Indiana Health Coverage Program Policy Manual
Chapter 1600 CATEGORIES OF ASSISTANCE Sections 1600.00.00 – 1621.00.00

Contents

1600.00.00 CATEGORIES OF ASSISTANCE

This chapter of the manual provides information regarding the Medicaid and Hoosier Healthwise program. It also defines each specific Medicaid category under which a person/family can qualify. Additionally, it explains the scope of coverage offered under each category.
The Medicaid program has categorical eligibility requirements which must be met in order to receive assistance. These requirements are discussed in detail in Chapter 2400 - Non-Financial Eligibility Requirements. The main sections in this chapter include:

- Categories of Assistance (Section 1600).
- Medical Assistance for the Aged, Blind, & Disabled (Section 1605).
- Hoosier Healthwise (Section 1610).

1600.05.00 MEDICAID ELIGIBILITY CATEGORIES SUMMARY

There are 35 categories under which individuals may be eligible for Medicaid coverage. The method used to determine income eligibility (Modified Adjusted Gross Income MAGI/non-MAGI), the type of coverage (traditional fee-for-service or managed care), and the scope of the benefits provided all vary based on the category under which individuals are eligible. (See Chapters 3200 and 3400 for an explanation of MAGI methodology.) The following table lists all of the Medicaid coverage categories, eligibility criteria for each category, the type of benefit package provided, and whether MAGI methods are applied to determine income eligibility.

https://www.in.gov/fssa/ompp/files/Aid-Category.pdf

1610.00.00 MEDICAL ASSISTANCE FOR THE AGED, BLIND & DISABLED (MED 1, MED 4)

Medicaid coverage is available to individuals who are aged, blind, or disabled. The scope of coverage varies depending upon the specific category under which an individual qualifies. The categories and scope of coverage are explained in the following sections.

As of April 2015, individuals eligible in MED 1 categories who are not in an institution or on a waiver and who are not eligible for Medicare will be enrolled in Hoosier Care Connect (HCC), a coordinated health care program. Hoosier Care Connect members will have to select a managed care entity (MCE) that will help coordinate care with the member's providers. Care coordination is individualized based on a member's assessed level of need determined through a health screening.

Individuals in MED 1 who are eligible for Medicare and those who reside in institutions or are on a HCBS Waiver will receive Traditional fee-for-service coverage.

1610.02.00 SSI ELIGIBLE INDIVIDUALS (MED 1)

This category is identified in the eligibility system as MASI.

To be eligible for MASI Medicaid, an individual must be determined to be disabled by the Social Security Administration. When determined SSI disabled and receiving SSI payments, the proper category of assistance is MASI. MASI is based on categorical eligibility and does not have a budget or redetermination. It is a full coverage category with no cost sharing and is at the top of the Medicaid hierarchy, therefore, it should not be replaced with any other category of medical coverage.

MASI should be given only based on information received via SDX Interface from the Social Security Administration. The SDX Payment Information page displays the detailed payment status codes for MASI budgeting. The "Payment status code" indicates if an individual is receiving any dollar amount (SSI benefits) and the "Medicaid Eligibility Code" indicates if the SSI applicant is eligible for Federally administered Medicaid coverage (MASI).

There are several codes received from SSA via SDX interface, however only one will form SSI. Please see below for detailed information:

This population receives SSI payments:

- Federally administered Medicaid coverage should be continued regardless of payment status code (1619(b) participants)

This population may or may not be receiving SSI payments:

- Goldberg/Kelly payment continuation
- Eligible for Medicaid (N24 Payment Status Only)
- Eligible for Medicaid (1634 States Only)

All the remaining listed codes are not eligible for MASI budgeting:

