INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Member Eligibility and Benefit Coverage

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletins, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT2026168 – IHCP updates billing requirements for retroactive Healthy Indiana Plan eligibility*
- *BT2026145 – Immigration status requirement changes for Medicaid Eligibility*
- *BT2026129 – OMPP changing lookback period for claims with retroactive QMB coverage*
- *BT2025157 – MDwise to end participation as a managed care health plan for HIP and Hoosier Healthwise*
- *BT2025123 – Providers to be able to access PACE liability and transfer-of-property penalty information Sept. 25*
- *BT2025121 – IHCP Portal Institutional Level of Care and Hospice panel update available Sept. 25*

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Revision History

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1.1	Policies and procedures as of Sept. 1, 2016 (CoreMMIS updates as of Feb. 13, 2017) Published: June 20, 2017	Scheduled update	FSSA and HPE
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8.0	Policies and procedures as of Oct. 1, 2024 Published: Dec. 26, 2024	Scheduled update: • Reorganized and edited text as needed for clarity • Updated with PathWays information • Replaced IVR system references with virtual assistant (GABBY) • Removed references to ESRD patient liability • Updated *Table 1 – IHCP Programs and Associated Benefit Plans* • Updated figures in the *Member Identification* section to reflect the most member current cards • Added the *PathWays Member Card* section • Updated the *Eligibility Verification System* section • Updated the *Information Available Through the EVS* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated the *Transfer of Property Details* section • Updated the *Managed Care Assignment Details* section • Updated the *Waiver Liability Details* section • Updated the *Institutional Level of Care and Hospice* section • Updated the *Traditional Medicaid* section and *Indiana Breast and Cervical Cancer Program* subsection • Updated the *Medicare Savings Programs* section • Removed the *Eligibility Verification for QMB-Also and SLMB-Also Members With Liability* section • Added information about LIS eligibility in the *Medicaid and the Medicare Prescription Drug Coverage Program* section • Updated the *Additional Benefit Options* section • Updated the *1915(c) HCBS Waiver Services* section • Updated the *1915(i) State Plan HCBS Program Services* section • Updated the *Managed Care Entities* section • Updated the *Services Carved-Out of Managed Care* section • Updated the *Services Excluded From Managed Care* section • Updated the *Hoosier Care Connect* section • Added the *Indiana PathWays for Aging* section and the following subsections: ➢ *Medicare Cost-Sharing Coverage for PathWays Members* ➢ *HCBS Waiver Benefits for PathWays Members* • Updated the *Hoosier Healthwise* section and subsections • Reorganized and updated *Section 5: Member Cost-Sharing and Liability Policies and all subsections*	

Version	Date	Reason for Revisions	Completed By
		• Updated EOBs 6232, 6235 and 6310 in *Table 8 – EOBs Related to Benefit Limit Information Available through the EVS* • Updated the *Retroactive Eligibility for Managed Care Members* section • Updated the *Member Appeals Regarding Healthcare Actions* section	
8.1	Policies and procedures as of Oct. 1, 2024 Published: July 17, 2025	Correction: • Removed copayment obligation from Presumptive Eligibility – Adult benefit plan in *Table 6 – Presumptive Eligibility Benefit Plans and Coverage*	FSSA and Gainwell
8.2	Policies and procedures as of Oct. 1, 2024 Published: Aug. 27, 2025	Interim update: • Added note on title page pointing to *IHCP Bulletins BT2025123 and BT2025121*	FSSA and Gainwell
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8.6	Policies and procedures as of Oct. 1, 2024 Published: Oct. 13, 2026	Interim update: • Added note on title page pointing to *IHCP Bulletin BT2026168*	FSSA and Gainwell

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Section 1: Member Eligibility Overview

> *Note: For updates to the information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

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.

Outreach locations can screen for possible eligibility using established guidelines; however, the final eligibility determination is made through the Division of Family Resources (DFR). Providers should advise people interested in applying for IHCP benefits to submit an *Indiana Application for Health Coverage* using any of the following options:

- Apply online through the FSSA Benefits Portal.
- Apply by telephone by calling the DFR call center at 800-403-0864.
- Apply in person at their local DFR office.

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 in.gov/medicaid/members.

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 any IHCP-enrolled provider for 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, IHCP members receive benefits under either the fee-for-service (FFS) delivery system or the managed care delivery system, depending on which program they are enrolled in. However, certain services and benefit options cross over delivery systems and are delivered as FFS for *all* eligible members, including members enrolled under a managed care program.

IHCP programs and services are delivered as follows:

- FFS programs and services are delivered by enrolled IHCP providers and reimbursed directly through the IHCP fiscal agent, Gainwell Technologies, or by the FFS pharmacy benefit manager, Optum Rx. See *Section 2: Fee-for-Service Programs and Benefits* for information about FFS programs as well as certain benefit options that are delivered as FFS regardless of whether the member is enrolled in an FFS or managed care program.
- Managed care programs and services are delivered by enrolled IHCP providers that participate in managed care networks. Services are reimbursed by managed care entities (MCEs) contracted by the state of Indiana to manage the care for their members, or by subcontractors of the MCEs. See *Section 3: Managed Care Programs* for information about the IHCP managed care programs and benefit plans.

See *Section 4: Special Programs and Processes* for information about special programs and processes, including coverage for presumptively eligible individuals as well as information about the Right Choices Program.

Table 1 lists the specific IHCP benefit plans associated with each program, benefit option, or special process.

Table 1 – IHCP Programs and Associated Benefit Plans

Fee-for-Service Program	Benefit Plan Name
Traditional Medicaid	Full Medicaid* *With no managed care program assignment* *(Fee-for-service [FFS] or FFS plus nonemergency medical transportation [NEMT])*
	Package A – Standard Plan* *With no managed care program assignment* *(FFS or FFS plus NEMT)*
Medicare Savings Programs *Note: Members with QMB or SLMB can also be enrolled in either Traditional Medicaid or the Indiana PathWays for Aging managed care program. For eligible members, Medicare premiums are paid by the state through the IHCP FFS contractor, regardless of FFS or managed care enrollment.*	Qualified Disabled Working Individual [QDWI]
	Qualified Individual [QI]
	Qualified Medicare Beneficiary [QMB]
	Specified Low Income Medicare Beneficiary [SLMB]
Emergency Services Only (ESO)	Package E – Emergency Services Only
	ESO Coverage with Pregnancy Coverage [Package B]
Family Planning Eligibility Program	Family Planning Eligibility Program
590 Program	590 Program

Managed Care Program	Benefit Plan Name
Healthy Indiana Plan (HIP)	HIP Basic
	HIP Plus
	HIP State Plan Basic
	HIP State Plan Plus
	HIP State Plan Plus Copay
	HIP Maternity *[Provides full Indiana Medicaid State Plan coverage.]*
Hoosier Care Connect	Full Medicaid* *With Hoosier Care Connect managed care program assignment*
	Package A – Standard Plan* *With Hoosier Care Connect managed care program assignment*
Hoosier Healthwise	Package A – Standard Plan* *With Hoosier Healthwise managed care program assignment*
	Package C – Children's Health Plan (SCHIP)
Indiana PathWays for Aging (PathWays)	Full Medicaid* *With Indiana PathWays for Aging managed care program assignment*
Program of All-Inclusive Care for the Elderly (PACE)	Program of All-Inclusive Care for the Elderly

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

Benefit Option (Fee-for-Service Unless Otherwise Indicated)	Benefit Plan Name
1915(i) State Plan Home- and Community-Based Services (HCBS)	Adult Mental Health Habilitation
	Children's Mental Health Wraparound
	Behavioral & Primary Healthcare Coordination
1915(c) HCBS Waiver *Note: The Indiana PathWays for Aging Waiver is delivered as managed care. All other HCBS waivers are delivered as fee-for-service (FFS).*	Aged and Disabled HCBS Waiver [Health and Wellness HCBS Waiver]
	Aged and Disabled HCBS PathWays [Indiana PathWays for Aging HCBS Waiver]
	Community Integration and Habilitation HCBS Waiver
	Family Supports HCBS Waiver
	Traumatic Brain Injury HCBS Waiver
Money Follows the Person (MFP) Demonstration Grant	MFP Community Integration and Habilitation
	MFP Demonstration Grant HCBS Waiver [MFP Aged and Disabled Demonstration Grant]
Medicaid Rehabilitation Option (MRO)	Medicaid Rehabilitation Option

Special Program or Process	Benefit Plan Name
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 [Presumptive Eligibility for Inmates]
Medical Review Team (MRT)	Medical Review Team
Preadmission Screening and Resident Review (PASRR) *Note: No services are reimbursable under this benefit. PASRR assessments are performed by an IHCP contractor and not billable by providers.*	PASRR Individuals with Intellectual Disability
	PASRR Mental Illness (MI)

Member Identification

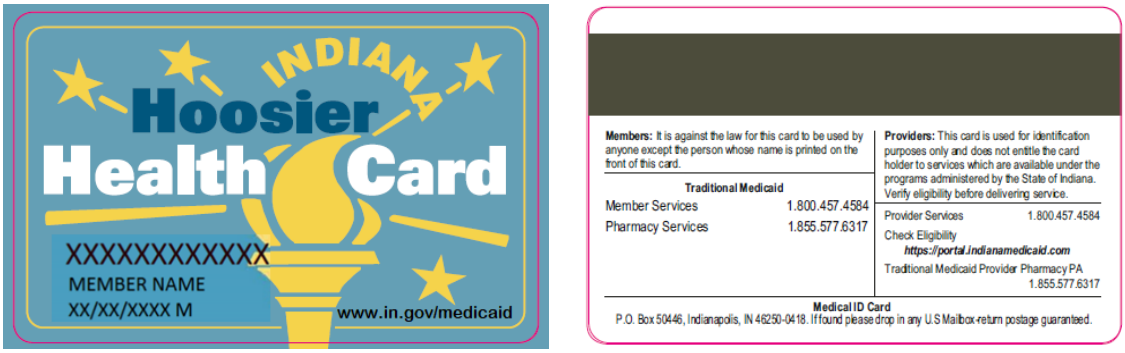
Each IHCP member is issued a 12-digit identification number that is referred to as the Member ID. The Member ID is assigned by the FSSA DFR through the automated Indiana Eligibility Determination Services System (IEDSS). Each member also receives a member identification card. The type of card received 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 front of the Hoosier Health Card contains the following information about the member (as shown in Figure 1):

- *IHCP Member ID*
- *Name*
- *Date of birth*
- *Gender*

Figure 1 – Hoosier Health Card



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 IHCP Core Medicaid Management Information System (*Core*MMIS). 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 that members are expected to retain for their 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 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

Healthy Indiana Plan (HIP) members receive member ID cards from their individual MCEs: Anthem, CareSource, Managed Health Services (MHS) or MDwise. Examples of HIP cards from each MCE are provided in Figures 2 through 5; the actual cards may vary depending on the specific plan in which the member is enrolled. Member identification numbers are located in the indicated areas on the HIP cards shown in the figures.

Note: Effective Jan. 1, 2026, MDwise is no longer participating as an IHCP MCE.

Figure 2 – Sample Anthem HIP Member Card

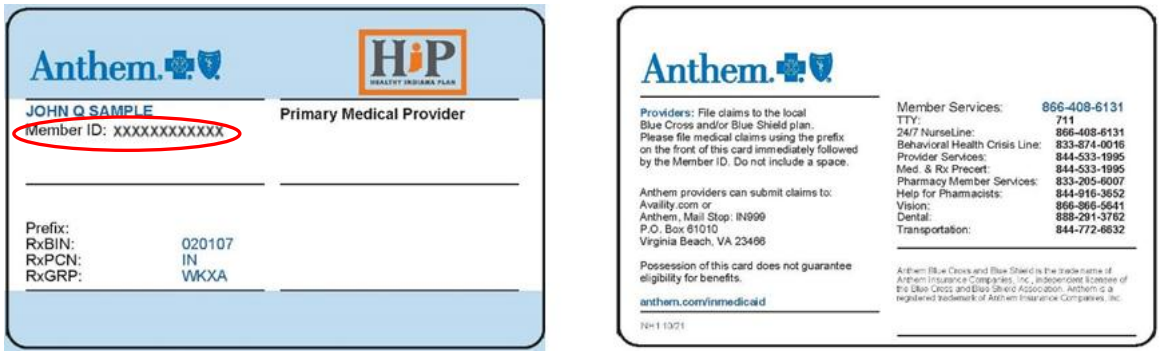


Figure 3 – Sample CareSource HIP Member Card

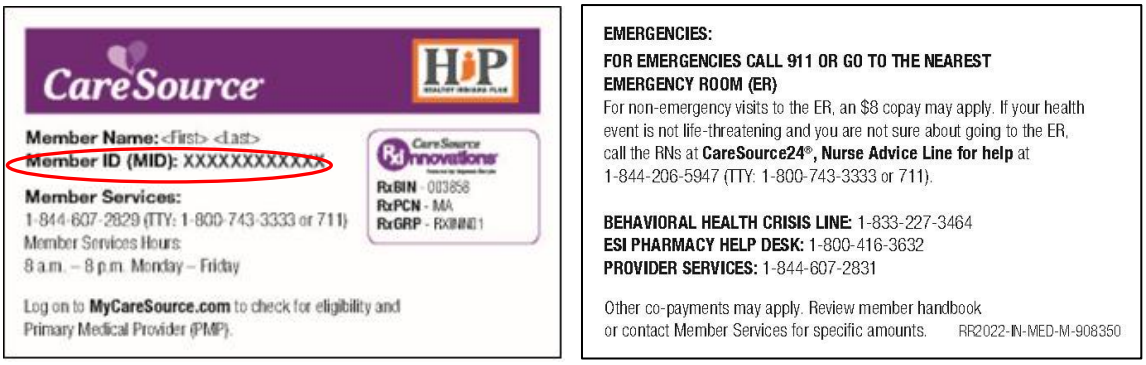


Figure 4 – Sample MHS HIP Member Card

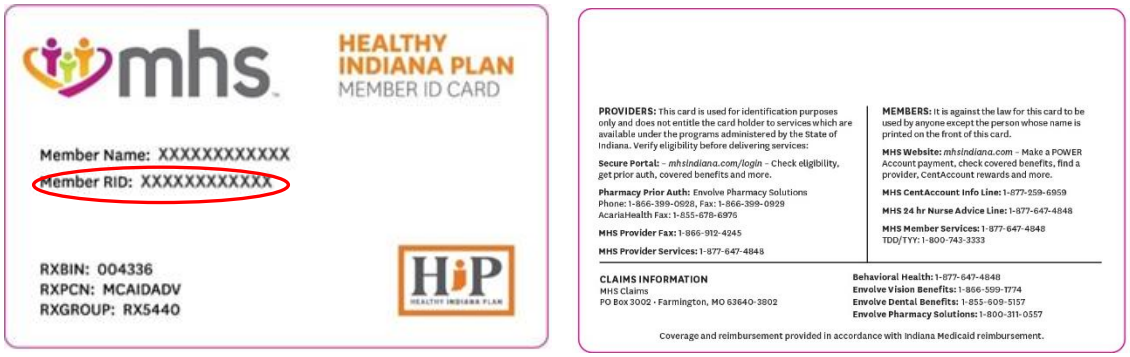


Figure 5 – Sample MDwise HIP Member Card



Hoosier Care Connect Member Card

Hoosier Care Connect members receive member ID cards from their individual MCEs: Anthem, MHS or UnitedHealthcare. Examples of Hoosier Care Connect member cards are provided in Figures 6–8. Member identification numbers are located in the indicated areas.

Figure 6 – Sample Anthem Hoosier Care Connect Member Card

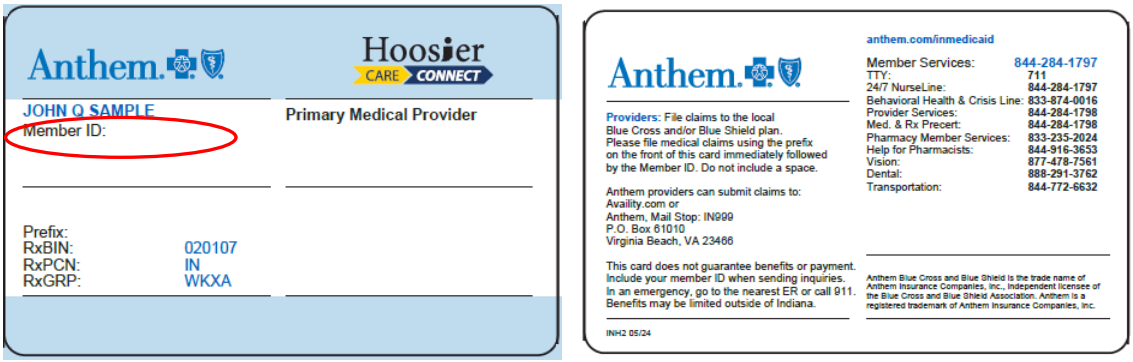


Figure 7 – Sample MHS Hoosier Care Connect Member Card

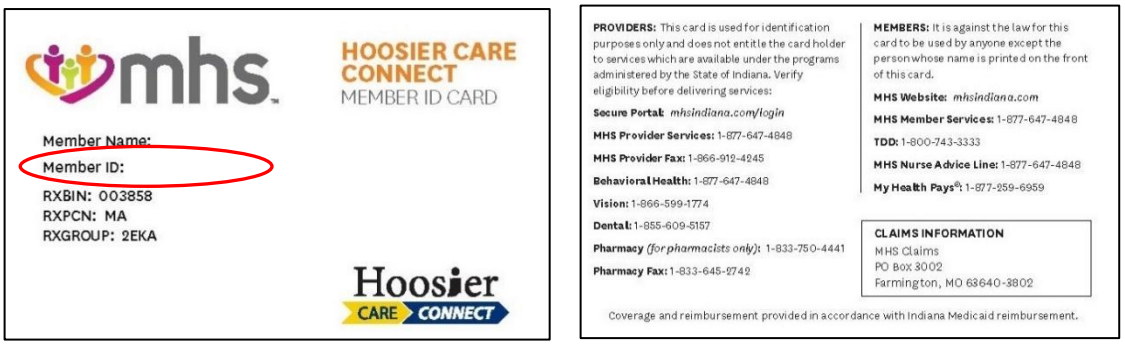


Figure 8 – Sample UnitedHealthcare Hoosier Care Connect Member Card

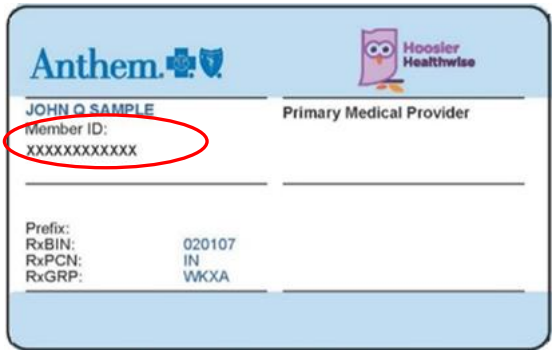


Hoosier Healthwise Member Card

Hoosier Healthwise members receive member ID cards from their individual MCEs: Anthem, CareSource, MHS and MDwise. Examples of Hoosier Healthwise member cards are provided in Figures 9–12. Member identification numbers are located in the indicated areas.

