She has no health insurance that will cover her treatment.

**HCBS Waiver Liability and ESRD Patient Liability**

Some individuals with income in excess of the Traditional Medicaid threshold, who are approved for HCBS waiver services, are enrolled in Traditional Medicaid under the waiver liability provision. Waiver liability is similar to a deductible. Medicaid provider responsibilities to members enrolled under the waiver liability provision are published in *Indiana Administrative Code 405 IAC 1-1-3.1*. A similar patient liability provision is available for some members eligible for ESRD services. For purposes of this section, the term “liability” is used to reference both the HCBS waiver liability and the ESRD patient liability.

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 liability remaining for the month.
A provider may bill a member for the amount listed under PATIENT RESP on the Remittance Advice (RA). The IHCP does not require the member to pay the provider until the member receives the liability summary 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 members with liability 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 member with liability before the member receives the 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 liability obligation remaining at the time the claim adjudicates or the usual and customary charge.

When a provider verifies member eligibility, if the member has a liability, the EVS indicates the dollar amount of the remaining liability obligation for the month. (On the Portal, the liability amount is listed in the Waiver Liability Details panel.) Providers can use the enhanced liability information to assist members with financial planning for payment of the liability. Providers may not collect the liability obligation from the member at the time of service. Providers may bill the member for the amount credited to 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 Low-Income Subsidy (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 Programs – 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 individuals through a program called the Medicare Savings Program. These individuals must meet the following eligibility criteria to receive assistance with Medicare-related costs:

- Entitled to Medicare
- Low income
- Few personal resources
Member Eligibility and Benefit Coverage

Section 2: Fee-for-Service Programs and Benefits

Medicare Savings Program coverage falls into the following categories:

- **QMB Only** – 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 Medicaid-covered service for a member who has only QMB coverage. If the member still wants the service, the member is responsible for payment. See the Provider Enrollment module for additional information about billing an IHCP member for noncovered services. When the EVS identifies a member as having only Qualified Medicare Beneficiary coverage (without also having Full Medicaid or Package A 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.

- **QMB Also 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. When the EVS identifies a member as having Qualified Medicare Beneficiary coverage and also Full Medicaid or Package A coverage (without waiver liability), Medicaid claims for services not covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.

- **QMB Also 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. When the EVS identifies a member as having Qualified Medicare Beneficiary coverage and also Full Medicaid or Package A coverage, but with an unmet waiver liability, claims may process toward the member’s waiver liability amount; however, until the 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** – 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 Medicaid-covered service for a member who has only SLMB coverage. When the EVS identifies a member as having only Specified Low Income Medicare Beneficiary coverage (without also having Full Medicaid or Package A 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 without HCBS 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. When the EVS identifies a member as having Specified Low Income Medicare Beneficiary coverage and also Full Medicaid or Package A coverage (without waiver liability), Medicaid claims for services not covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.

- **SLMB Also with HCBS 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. When the EVS identifies a member as having Specified Low Income Medicare Beneficiary coverage and also Full Medicaid or Package A coverage, but with an unmet waiver liability, 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** – The member’s benefit is payment of the member’s Medicare Part B premium. The EVS identifies this coverage as Qualified Individual.

• **QDWI** – The member’s benefit is payment of the member’s Medicare Part A premium. The EVS identifies this coverage as Qualified Medicare Beneficiary.

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.

**Note:** The term coinsurance and copayment are interchangeable terms. When referred to in outputs such as the IVR, Provider Healthcare Portal, Remittance Advice, and so forth, the term “coinsurance” represents coinsurance and/or copayment.

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### Eligibility Verification for QMB Also and SLMB Also Members with Liability

The IHCP EVS is designed to inform a provider of a member’s Traditional Medicaid and QMB dual eligibility (QMB Also), or Traditional Medicaid and Medicare Part B eligibility (SLMB Also), status when liability has not been met for the month. The EVS maintains all historical waiver and ESRD patient liability information. The EVS reports the dollar amount of the remaining liability obligation for the month. Providers may not collect the liability obligation from the member until the claim is adjudicated showing that the member liability has been applied to the provider claim.

Providers may use the IVR system or the Provider Healthcare Portal to verify eligibility for Medicare Savings Plan members with liability. The systems provide the following information:

- That the member is QMB Also or SLMB Also
  - For QMB Also members, the EVS indicates both Qualified Medicare Beneficiary coverage and Full Medicaid or Package A coverage
  - For SLMB Also members, the EVS indicates both Specified Low Income Medicare Beneficiary coverage and Full Medicaid or Package A coverage
- That the member has liability
- Whether or not the member’s liability has been met for the month
- If the member’s liability has not been met, the amount that remains for the month

Services rendered up to the cost of the member liability are the responsibility of the member to pay that rendering provider, and it is the responsibility of the provider to collect the liability payment from the member. Costs for rendered services beyond the liability are paid by the IHCP, and medically necessary services beyond the cost of the liability must still be provided to the member.

**Note:** When using the Provider Healthcare Portal to verify eligibility, users must click the Full Medicaid or Package A hyperlink in the Coverage column of the eligibility verification results to access the Waiver Liability Details panel, which contains information about the member’s liability status for the month.
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 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 Formulary and barbiturates (when used for medically accepted indications other than epilepsy, cancer, or chronic mental health disorders; for example, the combination product butalbital/aspirin/caffeine, indicated for headaches). Enrollment in Medicare Part D prescription drug coverage is voluntary.

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.

Note: The IHCP does not cover compounded drug products containing a Medicare Part D-covered drug product for dually eligible members.

The Medicare LIS, also known as “Extra Help,” is a federal subsidy provided by Medicare that helps members pay for their Medicare PDP premiums, copays, 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.”

Emergency Services Only – Package E

Emergency Services Only (Package E) is for individuals who are otherwise eligible for Medicaid, but who may not meet citizenship or immigration-status requirements for the program. Health coverage under Package E is limited to treatment for medical emergency conditions. The Omnibus Budget Reconciliation Act of 1986 (OBRA) defines an emergency medical condition as follows:

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.

Children born in the United States to Package E members are eligible for full IHCP 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 United States for five 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.

Package E members are in the FFS delivery system only. For billing instructions for Package E claims, see the Claim Submission and Processing module.
Family Planning Eligibility Program

The Family Planning Eligibility Program provides only family planning services to qualifying men and women, per Indiana Code IC 12-15-46 Medicaid Waivers and State Plan Amendments.

The Family Planning aid category includes men and women of any age who:

- Do not qualify for any other category of Medicaid
- 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

Services rendered to members in the Family Planning Eligibility Program are reimbursed through the FFS delivery system. Providers must verify eligibility before rendering services.

The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy. Services covered under the Family Planning Eligibility Program include:

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

Services not covered under the Family Planning Eligibility Program 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 and STIs that have advanced to a chronic condition
- Emergency room services
- Services unrelated to family planning

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.

For more information, see the Family Planning Eligibility Program module.

590 Program

The 590 Program provides coverage for certain healthcare services provided to members 21 to 64 years of age who are residents of state-owned facilities. These facilities operate under the direction of the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) and the Indiana State Department of Health (ISDH). Incarcerated individuals residing in Department of Correction (DOC) facilities are not covered by the 590 Program.

The 590 Program is part of the fee-for-service delivery system. Members enrolled in the 590 Program are eligible for the full array of benefits covered by the IHCP, with the exception of transportation services (which are provided by facility). Only 590-enrolled providers can render services to 590 members.

For more information about program eligibility, coverage, and reimbursement, see the 590 Program module.

