

Indiana Health Coverage Program Policy Manual

CHAPTER: 1600  
CATEGORIES OF ASSISTANCE

SECTION: 1600  
TABLE OF CONTENTS

1600.00.00 CATEGORIES OF ASSISTANCE

1600.05.00 MEDICAID ELIGIBILITY CATEGORIES SUMMARY

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

1610.02.00 SSI ELIGIBLE INDIVIDUALS (MED 1)

1610.05.00 AGED INDIVIDUALS (MED 1)

1610.10.00 BLIND INDIVIDUALS (MED 1)

1610.20.00 DISABLED INDIVIDUALS (MED 1)

1610.25.00 RCAP ELIGIBLE INDIVIDUALS (MED 1)

1610.26.00 EMPLOYEES WITH DISABILITIES (MED 1)

1610.30.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

1610.35.00 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (MED 4)

1610.40.00 QUALIFIED DISABLED WORKER (MED 4)

1610.45.00 QUALIFIED INDIVIDUALS (MED 4)

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

1620.00.00 HOOSIER HEALTHWISE (MED 3)

1620.05.00 LOW INCOME PARENTS / CARETAKERS

1620.05.15 Transitional Medical Assistance

1620.35.00 CHILDREN AGE 19 or 20 (MED 3)

1620.35.05 Native American/Alaska Native HIP 2.0 (MED 3)

1620.36.00 HIP State Plan Plus (MED 3)

1620.37.00 HIP Basic-State Plan (MED 3)

1620.38.00 HIP State Plan PLUS with Co-pays (MED 3)

1620.39.00 HIP Regular Plan Plus (MED 3)  
1620.39.05 HIP Regular Basic (MED 3)  
1620.40.00 CHILDREN IN PSYCHIATRIC FACILITIES (MED 3)  
1620.45.00 REFUGEE MEDICAL ASSISTANCE (MED 2)  
1620.50.00 PREGNANT WOMEN - FULL COVERAGE (MED 3)  
1620.60.00 CHILDREN UNDER AGE 1 (MED 3)  
1620.65.00 CHILDREN AGE 1 - 5 (MED 3)  
1620.70.00 CHILDREN AGE 6 - 18 (MED 3)  
1620.71.00 CHILDREN AGE 1 - 19 (MED 3)  
1620.72.00 CHILDREN'S HEALTH PLAN (MED 3)  
1620.73.00 FOSTER CARE INDEPENDENCE  
1610.74.00 FORMER FOSTER CHILDREN  
1620.75.00 NEWBORNS  
1620.80.00 FAMILY PLANNING SERVICES  
1621.00.00 BREAST AND CERVICAL CANCER TREATMENT SERVICES

<b>Indiana Health Coverage Program Policy Manual</b>	
<b>CHAPTER: 1600</b>	<b>SECTION: 1600.00.00</b>
<b>CATEGORIES OF ASSISTANCE</b>	<b>CATEGORIES OF ASSISTANCE</b>

**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 are:

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.

Aid Category	Eligibility Criteria/Description	Benefit Package	MAGI applies
MA SI: SSI Recipients	-Receive SSI benefits	Hoosier Care connect (HCC) or Traditional Medicaid Fee-for-Service (FFS)	N
MA X: Newborns	-Born to mother on Medicaid -Age: 0-1 -No FPL Standard	Hoosier Healthwise (HHW) Package A	N
MA Y: Children	-Age: 0-1 -Up to 208% FPL	HHW Package A	Y
MA Z: Children	-Age: 1-5 -Up to 141% FPL	HHW Package A	Y
MA 2: Children	-Age: 6-18 -Up to 106% FPL	HHW Package A	Y
MA 9: Children- MCHIP	-Age: 1-5      141% to 158% FPL -Age 6-18      106% to 158% FPL	HHW Package A	Y
MA10: Children- SCHIP	-Age: 0-1      208% to 250% FPL -Age: 1-18      158% to 250% FPL	HHW/Package C	Y