> *Note: Effective Jan. 1, 2026, MDwise is no longer participating as an IHCP MCE.*

Figure 9 – Sample Anthem Hoosier Healthwise Member Card



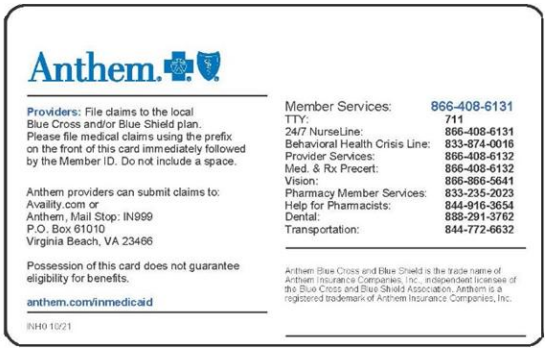


Figure 10 – Sample CareSource Hoosier Healthwise Member Card





Figure 11 – Sample MHS Hoosier Healthwise Member Card



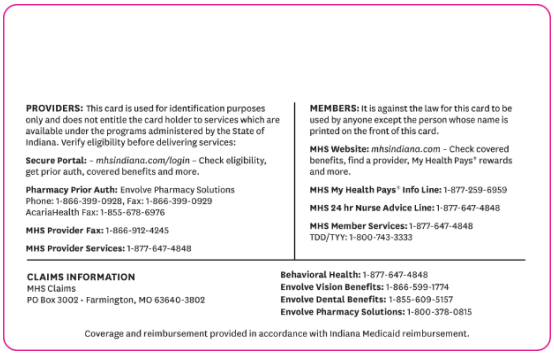
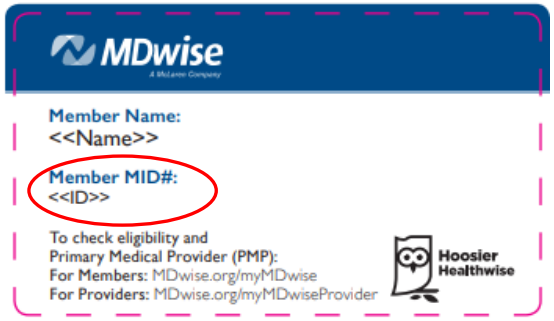


Figure 12 – Sample MDwise Hoosier Healthwise Member Card





PathWays Member Card

Indiana PathWays for Aging (PathWays) members receive member ID cards from their individual MCEs: Anthem, Humana and UnitedHealthcare. Examples of PathWays member cards are provided in Figures 13–15. Member identification numbers are located in the indicated areas.

Figure 13 – Sample Anthem PathWays Member Card

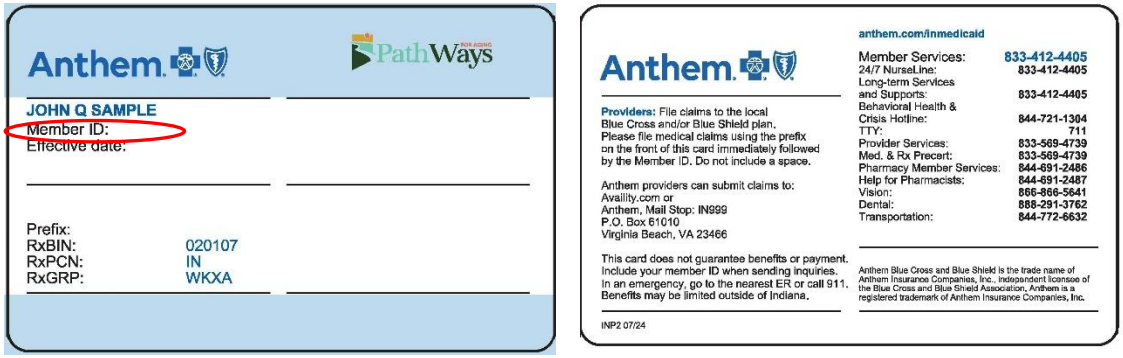


Figure 14 – Sample Humana PathWays Member Card



Figure 15 – Sample United Healthcare PathWays Member Card



Eligibility Verification System

Providers are required to verify member eligibility on the date of service. Due to varying circumstances, a member may have periods of inactive coverage. If a member's coverage is inactive at the time services are rendered, the claims will not be reimbursed. Providers that fail to verify eligibility are at risk of claims being denied due to member ineligibility or coverage limitations.

> *Note: Providers serving IHCP members in a long-term care (LTC) facility setting are responsible for verification of the member's eligibility and coverage status at the onset of service delivery as well as on an ongoing basis. At a minimum, LTC facility providers should verify this information monthly – ideally at the beginning of each calendar month, which is when eligibility changes are most likely to occur.*

Viewing a member ID card alone does not ensure member eligibility. Providers can verify member eligibility by using one of the following Eligibility Verification System (EVS) options:

- IHCP Provider Healthcare Portal (IHCP Portal) – See the *Eligibility Verification on the IHCP Portal* section for instructions.
- Approved vendor software for the 270/271 batch or interactive eligibility benefit transactions – See the *Electronic Data Interchange* module for details.
- Virtual assistant (GABBY) at 800-457-4584, option 2. (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:

- Member's IHCP Member ID
- Member's Social Security number and date of birth
- Member's first and last name and date of birth

If the member is not eligible on the date of service, the member can be billed for services. The member must be notified of ineligibility and agree in writing to cover any cost accrued from the services rendered. 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. See the *Provider Responsibilities for Retroactive Eligibility* section for more information.

Information Available Through the EVS

It is important that providers verify member eligibility on the date of service. 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 eligibility-related claim denials are 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 individual has IHCP coverage on the date of service
- What type of IHCP coverage the member has on the date of service, including:
  - What benefit plan or plans the member is enrolled in (see Table 1 for a list of benefit plans associated with the various IHCP programs)
  - For applicable members, what services are authorized under the member's Medicaid Rehabilitation Option (MRO) or 1915(i) State Plan Home- and Community-Based Services (HCBS) benefit (for applicable provider types only), as well as level-of-need information (for MRO members only)
  - Whether the member has a copayment responsibility for certain services

- Whether the member has other insurance coverage (known as third-party liability [TPL]) that takes precedence over the IHCP coverage (for more information, see the *Third-Party Liability* module)
- Whether a member is enrolled through a managed care program (such as HIP, Hoosier Care Connect, Hoosier Healthwise or PathWays) and, if so, to which MCE and primary medical provider (PMP) the member is assigned (name and telephone number) and the MCE delivery network associated with the member's PMP, if applicable

> *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. 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.*

- Whether the member is restricted, through the Right Choices Program, to a designated pharmacy, PMP and PMP-referred providers
- Whether the member has a monthly liability obligation (such as HCBS waiver or LTC patient liability), as well as information about the liability amount
- Whether the member has a level of care (LOC) assignment for long-term care (LTC) in a nursing facility or group home, or for hospice care
- Whether the member is ineligible for IHCP coverage of LTC facility or HCBS waiver services on the date of service due to a transfer of property penalty period
- Whether member benefit limits have been reached (for FFS members only; designated services only)

> *Note: Benefit limit information provided by the EVS reflects only claims that are processed in CoreMMIS. Claims paid by MCEs are not reflected in the EVS benefit limit information. For benefit limit information related to pharmacy benefits, providers are advised to contact the FFS pharmacy benefit manager, Optum Rx.*

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 IEDSS. The timing of the process (with the exception of Friday's activity) is as follows:

1. Information from IEDSS is downloaded from all counties daily after the close of business.
2. This file is passed electronically to *Core*MMIS between midnight and 5 a.m. the next day.
3. *Core*MMIS 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 *Core*MMIS Tuesday morning, between midnight and 5 a.m., *Core*MMIS 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 options can be used to verify the eligibility status of a member for dates of service up to seven years in the past. Eligibility inquiries are limited to a one-calendar-month date span.

> *Note: Eligibility cannot be verified for future dates because eligibility cannot be guaranteed before the date of service.*

Providers may verify eligibility for members for any date of service that is within the provider's IHCP enrollment period. However, the EVS restricts providers from accessing member eligibility information for dates of service on which the provider was not actively enrolled in the IHCP. If providers enter a date span, each day in the date span must be within the provider's enrollment period. For example, if the provider is enrolled in the IHCP from 11/1/15 to 5/7/20, and an eligibility inquiry is entered for a date span of 5/1/20 to 5/10/20, the dates of 5/8, 5/9 and 5/10 all fall outside the provider's enrollment period. 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.

Proof of Eligibility Verification

Providers must retain proof that member eligibility was verified. For verification conducted via the phone-based virtual assistant (GABBY), providers must document the verification number provided by GABBY 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 IHCP 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 IHCP Portal to the Written Correspondence Unit with a completed claim. The *Claim Submission and Processing* module provides additional information about written correspondence policies.

Eligibility Verification on the IHCP Portal

To verify eligibility online via the IHCP Portal, users must first establish a registered account on the portal, as described in the *Provider Healthcare Portal* module.

Use the following steps to verify eligibility on the IHCP Portal:

1. Log in to the IHCP Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers.
2. Click the Eligibility tab on the IHCP Portal menu bar to access the *Eligibility Verification Request* panel.
3. Enter one of the following:
   - Member ID
   - Member's Social Security number (SSN) and birth date
   - Member's last name, first name and birth date
4. Enter the date, or date range, for which eligibility is being checked:
   - The **Effective From** field is always required. If a date is not entered in this field, the IHCP Portal defaults this field to the current date. This field only accepts current and previous dates.
   - The **Effective To** field is optional. If a date is entered, it must be on or after the date in the Effective From field and must be within the same calendar month as that date. If a date is not entered in this field, it will default to the date in the Effective From field.
5. Click **Submit** to determine the member eligibility for the specified date or date range.

Figure 16 – Eligibility Verification Request Panel



6. The IHCP Portal displays results of the search:
   - If the search criteria do not match information in the portal, a message appears above the search panel stating: "Error: Member not found; confirm and/or revise search criteria." (See Figure 17.)
   - If the portal finds results for the search criteria entered, but the member does not have coverage for the dates searched, the words "Not Eligible" appear in the coverage details for that member. (See Figure 18.)
   - If the portal finds coverage for the dates entered, it lists the member's benefit plans, as well as additional information, on the *Coverage Details* page. (See Figure 19.)

Figure 17 – Eligibility Verification Request – No Information Found

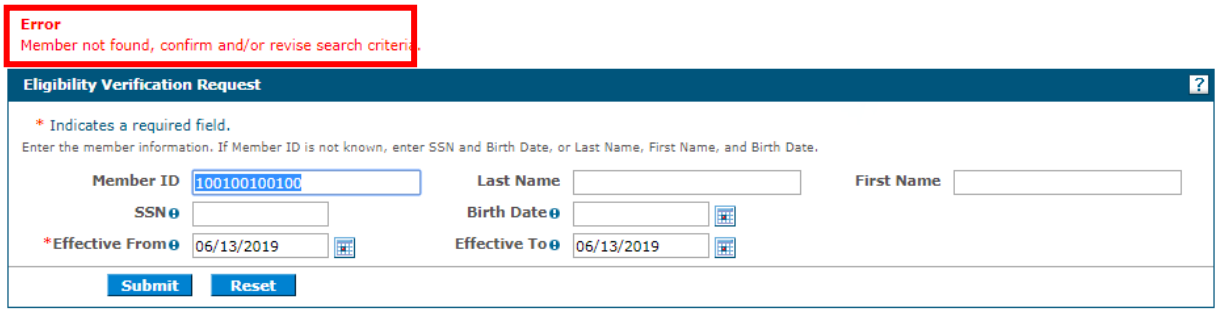
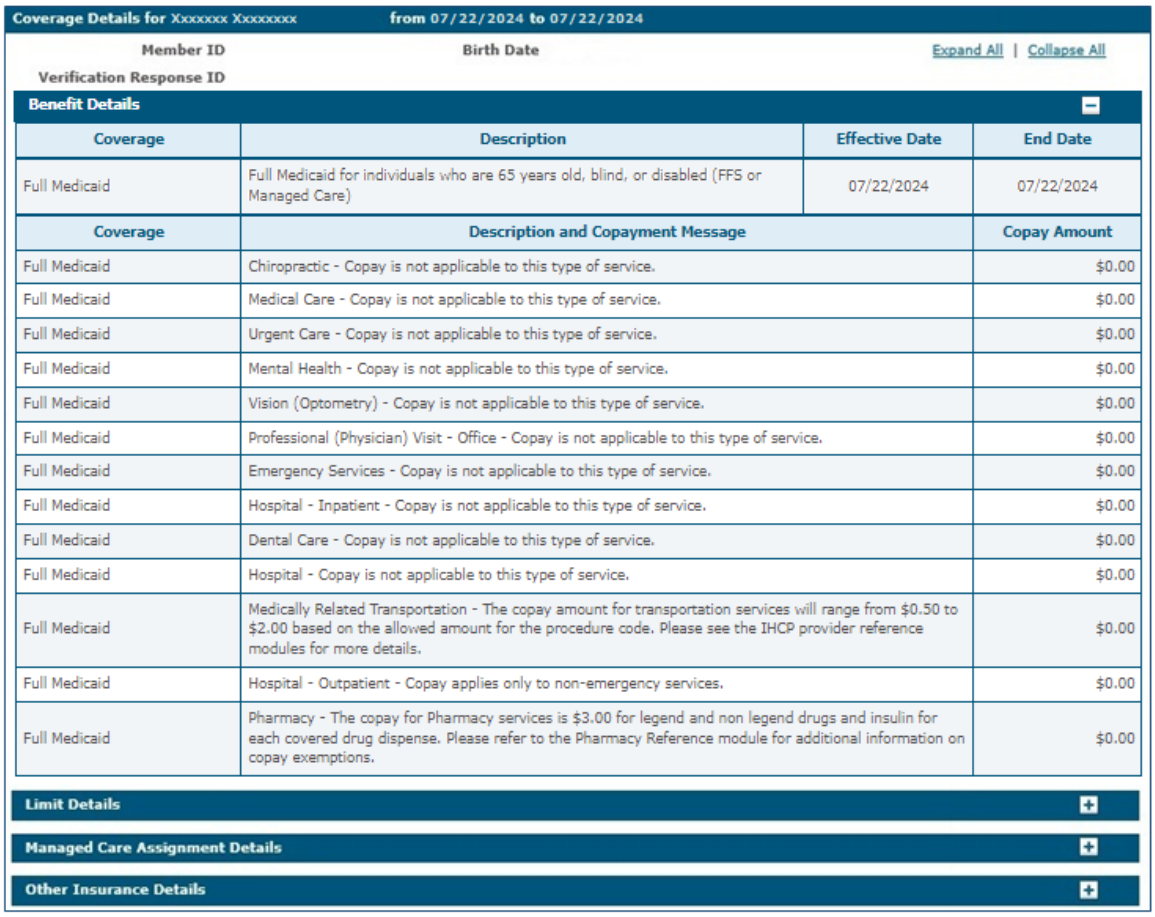


Figure 18 – Eligibility Verification Request – No Coverage for Dates Searched



Figure 19 – Eligibility Verification Information – Coverage Details



Coverage Details for Xxxxxxx Xxxxxxxx **from** 07/22/2024 **to** 07/22/2024

Member ID **Birth Date** Expand All | Collapse All

Verification Response ID

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	07/22/2024	07/22/2024

Coverage	Description and Copayment Message	Copay Amount
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Medical Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Urgent Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Mental Health - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Vision (Optometry) - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Professional (Physician) Visit - Office - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Emergency Services - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Hospital - Inpatient - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Dental Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Hospital - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Medically Related Transportation - The copay amount for transportation services will range from $0.50 to $2.00 based on the allowed amount for the procedure code. Please see the IHCP provider reference modules for more details.	$0.00
Full Medicaid	Hospital - Outpatient - Copay applies only to non-emergency services.	$0.00
Full Medicaid	Pharmacy - The copay for Pharmacy services is $3.00 for legend and non legend drugs and insulin for each covered drug dispense. Please refer to the Pharmacy Reference module for additional information on copay exemptions.	$0.00

Limit Details

Managed Care Assignment Details

Other Insurance Details

> *Note: For a claim to be considered for payment, the date of service must fall within an effective date range.*

7. Within the *Coverage Details* panel, all panels other than *Benefit Details* are initially collapsed. As you expand **(+)** the panels, you are able view to more information. You can also select *Expand All* to display all the information for all the panels. Only panels applicable to the member's coverage are displayed.

The following sections describe all possible panels returned with an eligibility verification request.

Benefit Details

The *Benefit Details* panel lists the member's coverage, including benefit plan name and description, and copayment requirements:

- For more information about IHCP benefit plans, see Table 1 and *Section 2: Fee-for-Service Programs and Benefits*, *Section 3: Managed Care Programs*, and *Section 4: Special Programs and Processes*.
- For more information about copayments, see *Section 5: Member Cost-Sharing Policies*.

For Medicaid Rehabilitation Option (MRO) members, the description in the *Benefit Details* panel also provides information about the member's level of need and service package assignment.