HIP Employer Link

*HIP Employer Link* helps lower-income employed individuals afford the cost of their employer-sponsored health insurance. An individual working for an approved *HIP Employer Link* employer can enroll in the program if he or she meets the established criteria. Individuals eligible for *HIP Employer Link* coverage include:

- HIP-eligible Hoosiers age 19 through 64 years with access to a qualifying employer-sponsored insurance plan
- HIP-eligible spouses age 19 through 64 years eligible for coverage under a *HIP Employer Link* member’s qualifying employer-sponsored health insurance plan
- HIP-eligible dependents age 19 through 25 years (up to age 26) eligible for coverage under a *HIP Employer Link* member’s qualifying employer-sponsored health insurance plan
HIP Employer Link members receive the following benefits through the IHCP:

- Employer-sponsored insurance premium assistance – Members receive a monthly reimbursement check for a portion of the premium costs deducted from their paycheck by the employer.

- A $4,000 POWER Account – An account similar to a health savings account that is used to cover out-of-pocket medical expenses such as copayments and coinsurance for covered medical services, and plan deductibles.

- Wraparound IHCP services – These HIP Employer Link benefits are provided in addition to the benefits covered by the employer-sponsored health insurance plan:
  - IHCP-covered services provided at federally qualified health centers (FQHCs) or rural health clinics (RHCs) regardless if the center is in the commercial plan network or covered by the employer plan
  - 72-hour emergency supply of prescription medications
  - Family planning services not covered by the employer-sponsored plan
  - Nonemergency transportation for limited populations including:
    - Pregnant women who elect to maintain coverage in HIP Employer Link at their annual redetermination
    - Qualified low-income parents and caretakers
    - Members receiving Transitional Medical Assistance (TMA)
  - EPSDT services not covered by the plan for members that are 19 or 20 years of age

All services rendered to a HIP Employer Link member must be billed to the member’s employer-sponsored insurance plan as the primary payer. After the claim has been adjudicated by the employer-sponsored insurance plan, the provider may submit an FFS claim to the IHCP to receive direct reimbursement for the member’s out-of-pocket costs.

Medicaid Inpatient Hospital Services Only

The IHCP covers inpatient services for IHCP-eligible inmates admitted as inpatients to an acute care hospital, nursing facility, or intermediate care facility. Covered inpatient services exclude transportation services, per Section 1905 (a)(A) of the Social Security Act. Eligibility for IHCP coverage requires the inmate to meet standard eligibility criteria, as determined by the Indiana FSSA Division of Family Resources (DFR). When an inmate is admitted to the inpatient facility, the medical provider will assist the inmate in completing the Indiana Application for Health Coverage. The IHCP EVS indicates a benefit plan of Medicaid Inpatient Hospital Services Only for inmates with this coverage.

Fee-for-Service Benefits

Members meeting certain eligibility criteria may be eligible for services in addition to their primary benefit plan. The following additional services are delivered and reimbursed through the FFS delivery system:

- 1915(c) Home and Community-Based Services (HCBS) waiver services – Certified individuals may receive home and community-based services under a Medicaid waiver, in conjunction with Traditional Medicaid benefits.

- 1915(i) HCBS nonwaiver services – Certified individuals may receive home and community-based services in conjunction with Traditional Medicaid or with the HIP State Plan, Hoosier Care Connect, or Hoosier Healthwise benefits.

- MRO services – Certified individuals may receive MRO services in conjunction with Traditional Medicaid or with HIP State Plan, Hoosier Care Connect, or Hoosier Healthwise benefits.
• ESRD services – Members in need of ESRD services receive related care in conjunction with Traditional Medicaid benefits.

• Hospice services – Some members enrolled in the managed care delivery system may be required to transition to Traditional Medicaid (under the FFS delivery system) to receive coverage of in-home and/or institutional hospice services. See the Hospice Services module for details.

• Long-term care – Some members enrolled in the managed care delivery system may be required to transition to Traditional Medicaid (under the FFS delivery system) to receive coverage of long-term care services. See the Long-Term Care module for details.

**1915(c) HCBS Waiver Services**

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

Eligibility for all HCBS waivers requires the following:

• The member must meet IHCP eligibility guidelines for Traditional Medicaid.

• The member would require institutionalization in the absence of the waiver or other home-based services.

• If the member is enrolled in managed care, the member must be disenrolled from managed care and enrolled in Traditional Medicaid to receive authorized HCBS waiver services.

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

Indiana offers five HCBS waivers that target specific groups:

• See the Division of Aging Home and Community-Based Services Waivers module for information about the following two waivers for individuals who meet nursing facility (NF) level of care:
  – Aged and Disabled Waiver
  – Traumatic Brain Injury Waiver

• See the Division of Disability and Rehabilitative Services Home and Community-Based Services Waivers module for information about the following two waivers for individuals who meet ICF/IID level of care:
  – Community Integration and Habilitation Waiver
  – Family Supports Waiver

• See the Division of Mental Health and Addiction Psychiatric Residential Treatment Facility Transition Waiver module for information about the following waiver for children who meet PRTF level of care (no new enrollment as of September 30, 2012):
  – PRTF Transition Waiver

HCBS waiver services allow members to live in a community setting and avoid institutional placement. To be eligible for any waiver program, an individual must meet both Medicaid guidelines and waiver eligibility guidelines.
1915(i) HCBS Nonwaiver 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 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. Eligible individuals may receive authorized services in conjunction with Traditional Medicaid, HIP State Plan, Hoosier Care Connect, or Hoosier Healthwise benefits.

Indiana administers the following 1915(i) HCBS programs through the FSSA DMHA:

- Adult Mental Health and Habilitation (AMHH) – See the Division of Mental Health and Addiction Adult Mental Health and Habilitation Services module.
- Behavioral and Primary Healthcare Coordination (BPHC) – See the Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services module.
- Child Mental Health Wraparound (CMHW) – See the Division of Mental Health and Addiction Child Mental Health Wraparound Services module.

Medicaid Rehabilitation Option Services

The IHCP reimburses for authorized Medicaid Rehabilitation Option (MRO) services for members with mental illness when the provider for those services is an enrolled mental health center that meets applicable federal, state, and local laws concerning the operation of community mental health centers (CMHCs). MRO services include outpatient mental healthcare for the seriously mentally ill or seriously emotionally disturbed, partial hospitalization services, and case management services. Outpatient mental health services may include clinical attention in the member’s home, workplace, mental health facility, emergency department, or wherever needed. A qualified mental health professional, as outlined in 405 IAC 5-21.5-1(c), must render these services.

For more information about MRO services, see the Medicaid Rehabilitation Option Services module.

End-Stage Renal Disease Services

Effective June 1, 2014, the IHCP instituted a program that grants eligibility to members with ESRD at risk of losing access to transplant services as a result of ending the spend-down program. To be eligible for Medicaid ESRD provisions, members must:

- Be eligible for Medicare
- Not be in an institutional setting or on a waiver
- Have income between 150% and 300% of the federal poverty level (FPL)

These individuals are subject to a monthly ESRD patient liability. As authorized and approved by the Centers for Medicare & Medicaid Services (CMS), for the temporary program, the liability amount is calculated based on the spend-down methodology in effect on May 31, 2014. The Eligibility Verification System (EVS) indicates liability requirements for these individuals. (On the Provider Healthcare Portal, ESRD patient liability appears in the Waiver Liability Details panel.)
Section 3: Managed Care Programs

The State has mandated a managed care delivery system for Indiana Health Coverage Programs (IHCP) members enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. In each program, members are assigned to a managed care entity (MCE). Each MCE maintains its own provider and member services units.