	-Children 0-18 who lose Medicaid eligibility due to the elimination of income disregards		
MA 8: Children under 19 with adoption assistance	-Automatically eligible if receiving adoption assistance -No FPL standard	HCC or Traditional Medicaid FFS	N
MA 4: Foster children	-Automatic coverage for foster children All are IV-E MAGI excepted -No FPL standard	HCC or Traditional Medicaid FFS	N
MA 14: Former Foster Children	-Independent Former Foster Care up to age 21 -Ages 18-20 -Up to 210% FPL	HCC or Traditional Medicaid FFS	N
MA 15: Former Foster Children Enrolled in Medicaid as of 18 <sup>th</sup> birthday	-Former foster children enrolled in Medicaid as of 18 <sup>th</sup> birthday. Those not eligible for any other Medicaid coverage. Coverage up to age 26. -Ages 18-25 -No FPL standard.	HCC or Traditional Medicaid FFS	Y
MAGF (Parents/	-Parent or caretaker of	HHW Package	Y

Caretaker Relatives)that have Medicare or receive HCBS Waivers	dependent child(ren) -Up to the MAGI equivalent 1988 AFDC income standards	A	
MAGP (Pregnant Women)	-Pregnant -Up to 208% FPL	HHW Package A	Y
MA E Family Planning	Potential beneficiary cannot be eligible for any other Medicaid category.  -No age requirement  -Up to 141% FPL	Family Planning Only	Y
MA O: Children 19-21 residing in an inpatient psychiatric facility eligible	-Age: 19-21 -Up to the MAGI equivalent 1988 AFDC income standards	Traditional Medicaid FFS	Y
MA T: Children Age 19 or 20 living with	-Age: 19-20 -Up to the MAGI equivalent 1988 AFDC income standards	HHW Package A	Y

parent or specified relative and has Medicare or receives HCBS Waiver			
MA A: Aged	-Age: over 64 years -Up to 100% FPL (SSI Income Methodology) *effective after 1634 conversion	HCC or Traditional Medicaid FFS	N
MA B: Blind	-No age requirement. -Up to 100% FPL (SSI Income Methodology) *effective after 1634 conversion	Traditional Medicaid FFS	N
MA D: Disabled	-No age requirement -Up to 100% FPL (SSI Income Methodology) *effective after 1634 conversion	HCC or Traditional Medicaid FFS	N
MA 12: Breast and Cervical Cancer	-Diagnosed with breast or cervical cancer through the ISDH BCCP program -Up to 200% FPL	HCC or Traditional Medicaid FFS	N
MADW- MEDWorks MADI- Medically	-Working disabled individual -Countable income up to 350% FPL	HCC or Traditional Medicaid	N

Improved		FFS	
MA R: RCAP Related Coverage	Automatic coverage for RCAP beneficiaries	HCC or Traditional Medicaid FFS	N
MAHL HIP Employer Benefit	Adult - HIP Link -up to 133% FPL	HIP LINK	Y
MANA American Indian/Alaska Native	Adult - HIP PLUS - Native American only (no Co-Pays) -Age: 19-64 -up to 133% FPL	Traditional Medicaid FFS	Y
MAPC HIP PLUS State Plan with co-pays	Adult - HIP PLUS - State Plan with Co-pays -Age: 19 - 64 -Up to 133% FPL	HIP State Plan	Y
MARB HIP Regular Basic	Adult - HIP BASIC (Regular Basic) -Age: 19 - 64 -Up to 100% FPL	HIP Regular Basic	Y
MASB HIP Basic-State Plan	Adult - HIP BASIC - State Plan -Age: 19 - 64	HIP State Plan Basic	Y