Figure 20 – Benefit Details

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	02/14/2020	02/14/2020
Medicaid Rehabilitation Option	Medicaid Rehabilitation Option for Adults with Level of Need = 4, Service Package 4	02/14/2020	02/14/2020

Coverage	Description and Copayment Message	Copay Amount
Full Medicaid	Medical Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Dental Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Hospital - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Emergency Services - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Professional (Physician) Visit - Office - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Hospital - Inpatient - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Urgent Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Mental Health - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Vision (Optometry) - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Medically Related Transportation - The copay amount for transportation services will range from $0.50 to $2.00 based on the allowed amount for the procedure code. Please see the IHCP provider reference modules for more details.	$0.00
Full Medicaid	Hospital - Outpatient - Copay applies only to non-emergency services.	$0.00
Full Medicaid	Pharmacy - The copay for Pharmacy services is $3.00 for legend and non legend drugs and insulin for each covered drug dispense. Please refer to the Pharmacy Reference module for additional information on copay exemptions.	$0.00

Detail Information

For applicable providers, the following benefit plans will appear as a hyperlink in the *Benefit Details* panel (Figure 20):

- Adult Mental Health Habilitation
- Behavioral & Primary Healthcare Coordination
- Child Mental Health Wraparound
- Medicaid Rehabilitation Option

Providers can click the linked plan name to view the *Detail Information* panel (Figure 21), which shows the specific services authorized for the member under that plan.

> *Note: The IHCP Portal displays the Detail Information panel only for those providers with the correct specialty for MRO or 1915(i) HCBS program services. For all other provider specialties, the plan names will not appear as a hyperlink and the Detail Information panel will not be accessible.*

For details about these benefit plans, see the *Medicaid Rehabilitation Option Services* and *1915(i) State Plan HCBS Program Services* sections.

Figure 21 – Detail Information for an MRO Benefit

Detail Information

Total Records: 5

Authorization Number	Status	Provider	Code	Description	Service Dates	Units Authorized	Units Used	Amount Authorized	Amount Used
X100100100	APPROVED	PSYCHIATRIC CENTER	H0031 HW	MH HEALTH ASSESS BY NON-MD	08/10/2017 - 02/06/2018	1	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H0004 HW	ALCOHOL AND/OR DRUG SERVICES	08/10/2017 - 02/06/2018	32	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H0004 HW U1	ALCOHOL AND/OR DRUG SERVICES	08/10/2017 - 02/06/2018	48	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H2035 HW	A/D TX PROGRAM, PER HOUR	08/10/2017 - 02/06/2018	32	-	-	-
X100100100	APPROVED	PSYCHIATRIC CENTER	H2017 HW	PSYSOC REHAB SVC, PER 15 MIN	08/10/2017 - 02/06/2018	1820	-	-	-

Transfer of Property Details

Some members incur a transfer of property penalty while they are transferring assets. The IHCP does not reimburse for extended care facility or HCBS waiver services provided during this period. The IHCP Portal will display the *Transfer of Property Details* panel if the member is ineligible for coverage of these services on the dates searched due to a transfer of property penalty period.

Extended-care facilities (provider type 03) and waiver providers (provider type 32) should continue to submit claims to the IHCP for services provided during the member's transfer-of-property period. Providers may bill the member directly for these services during this period, but it is recommended to wait until after the IHCP claim has processed and denied before doing so.

Figure 22 – Transfer of Property Details

Transfer of Property Details

Description	Effective Date	End Date
Transfer of Property Penalty Period	05/01/2024	05/01/2024

Limit Details

The *Limit Details* panel lists unit or dollar limits that may apply to the member for certain services. For applicable services, if any portion of the limit has already been reimbursed under the FFS delivery system, the panel shows a description of the limit, the limit amount allowed and the amount that is still remaining to the member. The amount indicated as remaining is based on FFS paid claims. The *actual* amount remaining may be different – for example, if a service has been rendered but the claim has not yet been paid. See *Section 6: Benefit Limit Information* for more information.

Figure 23 – Limit Details

Limit Details

The Dollar Limits and Service Limits may not reflect recent claims.

Service Limits	Limit	Remaining
6195 FRAMES INITIAL OR REPAIR/REPLACEMENT 21 YRS O	1	-
6272 LENSES INITIAL REPAIR/REPLACEMENT MEMBER 21 Y	2	-
6298 ROUTINE VISION EXAM AGE 21-999 LTD TO 1/24 MO	1	-

> *Note: Although this panel may appear in the eligibility verification results for a managed care member, the information shown is based on FFS claims only. Providers must contact the member's MCE for benefit limit information pertaining to services rendered under the managed care delivery system.*

Managed Care Assignment Details

For members enrolled in a managed care program, such as HIP, Hoosier Care Connect, Hoosier Healthwise or PathWays, the *Managed Care Assignment Details* identifies the member's managed care program, PMP name and telephone number, MCE name and telephone number, and delivery network associated with the PMP, if a delivery network is applicable. The option to submit a Notification of Pregnancy (NOP) for managed care members is also available from this panel; see the *Obstetrical and Gynecological Services* module for details.

Figure 24 – Managed Care Assignment Details – Managed Care

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Hoosier Care Connect		XXXXXXXXXXXX	XXXXXXXXXXXX
Effective Date	**End Date**	**MCO / CMO Name**	**MCO / CMO Phone**
06/21/2018	06/21/2018	ANTHEM	XXXXXXXXXXXX

Enter NOP Print Blank NOP

For FFS members subject to brokerage requirements for designated nonemergency medical transportation (NEMT) services, the *Managed Care Assignment Details* panel displays the name of the broker that must be used to arrange the transportation. These members are still considered FFS for all other services; however, scheduling and billing of the NEMT service must be done through the broker, except in the case of certain NEMT services that are exempt from the brokerage requirement. For more information, see the *Transportation Services* module.

Figure 25 – Managed Care Assignment Details – FFS with Brokered NEMT

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			
Effective Date	**End Date**	**MCO / CMO Name**	**MCO / CMO Phone**
05/05/2023	05/05/2023	VERIDA, INC	

Right Choices Program

The Right Choices Program (RCP) locks members in to a single PMP and pharmacy. Additional providers may be authorized as needed, by PMP referral only.

If a member is enrolled in the RCP on the dates searched, the *Right Choices Program* panel is displayed and lists the member's PMP, lock-in pharmacy and any authorized referral providers. With the exception of hospital services and services specifically carved out of the RCP, IHCP coverage for the RCP member is limited to the specific providers listed. See the *Right Choices Program* module for more information.

Figure 26 – Right Choices Program

Right Choices Program

Indicates a PMP Provider.

RCP Provider	PMP	RCP Provider Phone	Service	Effective Date	End Date
XXXXXXXXX XXXXXXXXX	Yes	X-XXX-XXX-XXXX	RCP-Physician	05/26/2020	05/27/2020
XXXXXXXXX XXXXXXXXX	No	X-XXX-XXX-XXXX	RCP-Physician	05/26/2020	05/27/2020
XXXXXXXXX XXXXXXXXX	No	X-XXX-XXX-XXXX	RCP-Physician	05/26/2020	05/27/2020
XXXXXXXXX XXXXXXXXX	No	X-XXX-XXX-XXXX	RCP-Pharmacy	05/26/2020	05/27/2020

Waiver Liability Details

Certain HCBS waiver members must meet a monthly liability obligation before their HCBS waiver coverage begins. See the *HCBS Waiver Liability* section for details.

When verifying eligibility for a member who is subject to a monthly HCBS waiver liability, the *Waiver Liability Details* panel will be displayed, as follows:

- For FFS members with a waiver liability, the panel will show the member's liability obligation and the remaining balance. The balance amount shown may not reflect claims not yet processed. Providers may bill the member for the amount credited to liability after the claim is adjudicated.
- For managed care members with a PathWays Waiver liability, a note is displayed indicating that the member has a waiver liability and instructing the provider to contact the member's MCE for more information. For the PathWays Waiver, the MCEs will track and update waiver liability obligation within their own systems. When verifying eligibility for PathWays Waiver services, it is important to check with the member's MCE to confirm the current waiver liability balance.

Figure 27 – Waiver Liability Details (FFS Member)

Waiver Liability Details

These amounts are based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the Waiver Liability amount deducted from the adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Waiver Liability Summary Notice listing the amount applied to Waiver Liability.

Month	Waiver Liability Obligation	Waiver Liability Balance
May 2024	$977.00	$977.00

Institutional Level of Care and Hospice

For members with a nursing facility, intermediate care facility for individuals with intellectual disability (ICF/IID) and/or hospice level of care (LOC) assignment for the dates searched, the *Institutional Level of Care and Hospice* panel displays the applicable LOC. See the *Hospice Services* and *Long-Term Care* modules for more information about these LOCs.

> *Note: The IHCP Portal displays hospice LOC assignment for FFS members only. To confirm hospice benefits provided under a managed care program, providers must contact the member's MCE.*

If the member is required to pay a patient liability, that information is displayed as follows:

- For FFS members, the liability amount is displayed at the bottom of the panel as the Patient Liability/Client Obligation.
- For PathWays members, a note is displayed indicating that the member has a patient liability and instructing the provider to contact the member's MCE for more information. For these members, the MCE will track and update the patient liability obligation. It is important to check with the member's MCE to verify the current patient liability balance.

Figure 28 – Institutional Level of Care and Hospice (FFS Member)

Institutional Level of Care and Hospice

Level of Care	Provider	Effective Date	End Date
Hospice Program; Auth for 1st 90 day period	XXXXXXXXXXXXX	01/13/2020	01/31/2020
Nursing Facility Level of Care	XXXXXXXXXXXXX	01/27/2020	01/31/2020
Patient Liability/Client Obligation: $0.00			

Other Insurance Details

The *Other Insurance Details* panel displays information about other coverage, in addition to IHCP benefits, on file for the member. The information provided includes the carrier's name (and Carrier ID), address, and telephone number and the policyholder's policy ID, group ID, name and coverage type. For more information about billing and reimbursement for members with other insurance, in addition IHCP coverage, see the *Third-Party Liability* module.

Figure 29 – Other Insurance Details

Other Insurance Details

Carrier Name (Carrier ID)	Address	Phone Number	Policy ID	Group ID	Policy Holder	Coverage Type
Medicare					MEMBER NAME (00000000000)	MEDICARE A
Medicare					MEMBER NAME (00000000000)	MEDICARE B
Medicare					MEMBER NAME (00000000000)	MEDICARE PART D
CARRIER NAME PART D (0000000)	P.O. BOX 00000 XXCITY, IN 00000	1-800-000-0000	000	X0000	MEMBER NAME (00000000000)	MEDICARE PART D

> *Note: Providers can submit information about a member's other insurance by using the IHCP Portal's Secure Correspondence link, with TPL Update selected as the category. Updates can take up to 20 business days to be verified. See the Third-Party Liability module for details.*

Demographic Details

The *Demographic Details* panel displays the address on file for the member.

Figure 30 – Demographic Details

Demographic Details

Street Address

City State Indiana ZIP Code

Section 2: Fee-for-Service Programs and Benefits

Indiana Health Coverage Programs (IHCP) members enrolled in programs delivered as fee-for-service (FFS) are not enrolled with a managed care entity (MCE) 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 either of the following benefit plans with no managed care assignment other than for nonemergency medical transportation (NEMT):
  - Full Medicaid
  - Package A – Standard Plan
- Medicare Savings Programs
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-Income Medicare Beneficiary (SLMB)
  - Qualified Individual (QI)
  - Qualified Disabled Working Individual (QDWI)
- Emergency Services Only (ESO)
  - Package E – Emergency Services Only
  - ESO Coverage with Pregnancy Coverage (Package B)
- Family Planning Eligibility Program
- 590 Program

See the *Additional Benefit Options* section for information about add-on benefit plans with coverage of additional services.

See *Section 4: Special Programs and Processes* for information about presumptive eligibility (PE) coverage and other special programs and processes provided as FFS.

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 under the age of 60 residing in a nursing facility, or persons of any age residing in an intermediate care facility for individuals with intellectual disability (ICF/IID) or other non-nursing-facility institution
- Persons under the age of 60 who are eligible for Hoosier Healthwise and who qualify for IHCP hospice benefits
- Persons eligible for a Home- and Community-Based Services (HCBS) waiver program other than the Indiana PathWays for Aging Waiver (see the *HCBS Waiver Benefits for PathWays Members* section), including those with a waiver liability (see the *HCBS Waiver Liability* section)
- Persons under the age of 60 who are eligible for both Medicare and Medicaid (dually eligible)
- Persons enrolled in the Breast or Cervical Cancer Treatment Program

- Refugees who do not qualify for any other aid category
- Children receiving adoption assistance
- Wards of the state
- Foster children
- Former foster children who turned 18 years of age while in foster care (in any state), were enrolled in Medicaid at some point while in foster care, are under age 26
- American Indian/Alaska Native members who opt out of Healthy Indiana Plan (HIP), or who qualify for but choose not to opt in to Indiana PathWays for Aging (PathWays)

Traditional Medicaid members are eligible for full coverage of Medicaid services, as described in the *Indiana Medicaid State Plan*. For details, see the *Indiana Medicaid State Plan* page at in.gov/medicaid/providers.

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) HCBS waiver services, 1915(i) State Plan HCBS program services, Medicaid Rehabilitation Option (MRO) services, hospice services and LTC facility services. These additional services are also delivered on an FFS basis for Traditional Medicaid members. Providers must consult the EVS to determine the member's eligibility status and coverage details.

Indiana Breast and Cervical Cancer Program

Individuals diagnosed with female breast cancer or cervical cancer through the Indiana Breast and Cervical Cancer Program (BCCP) of the Indiana Department of Health are eligible for Traditional Medicaid coverage during the course of treatment. These members are in the FFS delivery system only. To be eligible, an individual must meet the following criteria:

- Must be younger than 65 years old ***or*** not enrolled in Medicare Part B (if age 65 or older)
- Must not be eligible for another Medicaid category
- Must not be covered by any other insurance that includes breast or cervical cancer treatment

Alternatively, an individual who has been diagnosed with female breast cancer or cervical cancer, but **not** screened through BCCP, can receive Traditional Medicaid coverage during the course of their treatment, if they meet the following criteria:

- They are between the ages of 18 and 65.
- They have income at or below 200% of the federal poverty level (FPL).
- They are not eligible for Medicaid under any other category.
- They have no health insurance that will cover their treatment.

For more information about the BCCP, see the *Breast and Cervical Cancer Program* page at in.gov/health.

Medicare Savings Programs

Federal law requires that state Medicaid programs pay Medicare premiums, as well as, in some cases, Medicare coinsurance or copayment[1] and deductibles, for certain elderly and disabled individuals through a **Medicare Savings Program**. These individuals must meet the following general eligibility criteria to receive assistance with Medicare-related costs:

[1] *The terms "coinsurance" and "copayment" are interchangeable. When referred to in outputs such as the phone-based virtual assistant (GABBY), IHCP Portal, remittance advice (RA) and so forth, the term "coinsurance" represents coinsurance and/or copayment.*

- Entitled to Medicare
- Low income
- Few personal resources

Depending on more specific eligibility factors, Medicare Savings Programs assist with Medicare costs as follows:

- **Qualified Medicare Beneficiary (QMB)** – For QMBs, the IHCP pays the Medicare Part A premiums (as necessary) and Medicare Part B premiums, as well as Medicare deductibles and coinsurance or copayment for Medicare-covered services when the Medicare payment amount is less than the Medicaid allowed reimbursement amount. The member is never responsible for the amount disallowed (paid at zero) when Medicare paid more than the Medicaid allowed amount for the service.
- **Specified Low-Income Medicare Beneficiary (SLMB)** – For SLMBs, the IHCP pays Medicare Part B premiums, but not Medicare Part A premiums or Medicare deductibles or coinsurance/copayment.
- **Qualified Individual (QI)** – For QIs, the IHCP pays Medicare Part B premiums only.
- **Qualified Disabled Working Individual (QDWI)** – For QDWIs, the IHCP pays Medicare Part A premiums only.

Members who have both QMB coverage and ***also*** Full Medicaid or Package A coverage are known as **QMB-Also**. Members who have both SLMB 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**.

Members who have Full Medicaid or Package A coverage and who are enrolled in Medicare but do ***not*** qualify for a Medicare Savings Program are known as **Other Full Benefit Dual Eligible (Other FBDE)** members. The IHCP provides the same level of coverage for Other FBDE members as it provides for SLMB-Also members.

Table 2 summarizes the various coverage categories for dually eligible members (Medicaid members who are also enrolled in Medicare).

> *Note: Prior to July 1, 2024, all dually eligible members with Full Medicaid or Package A benefits received Medicaid coverage through the fee-for-service delivery system.*
>
> *Effective July 1, 2024, dually eligible members with Full Medicaid or Package A benefits (including QMB-Also, SLMB-Also and Other FBDE members) may receive this coverage as either FFS (if they are enrolled under Traditional Medicaid) **or** as managed care (if they are enrolled under Indiana PathWays for Aging [PathWays]).*

Table 2 – Coverage Categories for Dually Eligible Members

Coverage Type	Description of Coverage	Notes
QMB-Only	The member's benefits are limited to payment of: • The member's Medicare Part A premiums (if not entitled to free Part A) and Part B premiums • Deductibles and coinsurance or copayment for Medicare-covered services **IHCP 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.	When the EVS identifies a member as having only *Qualified Medicare Beneficiary* coverage (without also having *Full Medicaid* or *Package A – Standard Plan* 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. 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.
QMB-Also	The member's benefits include payment of: • The member's Medicare Part A premiums (if not entitled to free Part A) and Part B premiums • Deductibles and coinsurance or copayment on Medicare-covered services • Indiana Medicaid State Plan benefits (excluding prescription drug coverage, as stated in the *Medicaid and the Medicare Prescription Drug Coverage Program* section) *Note: Members may receive this coverage as either fee-for-service (Traditional Medicaid) or as managed care in the PathWays program.* • Any additional IHCP services for which the member qualifies, such as 1915(c) HCBS waiver services or LTC facility services *Note: If the member has an HCBS waiver liability or LTC patient liability, reimbursement for those services does not begin until that month's liability has been met. Reimbursement for Indiana Medicaid State Plan services and payment of Medicare premiums, deductibles and coinsurance are not impacted by the waiver liability.*	When the EVS identifies a member as having *Qualified Medicare Beneficiary* coverage **and also** *Full Medicaid* or *Package A – Standard Plan* coverage, claims for services covered by Medicare (including Medicare-covered services provided through a Medicare Advantage Plan) may cross over to Medicaid for additional payment consideration. Medicaid claims for services **not** covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.