- REFUSED TO ASSIGN RIGHTS TO TPL
- DEEMING WAIVED, CHILD UNDER A STATE HOME CARE PLAN
- REFERRED TO THE STATE FOR MEDICAID DETERMINATION DUE TO ENTITLEMENT OR INCREASE IN DAC BENEFITS UNDER T2
- ELIGIBLE UNDER STATE DETERMINATION (OBSOLETE)
- TITLE VIII SPECIAL VETERANS BENEFIT RECEIPIENT
- INELIGIBLE PER STATE DETERMINATION (OBSOLETE)
- DRUG ADDICITON AND/OR ALCOHOLISM (OBSOLETE)
- MEDICAID QUALIFYING TRUST MAY EXIST
- REFERRED TO STATE FOR DETERMINATION (1634 STATES) - FEDERAL DETERMINATION NOT POSSIBLE
- STATE DETERMINATION - NOT SSA RESPONSIBILITY

- WIDOW(ER) - 1634 STATES

If the worker questions whether MASI is the correct category, they should contact Helpdesk/PAL rather than open MASI without the correct SSA determination.

If a person has deemed SSI eligibility but is not receiving payments because another SSA benefit amount is more than the maximum SSI amount (such as disabled adult children members), these members should be determined for MED 1 eligibility under normal income and resource rules. The maximum SSI payment amount should be entered as SSI income, and any excess above that amount should be entered as Social Security income. This will cause the income to be properly counted in the budget for all programs. This would apply to some widow/ers (see 2414.10.20) and Disabled Adult Children (see 2414.10.10).

1610.05.00 AGED INDIVIDUALS (MED 1)

This category is identified in IEDSS as MA A.

To be eligible in this category, an individual must be age 65 or older.[1] A person is categorically eligible for MA A beginning with the month they turn age 65.

The full range of Medicaid covered services is available to recipients in the MA A category except for aliens who are eligible for emergency services only.

1610.10.00 BLIND INDIVIDUALS (MED 1)

This category is identified in IEDSS as MA B.

To be eligible in this category an individual must meet the definition of blindness set forth in State regulation. The definition is the same as that of the SSI program.[2]

The full range of Medicaid covered services is available to recipients in the MA B category, except for aliens who are eligible for emergency services only.

1610.20.00 DISABLED INDIVIDUALS (MED 1)

This category is identified in IEDSS as MA D.

To be eligible under this category, individuals must be substantially impaired as set forth in the definition of disability in State law.[3]

The full range of Medicaid covered services is available to receipts in the MA D category except for aliens who are eligible for emergency services only.

1610.25.00 RCAP ELIGIBLE INDIVIDUALS (MED 1)

This category is identified in IEDSS as MA R.

To be eligible for Residential Care Assistance Program-related Medicaid, an individual must:

- Be approved for Room and Board Assistance (RBA).
- Be aged, blind, or disabled. The aged, blind, and disabled requirements for RCAP-related Medicaid are the same as those for RCAP.[4]

The full range of Medicaid covered services is available to recipients in the MA R category.

1610.26.00 EMPLOYEES WITH DISABILITIES (MED 1)

MEDWorks – Medicaid for Employees with Disabilities – consists of two categories identified in IEDSS as MADW and MADI.

A federal law known as the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIA) added two new optional Medicaid categories designed to remove barriers to employment for persons with disabilities by providing access to health care. Effective July 1, 2002, Indiana's Medicaid Program was expanded to cover these categories with the enactment of P.L. 287-2001.

MADW is the basic MEDWorks category for individuals who meet the Medicaid definition of disability without regard to the person's employment. MADI is the medically improved category for persons who lose eligibility in the basic category because of an improvement in their medical condition which although is not a medical recovery, is improved to the extent that the Disability definition for the basic category is no longer met.[5]
To be eligible, individuals must be age 16-64. Depending on their income, some MEDWorks members must pay premiums. All members pay the regular Medicaid co-payments.

1610.30.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

This category is identified in IEDSS as MA L.

To be eligible in this category an individual must be entitled to Medicare Part A.[6] There is no other blindness or disability requirement for the QMB category. Medicaid coverage under QMB is limited to payment of the following:[7]

- The monthly premium for Medicare Part B
- The monthly premium for Premium Hospital Insurance under Medicare Part A for individuals not entitled to free Part A
- Medicare Parts A and B deductibles and co-insurance.