Member enrollment in managed care is effective on the 1st or 15th calendar day of a month and may be confirmed by any of the Eligibility Verification System (EVS) options described in the Electronic Data Interchange, Interactive Voice Response System, and Provider Healthcare Portal modules.

A member-requested change from one MCE to another is effective on the first of the month. MCE changes are completed by the enrollment broker during a member’s Open Enrollment period or as a just cause.

Healthy Indiana Plan

HIP is a program sponsored by the state of Indiana that provides an affordable healthcare choice to thousands of individuals throughout Indiana. HIP provides health insurance for adults between the ages of 19 and 64 whose income is at or under 133% of the federal poverty level (FPL), who are not on Medicare, and who do not qualify for another Medicaid program. HIP is a managed care program with vision and dental services, when applicable, carved into the managed care arrangement. Indiana offers HIP members a comprehensive benefit package through a deductible health plan paired with a personal healthcare account called a Personal Wellness and Responsibility (POWER) Account. HIP comprises four distinct benefit packages: HIP Plus, HIP Basic, HIP State Plan – Plus, and HIP State Plan – Basic.

- **HIP Plus** is available for those members who choose to make monthly contributions to their individual POWER Account. Members enrolled in HIP Plus have predictable and affordable contributions and also receive a benefit package that includes vision and dental services.

- **HIP Basic** is for members with income at or below 100% FPL who fail to make a POWER Account contribution. HIP Basic requires the member to make copayments at the point of service for each service received from a provider. Copayments for services received range from $4 for a doctor visit to $75 for inpatient hospitalization. HIP Basic does not cover vision or dental services. Formulary for pharmacy is limited in the HIP Basic plan.

- **HIP State Plan – Plus** offers access to all the benefits available under the State Plan. Members with this benefit package have the same cost-sharing requirements as HIP Plus – they must make monthly POWER Account contributions, and they do not have copayments for services.

- **HIP State Plan – Basic** offers access to all benefits available under the State Plan. Members with this benefit package have the same cost-sharing requirements and copayments for all services as HIP Basic members.

HIP members are not fully eligible, nor enrolled as members, until one of the following occurs:

- Payment of the member’s first POWER Account contribution
- A $10 Fast Track payment to the selected health plan
- The expiration of the 60-day payment period for individuals at or below 100% FPL

HIP-eligible members who are still in the initial 60-day payment period and who have not yet paid their first POWER Account contribution or Fast Track payment are referred to as conditionally eligible.
Applicants complete the Indiana Application for Health Coverage, the same application individuals use to apply for all 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 before their Fast Track payment or first POWER Account contribution is made and will not be able to make changes after payment unless they have an unresolved just cause issue or are at redetermination. Coverage for HIP Plus begins on the first day of the month in which receipt of the Fast Track payment or 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, HIP Basic coverage will be established after the 60 day payment period expires. The individual will be enrolled in HIP Basic on the first day of the month in which the 60th day occurs.

**Member Eligibility**

Eligibility in HIP is limited to 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. Individuals with Medicare do not qualify.

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

Pregnant women are eligible to remain in HIP if they become pregnant while enrolled in the program. If a woman applies for HIP while pregnant, she will be enrolled in the HIP pregnancy package, which provides 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 wraparound benefits that mirror the services provided in Hoosier Healthwise Package A so there is no difference in coverage. If a woman is pregnant when she is due for her annual redetermination, she will be moved to the Hoosier Healthwise program for the duration of her pregnancy.

Another group of individuals eligible for State Plan benefits includes those deemed to be medically frail, as defined by Code of Federal Regulations 42 CFR §440.315(f).

**Medically Frail**

Within the HIP-eligible population, the IHCP identifies those members who may be medically frail and provides enhanced coverage for those individuals who meet the medically frail criteria.

Federal regulations define the medically frail as individuals with one or more of the following:

- Disabling mental disorder
- Chronic substance abuse disorder
- Serious and complex medical condition
- Physical, intellectual, or developmental disability that significantly impairs the individual’s ability to perform one or more activities of daily living
- Disability determination from the Social Security Administration (SSA)
HIP-eligible medically frail individuals will be enrolled in one of the HIP State Plan options and will receive coverage for comprehensive State Plan benefits equivalent to Package A benefits, including nonemergency transportation to medical appointments.

Like all HIP-eligible individuals, medically frail HIP members will be enrolled with one of the HIP MCEs and required to contribute to POWER Account or make copayments. Members will be enrolled in HIP State Plan – Plus if they make their Fast Track payment or monthly POWER Account contribution. Members at or below 100% FPL who do not make their monthly contributions will be enrolled in HIP State Plan – Basic. Although medically frail individuals are exempt from being locked out of the program for nonpayment of POWER Account contributions, those with incomes higher than 100% of the FPL who do not make their required contributions will continue to owe their required POWER Account contribution amounts and will also incur additional costs in the form of copayments until their owed contribution amount has been paid.

Individuals with one of the following will automatically be deemed medically frail:

- A disability determination from the SSA
- A verified impairment with an activity of daily living

MCEs apply claims data through Milliman underwriting guidelines (MUGs) to determine whether members qualify as medically frail. Individuals with a qualifying condition will be assessed by their MCE to verify that the condition is active and to determine how well the condition is controlled, as well as to identify any complicating comorbidities. Those members designated medically frail as a result of the MCE’s assessment will be enrolled in the HIP State Plan option.

**Personal Wellness and Responsibility Account**

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

The POWER Account comprises a monthly member contribution plus a State contribution. Members pay a monthly contribution for HIP Plus coverage that 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.

**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.

Table 2 lists categories of services and indicates whether HIP Basic, HIP Plus, and HIP State Plan include benefits within each category. For HIP State Plan, the benefits within each category marked Yes are equivalent to those in the Medicaid State Plan.

For information about provider billing and reimbursement for services delivered to HIP members, contact the member’s MCE. MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.
Table 2 – HIP Benefit Comparison by Plan

<table>
<thead>
<tr>
<th>Services</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
<th>HIP State Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory patient services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>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</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Maternity services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental health and substance abuse services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Nonemergency transportation services</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rehabilitative and habilitative services and devices</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventive care services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dental services</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Vision services</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Services that are not medically necessary</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Any other services not approved by the Centers for Medicare &amp; Medicaid Services (CMS) in the specified benefit plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Hoosier Care Connect**

Hoosier Care Connect is a risk-based managed care program designed to improve the quality of care and clinical outcomes for members eligible for the IHCP on the basis of age, blindness, or disability. Hoosier Care Connect members pick a health plan and a primary doctor. The health plan will assist members in coordinating their healthcare benefits and tailor the benefits to individual needs, circumstances, and preferences. Hoosier Care Connect members receive full Medicaid benefits, in addition to care coordination services and other FSSA-approved enhanced benefits developed by the MCEs.

