Indiana Health Coverage Programs

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Benefit Enrollment and Maintenance (834)

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Preface

The Health Insurance Portability and Accountability Act (HIPAA) adopted standard transaction sets for Electronic Data Interchange (EDI) of health care data. Covered entities must adhere to the content and format requirements as defined in the ASC X12N Implementation Guides.

The Indiana Health Coverage Programs (IHCP) has developed this document to serve as a companion document to provide guidance and clarification as it applies to the IHCP. It is not intended to modify, contradict or reinterpret the rules established by the ASC X12N Implementation Guides.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.

- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

The associated ASC X12 TR3's are available at http://store.x12.org/store

Unique ID	Name
005010X220	Benefit Enrollment and Maintenance (834)
005010X220A1	Benefit Enrollment and Maintenance (834) Errata

3 Instruction Tables

These tables contain one or more rows for each segment where supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.
BLACK TEXT represents notes that apply to all Programs – Hoosier Healthwise (HHW), Presumptive Eligibility (PEPW) and Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC)
BLUE TEXT represents notes that apply to Hoosier Healthwise (HHW) and/or Hoosier Care Connect (HCC) and/or Presumptive Eligibility (PEPW), and/or Program for All-inclusive Care for the Elderly (PACE), and/or Hospital Presumptive Eligibility – Adult (HPE – Adult) as noted
GREEN TEXT represents notes that only apply to Presumptive Eligibility (PEPW)
PURPLE TEXT represents notes that only apply to Healthy Indiana Plan (HIP) and/or Hospital Presumptive Eligibility – Adult (HPE – Adult) as noted
RED TEXT represents notes that only apply to Hospital Presumptive Eligibility - Adult (HPE - Adult)
AQUA TEXT represents notes that only apply to Fast Track Eligibility (FTE)

005010X220A1 Benefit Enrollment and Maintenance (834)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
32		BGN	Beginning Segment			
33		BGN02	Reference Identification			**HHW/HCC/PEPW/PACE *PEPW will be phased out beginning in 2018** The transaction set reference number consists of the nine-digit MCE ID and one-character = A, the creation date, the file type (A – Audit, C – Change), and a three-digit sequential number. The three-digit sequential number is used when the number of 834 transactions exceeds the National Electronic Data interchange Transaction Set Implementation Guide (IG) requirement. 001 represents the first 10,000, 002 represent the second 10,000 and so forth. **HIP** The transaction set reference number consists of the first eight digits of the Insurer ID, the placeholder region code (A), the creation date, the file type (A – Audit, C – Change), the type of

33		BGN02	Reference Identification – continued			members contained in the file (C – Conditional, F – Fully eligible), and a three-digit sequential number. The three-digit sequential number is used when the number of 834 transactions exceeds the National Electronic Data interchange Transaction Set Implementation Guide (IG) requirement. 001 represents the first 10,000, 002 represent the second 10,000 and so forth. **HPE – Adult/FTE** The transaction set reference number consists of the first eight digits of the Insurer ID, the placeholder region code (A), the creation date, the file type (A – Audit, C – Change), the type of members contained in the file (F – Fully eligible), and a three-digit sequential number. The three-digit sequential number is used when the number of 834 transactions exceeds the National Electronic Data interchange Transaction Set Implementation Guide (IG) requirement. 001 represents the first 10,000, 002 represent the second 10,000 and so forth.
36		REF	Transaction Set Policy Number			
36		REF02	Reference Identification		10	**HHW/CS/HCC/PEPW/PACE *PEPW will be phased out beginning in 2018** The master policy number is the nine-digit MCE ID and the one-character region code. **HIP/HPE – Adult/FTE** The master policy number is the nine-digit MCE ID followed by a region code of ‘A’.
39	1000A	N1	Sponsor Name			
39	1000A	N102	Name			IHCP sends "Indiana Health Coverage Program"
40	1000A	N104	Identification Code			IHCP sends "IHCP"
47	2000	INS	Member Level Detail			IHCP sends no more than 10,000 INS segments in a single 834 transaction
48	2000	INS01	Yes/No Condition or Response Code	Y		The IHCP member is always the subscriber
48	2000	INS02	Individual Relationship Code	18		The IHCP member is always the subscriber
49	2000	INS03	Maintenance Type Code			**HHW/CS/HCC/PACE** 001 – Change 021 – Addition 024 – Cancellation or Termination 030 – Audit or Compare