An individual can be simultaneously eligible for QMB and any other full coverage MA.

1610.35.00 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (MED 4)

This category is identified in IEDSS as MA J.

To be eligible in this category, an individual must be entitled to Medicare Part A.[8] There is no other blindness or disability requirement for the Specified Low-Income Medicare Beneficiary (SLMB) category.

Medicaid coverage under SLMB is limited to payment of the Medicare Part B premium.[9]

An individual can be simultaneously eligible for SLMB and any other full coverage MA category.

1610.40.00 QUALIFIED DISABLED WORKER (MED 4)

This category is identified in IEDSS as MA G.

To be eligible in this category, an individual must have lost or will lose premium-free Medicare Part A coverage due to his employment status.[10]

Medicaid coverage under this category is limited to payment of the monthly premium for Medicare Part A.[11]

An individual is not eligible under this category if they are eligible for Medicaid under any other category.

1610.45.00 QUALIFIED INDIVIDUALS (MED 4)

This category is identified in IEDSS as MA I.

To be eligible in this category, an individual must be entitled to Medicare Part A.[12] There is a capped amount available for QIs each year.

MA I pays the Medicare Part B premium.[13]

An individual eligible under any other Medicaid category cannot be eligible as a QI.

1610.45.10 MEDICARE BUY-IN PROGRAM BENEFITS

Table 1. Medicare Savings Program Aid Categories

Aid Category in IEDSS	Benefit Name/Package	Minimum Federal Income Limit	Indiana's Income Limit (*more generous in most cases*)	Income Disregard	Benefit	Can Co-Exist with Full Medicaid category (Full Dual)?	Comments
MA L	Qualified Medicare Beneficiary, QMB	100% FPL	150% FPL	$20 general income disregard, $65 + ½ earned income disregard (example: earns $1,065 from a job, we deduct $65 and ½ of the income, and count only $500 of the earned income)	Pays Part A & B premiums, coinsurance, and deductibles	Yes	MA L/QMB can be open along with full Medicaid or can be open alone (partial dual).
MA J	Specified Low-Income Medicare Beneficiary, SLMB	120% FPL	170% FPL		Pays Part B premiums only	Yes	MA J/SMLB can be open along with full Medicaid or can be open alone (partial dual).

MA I	Qualified Individual, QI	135% FPL	185% FPL	Note: SSA COLA increases go into effect Jan. 1 of each year; we ignore the increase in Social Security income until new FPL amounts go into effect in March 1 of each year.	Pays Part B premiums only	No	All MA I/QI members are partial duals only.
MA G	Qualified Disabled & Working Individuals, QDWI	200% FPL	200% FPL		Pays Part A premiums only	No	All MA G/QDWI members are partial duals only.

1610.50.00 PREGNANT HOOSIER WHOSE INCOME INCREASES (MED 1, 4)

When a pregnant individual receives an increase in income, their Medicaid eligibility must continue without change.[14] They shall remain eligible in the same category regardless of an income increase.

The income that the member has when they report the pregnancy, determines if the member will go into MAMA or MAGP. Once the pregnancy coverage is open the category will not change until after the post-partum period ends.

1620.00.00 HOOSIER HEALTHWISE (MED 3)

Medical coverage is available to certain parents/caretakers, infants, and children, former foster children ages 18 to 26 who were enrolled in Medicaid (any state) on their 18th birthday, and pregnant women under the Hoosier Healthwise Program. Additionally, medical coverage under

the Healthy Indiana Plan (HIP) is available to adults between ages 19 and 64, effective February 1, 2015.

Hoosier Healthwise is funded by Title XIX-Medicaid and by the Children's Health Insurance Program-Title XXI and is composed of three benefit packages. Coverage under these packages is generally comprehensive, with a few exceptions, which are noted below. The packages are as follows:

- Package A (Standard Plan) provides comprehensive healthcare coverage to some eligible parents and other caretaker adults, infants and children, former foster children ages 18 to 26 who were enrolled in Medicaid (any state) on their 18th birthday, and pregnant women. There are no premiums or co-payments for children under age 18. IEDSS category codes under this package are, MA F, MAGP, MA X, MA Y, MA Z, MA 2, MA 9, and MA 15.