Individuals in the following eligibility categories who do not reside in an institution, are not receiving services through a home and community-based services (HCBS) waiver, and are not enrolled in Medicare will be enrolled in Hoosier Care Connect:

- Aged individuals (age 65 and over)
- Blind individuals
- Disabled individuals
- Individuals receiving Supplemental Security Income (SSI)
- Individuals enrolled in Medicaid for Employees with Disabilities (M.E.D. Works)
Children who fit the following descriptions may voluntarily enroll in Hoosier Care Connect:

- Wards of the State
- Foster children
- Former foster children
- Children receiving adoption assistance

Individuals will be removed from the Hoosier Care Connect program and transitioned to another IHCP program if they:

- Become eligible for Medicare
- Enter a nursing home for a length of stay greater than 30 days
- Enter a state psychiatric facility, a psychiatric residential treatment facility (PRTF), or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Begin receiving hospice benefits in an institutional setting
- Become eligible for and choose to enter an HCBS waiver program

### Hoosier Healthwise

The Hoosier Healthwise program provides coverage for children and pregnant women. Enrollment in Hoosier Healthwise is mandatory for aid categories that include children 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 (IHCP enrollees are excluded from mandatory participation in Hoosier Healthwise managed care:

- Individuals in nursing homes and other institutions, such as ICFs/IID
- Immigrants who do not have documentation or whose status is unverified
- Individuals receiving HCBS waiver or hospice services
- Members with HCBS waiver liability or end-stage renal disease (ESRD) patient liability
- Members eligible for the Family Planning Eligibility Program

Table 3 explains the Hoosier Healthwise benefit packages.

<table>
<thead>
<tr>
<th>Benefit Package</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package A</td>
<td>Full coverage for eligible children and pregnant women</td>
</tr>
<tr>
<td>Package C</td>
<td>Preventive, primary, and acute care services for eligible children</td>
</tr>
</tbody>
</table>

As part of the Hoosier Healthwise enrollment process, MCEs are responsible for making primary medical provider (PMP) assignments. Hoosier Healthwise members must select an MCE, and the MCE assists with selection of a PMP. The following provider specialties are eligible to enroll as a Hoosier Healthwise PMP:

- Family practice (type 31, specialty 316)
- General practice (type 31, specialty 318)
Member Eligibility and Benefit Coverage

Section 3: Managed Care Programs

- Internal medicine (type 31, specialty 344)
- Obstetrics/gynecology (type 31, specialty 328)
- General pediatrics (type 31, specialty 345)

The Division of Family Resources (DFR) determines whether 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 an MCE 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. During this maximum 14-day period to select an MCE, services received by the member are payable as fee-for-service under Traditional Medicaid.

Note: Unlike other Hoosier Healthwise members, members determined eligible for Hoosier Healthwise under the Presumptive Eligibility for Pregnant Women (PEPW) process must select their health plan through the enrollment broker or their presumptive eligibility coverage will not start. See the Presumptive Eligibility for Pregnant Women section for more information. 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.

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.

During the annual redetermination period, members may choose a different PMP within their selected MCE.

Package A

Hoosier Healthwise Package A – Standard Plan coverage encompasses the full array of IHCP benefits for children and pregnant women enrolled in the Hoosier Healthwise program.
**Package C**

Hoosier Healthwise Package C – Children’s Health Plan (SCHIP) provides preventive, primary, and acute healthcare coverage to children who meet the following eligibility 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 creditable health coverage or have had creditable health coverage at any time during a waiting period lasting no longer than 90 days.
- The child’s family must financially satisfy payment of monthly premiums.

Package C members fall under the Children’s Health Insurance Program (CHIP).

**Enrollment Process and Cost-Sharing Requirements**

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 4. After the first premium is paid, eligibility information is transferred to CoreMMIS.

**Table 4 – Hoosier Healthwise Package C Premium Comparison**

<table>
<thead>
<tr>
<th>Income (As a Percentage of the Federal Poverty Level)</th>
<th>Monthly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One Child</td>
</tr>
<tr>
<td>158% to 175%</td>
<td>$22</td>
</tr>
<tr>
<td>175% to 200%</td>
<td>$33</td>
</tr>
<tr>
<td>200% to 225%</td>
<td>$42</td>
</tr>
<tr>
<td>225% to 250%</td>
<td>$53</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.

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 that the Indiana Application for Health Coverage was received.

The child’s family may also be required to make copayments for ambulance transportation and pharmacy 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 the Hoosier Healthwise Package C Member Copayments section of this document.

**Coverage and Limitations**

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

- Ambulance transportation
- Anesthesia
- Certified nurse-midwife
- Chiropractic services
- Clinic services
- Diabetes self-management training
- Dental services
- Early intervention services
- Food supplements, nutritional supplements, and infant formulas
- Home health services
- Hospice (under fee-for-service only)*
- Hospital services
- Inpatient rehabilitative services
- Laboratory services
- Radiology services
- Medical supplies and equipment
- Mental health and substance abuse services
- Physicians’ surgical and medical services
- Podiatry services
- Prescription drugs
- Therapies
- Vision services

*Note: Hospice is a covered benefit for Package C members, but the member must be disenrolled from managed care and enrolled in Traditional Medicaid to receive these services. See the Hospice Services module for more information.

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 transportation** – 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 5 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 EPSDT/HealthWatch periodicity and screening schedule (see the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch module). 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** on the 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**

Children enrolled in Hoosier Healthwise, including children enrolled in 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 (CSHCS) at ISDH** – 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.

**Billing Procedures**

The billing procedures for 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.
**Hoosier Healthwise Package Comparison**

Table 5 compares benefit packages of the Hoosier Healthwise program. The following items apply throughout the table:

- Package A covered services and limitations are cited in 405 IAC 5; Package C covered services and limitations are cited in 405 IAC 3. See the *Indiana Administrative Code (IAC)* page at in.gov.
- Covered services not reimbursed by MCEs are covered and reimbursed for Hoosier Healthwise members under fee-for-service (FFS) reimbursement, unless otherwise indicated in Package A and C.