	<ul style="list-style-type: none"> <li>-Up to 100% FPL</li> <li>-Low-income parents and caretaker relatives</li> <li>-TMA eligible individuals</li> <li>-Low-income 19/20 year olds</li> <li>-Individuals who qualify as medically frail</li> </ul>		
MARP HIP Regular Plus	<p>Adult - HIP PLUS - (Regular Plus)</p> <ul style="list-style-type: none"> <li>-Age: 19 - 64</li> <li>-Up to 133% FPL</li> </ul>	HIP Regular Plus	Y
MASP HIP Plus - State Plan	<p>Adult - HIP PLUS - State Plan</p> <ul style="list-style-type: none"> <li>-Age: 19 - 64</li> <li>-Up to 133% FPL</li> <li>-Low-income parents and caretaker relatives</li> <li>-TMA eligible individuals</li> <li>-Low-income 19/20 year olds</li> <li>-Individuals who qualify as medically frail</li> </ul>	HIP State Plan Plus	Y

MA L: QMB (Qualified Medicare Beneficiary)	-Must be eligible for Medicare -Up to 150% FPL	Medicare Parts A & B, premium, deductible, and co-insurance	N
MA J: SLMB (Special Low-Income Medicare Beneficiary)	-Must be eligible for Medicare -Between 150% - 170% FPL	Medicare Part B Premium	N
MA I: Qualified Individual	-Must be eligible for Medicare -Between 170-185% FPL	Medicare Part B Premium	N
MA G: QDW (Qualified Disabled Worker)	-Must have lost free Medicare Part A coverage due to employment status -Up to 200% FPL	Medicare Part A Premium	N
MA F: Transitional Medical Assistance	-Medicaid-enrolled parents, caretaker relatives, and children who lose eligibility due to increased earnings; available for 2 6-month periods. -Up to 185% FPL	HHW Package A	N
MA Q: Refugees	Refugee Medical Assistance (RMA)  -Limited to 8 months of	FFS Traditional Medicaid	N

	assistance		
--	------------	--	--

**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 ICES as MA SI.

To be eligible for MA SI Medicaid an individual must receive SSI benefits.

**1610.05.00 AGED INDIVIDUALS (MED 1)**

This category is identified in ICES as MA A.

To be eligible in this category an individual must be age 65 or older.<sup>1</sup> A person is categorically eligible for MA A beginning with the month he turns 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.

Prior to June 1, 2014, individuals whose income exceeds the income standard and who meet all other eligibility requirements could qualify for Medicaid under the spend-down provision.

**1610.10.00 BLIND INDIVIDUALS (MED 1)**

This category is identified in ICES as MA B.

---

<sup>1</sup> 42 CFR 435.121; 405 IAC 2-2-1

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.<sup>2</sup>

Prior to June 1, 2014, individuals whose income exceeds the income standard and who meet all other eligibility requirements could receive Medicaid under the spend-down provision.

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 ICES 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.<sup>3</sup>

Prior to June 1, 2014, individuals whose income exceeds the income standard and who meet all other eligibility requirements could receive Medicaid under the spend-down provision.

The full range of Medicaid covered services is available to recipients 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 ICES as MA R.

To be eligible for Residential Care Assistance Program - related Medicaid an individual must<sup>4</sup>:

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.

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

**1610.26.00            EMPLOYEES WITH DISABILITIES (MED 1)**

M.E.D. Works - Medicaid for Employees with Disabilities -

---

<sup>2</sup> 42 CFR 435.121; 405 IAC 2-2-2

<sup>3</sup> 405 IAC 2-2-3

<sup>4</sup> 42 CFR 435.234

consists of two categories identified in ICES 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 MED Works 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.<sup>5</sup>

To be eligible, individuals must be age 16-64. Depending on their income, some MED Works 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 ICES as MA L.

To be eligible in this category an individual must be entitled to Medicare Part A.<sup>6</sup> There is no other blindness or disability requirement for the QMB category.

Medicaid coverage under QMB is limited to payment of:<sup>7</sup>

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; and

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)**

---

<sup>5</sup> IC 12-15-41; Social Security Act (SSA) 1902(a)(10)(ii)(XV); SSA 1902(a)(10)(ii)(XVI)

<sup>6</sup> SSA 1902(a)(10)(E)

<sup>7</sup> SSA 1905(p)(3)

This category is identified in ICES as MA J.