- Children who are wards of the State, children in the Adoption Assistance Program, foster children and former foster children (MA 4, MA 8, MA 15) may opt out of Traditional Medicaid FFS and voluntarily enroll in Hoosier Care Connect, a coordinated care program (see 1610.00.00 for a description of the Hoosier Care Connect program).

HIP is funded through a Section 1115 demonstration waiver with the CMS, Indiana's existing cigarette tax revenues, and from a Hospital Assessment Fee.[15] HIP coverage is available to adults aged between 19 and 64 years, who do not have Medicare, have income equal to or less than 133% of the FPL, and are not eligible for any other Medicaid category excluding low-Income parents/caretakers and transitional Medical Assistance.

Under HIP, a person will qualify for either State Plan Benefits or Regular Plan Benefits. Within each plan exists Plus and Basic. Please, refer to IHCPPM 3500.00 to see the difference in benefits and cost sharing between HIP Plus and HIP Basic. To receive coverage under either HIP State Plan Plus (MASP) or HIP Regular Plan Plus (MARP), a person must make financial contributions towards a Personal Wellness and Responsibility (POWER) account that is based on their income and the FPL percentage range that the member falls in, but can be no less than $1 per month, regardless of a person's income. To receive coverage under either HIP State Plan Basic (MASB) or HIP Regular Plan Basic (MARB), the income standard is 100% of the FPL.

- HIP State Plan Plus (MASP) benefits, refer to 3520.10.00
- HIP State Plan Basic (MASB) benefits, refer to 3520.15.00
- HIP Regular Plan Plus (MARP) benefits, refer to 3520.25.00.
- HIP Regular Plan Basic (MARB) benefits, refer to 3520.30.00

A woman who is a member of any HIP category who becomes pregnant will be moved into the MAMA category unless income increases at the same time. If this happens, she should go into MAGP.

1620.05.00 LOW INCOME PARENTS / CARETAKERS

This category is identified in the eligibility system as MAGF.

The category consists of parents and caretaker relatives of dependents less than 18 years of age and is reserved for members who do not qualify for HIP coverage due to Medicare, a waiver or refugee status. A parent includes biological, adopted, and stepparent. For the definition of a caretaker relative, please, refer to IHCPPM 2420.00.00. This category also consists of low-income parent and caretaker refugees for the first twelve months after arriving in the United States. For more information regarding MAGF coverage, see IndianaMedicaid.com or refer members to call the information number on the back of their Medicaid Card.

1620.05.15 TRANSITIONAL MEDICAL ASSISTANCE

This category is identified in IEDSS as MA F. Although MA F is considered Hoosier Healthwise, MA F is not considered a MED 3 category. Nor is it considered MED 2. Refer to IHCPPM Chapter 3800 for more specific information on MA F.

Up to 12 months of full medical coverage under the Transitional Medical Assistance (TMA) category is available to parents/caretaker relatives who have been discontinued from or are denied Medicaid because of the earnings of a caretaker relative who was eligible for and received Medicaid, with the Low-Income Parent/Caretaker (LIPCT) designation, in Indiana in three of the preceding six months. TMA is also available to certain dependents. Refer to Chapter 3800.

To qualify for TMA, the AG must be ineligible for Medicaid for being over 133% FPL (plus the 5% disregard) for one of the following reasons:[16]

- New or increased earnings of a parent or caretaker relative who is a participating
- member of the AG
- New or increased earnings of a MA sanctioned parent or caretaker relative who is
- a non-participant due to a sanction
- The effective date of TMA corresponds to the date of discontinuance or the date, on which the AG first becomes ineligible, whichever is earlier.[17]

1620.35.00 RESERVED

1620.35.05 NATIVE AMRICAN/ALASKA NATIVE HIP (MED 3)

Native Americans and Alaska Natives who qualify for HIP will automatically be placed into HIP State Plan. Additionally, Native American and Alaskan Native HIP members will not be required to make any financial contributions to a POWER Account or make any required co-pays.
If a Native American and Alaska Native chooses to be covered by fee-for-service, rather than managed care, the person will then have eligibility under the MANA category.