Table 5 – Comparing Hoosier Healthwise Benefit Packages A and C

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Reimbursed by MCE</th>
<th>Package A</th>
<th>Package C</th>
</tr>
</thead>
<tbody>
<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. Reimbursement is limited to a total of 50 office visits or treatments per member per year, which includes a maximum reimbursement of no more than 5 office visits per member, per year. For example a chiropractor may bill for a maximum of 5 visits and 45 treatments (5 + 45 = 50), but may not bill for 50 treatments and 5 visits (50 + 5 = 55).</td>
<td>Coverage is available for covered services provided by a licensed chiropractor. Limited to 5 visits and 14 therapeutic physical medicine treatments per member per calendar year. An additional 36 treatments may be covered if prior authorization is obtained based on medical necessity. There is a 50-treatment limit per calendar year.</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Yes</td>
<td>Coverage is 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 is 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; medically necessary dental services are reimbursed FFS</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.</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 (Self-referral)</td>
<td>Coverage is limited to 16 units per member, per calendar year. Additional units may be prior authorized.</td>
<td>Coverage is limited to 16 units per member, per calendar year. Additional units may be prior authorized.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed by MCE</td>
<td>Package A</td>
<td>Package C</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Drugs – Prescribed (Legend) (405 IAC 5-24)</td>
<td>No; reimbursed</td>
<td>The IHCP covers legend drugs if the drug is:</td>
<td>The IHCP covers legend drugs if the drug is:</td>
</tr>
<tr>
<td></td>
<td>FFS</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</td>
<td>• Not designated by the CMS as less than effective or identical, related, or similar to a less effective drug or terminated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>less than effective or identical, related, or similar to a less effective drug or terminated</td>
<td>• Not specifically excluded from coverage by the IHCP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not specifically excluded from coverage by the IHCP</td>
<td></td>
</tr>
<tr>
<td>Drugs – Over-the-counter (Nonlegend)</td>
<td>No; reimbursed</td>
<td>The IHCP covers nonlegend (over-the-counter) drugs on its formularies.</td>
<td>Noncovered, except for insulin</td>
</tr>
<tr>
<td></td>
<td>FFS</td>
<td>Formularies are available under the Pharmacy Services quick link at</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>indianamedicaid.com.</td>
<td></td>
</tr>
<tr>
<td>Early Intervention Services (EPSDT)</td>
<td>Yes</td>
<td>Covers comprehensive health and development history, comprehensive</td>
<td>Covers immunizations and initial and periodic screenings according to the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>physical exam, appropriate immunizations, laboratory tests, health</td>
<td>EPSDT/HealthWatch periodicity and screening schedule.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>education, vision services, dental services, hearing services, and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>other necessary healthcare services in accordance with the EPSDT/HealthWatch periodicity and screening schedule.</td>
<td></td>
</tr>
<tr>
<td>Emergency Services (405 IAC 12-15-12-15 and</td>
<td>Yes (Self-referral)</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>405 IAC 12-15-12-15 and 405 IAC 12-15-12-17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed by MCE</td>
<td>Package A</td>
<td>Package C</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Eye Care, Eyeglasses, and Vision Services (405 IAC 5-23)</td>
<td>Yes (Self-referral)</td>
<td>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, is 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 of age 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.</td>
<td>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.</td>
</tr>
<tr>
<td>Federally Qualified Health Centers (FQHCs)</td>
<td>Yes</td>
<td>Coverage is available for medically necessary services provided by licensed healthcare practitioners.</td>
<td>Coverage is available for medically necessary services provided by licensed healthcare practitioners.</td>
</tr>
<tr>
<td>Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)</td>
<td>Yes</td>
<td>Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.</td>
<td>Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.</td>
</tr>
<tr>
<td>Hospital Services – Inpatient* (405-IAC 5-17)</td>
<td>Yes</td>
<td>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 do not require PA.</td>
<td>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 do not require PA.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed by MCE</td>
<td>Package A</td>
<td>Package C</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<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>Home health coverage is available 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>Home health coverage is available 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. <strong>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid before hospice benefits can begin.</strong></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. <strong>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid before hospice benefits can begin.</strong></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. 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. An all-inclusive per diem rate is based on level of care.</td>
</tr>
<tr>
<td>(See the Inpatient Hospital Services module)</td>
<td></td>
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<td>Benefit</td>
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<tr>
<td>Medical Supplies and Equipment (includes prosthetic devices, implants, hearing aids, dentures, and so forth)** (405 IAC 5-19)</td>
<td>Yes (Except drug-related medical supplies and devices, dentures or dental devices, dental products, and dental supplies)</td>
<td>Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary. Incontinence supplies are covered for members 3 years old or older. Incontinence, urological, and ostomy supplies are covered for one of two contracted vendors. A maximum allowable benefit of $1,950 per member, per rolling 12-month period for all incontinence supplies is assigned. Providers may supply such services to an IHCP member only in 30-day increments. Certain procedures are limited to 15 months of continuous rental.</td>
<td>Covered when medically necessary. Maximum benefit of $2,000 per year or $5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased, depending on which is more cost efficient.</td>
</tr>
<tr>
<td>Mental Health Services – Outpatient* (405 IAC 5-19)</td>
<td>Yes (Except Medicaid Rehabilitation Option [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 health services providers in psychology (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>MRO – Community Mental Health Centers * (405 IAC 5-22-1)</td>
<td>No; reimbursed FFS</td>
<td>Coverage includes outpatient mental health services, partial hospitalization (group activity program), and case management.</td>
<td>Coverage includes outpatient mental health services, partial hospitalization (group activity program), and case management.</td>
</tr>
<tr>
<td>Mental Health Services – Inpatient** (Freestanding Psychiatric Facility) (405 IAC 5-20)</td>
<td>Yes</td>
<td>Reimbursement is available for inpatient psychiatric services provided to members 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>Nurse Midwife (405 IAC 5-22-3)</td>
<td>Yes</td>
<td>Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.</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>
</tr>
<tr>
<td>Benefit</td>
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</tr>
<tr>
<td>Nurse Practitioners (405 IAC 5-22-4)</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>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>
</tr>
<tr>
<td>Nursing Facility Services** (Long-term) (405 IAC 5-31-1, see the Long-Term Care module)</td>
<td>No</td>
<td>Long-term care nursing facility services require preadmission screening for LOC determination. <strong>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</strong> For a maximum of 60 days prior to LOC determination, coverage is available under managed care. Coverage includes room and board, nursing care, medical supplies, durable medical equipment, and transportation.</td>
<td>Noncovered</td>
</tr>
<tr>
<td>Nursing Facility Services (Short-term) (405 IAC 5-31-1)</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. Coverage includes room and board, nursing care, medical supplies, durable medical equipment, and transportation.</td>
<td>Noncovered</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed by MCE</td>
<td>Package A</td>
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</tr>
<tr>
<td>Nursing Facility Services – Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID)** (Long term) <em>(405 IAC 5-13-2, see the Long-Term Care module)</em></td>
<td>No</td>
<td>Long-term ICF/IID services require preadmission screening for LOC determination. <strong>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</strong> For a maximum of 60 days prior to LOC determination, coverage is available under managed care. Coverage includes room and board, mental health services, dental services, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services.</td>
<td>60 days maximum, pending and prior to LOC determination. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board, mental health services, dental services, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services. <strong>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</strong></td>
</tr>
<tr>
<td>Nursing Facility Services – Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID) ** (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. Coverage includes room and board, mental health services, dental, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services.</td>
<td>Noncovered</td>
</tr>
</tbody>
</table>

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**Benefit Reimbursed by MCE**

**Package A**

**Package C**

**Library Reference Number: PROMOD00009**

**Published: June 20, 2017**

**Policies and procedures as of September 1, 2016**

*(CoreMMIS updates as of February 13, 2017)*

**Version: 1.1**
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<thead>
<tr>
<th>Benefit</th>
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<th>Package A</th>
<th>Package C</th>
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</thead>
<tbody>
<tr>
<td>Occupational Therapy*</td>
<td>Yes</td>
<td>Services must be ordered by a doctor of medicine (MD) or doctor of osteopathy (DO) and provided by a licensed 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. PA is required for all members age 21 or older. For members 21 years of age and older, occupational therapy services are covered for no longer than two years from the initiation of the therapy unless there is a significant change in the member’s medical condition requiring longer therapy. For members under 21 years of age, occupational therapy services are covered when determined to be medically necessary.</td>
<td>Services are covered when determined to be medically necessary. Services must be ordered by an MD or DO and provided by a licensed therapist or assistant. Services are covered only when determined to be medically necessary. Maximum of 50 visits per rolling 12-month period (407 IAC 3-8-2), per type of therapy.</td>
</tr>
<tr>
<td>Organ Transplants**</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>(405 IAC 5-3-13)</td>
<td></td>
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<tr>
<td>Orthodontics**</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>(See the Dental Services module)</td>
<td></td>
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</tr>
<tr>
<td>Out-of-State Medical Services**</td>
<td>Yes</td>
<td>Coverage 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, durable medical equipment, and supplies. All out-of-state services are subject to the same limitations as in-state services.</td>
<td>Coverage 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, durable medical equipment, and supplies. Coverage is subject to any limitations included in the Package C benefit package.</td>
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<tr>
<td>(405 IAC 5-5)</td>
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<td>Benefit</td>
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</tr>
<tr>
<td>Physician Surgical and Medical Services*</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 calendar 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>(405 IAC 5-25)</td>
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<tr>
<td>Physical Therapy*</td>
<td>Yes</td>
<td>Services must be ordered by an MD or DO and provided by a licensed 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. PA is required for all members age 21 or older. For members 21 years of age and older, physical therapy services are covered for no longer than two years from the initiation of the therapy unless there is a significant change in the member’s medical condition requiring longer therapy. For members under 21 years of age, respiratory therapy services are covered when determined to be medically necessary.</td>
<td>Services are covered when determined to be medically necessary. Services must be ordered by an MD or DO and provided by a licensed therapist or assistant. Maximum of 50 visits per rolling 12-month period, per type of therapy.</td>
</tr>
<tr>
<td>(405 IAC 5-22-6)</td>
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<tr>
<td>Podiatric Services</td>
<td>Yes (Self-referral)</td>
<td>Laboratory services, x-ray services, hospital stays, and surgical procedures involving the foot are covered when medically necessary. No more than six routine foot care visits per year are covered.</td>
<td>Laboratory services, x-ray services, hospital stays, and surgical procedures involving the foot are covered when medically necessary. Routine foot care services are not covered.</td>
</tr>
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<td>(405 IAC 5-26)</td>
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### Benefit