						1. The monthly audit file consists of only 030. 2. The change file contains 001, 021, 024, and 030. 3. The only time a 030 is encountered is when the member level (001) changes and no change occurs in the benefit level (030). **PEPW *PEPW will be phased out beginning in 2018** 001 – Change 021 – Addition 024 – Cancellation or Termination The change file may contain 001, 021, or 024 **HIP** 001 – Change 021 – Addition 024 – Cancellation or Termination 025 – Reinstatement 030 – Audit or Compare 1. The monthly audit file consists of only 030. 2. 001 – A change to the member demographic data, power account amounts, eligibility dates, or capitation category. 3. 021 – A new conditionally eligible member, a member who has moved from conditionally to fully eligible, or a member who has moved from one plan to another. Type of eligibility will be sent in INS04. 4. 024 – A member who is being removed from the HIP plan. Can be conditionally or fully eligible. Reason for removal will be sent in INS04. 5. 025 – A conditional member who has an outstanding debt from a previous HIP enrollment. Notification sent to debt plan only. **HIP/HPE – Adult/FTE** 001 – Change 021 – Addition 024 – Cancellation or Termination 030 – Audit or Compare 1. The monthly audit file consists of only 030. 2. The change file may contain 001, 021, or 024
49	2000	INS04	Maintenance Reason Code			**HHW/CS/HCC/PACE** This code clarifies the type of change and distinguishes a change from a deletion. 07 – Termination of benefits only when INS03 = 024. 15 – Change in PMP when INS03 = 001. 29 – Member moving from PE to Medicaid AI – Member type of unpassed status when INS03 = 021. XN – Notification Only – used when INS03 = 030

						NULL – Deletion only when INS03 = 024 without a reason code. Most of the time, the IHCP sends a NULL value in INS04. However, a NULL is only meaningful when the Maintenance Type code is 024. Unpassed is a member that was not on the last roster and has ending eligibility prior or equal to the end of the current month and starting eligibility prior to the start date of the current roster. **PEPW *PEPW will be phased out beginning in 2018** This code clarifies the type of change and distinguishes a change from a deletion. 07 – Termination of benefits only when INS03 = 024. 15 – Change in PMP when INS03 = 001. 22 – Member changes plans. 25 – Change in member name and/or social security number. 28 – Used when INS03 = 021. 29 – Member moving from PE to Medicaid when INS03 = 001. NULL – Deletion only when INS03 = 024 without a reason code. When INS03 = 024 and INS04 = 29, the member was associated with your MCE prior to being moved to Medicaid, and the Medicaid eligibility dates overlap one or more of the days the person was with your plan. This pertains to members that were assigned to your MCE in the past. **HIP** This code clarifies the type of change and distinguishes a change from a deletion. CONDITIONALLY ELIGIBLE MEMBERS: 03 – Will be sent along with INS03 = 024 to indicate a member who has passed away. Member date of death will be sent in INS12. 14 – Will be sent along with INS03 = 024 to indicate a member who withdrew from HIP prior to making an initial POWER account contribution. 22 – When sent with INS03 = 024, indicates a member no longer eligible for this plan due to a plan change another HIP plan. When sent with INS03 = 021, indicates a member coming from another HIP plan or HIP Link Eligibility. When sent with INS03 = 001, indicates a change to the member's aid category, income, capitation category or FPL. The type of change will be indicated in HD04. 25 – Indicates a change has been made to the member's name, SSN, date of birth, or RID. 27 – When sent with INS03 = 021, indicates a new conditionally eligible HIP member. When sent with INS03 = 025, indicates a conditionally eligible HIP member who was previously on HIP and has an outstanding member debt. 29-When sent with INS03=024, indicates a member who is moving from conditional to fully eligible. 33 – Indicates a change to the member's POWER account