Coverage Type	Description of Coverage	Notes
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 – Standard Plan* 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. See the *Provider Enrollment* module for additional information about billing an IHCP member for noncovered services.
SLMB-Also	The member's benefits include payment of: • The member's Medicare Part B premiums • Indiana Medicaid State Plan benefits (excluding prescription drug coverage, as stated in the *Medicaid and the Medicare Prescription Drug Coverage Program* section) *Note: Members may receive this coverage as either fee-for-service (Traditional Medicaid) or as managed care in the PathWays program.* • Any additional IHCP services for which the member qualifies, such as 1915(c) HCBS waiver services or LTC facility services *Note: If the member has an HCBS waiver liability or LTC patient liability, reimbursement for those services does not begin until that month's liability has been met. Reimbursement for Indiana Medicaid State Plan services and payment of Medicare premiums are not impacted by the waiver liability.*	When the EVS identifies a member as having *Specified Low Income Medicare Beneficiary* coverage **and also** *Full Medicaid* or *Package A – Standard Plan* coverage, claims for services covered by Medicare (including Medicare-covered services provided through a Medicare Advantage Plan) may cross over to Medicaid for additional payment consideration. Medicaid claims for services **not** covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.
QI	The member's benefit is limited to payment of the member's Medicare Part B premium only.	The EVS identifies this coverage as *Qualified Individual*.
QDWI	The member's benefit is limited to payment of the member's Medicare Part A premium only.	The EVS identifies this coverage as *Qualified Disabled Working Individual*.

Coverage Type	Description of Coverage	Notes
Other FBDE	The member's benefit is the same as SLMB-Also.	There is no special designation in the EVS to identify these members. The EVS will show their *Full Medicaid* or *Package A – Standard Plan* coverage, but because they are not enrolled in a Medicare Savings Program, there is nothing to indicate that they are dually eligible. However, the IHCP provides a minimum of SLMB-Also level coverage for *all* Full Medicaid and Package A members who also have Medicare. Claims for services covered by Medicare (including Medicare-covered services provided through a Medicare Advantage Plan) may cross over to Medicaid for additional payment consideration. Medicaid claims for services **not** covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.

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.

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

Enrollment in Medicare Part D prescription drug coverage is voluntary. However, the IHCP will not pay for prescriptions for dually eligible members who have opted out of Medicare Part D, unless the prescription is for a Part D-excluded drug. 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, including those who decline the Medicare Part D coverage or disenroll from the Medicare PDP.

For general information about IHCP drug coverage and claim processing for FFS dually eligible members, see the *Pharmacy Services* module. For those in PathWays, refer to guidance provided by the member's MCE.

Affected members should be encouraged to sign up for Medicare Part D as soon as possible. The following options are available for assistance understanding, selecting and enrolling in a Medicare prescription drug plan:

- Call the Indiana State Health Insurance Assistance Program (SHIP) at 800-452-4800 (TTY users call 866-846-0139).
- Call Medicare directly at 800-Medicare (800-633-4227) (TTY users call 877-486-2048) or visit the *Drug Coverage (Part D)* page at medicare.gov.
- Contact a trusted local insurance agent.

The Medicare Low-Income Subsidy (LIS), also known as "Extra Help," is a federal subsidy provided by Medicare that helps members pay for their Medicare PDP premiums, copays and deductibles. Members need to apply for this assistance program through Social Security at 800-722-1213 or access help online at the Social Security Administration website at ssa.gov. If the member chooses a Medicare PDP with higher premiums than the amount that Medicare will subsidize, the member will have to pay the difference.

Assistance can also be obtained through any of the local Social Security offices in the member's area. When members qualify for LIS for one month, Medicare deems LIS eligibility for the remainder of the calendar year.

Emergency Services Only

Emergency Services Only (ESO) benefit plans – Package E and Package B – offer limited coverage for individuals who would otherwise be eligible for full Medicaid coverage, but who do not meet citizenship or immigration-status requirements for the program.

> *Note: Children born in the United States to ESO (Package E or B) members are categorically eligible for full Medicaid coverage, at least for the month of birth, upon determination of eligibility through the DFR.*
>
> *Children who are not born in the United States are eligible only for ESO coverage, 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.*
>
> *Outreach locations can screen for eligibility using established guidelines; however, the final eligibility determination is made through the DFR.*

ESO members are in the FFS delivery system. For billing instructions for ESO claims, see the *Claim Submission and Processing* module.

Emergency Services Only (Package E)

Coverage under Package E is limited to treatment for medical emergency conditions only. 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 members enrolled under Package E, labor and delivery services are also considered emergency medical conditions.

Emergency Services Only Coverage With Pregnancy Coverage (Package B)

The IHCP provides ESO Coverage with Pregnancy Coverage (also known as Package B) benefits for women who are lawful permanent residents and who are pregnant or within the 60-day postpartum period. In addition to all services covered under Package E, Package B also provides coverage for prenatal and postpartum services until 60 days after the pregnancy ends.

Family Planning Eligibility Program

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

The Family Planning aid category includes members of any age or gender who:

- Do not qualify for any other category of Medicaid
- Are not pregnant
- Have not had a hysterectomy or sterilization

- Have family 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 members 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 examinations
- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods
- Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, within the parameters described in the *Obstetrical and Gynecological Services* module
- 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 human immunodeficiency virus (HIV), within the parameters described in the *Laboratory Services* module
- Tubal ligations
- Hysteroscopic sterilization with an implant device
- Vasectomies

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.

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

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 through 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 Department of Health. 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). Coverage is limited to services performed outside the 590 Program facility and to claims over $150 dollars. Only 590-enrolled providers can render services to 590 Program members.

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

Additional Benefit Options

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, except as indicated:

- **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 or the PathWays managed care program. The Indiana PathWays for Aging Waiver is reimbursed through the managed care delivery system (except in the case of members who meet the opt-in criteria for the PathWays managed care program but do not opt in to it and instead remain in Traditional Medicaid and, if eligible, receive PathWays Waiver benefits as FFS). All other HCBS waivers are reimbursed as FFS and are available only to members enrolled in Traditional Medicaid; members must be disenrolled from managed care to participate in any HCBS waiver other than the PathWays Waiver.

  Money Follows the Person (MFP) demonstration grant services may be available as a 12-month transitionary benefit for individuals moving from an institutional setting to a 1915(c) HCBS waiver. All MFP coverage is delivered as FFS; it is carved out of managed care for PathWays members and excluded from all other managed care programs.
- **1915(i) State Plan Home- and Community-Based Services (HCBS) program services** – Certified individuals may receive designated *nonwaiver* home- and community-based services in conjunction with Traditional Medicaid, *HIP State Plan, HIP Maternity*, Hoosier Care Connect, Hoosier Healthwise or PathWays benefits. These services are carved out of managed care and reimbursed as FFS for all members.
- **Medicaid Rehabilitation Option services** – Certified individuals may receive MRO services in conjunction with Traditional Medicaid, *HIP State Plan*, *HIP Maternity*, Hoosier Care Connect, Hoosier Healthwise or PathWays benefits. MRO services are carved out of managed care and reimbursed as FFS for all members.

- **Long-term care (LTC) facility services** – Traditional Medicaid members approved for an applicable level of care (LOC) may receive coverage of long-term care provided in a nursing facility or an intermediate care facility for individuals with intellectual disability (ICF/IID). PathWays members with an approved LOC may receive nursing facility coverage through their MCE. Members enrolled in a managed care program *other than* PathWays must be transitioned to Traditional Medicaid to receive coverage of LTC in a nursing facility. ICF/IID coverage is available *only* to Traditional Medicaid members. See the *Long-Term Care* module for details.
- **Hospice services** – Hospice services are available to eligible Traditional Medicaid and managed care members who have been approved for a hospice level of care. Members enrolled in the Hoosier Healthwise managed care program are required to transition to Traditional Medicaid (under the FFS delivery system) to receive coverage of in-home and/or institutional hospice services. For all other managed care programs, hospice services are covered within the managed care delivery system. See the *Hospice Services* 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 qualifying members who require the level-of-care (LOC) services provided in a nursing facility, hospital or ICF/IID, but who choose to remain in the home.

The Indiana Division of Disability and Rehabilitative Services (DDRS) offers four HCBS waivers:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports Waiver (FSW)
- Traumatic Brain Injury (TBI) Waiver
- Health and Wellness (H&W) Waiver

Note: Previously, two HCBS waivers were offered under the Indiana Division of Aging – the TBI Waiver and the Aged and Disabled (A&D) Waiver. On July 1, 2024, the TBI Waiver was moved to under the DDRS, and the A&D Waiver was split into two separate waivers: the H&W Waiver, under the DDRS, and the Indiana PathWays for Aging (PathWays) Waiver, under the Indiana Office of Medicaid Policy and Planning (OMPP).

Currently, the Eligibility Verification System (EVS) identifies H&W Waiver coverage as "Aged and Disabled HCBS Waiver," and PathWays Waiver coverage as "Aged and Disabled HCBS PathWays." For information about using the EVS, see the Eligibility Verification System section.

The PathWays Waiver offers the same services as the H&W Waiver, but as a managed care benefit available to eligible PathWays members. All other HCBS waivers continue to be available only to members enrolled under FFS Traditional Medicaid. For information about the PathWays Waiver, see HCBS Waiver Benefits for PathWays Members in Section 2: Managed Care Programs and Benefits.

Eligibility for any of the four DDRS HCBS waivers requires the following:

- The individual would require institutionalization in the absence of the waiver or other home-based services.
- The individual meets IHCP eligibility guidelines for Traditional Medicaid.
  - Individuals with income exceeding the limit for Traditional Medicaid but who otherwise qualify for HCBS waiver services may be enrolled with a monthly liability; see the *HCBS Waiver Liability* section.
  - The CIH, FSW, H&W and TBI waivers are offered solely through FFS Medicaid. Members must be disenrolled from managed care in order to have one of these waivers.

Members may only have one 1915(c) HCBS waiver at a time. The HCBS waivers are not entitlement programs and can serve only a limited number of members.

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. For more information about the CIH, FSW, H&W or TBI waiver, see the *Division of Disability and Rehabilitative Services: Home- and Community-Based Services Waivers* module. For general information about billing waiver services, see the *Home- and Community-Based Services Billing Guidelines* module.

Money Follows the Person

The Division of Aging and the Division of Disability and Rehabilitative Services (DDRS) also administer Money Follows the Person (MFP) demonstration grants, which are funded through a federal grant from the CMS. Indiana's MFP program is specifically designed as a transition program to assist individuals who live in qualifying institutions to move safely into the community and to ensure a safe adjustment to community living. MFP participants that continue to meet eligibility standards transition into one of the 1915(c) HCBS waivers that the grant is mirrored after: CIH, H&W, or PathWays. All potential MFP participants must meet the same eligibility criteria as those for the 1915(c) waivers. For more information about the MFP program, see the *Money Follows the Person* page at in.gov/fssa.

1915(i) State Plan HCBS Program 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*, *HIP Maternity*, Hoosier Care Connect, Hoosier Healthwise or PathWays benefits. 1915(i) HCBS services are carved out of managed care and reimbursed as FFS for all members

Indiana administers the following 1915(i) State Plan 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 community-based mental healthcare for individuals with serious mental illness, youth with serious emotional disturbance, and individuals with substance use disorders.

MRO 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.

The state of Indiana has mandated a managed care delivery system for Indiana Health Coverage Programs (IHCP) members enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging (PathWays). In each of these programs, members are enrolled in a managed care entity (MCE). The Program of All-Inclusive Care for the Elderly (PACE) is also a managed care program, but instead of MCEs, the program is administered by designated PACE organizations.

Member enrollment in managed care is effective on the 1st calendar day of a month, with some exceptions, particularly for newborns born to MCE members. Managed care enrollment and MCE assignment may be confirmed by any of the Eligibility Verification System (EVS) options described in the *Eligibility Verification System* section.

Managed Care Entities

Each MCE maintains its own provider network and has its own provider and member services units. The *IHCP Quick Reference Guide* at in.gov/medicaid/providers includes contact information for participating MCEs under each applicable program:

- Anthem – HIP, Hoosier Care Connect, Hoosier Healthwise, PathWays
- CareSource – HIP, Hoosier Healthwise
- Humana – PathWays
- Managed Health Services (MHS) – HIP, Hoosier Care Connect, Hoosier Healthwise
- MDwise – HIP, Hoosier Healthwise
- UnitedHealthcare – Hoosier Care Connect, PathWays

Note: Effective Jan. 1, 2026, MDwise is no longer participating as an IHCP MCE.

IHCP applicants have an opportunity to select an MCE (sometimes referred to as a "health plan") during the application process. If the applicant does not select an MCE, one will be auto-assigned according to the state's methodology. The state's enrollment broker, Maximus, provides potential members with information about the basic features of managed care and about the MCEs operating in the applicant's service area.

Managed care members can contact Maximus to change their MCE selection during designated redetermination (or "open enrollment") periods each year. Members may also change MCEs at any time throughout their enrollment, if the change is for just cause, in accordance with *Code of Federal Regulations 42 CFR 438.56*. (When disenrolling from an MCE for just cause, members are required to attempt to resolve concerns with their MCE and exhaust the MCE's internal grievance and appeal process before requesting an MCE change.)

A member-requested change from one MCE to another is effective on the first day of the month.

Primary Medical Providers

As part of the managed care enrollment process, MCEs are responsible for assisting members with the selection of a primary medical provider (PMP). The name and telephone number of the member's designated PMP are provided during the eligibility verification process.

See the *Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise Provider Enrollment* section of the *Provider Enrollment* module for a list of IHCP provider specialties that are eligible to enroll as a PMP.

> *Note: The information currently published in the Provider Enrollment module section referenced above also applies to PathWays PMP enrollment. During the next revision of that module, the section will be updated to include the PathWays references.*

Self-Referral Services

Most services in managed care require referral from a PMP. Self-referral services are an exception. The MCE reimburses any IHCP-enrolled providers for the following self-referral services unless other parameters are indicated:

- Chiropractic services rendered by a licensed chiropractor within chiropractic scope of practice
- Podiatry services rendered by a licensed podiatrist or physician
- Eye care services (except surgical services) rendered by a licensed optometrist or physician
- Routine dental services rendered by a licensed dental provider *within the MCE's network*
- Diabetes self-management training (DSMT) services
- Immunizations
- Family planning services
- Emergency services, as defined in *Indiana Code IC 12-15-12-0.3* and *IC 12-15-12-0.5*

  *(Note: Services may be rendered by **any** qualified provider, but for non-IHCP-enrolled providers, retroactive enrollment is required to facilitate payment.)*
- Urgent care services
- Psychiatric services rendered by any IHCP-enrolled provider licensed to provide psychiatric services within their scope of practice
- Behavioral health services, such as mental health, substance abuse treatment and chemical dependency services rendered by any of the following providers within the MCE's network:
  - Outpatient mental health clinics
  - Community mental health centers (CMHCs)
  - Licensed psychologists
  - Health service providers in psychology (HSPPs)
  - Licensed clinical social workers (LCSWs)
  - Licensed marriage and family therapists (LMFTs)
  - Licensed mental health counselors (LMHCs)
  - Licensed clinical addiction counselors (LCACs)
  - Licensed independent practice school psychologists
  - Advanced practice registered nurses (APRNs), under *IC 25-23-1-1(b)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  - Persons holding a master's degree in social work, marital and family therapy, or mental health counseling (for outpatient mental health services as defined under *Indiana Administrative Code 405 IAC 5-20-8*)

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

Services Carved-Out of Managed Care

Claims for services provided under the managed care delivery system are submitted to the MCE in which the HIP, Hoosier Care Connect, Hoosier Healthwise or PathWays member is enrolled (or to vendors contracted by that entity). However, certain services are "carved out" of the managed care programs and must be submitted as fee-for-service (FFS) claims.

Services that are *carved out of managed care* are the financial responsibility of the state. For pharmacy services that are carved out of managed care, all prior authorization requests (if applicable) and claims must be submitted to the FFS pharmacy benefit manager. For nonpharmacy services that are carved-out of managed care, all prior authorization requests (if applicable) must be submitted to the FFS PA-UM contractor, and all claims must be submitted to the FFS claim-processing contractor.

The following services are carved out of managed care:

- Services provided by a school corporation as part of a student's Individualized Education Program (IEP), Individualized Family Services Plan (IFSP), or other qualifying educational program or plan
- First Steps services
- Designated drugs:
  - Under the pharmacy benefit – Drugs listed in *Drug Therapies Carved-Out of the Managed Care Pharmacy Benefit*, accessible from the Carved-out Pharmacy Benefit Drugs quick link on the Optum Rx Indiana Medicaid website
  - Under the medical benefit – Drugs listed in *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group*, accessible from the *Code Sets* page at in.gov/medicaid/providers
- Coronavirus disease 2019 (COVID-19) vaccination services
- Dental procedure code D0606 – *Molecular testing for a public health-related pathogen, including coronavirus*
- Crisis intervention services, excluding mobile crisis services
- Medicaid Rehabilitation Option (MRO) services

  (Note: This carve-out does not extend to care coordination or ancillary services related to MRO, such as transportation.)
- 1915(i) State Plan Home- and Community-Based Services (HCBS), provided through the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA), including:
  - Adult Mental Health and Habilitation (AMHH)
  - Behavioral and Primary Healthcare Coordination (BPHC)
  - Child Mental Health Wraparound (CMHW)
- Money Follows the Person (MFP) Aged and Disabled Demonstration Grant services provided to PathWays members transitioning from a nursing facility to the PathWays Waiver

  (Note: Services provided under the MFP Aged and Disabled Demonstration Grant are carved out of managed care ***only*** *for PathWays members; for all other managed care members, they are excluded services.)*
- Comprehensive environmental lead investigation (initial and follow-up services) provided by a county health department to members with a confirmed elevated blood lead level

Services Excluded From Managed Care

In addition to certain services being carved out of the managed care program, some services are *excluded* from managed care, and members must be disenrolled or suspended from managed care and moved to a fee-for-service program when they qualify for such services. Examples include:

- Psychiatric residential treatment facility (PRTF) services
- Psychiatric treatment in a state hospital
- 590 Program services
- Long-term care services in a nursing facility (NF)

  *(Note: This exclusion does **not** apply to members enrolled in the **PathWays** program, which includes coverage for LTC in an NF for members with a qualifying LOC.*

  *Also note that all managed care programs include coverage for **short-term** stays in a nursing facility. The maximum length of stay varies by program. See the Long-Term Care module for details.)*
- Long-term care services in an intermediate care facility for individuals with intellectual disability (ICF/IID)
- Hospice services

  *(Note: This exclusion applies **only** to Hoosier Healthwise members; hospice services are **not** excluded from HIP, Hoosier Care Connect or PathWays.)*
- DDRS 1915(c) HCBS waiver services, including:
  - Community Integration and Habilitation (CIH) Waiver
  - Family Supports Waiver (FSW)
  - Health and Wellness (H&W) Waiver
  - Traumatic Brain Injury (TBI) Waiver
- Money Follows the Person (MFP) demonstration grant services provided to members transitioning from an institutional setting to the CIH or H&W Waiver

> *Note: The PathWays Waiver (which is provided through the OMPP rather than the DDRS) offers the same services as the H&W Waiver, but as a managed care benefit for qualifying members enrolled in the PathWays program. When MFP Aged and Disabled Demonstration Grant services are provided to PathWays members who are transitioning from a nursing facility to the PathWays Waiver, those services are carved out of managed care and provided as FFS. All other HCBS waiver and MFP demonstration grant services are excluded for managed care members.*

Healthy Indiana Plan

HIP is a state-sponsored managed care program that provides an affordable healthcare choice to thousands of adults throughout Indiana who do not qualify for coverage under any other Medicaid program. Indiana offers HIP-eligible 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 coverage is focused on preventive services and covers essential medical services, similar to commercial plans. For more information about HIP, including details about the specific services covered as well as cost-sharing obligations such as POWER Account contributions (PACs) and copayments, see the *Healthy Indiana Plan* module.