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<tr>
<th>Benefit</th>
<th>Reimbursed by MCE</th>
<th>Package A</th>
<th>Package C</th>
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</thead>
</table>
| **Psychiatric Residential Treatment Facility (PRTF)** **(405 IAC 5-20-3.1)** | No                | 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. **Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.**  
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. | 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. **Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.**  
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. |
<p>| <strong>Rehabilitation Unit Services – Inpatient</strong> <strong>(405 IAC 5-32)</strong>         | Yes               | 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. | Covered up to 50 calendar days per calendar year. |</p>
<table>
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<th>Benefit</th>
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<tbody>
<tr>
<td><strong>Respiratory Therapy</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Yes</td>
<td>Services must be ordered by an MD or DO and provided by a licensed 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. PA is required for all members age 21 or older. For members 21 years of age and older, respiratory therapy services are covered for no longer than two years from the initiation of the therapy unless there is a significant change in the member’s medical condition requiring longer therapy. For members under 21 years of age, respiratory therapy services are covered when determined to be medically necessary.</td>
<td>Services are covered when determined to be medically necessary. Services must be ordered by an MD or DO and provided by a licensed therapist or assistant. Maximum of 50 visits per rolling 12-month period (&lt;i&gt;407 IAC 3-8-2&lt;/i&gt;), per type of therapy.</td>
</tr>
<tr>
<td><strong>Rural Health Clinics (RHCs)</strong></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 RHC.</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 RHC.</td>
</tr>
<tr>
<td><strong>Smoking Cessation Services</strong></td>
<td>Yes&lt;sup&gt;(Except pharmacy benefits)&lt;/sup&gt;</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>Benefit</td>
<td>Reimbursed by MCE</td>
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</tr>
<tr>
<td>Speech, Hearing and Language Disorders*</td>
<td>Yes</td>
<td>Services must be ordered by an MD or DO and provided by a licensed 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. PA is required for all members age 21 or older. For members 21 years of age and older, rehabilitative therapy services are covered for no longer than two years from the initiation of the therapy unless there is a significant change in the member’s medical condition requiring longer therapy. For members under 21 years of age, rehabilitative therapy services are covered when it is determined to be medically necessary.</td>
<td>Services are covered when determined to be medically necessary. Services must be ordered by an MD or DO and provided by a licensed therapist or assistant. Maximum of 50 visits per rolling 12-month period, per type of therapy.</td>
</tr>
<tr>
<td>Substance Abuse Services – Inpatient (Freestanding Psychiatric Facility) **</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>Substance Abuse Services – Outpatient*</td>
<td>Yes (Except MRO services)</td>
<td>Coverage includes substance abuse services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as HSPP.</td>
<td>Coverage includes substance abuse services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as HSPP.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Reimbursed by MCE</td>
<td>Package A</td>
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<tr>
<td>Transportation – Emergency</td>
<td>Yes</td>
<td>Coverage has no limit or prior authorization requirement 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>(405 IAC 5-30)</td>
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<tr>
<td>Transportation – Nonemergent</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>
<tr>
<td>(405 IAC 5-30)</td>
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</tbody>
</table>

* Prior authorization required under certain circumstances
** Prior authorization always required

Note: In general, all noncontracted, out-of-network providers require PA. Contracted, in-network providers must contact the MCE to determine whether PA is required.

Program of All-Inclusive Care for the Elderly

The IHCP Program of All-Inclusive Care for the Elderly (PACE) is a risk-based managed care Medicare and Medicaid program that serves 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 (*Contact local Area Agency on Aging for guidelines.*)

PACE participants are required to sign an enrollment agreement indicating they understand that 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 the member is a PACE participant. The IHCP will deny payment of fee-for-service claims submitted by non-PACE providers for PACE members.

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 4: Special Programs and Processes

The Indiana Health Coverage Programs (IHCP) offers a variety of special programs and processes designed to serve special populations.

Presumptive Eligibility Processes

The IHCP includes three authorized processes by which individuals can be determined presumptively eligible and receive temporary health coverage until the Family and Social Services Administration (FSSA) determines official eligibility:

- Presumptive Eligibility (PE)
- Hospital Presumptive Eligibility (Hospital PE)
- Presumptive Eligibility for Pregnant Women (PEPW)

Based on the aid category of the applicant, the following benefit plans may be assigned during the period of presumptive eligibility:

- Presumptive Eligibility for Pregnant Women
- Medicaid Inpatient Hospital Services Only
- Presumptive Eligibility Family Planning Services Only
- Presumptive Eligibility – Package A Standard Plan
- Presumptive Eligibility – Adult

A member’s presumptive eligibility coverage period begins on the day a qualified provider (QP) determines an individual presumptively eligible for coverage. Services delivered prior to this date are not covered. For presumptive eligibility benefit plans that include inpatient hospital coverage:

- If a hospital admission date is before the presumptive eligibility start date, and the inpatient service is reimbursed using the diagnosis-related group (DRG) methodology, no portion of that member’s inpatient stay will be considered a presumptive-eligibility-covered service.
- If a hospital admission date is before the presumptive eligibility start date, and the inpatient service is reimbursed on a level-of-care (LOC) per diem basis, dates of service on or after the member’s presumptive eligibility start date will be covered.

Dates of service before the member’s presumptive eligibility start date are not covered.
**PE and Hospital PE**

General applicant requirements for PE and Hospital PE are as follows:

- Must be a U.S. citizen, qualified noncitizen, or a qualifying immigrant with one of the following immigration statuses:
  - Lawful permanent resident immigrant living lawfully in the United States for five years or longer
  - Refugee
    - Individual granted asylum by immigration office
    - Deportation withheld by order from an immigration judge
    - Amerasian from Vietnam
    - Veteran of U.S. Armed Forces with honorable discharge
    - Other qualified alien
- Must be an Indiana resident
  - An Indiana address must be provided on the application.
- Must not be a current IHCP member
- Must not be enrolled in any presumptive eligibility process – Hospital PE, PE, or PEPW
- Must not be currently incarcerated *(exception described under Hospital PE)*
- Must not be an adult (21–64) admitted to, or a resident of, an institute for mental disease (IMD)
- Must meet the income level requirements specific to certain aid categories
- Must meet any additional requirements specific to certain aid categories

**Presumptive Eligibility (PE)**

The Presumptive Eligibility (PE) process allows community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and local health departments to make PE determinations for certain eligibility groups to receive temporary health coverage under the IHCP until official eligibility is determined.