1620.36.00 HIP STATE PLAN PLUS (MED 3)

This category is identified in IEDSS as MASP.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age and have income equal to or less than 133% of the FPL, unless the person qualifies for TMA. The upper age limit is waived for Low-Income Parent/Caretakers. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program. Eligible participants include:

- Low Income parents and caretaker relatives
- TMA eligible individuals; or
- Individuals that qualify as medically frail.[18]

HIP Plus State Plan requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MASP members, who are American Indian/Alaska Natives, are not required to make a financial contribution to a POWER Account.

1620.37.00 HIP BASIC-STATE PLAN (MED 3)

This category is identified in IEDSS as MASB.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age (upper age limit is waived for low-income parent/caretakers). They must have income at or below 100% FPL. They will be enrolled in HIP Basic State Plan if they fail to make financial contributions toward a POWER account and fall into one of the following groups:

- Low-income parents and caretaker relatives
- Individuals that qualify as medically frail.[19]

1620.38.00 HIP STATE PLAN PLUS WITH CO-PAYS (MED 3)

This category is identified in IEDSS as MAPC.

- To be eligible in this category an adult must have been eligible under MASP, while being determined medically frail, having income between 100% FPL and 133% FPL, and fail to make ongoing financial contributions to a POWER account.
- If an MAPC member's income decreases to below 100% FPL, they will be moved into the State Plan Basic category.

1620.39.00 HIP REGULAR PLAN PLUS (MED 3)

This category is identified in IEDSS as MARP.

To be eligible in this category an adult must at least 19 years of age and less than 65 years of age. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible for any other Medicaid category.[20] The income standard is 133% FPL. HIP Regular Plus requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department.

1620.39.05 HIP REGULAR BASIC (MED 3)

This category is identified in IEDSS as MARB.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age with income at or below 100% FPL and will be enrolled in HIP Basic after failing to make financial contributions to a POWER account. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible under any other Medicaid category.[21] The HIP Basic benefit package applies co-payments to services. The "HIP Basic" Plan maintains essential benefits, but incorporates reduced benefit coverage, has a more limited pharmacy benefit, does not include dental, and does not include vision benefits.

1620.40.00 CHILDREN IN PSYCHIATRIC FACILITIES (MED 3)

This category is identified in IEDSS as MA O.

To be eligible in this category a child must be under age 21, an inpatient of a Medicaid certified psychiatric facility, and meet MAGF eligibility requirements (except the age 18 limitations) as if they were living at home. [22]A recipient who is approved for MA O prior to his 21st birthday remains eligible until age 22 as long as he remains in the psychiatric facility.

1620.45.00 REFUGEE MEDICAL ASSISTANCE (MED 2)

This category is identified in IEDSS (Indiana Eligibility Determination Services System) as MA Q (Refugee Medical Assistance (RMA) 1st 12 months in the U.S).

Individuals receiving or eligible to receive Refugee Cash Assistance (RCA) are eligible for Medicaid under these categories. This is the category of last resort, after all other categories have been explored.

A MA Q (Refugee Medical Assistance (RMA) 1st 12 months in the U.S) AG that becomes ineligible for assistance due solely to new or increased earnings may receive continued Medicaid until the end of the twelve-month eligibility period. In cases where a member of the AG obtains private medical coverage, it is imperative to answer Third Party Liability questions located in IEDSS (Indiana Eligibility Determination Services System) under Non-financial questions and properly update information on the Third-Party Liability Detail Screen. A refugee may not receive Medicaid under this provision once his initial twelve-month eligibility period ends.