Member Eligibility and HIP Benefit Plan Assignment

Eligibility for HIP is limited to Indiana residents ages 19 through 64 whose family income is at or below 138% of the federal poverty level (FPL) (includes a 5% income disregard for individuals found ineligible at 133% FPL but who would be eligible with the disregard). Individuals with Medicare do not qualify for HIP.

HIP members are enrolled under one of six distinct benefit plans, as follows:

- ***HIP Plus* –** All HIP-eligible members are initially given the opportunity for coverage under the *HIP Plus* enhanced benefit package, which includes vision, dental and enhanced chiropractic services compared to *HIP Basic*. *HIP Plus* participation requires members to make monthly POWER Account contributions, except for individuals exempt from cost-sharing. *HIP Plus* members do not have copayments for services (except nonemergency use of the hospital emergency department). Member eligibility in *HIP Plus* is not final until either the first POWER Account or Fast Track prepayment is paid. To remain fully eligible for *HIP Plus*, members must continually make monthly POWER Account contributions.
- ***HIP Basic* –** HIP members with income at or below 100% FPL who do not make a Fast Track prepayment or initial POWER Account payment, or who fail to make subsequent monthly POWER Account payments, are not eligible for *HIP Plus* and are transferred to the *HIP Basic* benefit plan. *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 to $8 for a doctor visit or prescription filled, and may be as high as $75 for inpatient hospitalization. *HIP Basic* does not cover vision services, dental services (except for accident or injury) or chiropractic manipulation services. Formulary for pharmacy is limited in the *HIP Basic* plan.
- ***HIP State Plan Plus* –** The following HIP members qualify for *HIP State Plan Plus*:
  - *Section 1931*-eligibile parents and caretaker relatives eligible under *24 CFR 435.110*
  - Low-income 19- and 20-year-old dependents eligible under *42 CFR 4.35.222*
  - Individuals determined to be eligible for transitional medical assistance by the state in accordance with *Section 1925* of the *Social Security Act*
  - Individuals determined to be medically frail (see the *Healthy Indiana Plan* module for more information)

  This benefit plan offers access to the full set of benefits available under the State Plan (Package A), including nonemergency medical transportation. HIP members with this benefit plan have the same cost-sharing requirements as *HIP Plus* – they must make monthly POWER Account contributions, and they only have copayments on nonemergency use of the hospital emergency department.
- ***HIP State Plan Plus Copay*** – This benefit plan is available to members with an income between 100% and 133% FPL, who were eligible under *HIP State Plan Plus* due to a determination of being medically frail, and who fail to make ongoing financial contributions to a POWER Account. Under this benefit plan, members receive full Indiana Medicaid State Plan benefits but are required to pay copays. Additionally, unpaid POWER Account payments accrue as debt to the member for each month they are enrolled in *HIP State Plan Plus Copay*.
- ***HIP State Plan Basic* –** This benefit plan is available to members with income at or below 100% FPL, who were eligible under *HIP State Plan Plus*, and who fail to make financial contributions to a POWER Account. This plan offers access to all benefits available under the Indiana Medicaid State Plan. Members with this benefit package have the same cost-sharing requirements and copayments for all services as *HIP Basic* members.
- ***HIP Maternity* –** This benefit plan offers access to all benefits available under the Indiana Medicaid State Plan, with no cost-sharing obligations, for pregnant and postpartum HIP members.

  During the member's pregnancy and for a 12-month postpartum period, *HIP Maternity* offers enhanced benefits including vision, dental and chiropractic services; nonemergency transportation; and enhanced smoking cessation services. See the *Healthy Indiana Plan* module for more information on pregnant HIP members and applicants.

HIP Member Application, MCE Selection and Enrollment Process

For HIP member information and details about applying for HIP benefits, see the HIP website at in.gov/fssa/hip or call 877-GET-HIP9.

Applicants may select an MCE on the application or one will be auto-assigned, if not already assigned for the current calendar year. HIP applicants must also be assigned to a primary medical provider (PMP); the MCE will assist with the PMP assignment. HIP members are able to change their MCE selection any time before making their first POWER Account contribution or within 60 days of assignment to an MCE, whichever comes first. After payment, HIP members are not able to make MCE changes until the annual open enrollment period (November 1 through December 15), unless they have an unresolved just-cause issue, as described in the *Managed Care Entities* section. Members who change MCEs during the open enrollment period will start with their newly selected MCE the first day (January 1) of the following year.

If a $10 Fast Track prepayment was not made at the time of application, the selected MCE sends the applicant an invoice for the payment. HIP applicants have 60 days from the date on the invoice to make either a Fast Track payment or their first POWER Account contribution to be enrolled in *HIP Plus*.

Individuals approved for HIP who are still in the initial 60-day payment period and who have not yet paid their Fast Track payment or first POWER Account contribution are referred to as *conditionally eligible.* These individuals do not become fully eligible, nor enrolled as a member, until one of the following occurs:*

- Fast Track payment to the selected MCE (if applicable and approved for HIP)
- Payment of their first POWER Account contribution
- The expiration of the 60-day payment period (for individuals at or below 100% FPL)

> **Note: IHCP members transitioning into HIP from another IHCP program (for example, from Presumptive Eligibility Adult or Package C – Children's Health Insurance Plan) remain covered under their previous plan, with no gap in coverage, during the HIP conditional eligibility period.*

Coverage for *HIP Plus* begins on the first day of the month in which the Fast Track payment or initial monthly POWER Account contribution was paid. Coverage may occur in a different month from that in which payment was made in the following situations:

- If the member was previously covered under a different Medicaid category (for example, Family Planning or Presumptive Eligibility) and is transitioning to HIP
- If the member was not Fast Track eligible (did not complete redetermination)
- If the member paid an MCE that the member was not assigned to

> *Note: IHCP providers that assist individuals with submitting a HIP Fast Track prepayment may be able to request retroactive PA for services rendered during the member's coverage period, after the individual has been determined fully eligible for benefits. This process applies only to applicants who **do not** pursue temporary coverage through Presumptive Eligibility and who submit an IHCP application with a Fast Track prepayment. See the Healthy Indiana Plan module for details.*

Individuals who choose not to make their initial contribution will remain conditionally eligible and will be unable to receive coverage for services while they are conditionally eligible. If no payment has been made when the 60-day payment period expires, one of the following occurs:

- Individuals with income at or below 100% of the FPL will be enrolled in *HIP Basic Potential Plus*, with coverage effective the first day of the month in which the 60th day occurs.
- Individuals with income over 100% of the FPL will not be enrolled. They will need to reapply to receive HIP coverage.

Hoosier Care Connect

Hoosier Care Connect is a managed care program designed to improve the quality of care and clinical outcomes for individuals under age 60 who are eligible for the IHCP on the basis of blindness or disability. Hoosier Care Connect members receive full Indiana Medicaid State Plan benefits, in addition to care coordination services and other FSSA-approved enhanced benefits developed by the MCEs.

Individuals who meet eligibility criteria (including income guidelines, when applicable) for any of the following aid categories, and who are age 59 or younger, not residing in an institution, not receiving services through a Home- and Community-Based Services (HCBS) waiver, and not enrolled in Medicare, **will be enrolled** in Hoosier Care Connect:

- Blind individuals
- Disabled individuals
- Individuals receiving Supplemental Security Income (SSI)
- Individuals enrolled in Medicaid for Employees with Disabilities (MEDWorks)

Individuals who fit the following descriptions, and also meet requirements for Hoosier Care Connect enrollment, may opt out of Traditional Medicaid (FFS) and **voluntarily enroll** in Hoosier Care Connect:

- Wards of the state
- Foster children
- Former foster children who turned 18 years of age while in foster care (in any state), were enrolled in Medicaid at some point while in foster care, and are under age 26
- Children receiving adoption assistance

Members will be removed from Hoosier Care Connect and **transitioned** to another IHCP program (Traditional Medicaid or PathWays) if they:

- Turn 60 years old
- Become eligible for Medicare
- Enter a state psychiatric facility, a psychiatric residential treatment facility (PRTF) or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Become eligible for and choose to enter an HCBS waiver program
- Enter a nursing home for a length of stay greater than 30 days

However, Hoosier Care Connect members who qualify for hospice services will remain enrolled with their MCE for the duration of the hospice period. Members will not be transitioned to another IHCP program while receiving Hoosier Care Connect hospice benefits, whether in a home or institutional setting.

MCE Selection for Hoosier Care Connect

Hoosier Care Connect members pick an MCE and a PMP. The MCE assists members in coordinating their healthcare benefits and tailoring the benefits to individual needs, circumstances and preferences.

Hoosier Care Connect members may change their MCE selection during the first 90 days of enrollment or during the annual redetermination period. Outside of those periods, members may move to another MCE only for reasons that meet the standard of *just cause*. See the *Managed Care Entities* section for details.

Indiana PathWays for Aging

> *Note: The Indiana PathWays for Aging program officially launched on July 1, 2024. Existing IHCP members who met PathWays eligibility criteria were transitioned to the PathWays program.*

Indiana PathWays for Aging (PathWays) is a managed long-term services and supports (LTSS) program that provides coverage for individuals age 60 and older who are eligible for Medicaid based on age, blindness or disability and have limited income and resources. PathWays members receive full Indiana Medicaid State Plan benefits, in addition to nursing facility or HCBS services for qualifying individuals, as well as care coordination services and other FSSA-approved enhanced benefits developed by the MCEs.

Individuals age 60 and older who meet eligibility criteria (including income guidelines) for any of the following aid categories, and who do not fall into one of the opt-in groups detailed later in this section, **will be enrolled** with an MCE in the PathWays program:

- Aged individuals
- Blind individuals
- Disabled individuals
- Individuals receiving Supplemental Security Income (SSI)
- Individuals enrolled in Medicaid for Employees with Disabilities (MEDWorks)

This includes individuals who meet PathWays age and aid category requirements and who qualify for Indiana PathWays for Aging (PathWays) Waiver services, nursing facility services or hospice services. It also includes full-benefit dually eligible individuals (Qualified Medicare Beneficiary [QMB]-Also, Specified Low-Income Medicare Beneficiary [SLMB]-Also, and Other Full-Benefit Dual Eligible [Other FBDE]) who qualify for both Full Medicaid and Medicare.

The following individuals are **excluded** from PathWays:

- Anyone 59 years of age or younger
- Partial-benefit dually eligible individuals (QMB-Only, SLMB-Only, Qualified Individual [QI], Qualified Disabled Working Individual [QDWI])
- Recipients of any of the following HCBS waivers, administered by the Indiana Division of Disability and Rehabilitative Services (DDRS)*:
  - Community Integration and Habilitation (CIH) Waiver (or the associated MFP CIH Demonstration Grant)
  - Family Supports Waiver (FSW)
  - Traumatic Brain Injury (TBI) Waiver

> **Note: Recipients of the DDRS Health and Wellness (H&W) Waiver will be moved to the Indiana PathWays for Aging (PathWays) Waiver, administered by the Office of Medicaid Policy and Planning (OMPP), if they remain eligible when they reach age 60 and are enrolled in the PathWays program.*

- Members enrolled in the Program of All-Inclusive Care for the Elderly (PACE)
- Room and Board Residential Care Assistance Program (RCAP) members
- Breast and Cervical Cancer Program (BCCP)-eligible members
- Members residing in a TBI facility out of state

- Members residing in an intermediate care facility for the individuals with intellectual disabilities (ICF/IDD), including group home residents
- Members residing in a state-operated facility
- Members eligible under any of the following aid categories or programs:
  - Emergency Services Only
  - Family Planning Services Only
  - HIP
  - Hoosier Healthwise

The following individuals are not excluded from PathWays enrollment, but they are not automatically enrolled into PathWays. These individuals **may voluntarily *opt in*** to PathWays, if they so choose:

- Members receiving hospice services under another IHCP program at the time that the IHCP would otherwise initiate the PathWays enrollment process (90 days prior to enrollment)
  - These individuals remain enrolled in FFS Medicaid unless they opt to enroll in PathWays or they stop receiving hospice services.
- Individuals who are American Indian or Alaska Native and a registered member of a federally recognized tribe, and who meet PathWays eligibility criteria
  - These individuals are enrolled in Traditional Medicaid (FFS Full Medicaid) unless they opt to enroll in PathWays.

MCE Selection for PathWays

MCE selection can be made by while enrollment in PathWays is pending. The enrollment broker is responsible for providing choice counseling to the member. If a member does not select an MCE, one will be assigned to them according to a state-directed process that will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered, such as the residential provider of the member (if applicable).

PathWays members will have the opportunity to change their MCE at the following intervals:

- Within 90 days of starting coverage
- At any time their Medicare and Medicaid plans become unaligned
- Once per calendar year for any reason
- At any time using the "just cause" process (see the *Managed Care Entities* section for details)
- During the Medicare open enrollment window (mid-October through mid-December) to be effective the following calendar year

Medicare Cost-Sharing Coverage for PathWays Members

PathWays members who are also enrolled in Medicare receive Medicare cost-sharing coverage included with their PathWays Indiana Medicaid State Plan benefits. The IHCP covers Medicare Part B premiums for all dually eligible PathWays members (QMB-Also, SLMB-Also and Other FBDE); for the QMB-Also members, it also covers Part A premiums. In addition, PathWays QMB-Also members receive coverage of Medicare deductibles, coinsurance and copayments, which are reimbursed through the member's MCE.

For more information, see the *Medicare Savings Programs* and *Medicaid and the Medicare Prescription Drug Coverage Program* sections. For information about billing and reimbursement procedures specific to dually eligible PathWays members, contact the appropriate MCE.

HCBS Waiver Benefits for PathWays Members

> *Note: On July 1, 2024, the Aged and Disabled (A&D) Waiver was split into two separate waivers: the Indiana PathWays for Aging (PathWays) Waiver, for eligible members age 60 and older, and the Health and Wellness (H&W) Waiver, for eligible members under age 60. Existing A&D Waiver members were transitioned into the appropriate waiver program. For information about the H&W Waiver and other FFS waivers administered by the DDRS, see the 1915(c) HCBS Waiver Services section. The PathWays Waiver is the only HCBS waiver available in conjunction with PathWays managed care enrollment. MFP Aged and Disabled Demonstration Grant participants may be enrolled in PathWays; however, MFP grant services are carved out of managed care for these members.*

The Indiana PathWays for Aging (PathWays) Waiver provides coverage of designated home- and community-based services for PathWays members who qualify for a nursing facility level of care (LOC), but who choose to remain in the home.

Individuals with income exceeding the limit for PathWays but who otherwise qualify for the PathWays Waiver services may be enrolled with a monthly liability. See the *HCBS Waiver Liability* section for details.

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

For more information about the PathWays waiver, see the *Office of Medicaid Policy and Planning Home- and Community-Based Services Waiver: Indiana PathWays for Aging* module. For general information about billing waiver services, see the *Home- and Community-Based Services Billing Guidelines* module.

Hoosier Healthwise

The Hoosier Healthwise program provides coverage for children and for pregnant individuals (during pregnancy and the 12-month postpartum period) who have a household income that is too high to qualify for HIP (138% FPL) but who remain Medicaid eligible by having a household income equal to or less than 208% FPL.

Hoosier Healthwise assignment 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 (based on household income/size) determines the benefit package.

The following IHCP members are **excluded from mandatory** assignment to Hoosier Healthwise managed care:

- Individuals in nursing homes and other institutions, such as PRTFs and ICFs/IID
- Individuals receiving psychiatric treatment in a state hospital
- Immigrants who qualify for Emergency Services Only (Package E or Package B) coverage
- Individuals receiving HCBS waiver services
- Individuals who are eligible for and opt to receive IHCP hospice services
- Members eligible for the Family Planning Eligibility Program

Table 3 explains the Hoosier Healthwise benefit packages.

Table 3 – Hoosier Healthwise Benefit Package Explanation

Benefit Package	Coverage
Package A	Full coverage for eligible children and pregnant individuals (extending through a postpartum period)
Package C	Preventive, primary and acute care services for eligible children

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 will immediately be assigned to the MCE that was chosen on the application or, if no MCE was chosen, to an MCE that is automatically selected for that member.

> *Note: 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.*

MCE Selection for Hoosier Healthwise

Hoosier Healthwise members may change their MCE selection during the first 90 days of enrollment or during the annual redetermination period. Outside of those periods, members may move to another MCE only for reasons that meet the standard of *just cause*. See the *Managed Care Entities* section for details.

Hoosier Healthwise – Package A

Hoosier Healthwise *Package A – Standard Plan* coverage encompasses the full array of Indiana Medicaid State Plan benefits for children and pregnant/postpartum individuals who meet the following guidelines:

- Infants (under 1 year of age): Under 209% of the FPL
- Children (age 1 through 18): Under 158% of the FPL
- Pregnant individuals: 139% – 208% of the FPL

For pregnant individuals who were eligible and enrolled (including retroactive enrollment) on the date their pregnancy ends, the IHCP must provide coverage described through the last day of the month in which the 12-month postpartum period ends.

Package A members do not have copayment or other cost-sharing requirements to receive covered healthcare services.