Aid categories eligible for PE include:

- Low-income infants and children
- Low-income parents or caretakers
- Low-income adults
- Low-income pregnant women
- Former foster care children
- Individuals eligible for family planning services only

After enrollment, the individual receives PE coverage until the last day of the month following his or her month of enrollment or until a determination is made on his or her completed Indiana Application for Health Coverage. The individual receives temporary coverage reimbursed on a fee-for-service (FFS) or managed care basis, appropriate to the aid category under which he or she qualifies, as shown in the following table.
## Table 6 – Coverage by Aid Category Under the PE Process

<table>
<thead>
<tr>
<th>Aid Category</th>
<th>Benefit Plan</th>
<th>Coverage Details</th>
<th>Delivery System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presumptively eligible infants, children, parents/caretakers, and former foster care children</td>
<td>Presumptive Eligibility – Package A Standard Plan</td>
<td>All services available under Package A – Standard Plan</td>
<td>FFS</td>
</tr>
<tr>
<td>Presumptively eligible pregnant women</td>
<td>Presumptive Eligibility for Pregnant Women</td>
<td>Ambulatory prenatal care services only</td>
<td>FFS</td>
</tr>
<tr>
<td>Individuals presumptively eligible for family planning benefits only</td>
<td>Presumptive Eligibility Family Planning services Only</td>
<td>Only services available under the Family Planning Eligibility Program</td>
<td>FFS</td>
</tr>
<tr>
<td>Presumptively eligible adults not eligible for another category</td>
<td>Presumptive Eligibility – Adult</td>
<td>Only services available under the Healthy Indiana Plan (HIP) Basic benefit plan, including copayment obligations</td>
<td>Managed care</td>
</tr>
</tbody>
</table>

For details about PE enrollment, including how to become a PE qualified provider, see the Presumptive Eligibility module.

### Hospital Presumptive Eligibility (Hospital PE)

The Hospital Presumptive Eligibility (Hospital PE) process allows acute care and psychiatric hospitals to enroll with the IHCP as Hospital PE qualified providers (QPs) for the purpose of making presumptive eligibility determinations for the IHCP.

The eligibility groups that may be determined presumptively eligible under the Hospital PE process include:

- Low-income infants and children
- Low-income parents or caretakers
- Low-income adults
- Low-income pregnant women
- Former foster care children
- Individuals eligible for family planning services only

For more information, see the Hospital Presumptive Eligibility module.

### Presumptive Eligibility for Inmates

Presumptive Eligibility for Inmates (PE for Inmates) is a component for Hospital PE that allows Hospital PE qualified providers to enroll eligible inmates into the IHCP for temporary coverage of authorized inpatient hospitalization services. PE for Inmates is available to individuals who meet the following requirements. The individual must:

- Be an inmate from a correctional facility operating under the memorandum of understanding or contract with the Indiana Family and Social Services Administration (FSSA)
- Not be on house arrest (individuals under house arrest may be eligible under Hospital PE or PE processes)
- Not be pregnant or admitted for labor and delivery
- Be admitted for inpatient hospitalization
- Be under the age of 65
- Meet all other standard PE requirements

Coverage during the PE for Inmates period is identified as the Medicaid Inpatient Hospital Services Only benefit plan. Inmates who go through the PE process must complete an Indiana Application for Health Coverage to retain inpatient benefits. Individuals who complete applications and are found eligible will be continue to be covered under the Medicaid Inpatient Hospital Services Only benefit plan for 12 months. If the inmate does not complete an Indiana Application for Health Coverage, his or her Medicaid Inpatient Hospital Services Only coverage will end on the last day of the month following the month in which the individual was found presumptively eligible. If the individual remains incarcerated after one year, he or she may reapply for coverage through the PE for Inmates process.

**Presumptive Eligibility for Pregnant Women**

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.

PEPW provides coverage to low-income pregnant women through a simplified application process, and covers most pregnancy-related outpatient services. Coverage begins on the date a qualified provider determines the woman to be presumptively eligible, using the process outlined in the Presumptive Eligibility for Pregnant Women module. The woman’s IHCP eligibility determination is subsequently completed by the Family and Social Services Administration (FSSA) Division of Family Resources (DFR). A patient’s failure to cooperate with the DFR to complete the Indiana Application for Health Coverage results in termination of PEPW benefits.

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
- Must not be enrolled in any presumptive eligibility process – Hospital PE, PE, or PEPW
- Be an Indiana resident
- An Indiana address must be provided on the application. Be a U.S. citizen, qualified noncitizen or a qualifying immigrant with one of the following immigration statuses:
  - Lawful permanent resident immigrant living lawfully in the United States for five years or longer
  - Refugee
    - Individual granted asylum by immigration office
    - Deportation withheld by order from an immigration judge
    - Amerasian from Vietnam
  - Veteran of U.S. Armed Forces with honorable discharge
    - Other qualified alien
- Not be currently incarcerated
- Have a family income 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.
The PEPW process provides coverage of pregnancy-related services only through Hoosier Healthwise, identified in the EVS as the Presumptive Eligibility for Pregnant Women benefit plan with Hoosier Healthwise managed care details.

The PEPW process allows qualified providers to make presumptive eligibility determinations for pregnant women. Providers that may be qualified under the PEPW process include certain medical practitioners, medical clinics, family planning clinics, health departments, and some hospitals.

Enrollment centers that are not qualified providers for the PEPW program can assist pregnant women by helping them complete and submit an Indiana Application for Health Coverage and by providing a referral to a qualified provider. However, it is critical that only one Indiana Application for Health Coverage is submitted for a member.

For more information, including criteria for becoming a qualified provider and PEPW billing and coding procedures, see the Presumptive Eligibility for Pregnant Women module.

PEPW benefits cover pregnancy-related ambulatory services including:

- Doctor visits for prenatal care
- Lab work related to pregnancy
- Prescriptions related to pregnancy
- Transportation for pregnancy- or emergency-related care

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

**Medical Review Team**

Individuals determined by the Social Security Administration to be disabled are considered disabled for Medicaid purposes. For all others, 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 Medical Review Team (MRT) determines whether an applicant meets the Medicaid disability definition based on medical information that the DFR collects and provides to the MRT.

**Note:** An individual 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.

To make timely determinations about an applicant’s alleged disability for coverage through the 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
Member Eligibility and Benefit Coverage

Section 4: Special Programs and Processes

- **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

See the [Claim Submission and Processing](#) module for MRT billing procedures.

### Right Choices Program

The Right Choices Program (RCP) is Indiana’s Restricted Card Program. The goal of the RCP is to provide quality care through healthcare management, ensuring that the right service is delivered at the right time and in the right place for Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, and Traditional Medicaid members who have been identified as using services more extensively than their peers. The RCP member remains eligible to receive all medically necessary, covered services allowed by the IHCP. However, services are reimbursed only when rendered by the member’s assigned RCP providers or when rendered by a specialist who has received a valid, written referral from the member’s primary RCP physician. See the [Right Choices Program](#) module for details about the RCP.

**Note:** To identify RCP members in the Provider Healthcare Portal, click on the member’s coverage plan to view details. If the member is assigned to RCP for the date of service, lock-in provider assignment will be displayed in a Right Choices Program detail panel.

### Preadmission Screening and Resident Review

The Preadmission Screening and Resident Review (PASRR) process is a requirement for all residents of IHCP-certified nursing facilities. The screening identifies individuals who may have a mental illness (MI), intellectual disability/developmental disability (ID/DD), mental illness/intellectual disability/developmental disability (MI/ID/DD), or related condition.

PASRR coverage is identified in the EVS as PASRR Mental Illness (MI) or PASRR Individuals with Intellectual Disability (IID).

See the [Long-Term Care](#) module for more information about the PASRR process.
Section 5: Member Copayment Policies

Note: This section does not apply to the Healthy Indiana Plan (HIP). For HIP copayment policies, providers must contact the appropriate HIP managed care entity (MCE). MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.