To be eligible in this category an individual must be entitled to Medicare Part A.<sup>8</sup> 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.<sup>9</sup>

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 ICES 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.<sup>10</sup>

Medicaid coverage under this category is limited to payment of the monthly premium for Medicare Part A.<sup>11</sup>

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

**1610.45.00 QUALIFIED INDIVIDUALS (MED 4)**

This category is identified in ICES as MA I.

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

MA I pays the Medicare Part B premium.<sup>13</sup>

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

**1610.50.00 PREGNANT WOMEN WHOSE INCOME INCREASES (MED 1, 4)**

---

<sup>8</sup> SSA 1902(a)(10)(E)

<sup>9</sup> SSA 1905(p)(3)(A)(ii)

<sup>10</sup> SSA 1902(a)(10)(E)

<sup>11</sup> SSA 1905(p)(3)(A)(i)

<sup>12</sup> SSA 1902(a)(10)(E)

<sup>13</sup> SSA 1905(p)(3)

When a pregnant woman receives an increase in income, her Medicaid eligibility must continue without change.<sup>14</sup> She remains eligible in the same category regardless of an income increase. If she were to be found eligible under MAGP, she may choose have her eligibility switched to that category.

**1620.00.00 HOOSIER HEALTHWISE (MED 3)**

Medical coverage is available to certain parents/caretakers, infants and children, former foster children up to age 21, former foster children ages 18 to 26 who were enrolled in Indiana Medicaid on their 18<sup>th</sup> birthday, and pregnant women under the Hoosier Healthwise Program. Additionally, medical coverage under the Healthy Indiana Plan (HIP 2.0) 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 Indiana Medicaid on their 18<sup>th</sup> birthday, and pregnant women. There are no premiums or co-payments for children under age 18. ICES category codes under this package are, MA F, MAGF, MAGP, MA T, MA X, MA Y, MA Z, MA 2, MA 9, and MA 15.

Package C (Children's Health Plan) provides comprehensive healthcare coverage to children under age 19. Although comprehensive, some services are subject to limits and some services covered under Package A are not covered under Package C. This package includes a premium (based on income and family size) and co-payments for certain services. The ICES category code under this package is MA 10.

Package E (Emergency Services Only) provides coverage for serious medical emergencies to some immigrants and certain visitors to the U.S. who meet all other categorical and financial requirements. There is no specific ICES category for this benefit package. ICES designate whichever category is appropriate to the individual's circumstances.

Children who are wards of the State, children receiving adoption assistance, foster children and former foster children (MA 4, MA 8, MA 14, MA 15) may opt out of Package A and voluntarily enroll in Hoosier Care Connect, a

---

<sup>14</sup> 1902(e)(6)

coordinated care program (see 1610.00.00 for a description of the Hoosier Care Connect program).

HIP 2.0 is funded through a Section 1115 demonstration waiver with the CMS, Indiana's existing cigarette tax revenues, and from a Hospital Assessment Fee.<sup>15</sup> HIP 2.0 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;
- Transitional Medical Assistance; &
- Low-Income 19/20 year olds that do not reside in a psychiatric facility.<sup>16</sup>

Under HIP 2.0, 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 equal to 2% of their income 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, unless a person qualifies for transitional medical assistance, and the person fails to make financial contributions toward a POWER account.

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 2.0 category who becomes pregnant and reports the pregnancy to the DFR will no longer have to make any required co-pays under HIP Basic or financial contributions to a POWER account under HIP Plus. Additionally, HIP members who become pregnant will be automatically switched to MAGP if they are pregnant at redetermination. If their due date is prior to their redetermination they can opt to remain in their HIP category during the course of the pregnancy.

---

<sup>15</sup>

[http://www.in.gov/fssa/hip/files/HIP\\_2.0\\_Financing\\_Overview.pdf](http://www.in.gov/fssa/hip/files/HIP_2.0_Financing_Overview.pdf)

<sup>16</sup> 405 IAC 10-4-1.

**1620.05.00            LOW INCOME PARENTS / CARETAKERS**

This category is identified in ICES as MAGF.