IHCP applicants determined eligible for Hoosier Healthwise Package A may also be determined eligible for retroactive coverage for up to three months prior to their application date. With the exception of newborns whose mothers were enrolled with a managed care assignment on the date of the child's birth, members determined retroactively eligible under a Hoosier Healthwise aid category are covered through the FFS delivery system during the retroactive period. See *Section 7: Retroactive Member Eligibility* for more information.

Hoosier Healthwise – 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 within the following limits:
  - For infants under 1 year of age – between 209% and 250% of the FPL
  - For children ages 1 through 18 – between 158% and 250% of the FPL,

- The child must not have creditable health coverage.
- The child's family financially meets all premium requirements, including payment of initial monthly premium after conditional approval of initial application, and, at the time of redetermination, they have not missed any month of premium payments.

Package C members fall under the State Children's Health Insurance Program (SCHIP).

Package C Enrollment Process and Cost-Sharing Requirements

A child determined eligible for Package C is made *conditionally eligible* pending the first premium payment. The child's family is expected to pay a monthly premium, as shown in Table 4. After the first premium is paid, eligibility information is transferred to *Core*MMIS.

Continuous eligibility is provided for members under the age of 19, including Hoosier Healthwise Package C members. An individual's continuous eligibility period begins on the effective date of their initial eligibility determination or most recent redetermination or renewal. The continuous eligibility period continues for 12 months, unless one of the following occurs:

- The individuals turns 19.
- The child or child's representative requests a voluntary disenrollment.
- The child is no longer a resident of Indiana.
- The FSSA determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of FSSA error or because of fraud, abuse or perjury attributed to the child or the child's representative.
- The child dies.
- The child becomes eligible for Medicaid.

At the end of the continuous eligibility period, the eligibility is subject to redetermination. At that time, the enrollment will not be renewed unless all monthly premiums have been paid for the previous eligibility period.

Table 4 – Hoosier Healthwise Package C Premium Rates

Income (As a Percentage of the Federal Poverty Level)	Monthly Premiums	
	One Child	Two or More
151% through 175%	$22	$33
176% through 200%	$33	$50
201% through 225%	$42	$53
226% through 250%	$53	$70

Package C members may be eligible for coverage of services rendered on or after the first day of the month in which they applied; however, their enrollment does not become effective until the first required monthly premium has been paid. The first premium month is the month after an eligibility determination is made; the month of application through the month the individual was determined to be eligible for Package C are premium-free. The child will be enrolled when the first premium has been paid, at which point, the child's eligibility will extend back to the first day of the month of application. For example, if an application was filed June 25 and approved July 15, and the applicant's required premium for August was paid in full on July 30, the member would not be enrolled until on or after July 30, but the member's eligibility would extend back to the first day of June. During the period between the first day of the month of application and the date the enrollment is entered into the system (after the first required premium is paid), member benefits will be covered through the FFS delivery system.

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.

> *Note: Although members are not eligible for Package C coverage before the month in which they apply for benefits, Package C members may be determined eligible for retroactive coverage for a **different** benefit plan under **another** category. If it is determined that a Package C member is retroactively eligible for another category, retroactive coverage can begin up to three months prior to the date of application, and providers that have rendered services to Package C members during the period of retroactive eligibility are bound by the requirements described in the Provider Responsibilities for Retroactive Eligibility section.*

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 *Copayment Policies* section of this module.

Package C Coverage and Limitations

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

- Ambulance transportation
- Anesthesia
- Certified nurse-midwife services
- 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 IHCP hospice 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 includes coverage for emergency ambulance transportation, subject to the prudent layperson standard as defined in *405 IAC 13-8-1*. This service is subject to a $10 copayment.
- *Nonemergency ambulance transportation* – Ambulance service for nonemergencies between medical facilities is covered under Package C when requested by a participating physician. A $10 copayment applies.
- *Chiropractic services* – Chiropractic coverage under Package C is limited to five visits and 14 therapeutic physical medicine treatments per member per year. 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 periodicity and screening schedule (see the *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services* module). Coverage of referral and treatment services is subject to the Package C benefit limitations.
- *Inpatient rehabilitative services* – Package C coverage is available for a maximum of 50 days of inpatient rehabilitative services per calendar year.
- *Medical supplies and equipment* – Package C coverage of medical supplies and equipment 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 under Package C when medically necessary.
- *Prescription drugs* –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 Package C continue to be $3 for generic drugs and $10 for brand name drugs.

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

Package C Billing Procedures

The billing procedures for Package C are the same as those for the other Hoosier Healthwise benefit plans.

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 13*. See the *Indiana Administrative Code (IAC)* page of the Indiana General Assembly website at iac.iga.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

Benefit	Reimbursed by MCE	Package A	Package C
Applied Behavior Analysis (ABA) Therapy (*405 IAC 5-22*)	Yes	Coverage is available for members under the age of 21 diagnosed with an autism spectrum disorder. Services must be provided in accordance with the Indiana Medicaid State Plan and the IAC.	Coverage is available for members diagnosed with an autism spectrum disorder. Services must be provided in accordance with the IAC.
Behavioral Health (Mental Health and Substance Use Disorder Treatment) Services – Outpatient* (*405 IAC 5-20-8*)	Yes (Except MRO services, which are reimbursed FFS; self-referral)	Coverage includes outpatient mental health and substance use disorder services (including partial hospitalization services), as defined in *405 IAC 5-20-8*, provided by psychiatric wings of acute care hospitals, outpatient mental health facilities, physicians, HSPPs, APRNs and other qualified licensed behavioral health professionals. For certain psychiatric services provided in an outpatient or office setting, members are limited to a combined total of 20 units per provider per rolling 12-month period, without prior authorization (see *Behavioral Health Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers). Separate limits and PA requirements apply for neuropsychological/psychological testing and psychiatric diagnostic interview examinations. MCEs are responsible for methadone treatment provided in a clinic setting.	Unless otherwise provided by *IC 12-17.6-4-2*, outpatient mental health and substance use disorder services are covered subject to the same coverage policies and benefit limitations as apply to Package A. MCEs are responsible for methadone treatment provided in a clinic setting.

Benefit	Reimbursed by MCE	Package A	Package C
Behavioral HealthServices – Inpatient** in a Freestanding Psychiatric Facility or Psychiatric Unit of an Acute Care Hospital (*405 IAC 5-20*)	Yes	Coverage includes inpatient mental health and substance use disorder services in a psychiatric unit of an acute care hospital **or** in a certified psychiatric hospital with 16 beds or fewer. For members under 21 years of age (or under 22 and began inpatient psychiatric services immediately before their 21st birthday), coverage includes inpatient mental and behavioral health services in an institution of mental disease (IMD) with **more than 16 beds**. MCEs may authorize coverage for *short-term* stays for members 21–64 years of age an IMD in lieu of services or settings covered under the Indiana Medicaid State Plan.	Unless otherwise provided by *IC 12-17.6-4-2*, inpatient mental health and substance use disorder services are covered subject to the same coverage policies and benefit limitations as applied under Package A.

Benefit	Reimbursed by MCE	Package A	Package C
Behavioral Health Services – Inpatient** in a State Psychiatric Hospital (*405 IAC 5-20-1*)	No	Inpatient services in a state psychiatric hospital are covered for Package A members under age 21. **Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid if the length of stay is expected to be more than 30 days.** *Note: Inpatient services in a state psychiatric hospital are noncovered for Package A members age 21 or older. Members in this age group who are admitted to a state psychiatric facility must also be disenrolled from Hoosier Healthwise, but are **not** eligible for Traditional Medicaid. However, these members may be eligible for limited coverage of services provided outside the facility as described in the 590 Program module.*	Unless otherwise provided by *IC 12-17.6-4-2*, inpatient mental health and substance use disorder services are covered subject to the same coverage policies and benefit limitations as apply to Package A. **Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.**
Chiropractic Services* *(405 IAC 5-12)*	Yes (Self-referral)	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 calendar year, which includes a maximum reimbursement of no more than five office visits per member, per calendar year. For example, a chiropractor may bill for a maximum of five visits and 45 treatments (5 + 45 = 50), but may not bill for 50 treatments and five visits (50 + 5 = 55).	Coverage is available for covered services provided by a licensed chiropractor. Reimbursement is limited to five 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.
Chronic Disease Management	Yes	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.	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.

Benefit	Reimbursed by MCE	Package A	Package C
Dental Services (*405 IAC 5-14*)	Yes (Routine dental services are self-referral within the member's MCE network)	Coverage for members age 21 and older includes dental services as described in *405 IAC 5-14*. For children under age 21, all medically necessary dental services are covered, even if the service is not otherwise covered under Package A. No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.	All medically necessary dental services are provided for children enrolled in Package C, even if the service is not otherwise covered under CHIP. No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.
Diabetes Self-Management Training Services* (*405-IAC 5-36*)	Yes (Self-referral)	Coverage is limited to 16 units per member, per rolling 12-month period. Additional units may be prior authorized.	Coverage is limited to 16 units per member, per rolling 12-month period. Additional units may be prior authorized.
Drugs – Prescribed (Legend) (*405 IAC 5-24*)	Yes (except drugs indicated in the *Services Carved-Out of Managed Care* section, which are reimbursed as FFS)	Covers legend drugs if the drug is: • Approved by the U.S. Food and Drug Administration (FDA) • Not designated by the Centers for Medicare & Medicaid Services (CMS) as less than effective or identical, related, or similar to a less than effective drug or terminated • Not specifically excluded from coverage by the IHCP	Covers legend drugs if the drug is: • Approved by the U.S. FDA • Not designated by the CMS as less than effective or identical, related, or similar to a less than effective drug or terminated • Not specifically excluded from coverage by the IHCP
Drugs – Over-the-Counter (Nonlegend)	Yes	Covers nonlegend (over-the-counter) drugs on the MCE formularies. Formularies are available from the MCE websites listed on the *Pharmacy Services* page at in.gov/medicaid/providers.	Covers nonlegend (over-the-counter) drugs on the MCE formularies. Formularies are available from the MCE websites listed on the *Pharmacy Services* page at in.gov/medicaid/providers.
Early Intervention Services (EPSDT) (*405 IAC 5-15*)	Yes (Immunizations are self-referral)	Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary healthcare services from birth through the month of the member's 21st birthday, as described in the *EPSTD Services* module).	Covers immunizations and initial and periodic screenings as described in the *EPSTD Services* module. Coverage of treatment services is subject to the Package C benefit plan coverage limitations.

Benefit	Reimbursed by MCE	Package A	Package C
Emergency Services (*IC 12-15-12-15* and *IC 12-15-12-17*)	Yes (Self-referral)	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.
Eye Care, Eyeglasses and Vision Services (*405 IAC 5-23*)	Yes (Self-referral, except for surgical services)	Coverage for the initial vision care examination is limited to one examination per calendar 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 calendar 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.	Vision care examination is limited to one examination per calendar year, unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, is limited to a maximum of one pair per calendar year, 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.

Benefit	Reimbursed by MCE	Package A	Package C
Family Planning Services and Supplies	Yes (Self-referral)	Family planning services include: • Limited history and physical examination • Pregnancy testing and counseling • Provision of contraceptive pills, devices and supplies • Education and counseling on contraceptive methods • Laboratory tests, if medically indicated as part of the decision-making process for choice of contraception • Diagnosis and treatment of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs) • Screening and counseling of members at risk for human immunodeficiency virus (HIV), and referral and treatment • Tubal ligation • Vasectomies • Hysteroscopic sterilization with an implant device • Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, if performed according to the United States Preventative Services Task Force guidelines	Family planning services include: • Limited history and physical examination • Pregnancy testing and counseling • Provision of contraceptive pills, devices and supplies • Education and counseling on contraceptive methods • Laboratory tests, if medically indicated as part of the decision-making process for choice of contraception • Diagnosis and treatment of STDs and STIs • Screening and counseling of members at risk for HIV and referral and treatment • Tubal ligation • Vasectomies • Hysteroscopic sterilization with an implant device • Cytology (Pap tests) and cervical cancer screening, including high-risk HPV DNA testing, if performed according to the United States Preventative Services Task Force guidelines
Federally Qualified Health Centers (FQHCs) (*405 IAC 5-16-5*)	Yes	Coverage is available for medically necessary services provided by licensed healthcare practitioners.	Coverage is available for medically necessary services provided by licensed healthcare practitioners.
Food Supplements, Nutritional Supplements and Infant Formulas** (*405 IAC 5-24-9*)	Yes	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services – Inpatient* (*405-IAC 5-17*)	Yes	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.	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.

Benefit	Reimbursed by MCE	Package A	Package C
Hospital Services – Outpatient* (*405 IAC 5-17*)	Yes	Outpatient hospital 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.	Outpatient hospital 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.
Home Health Services** (*405 IAC 5-16*)	Yes	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.	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.
Hospice Services** (*405 IAC 5-34*)	No	Hospice is available under Traditional Medicaid if the recipient is expected to die from illness within six months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days. **Member must be disenrolled from Hoosier Healthwise managed care and enrolled in Traditional Medicaid (FFS) before hospice benefits can begin.**	Hospice is available under Traditional Medicaid if the recipient is expected to die from illness within six months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days. **Member must be disenrolled from Hoosier Healthwise managed care and enrolled in Traditional Medicaid (FFS) before hospice benefits can begin.**
Laboratory and Radiology Services (*405 IAC 5-18 and 405 IAC 5-27*)	Yes	Coverage is available for medically necessary laboratory and radiology services, when ordered by a physician.	Coverage is available for medically necessary laboratory and radiology services, when ordered by a physician.
Long-Term Acute Care Hospitalization ** (*See the Inpatient Hospital Services* module)	Yes	Long-term acute care services are covered. An all-inclusive per diem rate is paid based on level of care.	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.
Medical Supplies and Equipment (includes prosthetic devices, implants, hearing aids, dentures and so forth)** (*405 IAC 5-19*)	Yes	Coverage is available for medical supplies, equipment and appliances suitable for use in the home when medically necessary.	Covered when medically necessary. Maximum benefit of $2,000 per calendar year or $5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased, depending on which is more cost efficient.

Benefit	Reimbursed by MCE	Package A	Package C
Medicaid Rehabilitation Option (MRO) – Community Mental Health Centers * (*405 IAC 5-22-1*)	No (Reimbursed as FFS)	Coverage includes community-based mental healthcare services (such addiction counseling, behavioral health counseling and therapy, and case management), for members with serious mental illness, youth with serious emotional disturbance, and individuals with substance use disorders. See the *Medicaid Rehabilitation Option Services* module for details.	Coverage includes community-based mental healthcare services (such addiction counseling, behavioral health counseling and therapy and case management), for members with serious mental illness, youth with serious emotional disturbance, and individuals with substance use disorders. See the *Medicaid Rehabilitation Option Services* module for details.
Nurse Midwife Services (*405 IAC 5-22-3*)	Yes	Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioner Services (*405 IAC 5-22-4*)	Yes	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.	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.
Nursing Facility Services – Long-Term** *(405 IAC 5-31-1, see the Long-Term Care module)*	No	Long-term care nursing facility services require preadmission screening for level-of-care (LOC) determination. **Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.** 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.	Noncovered

Benefit	Reimbursed by MCE	Package A	Package C
Nursing Facility Services – Short-Term (*405 IAC 5-31-1*)	Yes	The MCE may obtain services for its members in a nursing facility setting on a short-term basis (fewer than 30 consecutive 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. *Note: MCEs may be responsible for payment for up to 60 calendar days for members placed in a long-term care facility while the level of care determination is pending, allowing the member to be transitioned to FFS coverage.*	Noncovered
Nursing Facility Services – Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID) – Long-Term** *(405 IAC 5-13-2; see the Long-Term Care module)*	No	Long-term ICF/IID services require preadmission screening for LOC determination. **Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.** 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.	Noncovered

Benefit	Reimbursed by MCE	Package A	Package C
Nursing Facility Services – Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID) – Short-Term** (*405 IAC 5-31-1*)	Yes	The MCE may obtain services for its members in a nursing facility setting on a short-term basis (fewer than 30 consecutive 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. *Note: MCEs may be responsible for payment for up to 60 calendar days for members placed in a long-term care facility while the level of care determination is pending, allowing the member to be transitioned to FFS coverage.*	Noncovered
Occupational Therapy* (*405 IAC 5-22*)	Yes	Occupational therapy services must be ordered by the member's PMP or by another physician as part of an inpatient discharge plan of care or continuing plan of care. Services must be 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 (not to exceed 30 units for any combination of therapies).	Occupational therapy services must be ordered by the member's PMP or by another physician as part of an inpatient discharge plan of care or continuing plan of care. Services must be provided by a licensed therapist or assistant. Services are covered only when determined to be medically necessary.
Organ Transplants** (*405 IAC 5-3-13*)	Yes	Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.	Noncovered

Benefit	Reimbursed by MCE	Package A	Package C
Out-of-State Medical Services** (*405 IAC 5-5*)	Yes	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.	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.
Physician Surgical and Medical Services* (*405 IAC 5-25*)	Yes	Coverage includes reasonable services provided by a doctor of medicine (MD) or doctor of osteopathy (DO) for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. Members are limited to a maximum of 30 PMP office visits per provider per calendar year without PA.	Coverage includes reasonable services provided by an MD or DO for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. Members are limited to a maximum of 30 PMP office visits per provider per calendar year without PA.
Physical Therapy* (*405 IAC 5-22-6*)	Yes	Physical therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care. Services must be provided by a licensed therapist or certified physical therapist assistant (PTA) under the direct supervision of a licensed physical therapist or physician. 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 (not to exceed 30 units for any combination of therapies).	Physical therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care. Services must be provided by a licensed therapist or certified PTA under the direct supervision of a licensed physical therapist or physician. Services are covered when determined to be medically necessary.

Benefit	Reimbursed by MCE	Package A	Package C
Podiatric Services (*405 IAC 5-26*)	Yes (Self-referral)	Laboratory services, X-ray services, hospital stays and surgical procedures involving the foot are covered when medically necessary. Coverage includes one podiatry visit per calendar year. Up to six routine foot care services are covered per calendar year for members who are under a physician's care (within the past six months) for ~~with~~ diabetes mellitus, peripheral vascular disease or peripheral neuropathy.	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.
Psychiatric Residential Treatment Facility (PRTF) ** (*405 IAC 5-20-3.1*)	No	Reimbursement is available for medically necessary services provided to members younger than 21 years old in a PRTF. Reimbursement is also available for members 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 members younger than 21 years old in a PRTF. **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.
Rehabilitation Unit Services – Inpatient** (*405 IAC 5-32*)	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 days per calendar year.