Overview

Some Indiana Health Coverage Programs (IHCP) members are required to contribute a copayment for certain services. 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 the submitted charge.

Providers are advised to review the Indiana Administrative Code (IAC) for complete copayment narratives. The following services may require a copayment:

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

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.

Copayment Limitations and Exemptions

In accordance with federal regulations, IHCP members with cost-sharing obligations (such as copayments, contributions, premiums, deductibles, or other Medicaid-related charges) are not required to pay more than 5% of the family’s total countable income toward these charges. The 5% calculation considers the total cost-sharing amounts paid by all members in the household against the total countable income for the household. The IHCP applies this limit based on calendar quarters (January–March, April–June, July–September, and October–December).

IHCP members reaching 5% of the household income in a given quarter will receive written notice informing them that cost-sharing obligations are suspended for the remainder of the current quarter. The written notice will name the affected member, and the date of the notice will establish the calendar quarter affected. Members are instructed to present their notice to IHCP providers in lieu of paying a copayment. If a member shows the notice to an IHCP provider, the provider cannot charge the member a copayment if the date of service is within the same calendar quarter as the date on the notice.

Members in the following categories are exempt from cost-sharing obligations, including copayments:

- American Indians
- Alaskan Natives
- Under age 18, except for Package C members
- Pregnant
- Receiving hospice care
- Eligible for Medicaid due to a diagnosis of breast or cervical cancer

**Note:** Members residing in an institution are exempt from copayment obligations but are responsible for paying any applicable facility liability.

The Eligibility Verification System (EVS) will indicate if a member is exempt from copayments. Members in exempt categories are not affected by the cost-sharing tracking process – they should never be charged copayments.

### Service-Specific Copayment Policies

The specific copayment policies outlined in this section do not apply to Hoosier Healthwise Package C members. See the [Hoosier Healthwise Package C Member Copayments](#) section for Package C copayment policies.

**Note:** For copayment policies regarding services rendered to members enrolled in managed care plans, providers should contact the appropriate managed care entity.

### Transportation Services

Transportation providers may collect a copayment amount from the IHCP member equal to the information presented in Table 7.

**Table 7 – Transportation Service Copayments**

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

No copayment is required for accompanying parent 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.

**Note:** The transportation copayment for Hoosier Care Connect members is $1 each one-way trip, regardless of distance (effective January 1, 2016).

Emergency ambulance services are exempt from copayments.

### Pharmacy Services

For pharmacy services copayment information, see the [Pharmacy Services](#) module.
Nonemergency Services Rendered in the Emergency Department

Nonemergency services rendered in an emergency department setting are subject to a copayment of $3 per date of service.

Family planning services are exempt from the copayment requirements for nonemergency services rendered in an emergency department:

Hoosier Healthwise Package C Member Copayments

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

Transportation Services

Hoosier Healthwise Package C members receive ambulance transportation services, subject to a $10 copayment, in the following circumstances:

- Emergencies, subject to the prudent layperson definition of emergency in 405 IAC 11-1-6
- Between medical facilities when ordered by the treating physician

All other nonemergent transportation is not a covered service under Package C.

Pharmacy Services

Pharmacy copayments for Package C members are $3 for generic drugs and $10 for brand name drugs. Pharmacy services are billed to the member’s MCE or that MCE’s pharmacy benefit manager (PBM). FFS pharmacy services are billed to OptumRx. See the Pharmacy Services module for more information on pharmacy billing.
Section 6: Retroactive Member Eligibility

Eligibility for most Indiana Health Coverage Programs (IHCP) member eligibility categories may be established retroactively up to three months prior to the member’s date of application, as long as the member met eligibility requirements in each of those retroactive months. Exceptions include:

- Healthy Indiana Plan (HIP) members – Contact the member’s managed care entity (MCE) for more information.
- Hoosier Healthwise Package C members – See the Hoosier Healthwise Package C Members section for more information.
- Qualified Medicaid Beneficiaries (QMBs) – Eligibility is effective no earlier than month of application.

Note: Except in the case of newborns, in instances where a member is determined retroactively eligible, 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 this document.

Provider Responsibilities

Providers rendering services to members during a period of retroactive eligibility are bound by the requirements that follow. This policy is mandatory and applies only in instances where the provider was enrolled in the IHCP at the time the service was rendered.

When notified of member’s retroactive eligibility, the provider must refund to the member any payments made by the member for covered services rendered on or after the member’s 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 should 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 the Claim Submission and Processing module. 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 eligibility and 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 request 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, 2015, to a patient on a private-pay basis. On October 1, 2015, the patient is enrolled in the IHCP retroactively to May 1, 2015. The patient informs the provider and furnishes a member identification card. The provider verifies program eligibility using one of the EVS options. After member eligibility is verified, the provider refunds the full amount paid by the member for the services rendered on August 1, 2015. The provider bills the IHCP within one year of the date the member was retroactively enrolled (October 1, 2015). Providers must return money paid by the IHCP member as soon as possible, according to normal office policy. See the Third Party Liability module when there is also a third-party carrier involved.

**Hoosier Healthwise Package C Members**

Hoosier Healthwise Package C members are not eligible for coverage before the month in which they apply for benefits. Members become eligible for Hoosier Healthwise Package C benefits on the first day of the month in which they applied once the required first month’s premium has been paid. For example, if an application was filed in June and was approved June 15, and the applicant’s required first month’s premium was paid in full for June, eligibility would begin on the first day of June.

Hoosier Healthwise Package C members may be determined retroactively eligible for coverage under a different eligibility category or package 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 that period of retroactive eligibility are bound by the requirements described previously, in the Provider Responsibilities section.
If a member disagrees with any action that denies or delays member services or benefits – whether taken by the Indiana Health Coverage Programs (IHCP), the county office of the Family and Social Services Administration (FSSA) Division of Family Resources (DFR), or a contractor – the member can ask for a hearing (pursuant to Code of Federal Regulations 42 CFR 431.200 et seq. and Indiana Administrative Code 405 IAC 1.1) by filing an appeal.

The process for appealing decisions about eligibility is listed on the notice applicants receive from the DFR. More information about that process is available in the Hearing and Appeals document available at in.gov/fssa.

Appeals must be submitted in writing. Guidance to members on how to submit an appeal is available from the IHCP member website (Members Rights & Responsibilities > Appeals and Grievances) at indianamedicaid.com.

Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members must first exhaust their managed care remedies before submitting an appeal to the State.

All member requests for administrative hearings should include a letter stating the reason for appeal. The letter must be signed and must include the member’s name and other important information. The request should be sent to the following address:

Hearings and Appeals
Indiana Family and Social Service Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204

As an alternative, appeals regarding eligibility decisions can be sent to the local DFR office.

All appeals must be filed within 33 calendar days of the date the adverse decision was received or takes effect, whichever is later. If the request is for a continuing service (for example, home healthcare), at least 10 days’ notice plus three days’ mailing time must be given before the effective date of the denial or modification, except as permitted under 42 CFR 431.213 and 42 CFR 431.214. As required by statute, if the request for a hearing is received before the effective date of the denial or modification of continuing services, services are continued at the authorized level of the previous PA.

At the hearing, the member has the right to self-representation or to be represented by legal counsel, a friend, a relative, or another spokesperson of the member’s choice. The member is given the opportunity to examine the entire contents of his or her case file, and any and all materials used by the FSSA, county office, or the contractor that made the adverse determination. Other IHCP and assistance benefits are not affected by a request for a hearing.