Low-income Parent/Caretaker refugees who are within their first 12 months in the country will be placed into MAGF (Parent or Caretaker Relative, not eligible for HIP) instead of MA Q (Refugee Medical Assistance (RMA) 1st 12 months in the U.S). These members will remain in MAGF for the first twelve months. At the end of the twelve months, the State Eligibility system will explore all other eligible categories for the member, including HIP.

1620.50.00 PREGNANT Hoosiers - FULL COVERAGE (MED 3)

These categories are identified in IEDSS as MAMA and MAGP.

To be eligible for these categories pregnant individuals must have an attestation of pregnancy and have income less than or equal to 208% of the Federal Poverty Level, with the 5% MAGI disregard included if needed to pass.[23] There are no resource eligibility requirements for these categories.

If a pregnant individual receiving coverage under either of these two categories receives an increase in income which causes their countable income to exceed the standard, they remain eligible for pregnancy-related coverage through the end of the 12 months postpartum period, as explained in Section 1610.50.00.[24]

The 12-month postpartum period is available to an individual who meets one of the following criteria:

- Applies for Medical Assistance while pregnant and is eligible on the date pregnancy ends (by birth or other means).

- Applies for Medical Assistance while pregnant and is eligible on the date pregnancy ends (by birth or other means) and/or was both pregnant and financially eligible in the month of application or one of the three retro months prior to the application.

- Applies for Medicaid after the child is born (or the pregnancy is terminated by other means) and was both pregnant and financially eligible in the month of application or one of the three retro months prior to the application Month. For a pregnant individual who was eligible and enrolled on the date their pregnancy ends, the agency must provide coverage described through the last day of the month in which the 12-month postpartum period ends. [25]

Application Example 1:

- Retro Month 1 – Individual was pregnant but over the income limit for MAGP
- Retro Month 2 – individual was pregnant but over the income limit for MAGP
- Retro Month 3 – individual was pregnant, and pregnancy ended, and they were under the income limit for MAGP
- Application month – individual was over the income limit for MAGP.

In this case, the individual should be found eligible for retro month 3 and ongoing, as the increase in income should be disregarded until the postpartum period ends.

Application Example 2:

- Retro Month 1 – individual was pregnant but over the income limit for MAGP
- Retro Month 2 – individual was pregnant but over the income limit for MAGP
- Retro Month 3 – individual was pregnant, and pregnancy ended, and they were still over the income limit for MAGP
- Application month – individual was under the income limit for MAGP but fails income test for all other categories

In this case, the individual is not eligible for coverage, since she was not eligible for any retro month or the month that pregnancy ended, so income cannot be disregarded for their postpartum period.

Application Example 3:

- Retro Month 1 – individual was pregnant but over the income limit for MAGP
- Retro Month 2 – individual was pregnant and under the income limit for MAGP
- Retro Month 3 – individual was pregnant, and pregnancy ended, but they were over the income limit for MAGP
- Application month – individual was over the income limit for MAGP

In this case, the individual should be found eligible for Retro month 2 and ongoing, as the increase in income should be disregarded until the postpartum period ends.

1620.60.00 CHILDREN UNDER AGE 1 (MED 3)

This category is identified in IEDSS as MA Y.

To be eligible in this category a child must be under the age of one.[24]

The income standard for this category is less than or equal to 208% of the Federal Poverty Level and there are no resource requirements.

1620.65.00 CHILDREN AGE 1 - 5 (MED 3)

This category is identified in IEDSS as MA Z.

To be eligible in this category a child must be at least one year of age, but not six years old.

Income standards are based on 141% of the Federal Poverty Level and there are no resource requirements.[25]

1620.70.00 CHILDREN AGE 6 - 18 (MED 3)

This category is identified in IEDSS as MA 2.

To be eligible in this category a child must be at least age six (6), but under age nineteen (19).[26]

The income standard is based on 106% of the Federal Poverty Level and there are no resource requirements.

1620.71.00 CHILDREN AGE 1 - 19 (MED 3)

This category is identified in IEDSS as MA 9.