Benefit	Reimbursed by MCE	Package A	Package C
Respiratory Therapy* (*405 IAC 5-22*)	Yes	Respiratory therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a licensed respiratory therapist or certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency or clinic. PA is not required for inpatient or outpatient hospital, emergency, and oxygen in a nursing facility, for 30 calendar days following discharge from hospital when ordered by physician prior to discharge (not to exceed 30 units for any combination of therapies), and when ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis or upper respiratory infection (not to exceed 14 hours or 14 calendar days).	Respiratory therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a licensed respiratory therapist or certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency or clinic. Services are covered when determined to be medically necessary.
Rural Health Clinics (RHCs)	Yes	Coverage is available for services provided by a physician; physician assistant; nurse practitioner; or appropriately licensed, certified or registered therapist employed by the RHC.	Coverage is available for services provided by a physician; physician assistant; nurse practitioner; or appropriately licensed, certified or registered therapist employed by the RHC.
Speech, Hearing and Language Disorders* (*405 IAC 5-22*)	Yes	Speech-language therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a qualified therapist or assistant. PA is not required for initial evaluations or for services provided within 30 calendar days following discharge from a hospital when ordered by physician prior to discharge (not to exceed 30 units for any combination of therapies).	Speech-language therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a qualified therapist or assistant. Services are covered when determined to be medically necessary.
Tobacco Dependence Treatment (*405 IAC 5-37*)	Yes (Except pharmacy benefits)	Reimbursement is available for tobacco dependence drug treatment and counseling services.	Reimbursement is available for tobacco dependence drug treatment and counseling services.

Benefit	Reimbursed by MCE	Package A	Package C
Transportation – Emergency (*405 IAC 5-30*)	Yes	Coverage has no limit or PA requirement for emergency ambulance or trips to or from a hospital for inpatient admission or discharge, subject to the prudent layperson standard.	Covers emergency ambulance transportation using the prudent layperson standard. A $10 copayment applies.
Transportation – Nonemergency (*405 IAC 5-30*)	Yes	Coverage has no limit or PA requirement for medically necessary in-state ground transportation.	Ambulance services for nonemergencies between medical facilities are covered when requested by a participating physician; a $10 copayment applies.
Urgent Care Services	Yes (Self-referral)	Urgent care services are covered provided that they are medically necessary. Urgent care is needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.	Urgent care services are covered provided that they are medically necessary. Urgent care is needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.

** 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.

Wraparound Services for Hoosier Healthwise Children

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)* – 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 as follows:

- By calling First Steps at 800-545-7763 or accessing the First Steps website at in.gov/fssa/firststeps
- By calling CSHCS at 800-475-1355 or accessing the CSHCS website at in.gov/health

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is 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 [AAA] 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 and obtained from specified doctors, hospitals, pharmacies and other healthcare providers that contract with the PACE organization.

Before rendering services, IHCP providers should always verify member eligibility as described in the *Eligibility Verification System* section. The eligibility verification system (IHCP Provider Healthcare Portal, phone-based virtual assistant (GABBY) and 270/271 electronic transaction) will indicate if the member has current coverage under the PACE program. Providers can also check the member's Medicare or Medicaid (IHCP) cards for a sticker indicating that the member is a PACE participant. The IHCP will deny payment of all fee-for-service claims submitted 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

For additional information about PACE and the partner organizations serving Indiana's PACE participants in designated service areas, see the *Program of All-Inclusive Care for the Elderly* page at in.gov/fssa/da.

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

Presumptive Eligibility (PE) is an authorized IHCP process by which qualified providers (QPs) can determine individuals to be presumptively eligible, allowing them to receive temporary health coverage until the Family and Social Services Administration (FSSA) determines official eligibility.

For more information about PE process, including how to become a QP, see the *Presumptive Eligibility* module.

Presumptive Eligibility Coverage Period

The PE coverage period begins on the day the 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.

If the PE member submits a completed *Indiana Application for Health Coverage* before the end of the month following the month in which the PE coverage began, then the PE coverage will last until the FSSA makes an official eligibility determination. PE coverage ends immediately when the FSSA determines the applicant to be denied for IHCP coverage. If determined eligible, PE coverage continues through the end of the month the eligibility decision is made.

If a PE member does **not** have a completed *Indiana Application for Health Coverage* pending with the FSSA by the last day of the month following the month in which PE was established, the PE coverage will end on that date.

General Requirements for Presumptive Eligibility

General applicant requirements for 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, including a member of HIP*
  - Medical Review Team (MRT) and Preadmission Screening and Resident Review (PASRR) coverage are the only exceptions to this requirement; individuals with coverage under any *other* benefit plan are not eligible for PE.
  - Individuals who have recently applied for the IHCP but have not yet received a coverage determination may apply for PE to cover services while an IHCP decision is pending.
- Must not be enrolled in the PE process, currently or within time-frame restrictions*
  - Individuals are allowed only one PE coverage period per rolling 12 months (or per pregnancy, for Presumptive Eligibility for Pregnant Women).
- Must not be currently incarcerated*
- Must not be an adult (ages 21 through 64) who is admitted to or residing in an institute for mental disease (IMD)
- Must meet the income level, age and any other requirements specific to certain aid categories

> **Note:* *For incarcerated individuals applying for inpatient coverage through PE for Inmates, exceptions exist to the criteria marked with an asterisk (*). See the Presumptive Eligibility module for details.*

Presumptive Eligibility Aid Categories and Benefit Plans

Aid categories eligible for PE include:

- Infants (up to age 1)
- Children (ages 1 through 18)
- Adults (ages 19 through 64, without Medicare)
- Parents/Caretakers
- Former Foster Care Children (ages 18 through 25)
- Pregnant Women
- Family Planning (individuals eligible for family planning services only)

For details about income limits and other requirements specific to each aid category, see the *Presumptive Eligibility* module.

The benefit plan assigned during the PE period depends on the individual's aid category (with the exception of Medicaid Inpatient Hospital Services Only, which is assigned to presumptively eligible inmates regardless of their aid category). All presumptive eligibility benefit plans are provided under the fee-for-service (FFS) delivery system.

Table 6 – Presumptive Eligibility Benefit Plans and Coverage

PE Aid Category	Benefit Plan	Coverage Details
• Infants • Children • Parents/Caretakers • Former Foster Care Children	Presumptive Eligibility – Package A Standard Plan	All services available under Package A – Standard Plan (Indiana Medicaid State Plan services)
Pregnant Women	Presumptive Eligibility for Pregnant Women	Only ambulatory prenatal care services (See the *Presumptive Eligibility* module for details.)
Family Planning (individuals presumptively eligible for family planning services only)	Presumptive Eligibility Family Planning Services Only	Only services available under the Family Planning Eligibility Program (See the *Family Planning Eligibility Program* section for details.)
Adults not eligible for another category	Presumptive Eligibility – Adult	Only services available under *Healthy Indiana Plan (HIP) Basic* (See the *Healthy Indiana Plan* module for details.)
PE for Inmates	**Benefit Plan**	**Coverage Details**
Incarcerated individuals who are presumptively eligible, regardless of PE aid category	Medicaid Inpatient Hospital Services Only	Only inpatient services (See the *Presumptive Eligibility* module for details.)

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: Individuals receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) for their own disability automatically meet 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

- 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 special MRT billing procedures.

Preadmission Screening and Resident Review

The Preadmission Screening and Resident Review (PASRR) process is a requirement for all applicants to IHCP-certified nursing facilities (NFs). A **Level I screen** is completed to initiate the PASRR and to identify individuals who may have a mental illness (MI), intellectual disability/developmental disability (ID/DD), or mental illness and intellectual disability/developmental disability (MI/ID/DD). When indicated, a **Level II evaluation** is performed to identify the specialized needs of such individuals. For individuals seeking Medicaid coverage of their NF stay, an **LOC** assessment is completed to determine whether the individual meets state criteria for a nursing facility (NF) level of care.

Individuals undergoing the PASRR process are assigned one of two plans: *PASRR Mental Illness (MI)* or *PASRR Individuals with Intellectual Disability (IID)*. However, no services can be billed under these plans; the PASRR process is performed by an outside vendor and is not reimbursable to IHCP providers.

See the *Long-Term Care* module for more information about the PASRR process.

Right Choices Program (RCP)

The Right Choices Program (RCP) is the lock-in program developed by the IHCP in accordance with *Code of Federal Regulations 42 CFR Sections 455* and *456* and *Indiana Administrative Code 405 IAC 1-1-2(c)*. 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, PathWays and Traditional Medicaid members who have been identified as overusing or abusing services.

RCP members are locked in to a single primary medical provider (PMP) and a single pharmacy. If the member requires services from a different provider, such as a specialist, the PMP must submit a referral to the RCP Administrator; otherwise, the services will not be reimbursed. RCP members remain eligible to receive all medically necessary, covered services allowed by their existing benefit plans, as long as the services are provided in accordance with RCP requirements. See the *Right Choices Program* module for details.

> *Note: The IHCP Provider Healthcare Portal eligibility verification includes a Right Choices Program panel for members assigned to the RCP. Users can expand this detail panel to view lock-in provider assignments. See the Right Choices Program section for details.*

Section 5: Member Cost-Sharing and Liability Policies

Some Indiana Health Coverage Programs (IHCP) members have cost-sharing obligations, such as copayments, healthcare account contributions, premiums or other Medicaid-related charges. Additionally, certain members are subject to a liability obligation, which they must meet each month before IHCP begins reimbursing for designated services.

Cost-Sharing Policies

The cost-sharing policies outlined in this section pertain to copayments, contributions and premiums that are charged by the Medicaid program itself. Cost-sharing, as used here, does **not** include Medicaid member liability obligations or non-Medicaid charges.

> *Note: For specific cost-sharing policies regarding services rendered to members enrolled in managed care plans, providers should contact the appropriate managed care entity (MCE). MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For information about Personal Wellness and Responsibility (POWER) Account contributions and copayments for Healthy Indiana Plan (HIP) members, see the Healthy Indiana Plan module.*
>
> *For information on making premium payments for Hoosier Healthwise Package C or Medicaid for Employees with Disabilities (MEDWorks), see the HHW Package C/MEDWorks Premium page at in.gov/medicaid/members.*

Cost-Sharing Limitations and Exemptions

In accordance with federal regulations, IHCP members with cost-sharing obligations (copayments, contributions or premiums charged by the Medicaid program) 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. (For Package C members, the 5% limitation applies on a yearly basis.)

When the public-health-crisis-related moratorium on cost-sharing was lifted, effective July 1, 2024, cost-sharing requirements were not reinstated for many IHCP programs, in accordance with HEA 1513. Only the following cost-sharing obligations currently remain:

- Package C premium payments and copayments for applicable services (see Table 7) for Hoosier Healthwise Package C – Children's Health Insurance Program (CHIP) members
- MEDWorks premium payments for applicable Traditional Medicaid (fee-for-service), Hoosier Care Connect and Indiana PathWays for Aging members
- Healthy Indiana Plan (HIP) POWER Account contributions and copayments for applicable HIP members (see the *Healthy Indiana Plan* module for details, including copay amounts and services exempt from copayment)

Cost sharing no longer applies under any other IHCP program, including Presumptive Eligibility programs. Patient liability obligations do continue to apply under other programs, as described in the *Member Liability Provisions* section.

Within the programs that continue to have cost-sharing provisions, members in the following categories are **exempt** from cost-sharing obligations, including copayments, premiums or contributions:

- American Indian/Alaska Native with verified status as part of a federally recognized tribe
- Pregnant or within the 12-month postpartum period
- Receiving hospice care
- Under age 18, except for Package C members
- Eligible for Medicaid due to a diagnosis of breast or cervical cancer
- Eligible due to Foster Care, Adoption Assistance, or Former Foster Care member age 18 through 25

Members in exempt categories are not affected by the cost-sharing tracking process – they should never be charged copayments.

Copayment Policies

HIP and Package C are the only IHCP benefit plans that require members 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.

Copayment amounts will not be deducted from claims processed after the member's 5% cost-sharing obligation has been met in any given quarter. Providers will need to contact the MCE to determine whether the member's copayment obligation has been met for the quarter.

According to *Code of Federal Regulations 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 liability for the copayment. It is the member's responsibility to inform the provider if the member cannot afford to pay the copayment on the date of service.

Table 7 provides copayment amounts at a glance for Hoosier Healthwise Package C members.

Table 7 – Copayments at a Glance, for Hoosier Healthwise Package C

Service	Package C Copayment
Emergency transportation and physician-requested nonemergency ambulance transfers between medical facilities	$10
Pharmacy (preferred)	$3 per prescription
Pharmacy (nonpreferred)	$10 per prescription

For information about which services are subject to copay under certain Healthy Indiana Plan (HIP) benefit plans, as well as corresponding copayment amounts, see the *Healthy Indiana Plan* module.

Member Liability Provisions

When Indiana transitioned to a 1634 state, ending the Indiana Medicaid spend-down program, certain IHCP members continued to be subject to a monthly liability, as described in the following sections.

Patient Liability for LTC Facility Residents

IHCP members residing in a long-term care (LTC) facility may have a *patient liability* (also referred to as a *client obligation*), which is an amount the member must contribute toward their monthly care in the facility before IHCP coverage of LTC facility services begins. See the *Long-Term Care* module for more information.

For FFS members, this patient liability amount is displayed in the IHCP Portal as described in the *Institutional Level of Care and Hospice* section. For members enrolled in Indiana PathWays for Aging (PathWays), the facility should consult the member's MCE for patient liability information.

HCBS Waiver Liability

> *Note: The provisions described in this section apply only to HCBS waiver expenses. Effective Sept. 25, 2024, Indiana Medicaid State Plan services (under Full Medicaid or Package A – Standard Plan) are **not** impacted by the waiver liability. See the 1915(c) HCBS Waiver Services and HCBS Waiver Benefits for PathWays Members sections for information about service options associated with HCBS waivers.*

Individuals who are approved for a Home- and Community-Based Services (HCBS) waiver, but who have income in excess of the Medicaid threshold, may be enrolled in Traditional Medicaid or PathWays under the HCBS waiver liability provision. Waiver liability is similar to a deductible.

Members with an HCBS waiver liability are responsible for paying for HCBS waiver expenses up to the amount of their excess income each month. IHCP reimbursement for HCBS waiver services begins after this liability obligation is met. It is the member's responsibility to provide nonclaim verification of incurred expenses to the Division of Family Resources (DFR).

A waiver provider may bill a member for the amount listed under SPENDDOWN AMT on the remittance advice (RA). The IHCP does not require the member to pay the provider until the member receives the liability summary notice. 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 liability summary notice. Providers must bill their usual and customary charge to Medicaid. The maximum amount a provider can bill a member is the lesser of the liability obligation remaining at the time the claim adjudicates or the usual and customary charge. For general information on HCBS waiver billing, see the *Home- and Community-Based Services Billing Guidelines* module.

When a provider verifies member eligibility as described in the *Eligibility Verification System* section, the system will indicate if the member has a waiver liability. For FFS members, the system will also indicate the dollar amount of the monthly obligation as well as the balance remaining for that month (see Figure 31). For managed care members with an Indiana PathWays for Aging (PathWays) Waiver, the waiver liability obligation and monthly balance must be verified using the MCE's system. Providers can use the liability information to assist members with financial planning for payment of the liability.

Figure 31 – Waiver Liability Details Panel in the IHCP Portal Eligibility Verification (FFS Member Example)

Waiver Liability Details

These amounts are based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the Waiver Liability amount deducted from the adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Waiver Liability Summary Notice listing the amount applied to Waiver Liability.

Month	Waiver Liability Obligation	Waiver Liability Balance
May 2024	$977.00	$977.00

Providers may not collect the liability obligation from the member at the time of service. A provider may bill the member for the amount credited to liability after the provider receives an RA showing that the claim has been adjudicated.

Benefit Limits and Waiver Liability

In general, denied services do not credit waiver liability. For example, a waiver service that was not authorized for the member, and therefore reimbursement was denied by the IHCP, does not credit waiver liability.

> *Note: The information in this section pertains to **fee-for-service (FFS)** coverage. For managed care members, providers must follow the managed care entity (MCE) procedures for obtaining benefit limit information.*

Some Indiana Health Coverage Programs (IHCP) services are subject to benefit limits, based on the number of units or dollar amount reimbursed within a given time frame. Before rendering such services, providers must verify that the member's benefit limit has not been met.

For details about service-specific benefit limits, refer to the provider reference module applicable to that type of service.

Checking Benefit Limits on the EVS

Select member benefit limit information is available through the IHCP Eligibility Verification System (EVS), which providers can access through any of the following methods, as described in the *Eligibility Verification System* section:

- IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers
- Virtual assistant (GABBY) at 800-457-4584, option 2
- 270/271 Eligibility Benefit Inquiry and Response electronic transactions using approved vendor software

The EVS response consists of a description of the limit (including the applicable explanation of benefits [EOB] code that would be returned with claim denials if the limit is exceeded), what the limit is (the dollar amount or number of units allowed for the particular service within the given time frame), and how much is remaining for that member. The amount remaining reflects FFS paid claims only, and does not include payment for claims that are still in process.

See Figure 32 for an example of the benefit limits returned using the IHCP Portal.

Figure 32 – Benefit Limit Details on the IHCP Portal

Limit Details

The Dollar Limits and Service Limits may not reflect recent claims.

Dollar Limits	Limit	Remaining
6085 INCONTINENCE SUPPLIES LIMITED $1950/ROLLING YEAR	$1,950.00	$1,900.26
Service Limits	**Limit**	**Remaining**
6195 FRAMES INITIAL OR REPAIR/REPLACEMENT 21 YRS O	1	-
6272 LENSES INITIAL REPAIR/REPLACEMENT MEMBER 21 Y	2	-
6298 ROUTINE VISION EXAM AGE 21-999 LTD TO 1/24 MO	1	-

The system lists only services for which some reimbursement has been made. If the full amount is still remaining for a particular limit, that limit will not be displayed.

Not all benefit limits are tracked within the EVS. See Table 8 for a list of those limits that *are* returned by the EVS, as well as the associated EOB that would be returned if additional amounts were billed after the limit has been met. To avoid claim denials for the EOBs shown in Table 8, before rendering such services, providers should use the EVS to verify that the member has not exhausted the applicable benefit limits.