The category consists of parents and caretaker relatives of dependents less than 18 years of age. A parent includes biological, adopted, and step-parent. For the definition of a caretaker relative, please, refer to IHCPPM 2420.00.00.

**1620.05.15            Transitional Medical Assistance**

This category is identified in ICES 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. Please, 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 MAGF because of the earnings of a caretaker relative who was eligible for and received MAGF in Indiana in three of the preceding six months. TMA is also available to certain dependents. Please, refer to Chapter 3800. (NOTE: MAGF eligibility in the retro period for new application counts towards the three of six months.) To qualify for TMA, the AG must be ineligible for MAGF for one of the following reasons:<sup>17</sup>

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; or

The effective date of TMA corresponds to the date of discontinuance or the date, on which the AG first becomes ineligible, whichever is earlier.<sup>18</sup>

**1620.35.00            CHILDREN AGE 19 or 20 (MED 3)**

This category is identified in ICES as MA T.

To be eligible in this category a child must be either age 19 or 20, live in the home of a parent or caretaker relative, and meet the MAGF income requirements.<sup>19</sup> A parent includes biological, adopted, and step-parents. For the

---

<sup>17</sup> SSA 1925

<sup>18</sup> 1902(e)(1)(A)

<sup>19</sup> 42 CFR 435.222

definition of a caretaker relative, please, refer to IHCPPM 2420.00.00

**1620.35.05 Native American/Alaska Native HIP 2.0 (MED 3)**

Native Americans and Alaska Natives who qualify for HIP 2.0 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 ICES 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. Participants included are:

- Low Income parents and caretaker relatives;
- TMA eligible individuals;
- low-income 19/20 year olds; or
- individuals that qualify as medically frail.<sup>20</sup>

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 become pregnant or 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 ICES 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, unless the person

---

<sup>20</sup> 405 IAC 10-4-1

qualifies for TMA. 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;
- TMA eligible individuals;
- low income 19/20 year olds; or
- individuals that qualify as medically frail.<sup>21</sup>

MASB members who become pregnant will no longer be required to make co-pays for services throughout their pregnancy as well as the 60-day post-partum period.

#### **1620.38.00 HIP State Plan PLUS with Co-pays (MED 3)**

This category is identified in ICES 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.
- MAPC members who become pregnant will no longer be responsible for any cost-sharing to receive services throughout their pregnancy as well as the 60-day post-partum period.

#### **1620.39.00 HIP Regular Plan Plus (MED 3)**

- This category is identified in ICES 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.<sup>22</sup> The income standard is 133% FPL. HIP Regular Plus requires the participant to pay a monthly POWER Account contribution

---

<sup>21</sup> 405 IAC 10-4-1

<sup>22</sup> 405 IAC 10-4-1

(PAC) and only has co-payments on non-emergency use of the hospital emergency department.

- MARP members who become pregnant are not required to make a financial contribution to a POWER Account throughout their pregnancy as well as the 60-day post-partum period.

**1620.39.05            HIP Regular Basic            (MED 3)**

This category is identified in ICES 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.<sup>23</sup> 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.

MARB members who become pregnant are no longer required to make co-pays for services throughout the rest of their pregnancy as well as the 60-day post-partum period.

**1620.40.00            CHILDREN IN PSYCHIATRIC FACILITIES (MED 3)**

This category is identified in ICES 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 he were living at home.<sup>24</sup> A recipient who is approved for MA 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 ICES as MA Q.

Individuals receiving or would be eligible for receiving Refugee Cash Assistance (RCA) are eligible for Medicaid under this category. Additionally, if a refugee is ineligible for Medicaid under any other category, he can be eligible for

---

<sup>23</sup> 405 IAC 10-4-1

<sup>24</sup> IC 12-15-2-9; 42 CFR 435.222

Refugee Medical Assistance (RMA) under the spend-down provision if his income exceeds the RCA standard.<sup>25</sup>

A MA Q AG which becomes ineligible for assistance due solely to new or increased earnings may receive continued Medicaid until the end of the eight month eligibility period. In case where a member of the AG obtains private medical coverage, it is imperative to code it properly on AEFMC. A refugee may not receive Medicaid under this provision once his initial eight month eligibility period ends

**1620.50.00            PREGNANT WOMEN - FULL COVERAGE (MED 3)**

This category is identified in ICES as MAGP.