This category is an eligibility expansion effective July 1, 1998. It is funded under the federal "Children's Health Insurance Program" (CHIP) enacted in the Balanced Budget Act of 1997. To be eligible in this category:

- A child must be age 1 through age 5 with income between 141% - 158% of the federal poverty level; or
- Age 6 through 18 with income between 106% - 158% of the federal poverty level, and not eligible in any other Medicaid category.

There are no resource requirements.

1620.72.00 CHILDREN'S HEALTH PLAN (MED 3)

This category of Hoosier Healthwise is designated as MA 10 on IEDSS.

Effective January 1, 2000, comprehensive medical coverage, under an eligibility expansion funded through the federal Children's Health Insurance Program (CHIP), is available to Indiana children under the age of 19.[27] Under this category, also known as Package C, the income limit was 200% of the federal poverty guidelines at implementation and increased to 250% of the federal poverty guidelines, as of October 1, 2008. (Refer to IHCPPM Section 3010.30.00.)

There are no resource requirements. Coverage is provided only to children who are ineligible for all other categories of Hoosier Healthwise. MA 10 is, therefore, last in the IEDSS Medical Hierarchy. Please note, however, that a child who fails MA 9, but who would be eligible for MA D or MA B, could receive MA 10, if otherwise eligible. (Refer to IHCPPM Section 2035.30.10).

Unlike the other Hoosier Healthwise categories, MA 10 has cost-sharing requirements. There are premiums that must be paid as a condition of enrollment and ongoing eligibility, and there are co-payments for some services.

Retroactive coverage is not available under this category. Coverage begins with the month of application. (Refer to IHCPPM Section 2035.60.00.)

1620.73.00 FOSTER CARE INDEPENDENCE

Note: Effective 1/1/23, Former foster care children enrolled in Medicaid (any state) on their 18th birthday will transition to MA 15 (Refer to 1620.74.00 and 2035.30.25).

1620.74.00 FORMER FOSTER CHILDREN UP TO AGE 26

This category is identified in IEDSS as MA 15.

To be eligible under this category, an individual must have been in foster care and enrolled in Medicaid (any state) on his/her 18th birthday and must be 18 through 26 years old.[28]

There are no income standards or resource requirements for this eligibility group.

1620.75.00 NEWBORNS

This category is identified in IEDSS as MA X.

MA X is based on deemed eligibility and does not have a budget or redetermination. It is a full coverage category with no cost sharing and is at the top of the Medicaid hierarchy, therefore, it should not be replaced with any other category of medical coverage.

The only exception to this is if a newborn is approved for the MA D category. If an ongoing MA X child is approved for MA D, please contact the Helpdesk/PAL to remove the MA X coverage.

A child born to a individual who was receiving (and eligible for) Traditional Medicaid, HIP, or any Hoosier Healthwise benefit package except Package C (MA 10), at the time of the child's birth, is deemed automatically eligible for Medicaid in the Newborn category. Coverage in this category continues for 12 months from the month of birth. Refer to Sections 2225.10 and 2428.00.

1620.80.00 FAMILY PLANNING SERVICES

This category is identified in IEDSS as MA E.

Individuals may be eligible under this category when family planning services are requested.

There is no age requirement. Income standards are based on 141% of the Federal Poverty Level and there are no resource requirements.

1621.00.00 BREAST AND CERVICAL CANCER TREATMENT SERVICES

Breast and Cervical Cancer Treatment Program (ISDH): In Indiana, the Breast and Cervical Cancer Treatment program (BCCP) is administered by the State Department of Health. To be eligible, a individual must be screened and found to be in need of treatment for breast or cervical cancer by the BCCP and have income equal to or less than 200% of the Federal Poverty Level (FPL). The Indiana Breast and Cervical Cancer Program provides access to breast and cervical cancer screenings, diagnostic testing, and treatment for underserved and underinsured women who qualify for services. Eligibility includes:

- Indiana resident
- Uninsured or underinsured
- Insured with unmet deductible
- 30 - 49 years of age (for office visit, clinical breast exam, and Pap smear)
- 50 - 64 years of age (for office visit, clinical breast exam, Pap smear, and mammogram)
- 65 years of age and older if not enrolled in Medicare Part B
- At or below 200% of the FPL

BCCP Option 3 (MA 12): Alternatively, a individual can receive full Medicaid benefits and coverage for treatment under the BCCP Option 3 program, which is identified as the Medicaid category MA 12. To be eligible, an applicant must be diagnosed with breast or cervical cancer and referred to FSSA through ISDH, and also meet the following criteria:

- Indiana resident
- At least 18 years old but not over 64 years old
- Has income at or below 200% of the FPL
- Is not eligible for Medicaid under any other category and is not enrolled in Medicare
- Is uninsured or underinsured (cancer treatment not covered).

The effective date of coverage is based on dates of application and diagnosis.

Example 1: Application received 5/15/2020 with a diagnosis date of 4/15/2020. Effective date of coverage should be 4/1/2020.

Example 2: Application received 5/15/2020 with a diagnosis date of 12/15/2019. The effective date of coverage should be 2/1/2020. (It cannot go beyond 90 days prior to application month.)

For information on screening through BCCP and referrals for BCCP Option 3, see the ISDH website at: http://www.in.gov/isdh/24967.htm

1622.00.00 HCC (HOOSIER CARE CONNECT)

HCC is a managed care program for Medicaid members that are on a MED 1 category that are not:

- On Medicare
- In an institution
- On an approved HCBS waiver

HCC provides additional services including:

- Medication Therapy Management
- Health Care Coordination
- Access to a 24-hour Nurse Helpline

HCC information is not stored in the eligibility system and DFR will not have visibility to HCC assignments. If a member has a question about the HCC, they can contact their MCE (managed care entity) listed on their insurance card or by calling member services at 866-963-7383.

1623.00.00 590 PROGRAM

The 590 Program provides coverage for certain healthcare services provided to Indiana Health Coverage Programs (IHCP) members ages 21 through 64 who are residents of state-owned psychiatric facilities. These facilities operate under the direction of the Indiana Family and Social Services Administration (FSSA), the Division of Mental Health and Addiction (DMHA) or the Indiana Department of Health (IDOH). Individuals who are or incarcerated are not eligible for the 590 Program.

590 is not stored in the eligibility system, it is displayed in MMIS and is available in the Portal.

If an ongoing Medicaid member is reported as residing in a state-owned psychiatric facility and is intended to reside in the facility for 30 or more days, the facility details screen should be

updated, and the case will be suspended. When the facility reports the members release from the facility, the Medicaid should be unsuspended.

[1] 42 CFR 435.520
[2] 42 CFR 435.530
[3] 42 CFR 435.540
[4] IC 12-10-6-1
[5] IC 12-15-41; Social Security Act (SSA) 1902(a)(10)(ii)(XV); SSA 1902(a)(10)(ii)(XVI)
[6] SSA 1902(a)(10)(E)
[7] SSA 1905(p)(3)
[8] SSA 1902(a)(10)(E)
[9] 42 CFR 431.625(d)
[10] SSA 1902(a)(10)(E)
[11] SSA 1905(p)(3)(A)(i)
[12] SSA 1902(a)(10)(E)
[13] SSA 1905(p)(3)
[14] SSA 1902(e)(6)
[15] http://www.in.gov/fssa/hip/files/HIP_2.0_Financing_Overview.pdf
[16] 405 IAC 10-4-5
[17] 405 IAC 10-4-1
[18] 405 IAC 10-4-3
[19] 405 IAC 10-4-3
[20] 405 IAC 10-4-1
[21] 405 IAC 10-4-1

[22] 42 CFR 435.222
[23] 42 CFR 435.831(1); 42 CFR 435.603
[25] 42 CFR §435.170

[24] 42 CFR 435.222

[25] 42 CFR 435.222
[26] 42 CFR 435.222
[27] IC 12-17.6-3-2
[28] SSA 1902(a)(10)(A)(i)(IX)