Table 8 – EOBs Related to Benefit Limit Information Available through the EVS

Limit Description Displayed in the IHCP Portal	Corresponding EOB Description
6012 MEDICAL SERVICES 30 PER YEAR	Reimbursement is limited to 30 medical services per member per rolling calendar year, unless prior authorization for additional services has been obtained.
6054 ONLY ONE HEARING TEST PER 36 MO. WITHOUT PA	Audiological assessments are limited to once every 3 years per member. Prior authorization is required for payment of additional services.
6060 SPEECH THERAPY EVALUATIONS/ONE PER YEAR	Reimbursement for speech evaluation is limited to once every twelve months. Prior authorization is required for payment of additional evaluations.
6085 INCONTINENCE SUPPLIES LIMITED $1950/ROLLING YEAR	Incontinence supplies are limited to total dollar amount of $1,950.00 per rolling 12 months.
6090 PODIATRIST OFFICE VISITS LTD TO 1 PER YEAR	Indiana Medicaid benefits allow payment for one (1) podiatry office visit per recipient per calendar year.
6099 REIMBURSEMENT IS LIMITED TO 50 CHIROPRACTIC SVCS	Reimbursement is limited to no more than 50 chiropractic services per member per calendar year. These services could include up to five (5) office visits and spinal manipulation treatments, or physical medicine treatments.
6101 CHIROPRACTIC RESTRICTIVE OFFICE VISITS CODES (NP)	New patient chiropractic office visits are reimbursable once per provider per lifetime of the recipient.
6102 CHIROPRACTIC OFFICE VISITS LIMITED TO 5 PER YEAR	Indiana Heath Coverage Programs reimbursement limited to five chiropractic office visits per year. This recipient has received the maximum number allowable. Prior authorization is required for payment of additional visits.
6105 ONE FULL SPINE X-RAY PER YEAR FOR CHIROPRACTOR	Indiana Health Coverage Program reimbursement is limited to one (1) full spinal X-ray per recipient per calendar year by a chiropractor. Maximum reimbursement has been paid. Prior authorization is required for payment of additional visits.
6111 CHIROPRACTIC OFFICE VISITS LIMITED TO FIVE PER YEAR	Reimbursement is limited to five chiropractic office visits per year per member. This member has received the maximum number allowable.
6112 MAX OF 14-CHIRO THERAPEUTIC PHYS MED TRT PER YR	Therapeutic physical medicine treatments are limited to 14 per member per calendar year. This member has received the maximum number allowable.
6113 DME LIMITED TO $2000 PER MEMBER PER CAL YR	Durable medical equipment is limited to $2,000 per member per calendar year. This member has received the maximum amount allowable.
6114 DME LIMITED TO $5000 PER MEMBER PER LIFETIME	Reimbursement for durable medical equipment is limited to $5,000 per member per lifetime.

Limit Description Displayed in the IHCP Portal	Corresponding EOB Description
6120 OP MNTL HLTH/SUBS ABUSE OV 30 / CAL YR W/O PA (DTL)	Reimbursement is limited to 30 visits for outpatient mental health/substance abuse services per recipient per calendar year without prior authorization. This recipient has received the maximum number allowable.
6121 OP MNTL HLTH/SUBS ABUSE OV 50 / CAL YR W/PA (DTL)	Reimbursement is limited to 50 visits maximum for outpatient mental health/substance abuse services per recipient, per calendar year, with prior authorization. This recipient has received the maximum number allowable.
6122 CHIROPRACTIC THERAPEUTIC PHYSICAL MEDICINE TREATME	Therapeutic physical medicine treatments exceeding fourteen (14), up to a maximum of fifty (50), per recipient, per calendar year, require prior authorization.
6195 FRAMES INITIAL OR REPAIR / REPLACEMENT 21 YRS OLDER	Frames initial or repair/replacement- member over 21 years of age
6196 FRAMES INITIAL / REPLACEMENT MEMBER 21 YRS YOUNGER	Frames initial or replacement- member 21 years or younger
6209 FULL MOUTH OR PANORAMIC X-RAYS LIMIT ONCE /3 YRS	Full-mouth or panorex X-rays limited to once every three years.
6211 PERIODIC/LIMITED ORAL EVAL LIMIT 1 EVERY 6 MONTHS	Periodic or limited oral evaluations are limited to one every 6 months.
6212 FLUORIDE TREATMENT LIMITED TO 1 EVERY 6 MONTHS	Indiana Health Coverage Program benefits allow payment for one topical application of fluoride every six (6) months. Fluoride treatments are limited to recipients 0 through 20 years of age.
6221 PERIODONTAL ROOT PLAN/SCAL 4 TX/2YRS NON-INSTITUTI	Reimbursement limited to four treatments of periodontal root planing/scaling every two (2) years for non-institutionalized recipients between the ages of three (3) and twenty (20) years.
6222 PERIODONTAL ROOT PLAN/SCALING, 4 TX PER 2 YRS INST	Reimbursement is limited to four treatments of periodontal root planing and scaling for institutionalized recipients every two (2) years regardless of age.
6223 PERIODONTAL ROOT PLAN 21 YR OR > 4/LIFE NON-INST	Periodontal root planing/scaling 4x/lifetime/non-institutional 21 years and older.
6225 ONE SEALANT PER TOOTH PER LIFETIME	Indiana Health Coverage Program benefits allow payment for one sealant treatment per premolars and molars per lifetime.
6232 PROPHY INSTIT LIM 1/6 MOS	Prophylaxis is limited to one treatment every 6 months for institutional members of all ages.
6235 PROPHY NON-INST AGE 21> LIMIT 1/12 MOS	Prophylaxis is limited to one treatment every 12 months for non-institutional members 21 years or older.
6243 D0220 IS LIMITED TO ONE FILM ONCE A YEAR	D0220 is limited to one film once a year.
6244 D4355/D4346 LIMITED TO ONCE EVERY 3 YEARS (DTL)	D4355 [*full mouth debridement*]/ D4346 [*full mouth scaling*] limited to once every 3 years.

Limit Description Displayed in the IHCP Portal	Corresponding EOB Description
6271 LENSES INITIAL/REPLACEMENT, MEMBER YOUNGER THAN 21	Lenses initial or replacement- member 21 year or younger
6272 LENSES INITIAL REPAIR/REPLACEMENT MEMBER 21 YRS	Lenses initial repair/replacement member over 21 years of age
6297 ROUTINE VISION EXAM LIMIT TO 1/12 MONTHS AGE 0-20	Routine vision exams limited to one (1) per twelve (12) months for ages 1 to 20 years.
6298 ROUTINE VISION EXAM AGE 21-999 LTD TO 1/24 MO (DTL)	Routine vision exams are limited to one (1) per twenty-four (24) months for ages twenty-one to 999 years.
6310 PROPHY AGE 1-20 YRS LIMIT 1/6 MOS	Prophylaxis is limited to one treatment every 6 months for members aged 12 months through 20 years of age
6427 LEAD CASE MANAGEMENT LIMITED 26 UNITS IN 12 MONTHS	T1016 EP - case management each 15 minutes, provided as part of Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) is limited to 26 units per 12 months
6715 URINE DRUG TESTING LIM 16 PER CAL YEAR WITHOUT PA	Definitive urine drug testing (UDT) is limited to 16 per calendar year without a prior authorization.
6716 URINE DRUG TESTING LIM 52 PER CAL YEAR WITHOUT PA	Presumptive urine drug testing (UDT) is limited to 52 per calendar year without a prior authorization.
6752 PT EVAL LTD TO 1 PER 12 MO W/O APPROVED PA (DTL)	Reimbursement is limited to one physical therapy evaluation per member per 12 months unless prior authorization has been obtained.
6753 OCCUPATIONAL THERAPY EVALUATION - 1 PER 12 MONTHS	Reimbursement is limited to one occupational therapy evaluation per member per 12 months unless prior authorization has been obtained.
6855 MORE THAN 6 ROUTINE FOOT CARE TREATMENTS/1 YEAR	Reimbursement is limited to six routine foot care services per year for patients with diabetes mellitus, peripheral vascular disease, or peripheral neuropathy, unless prior authorization has been obtained.
6941 PEER RECOVERY LIMIT 1,460 UNITS IN 12 MONTHS	Peer recovery procedure in excess of 1,460 units is not allowed without prior approval.

Checking Benefit Limits via Written Correspondence

Not all benefit limits are tracked by the EVS. Additionally, the EVS may not include all the information that a provider needs to determine whether a member has exhausted a particular benefit – such as the dates the limits were exhausted. This situation can result in reduced reimbursement or no reimbursement for rendered services. Providers may submit secure correspondence through the IHCP Portal to inquire the date on which a particular member exceeded service limitations. Providers should allow up to four business days for a response.

To assist analysts in researching the issue and providing a resolution, providers should clearly state the reason for the inquiry. The Written Correspondence Unit may contact the provider for additional information if needed.

Providers should not send inquiries to resubmit claims previously rejected.

To submit an inquiry through the IHCP Portal, providers can create a secure correspondence message using the Coverage Inquiry category. For information about registering to use the IHCP Portal and submitting secure correspondence via the portal, see the *Provider Healthcare Portal* module.

Calendar Year Versus Rolling 12-Month Monitoring Period

Some IHCP service limitations are monitored via a rolling 12-month period, and some are monitored on a calendar-year basis. During claim processing, *Core*MMIS reviews the claim history to ensure services do not exceed established limitations. *Core*MMIS compares the service date for a particular claim with service dates that are already paid. *Core*MMIS looks back at service dates within the particular code's established service limitation. If the number of services or dollars has been exceeded for a specific benefit limit, prior authorization (PA) may be required based on medical necessity. If PA is not obtained, *Core*MMIS rejects the claim. In summary, *Core*MMIS generally *rolls back* one year from the service date and counts the number of units or dollars used. *Core*MMIS calculates benefit limits on a service-date-specific basis for paid claims.

> *Example 1:* This example illustrates a **calendar-year** monitoring period. IHCP members are authorized office or other outpatient visits at 30 per calendar year. A member became eligible on Feb. 1, 2023, and with four office visits per month (to a physician, chiropractor, podiatrist and behavioral health provider), reaches the 30-office-visit limitation in September 2023. Without PA, the member is not authorized for another office or other outpatient visit until Jan. 1, 2024 (the beginning of a new calendar year), at which point the restriction of 30 visits per calendar year is restored.
>
> *Example 2*: This example illustrates a **rolling 12-month** monitoring period. The IHCP limits coverage of diabetes self-management training (DSMT) services 16 units (four hours) per rolling 12-month period without prior authorization. A member became eligible on Feb. 1, 2023, and received two units (30 minutes) of DSMT on the first day of eligibility. The member continued to receive two units of DSMT each subsequent month, and in September 2023, the member reached the 16-unit limit. Without PA, the member is not authorized for anymore DSMT services until Feb. 2, 2024. The system restores the two units that were depleted on Feb. 1, 2023, 366 days after the date they were used (for leap years, the units would be restored on day 367). If the member in this example does not use another DSMT service until all 16 units are restored, the full complement of 16 units per rolling 12-month period would be totally restored in September 2024.

The following are examples of services that are limited on a **calendar-year** basis:

- Chiropractic services
- Podiatry services
- Office or other outpatient visits

The following are examples of services that are limited on a **rolling 12-month** basis:

- Dental services
- Diabetes self-management training
- Incontinence supplies

Billing Members for Services That Exceed Benefit Limits

Providers may bill IHCP members for services exceeding the benefit limitations under the following circumstances:

- If the EVS indicates that the limitation has already been met, the provider should inform the member that the service will not be covered. If the member still wishes to receive the service, they may be asked to sign a waiver stating the service will not be covered because benefits have been exhausted and the member will be responsible for the charges.
- If the EVS does not indicate that benefits have been exhausted, the provider may ask the member or their guardian to attest in writing that they have not received the service in question within the applicable time frame. The member is informed that, if the member is misrepresenting and the provider's claim is denied for exceeding benefit limitations, the member will be responsible for the charges.

See the *Charging Members for Noncovered Services* section of the *Provider Enrollment* module for more information.

Section 7: Retroactive Member Eligibility

For many Indiana Health Coverage Programs (IHCP) members, eligibility may be established retroactively up to **three months prior** to the date of application, if the member met eligibility requirements in each of those retroactive months.

However, certain exceptions exist:

- For Healthy Indiana Plan (HIP) coverage (other than *HIP Maternity*) – Eligibility is effective no earlier than the **first day of the month of application**. See the *HIP Member Application, MCE Selection and Enrollment Process* section and contact the member's managed care entity (MCE) for more information.
- For Hoosier Healthwise Package C coverage – Eligibility is effective no earlier than the **first day of the month of application**. See the *Package C Enrollment Process and Cost-Sharing Requirements* section and contact the member's MCE for more information.
- For Qualified Medicaid Beneficiary (QMB) coverage – Eligibility is effective no earlier than the **first day of the month after the month that the determination of eligibility was made**.
- For Presumptive Eligibility (PE) coverage – The PE overage period begins on the date the qualified provider determines the individual to be presumptively eligible for the IHCP.

> *Note: Pregnant applicants and children who initially received coverage through the PE process and are then approved for enrollment in HIP or Hoosier Healthwise may be found eligible for retroactive coverage, for up to three months prior to their IHCP application date, under Package A – Standard Plan. See the Presumptive Eligibility section for more information.*

Retroactive Eligibility for Managed Care Members

IHCP applicants determined eligible for Hoosier Care Connect, Hoosier Healthwise Package A, Indiana PathWays for Aging (PathWays) or *HIP Maternity* may also be determined eligible for retroactive coverage prior to their application date. Retroactive coverage for these members is provided through the fee-for-service (FFS) delivery system. During the retroactive time period, the Eligibility Verification System (EVS) will indicate the member's coverage as *Package A – Standard Plan* with **no** enrolling MCE indicated. For dates of service on and after the date eligibility was actually determined, the EVS will indicate the applicable benefit plan (such as *Package A – Standard Plan, Full Medicaid* or *HIP Maternity*) **with** a managed care assignment.

There are some exceptions to this policy, including when for when newborn whose mother was enrolled with a managed care assignment on the date of the child's birth. In this case, the baby is assigned to the mother's MCE, retroactively effective to the date of birth. The mother's and the baby's coverage remains with the MCE during the baby's retroactive period. After an IHCP Member ID is assigned to the baby, providers may send claims for the baby's care to the mother's MCE. Prior authorization (PA) for services may be required. Providers should check with the MCE about PA before submitting claims or retroactive PA requests. Another exception is for PathWays members who lose and reestablish Medicaid eligibility. If retroactive eligibility is established, the member is enrolled with the MCE they had when eligibility was lost.

For all other members, services rendered during the retroactive eligibility period must be billed through the FFS delivery system. Nonpharmacy claims should be submitted to Gainwell; pharmacy claims should be submitted to Optum Rx. For dates of service after the managed care member's retroactive eligibility period must be submitted to the MCE with which the member is enrolled.

Provider Responsibilities for Retroactive Eligibility

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 a provider learns of a member's retroactive eligibility, the provider must immediately return any payments to the member that the member paid for IHCP-covered services rendered during the member's retroactive eligibility period. If a provider's office observes specific refund procedures, and those refund procedures apply to all customers regardless of patient status, then 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 rendered during the member's retroactive eligibility period. Nonpharmacy claims should be submitted to Gainwell; pharmacy claims should be submitted to Optum Rx.

If the service was rendered more than 180 days prior to the claim being submitted, but within one year of the member's retroactive eligibility being awarded, the provider must include a claim note indicating "Retroactive eligibility. Please waive timely filing.". Retroactive billing procedures are discussed in the *Claim Submission and Processing* module.

If PA is required for the covered service, such authorization may be requested retroactively up to 12 months from the date of issuance of the member's Medicaid card. 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 a medical necessity.

The following example illustrates retroactive enrollment:

> An IHCP provider renders an IHCP-covered service on Feb. 1, 2022, to a patient on a private-pay basis. On April 1, 2022, the patient is enrolled in the IHCP retroactively to Nov. 1, 2021. 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 patient for the services rendered on Feb. 1, 2022. The provider then bills the IHCP for the service. If the provider submits the claim before Aug. 1, 2022, (180 days after the date of service), no additional documentation is required; otherwise, the claim must include a request to waive timely filing due to retroactive eligibility. The claim must be submitted to the IHCP before April 1, 2023 (one year after the eligibility determination).

See the *Third-Party Liability* module when there is also a third-party carrier involved.

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 managed care entity (MCE), the local 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.

Guidance to members on how to submit an appeal is available from the *Member Appeals* page on the IHCP member website at in.gov/medicaid/members.

Member Eligibility Appeals

Anytime the DFR takes an action on an individual's case, such as approving or denying an application for enrollment in a Medicaid program, the member or applicant will receive a notice from the DFR explaining the action and appeal rights. If the individual wants to appeal an action taken on their eligibility for Medicaid, they must follow the process outlined in the notice they received from the DFR.

Appeals regarding eligibility decisions can be sent to the local DFR office, as described in the decision letter.

Member Appeals Regarding Healthcare Actions

If a member wants to appeal an action that their health plan took regarding their healthcare, such as a coverage or prior authorization determination, the member must submit the appeal as follows:

- Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Indiana PathWays for Aging (PathWays) members must contact their MCE and work through their grievance process. Managed care members are allowed to file grievances orally or in writing at any time. Members have 60 calendar days from the date of action notice within which to file an appeal per *42 CFR 438.402(c)(2)(ii)*.
- After exhausting the MCE's grievance and appeals process, if the member is still not satisfied with the outcome, the member may request a state fair hearing and/or an external review by an independent review organization (IRO) within 120 days from the date of the MCE's decision. Members can find additional information regarding the state fair hearing and external review process in their appeal determination letter from their assigned MCE.
- Members in an IHCP fee-for-service (FFS) program can write a letter to the FSSA stating the reason for appeal. The letter must be signed and must include the member's name and other important information, such as the dates of the decision. The request should be sent to the following address:

  Family and Social Service Administration
  Office of Administrative Law Proceedings – FSSA Hearings
  402 W. Washington St., Room E034
  Indianapolis, IN 46204

  All FFS member appeals for healthcare actions 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 prior authorization.

Member Appeal Hearing

At the appeal 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. Members are given the opportunity to examine the entire contents of their case file and any and all materials used by the FSSA, local DFR office or the contractor that made the adverse determination. Other IHCP and assistance benefits are not affected by a request for a hearing.