To be eligible in this category a woman must have an attestation of pregnancy and have income less than or equal to 208% of the Federal Poverty Level, calculated with MAGI methodology. There are no resource eligibility requirements for this coverage category.

If a pregnant woman receiving coverage under the MAGP category receives an increase in income which causes her countable income to exceed the standard, she remains eligible for pregnancy-related coverage through the end of the 60 day postpartum period, as explained in Section 1610.50.00.<sup>26</sup>

The 60 day postpartum period is available to a woman who:

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

Applies for Medical Assistance after the child is born (or the pregnancy is terminated by other means) and is found to have been eligible for Medical Assistance in the application month or one of the three months of the retroactive period.

The 60 day period begins on the last day of pregnancy and extends through the end of the month in which the last day of the 60 day period ends.

During the 60 day period, Medicaid coverage is limited to payment of pregnancy-related and postpartum medical care.

**1620.60.00            CHILDREN UNDER AGE 1 (MED 3)**

This category is identified in ICES as MA Y.

---

<sup>25</sup> 42 CFR 435.406

<sup>26</sup> SSA 1902(e)(5); 42 CFR 435.170

To be eligible in this category a child must be under the age of one.<sup>27</sup>

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 ICES 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.<sup>28</sup>

**1620.70.00 CHILDREN AGE 6 - 18 (MED 3)**

This category is identified in ICES as MA 2.

To be eligible in this category a child must be at least age six (6), but under age nineteen (19).<sup>29</sup> 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 ICES 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 ICES.

---

<sup>27</sup> SSA 1902(a)(10)(A)(i)(IV)

<sup>28</sup> SSA 1902(a)(10)(A)(i)(VI)

<sup>29</sup> SSA 1902(a)(10)(A)(i)(VII)

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 nineteen.<sup>30</sup> 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 ICES Medical Hierarchy. Please note, however, that a child who fails MA 9, but who would be eligible for MA D or MA B with a spend-down, 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**

This category is identified in ICES as MA 14.

To be eligible under this category, individuals must be 18, 19, or 20 years of age and have been a ward in foster care on their 18<sup>th</sup> birthday in a state other than Indiana. Income standards are based on 210% of the Federal Poverty Level and there are no resource requirements.<sup>31</sup>

#### **1610.74.00 FORMER FOSTER CHILDREN UP TO AGE 26**

This category is identified in ICES as MA 15.

To be eligible under this category, an individual must have been in foster care and enrolled in Indiana Medicaid on his/her 18<sup>th</sup> birthday and must be 18 through 26 years old.<sup>32</sup>

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

#### **1620.75.00 NEWBORNS**

This category is identified in ICES as MA X.

---

<sup>30</sup> IC 12-17.6-3-2

<sup>31</sup> SSA 1902(a)(10)(ii)(XVII)

<sup>32</sup> SSA 1902(a)(10)(A)(i)(IX)

A child born to a woman who was receiving (and eligible for) traditional Indiana Medicaid or any Hoosier Healthwise benefit package except Package C, at the time of the child's birth, is deemed automatically eligible for Medicaid in the Newborn category. Coverage in this category continues for the 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 ICES 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**

This category is identified in ICES as MA 12. To be eligible a woman must be screened and found to be in need of treatment for breast or cervical cancer by the Breast and Cervical Cancer Treatment program (BCCP) and have income equal to or less than 200% of the FPL. In Indiana, the BCCP is administered by the State Department of Health. Alternatively, a woman can receive coverage for treatment under the BCCP Option 3 program if she was diagnosed with breast or cervical cancer, but not screened through BCPP if:

She is between the ages of 18 and 65.

She has income at or below 200% of the FPL.

She is not eligible for Medicaid under any other category.

She has no health insurance that will cover her treatment.