						contribution amount. Also can indicate a change to one or more of the HIP 2.0 indicators found in Loop 2700 – Additional Reporting Categories. 43 – Indicates the member's address, phone number, secondary phone number, case number, companion case number, email address and /or PMP directory indicator has changed. XN – Sent along with INS03 = 030 for all monthly audit records. FULLY ELIGIBLE MEMBERS: 03 – Will be sent along with INS03 = 024 to indicate a member who has passed away. Member date of death will be sent in INS12. 06 – When sent with INS03 = 024, indicates a member's eligibility was replaced or deleted from the HIP program. The HD04 segment will contain ELIG CHANGE or DEATH. 07 – Will be sent along with INS03 = 024 to indicate a member being terminated due to a change in aid category. When sent with a LIFETIME code in HD04 this indicates the lifetime maximum limitation has been reached. When sent with a RE-FAILS REDETERM code in HD04 this indicates the member failed the redetermination process. 14 – Will be sent along with INS03 = 024 to indicate a member being terminated from HIP due to voluntarily withdrawing from the Plan. 15 – Change in PMP when INS02 = 001. 17 – Indicates a member being terminated from HIP due to non-payment of POWER account. 22 – When sent with INS03 = 024, indicates a member being terminated due to a plan change to another HIP plan. When sent with INS03 = 021, indicates a member coming from another HIP plan or HIP Link eligibility. When sent with INS03 = 001, indicates a change to the member's eligibility dates, capitation category or FPL. The type of change (plan change / date change / capitation category change) will be indicated in HD04. 25 – Indicates a change has been made to the member's name, SSN, date of birth, or RID. 28 – Indicates a new fully eligible HIP member. Note: members who were previously a part of HIP and are returning to the plan, such as women who left due to pregnancy, will be treated as new members as long as they do not have outstanding debt. 33 – Indicates a change to the member's POWER account contribution amount. Also can indicate a change to one or more of the HIP 2.0 indicators found in Loop 2700 – Additional Reporting Categories. This will also be the default value if no other maintenance reason code is found in the hierarchy. 43 – When sent with INS03 = 001, indicates the member's address or phone number has changed. When sent with INS=024, indicates the member is being terminated from HIP due to moving out of state. XN – Sent along with INS03 = 030 for all monthly audit records. XT – Indicates a member has access to or currently has other health insurance.

						AI – Sent with INS03 = 001 for members staying with the same plan as a result of redetermination. **HPE - Adult** This code clarifies the type of change and distinguishes a change from a deletion. 06 – When sent with INS03 = 024, indicates a member's eligibility was replaced or deleted from the HIP program. 07 – Termination of benefits only when INS03 = 024. 15 – Change in PMP when INS03 = 001. 22 – Member changes plans. 25 – Change in member name and/or social security number. 28 – Used when INS03 = 021. 33 – Indicates a change to one or more of the HIP 2.0 indicators found in Loop 2700 – Additional Reporting Categories. 43 – Indicates the member's address, phone number, secondary phone number, case number, email address has changed. **FTE** 03 – Will be sent along with INS03 = 024 to indicate a member who has passed away. 14 – Will be sent along with INS03 = 024 to indicate a member who has been denied. 22 – When sent with INS03=24, indicates a member being terminated due to a plan change to another FTE plan. When sent with INS03=21, indicates a member coming from another FTE plan. 25 – Indicates a change has been made to the member's name, SSN, or date of birth. 27 – When sent with INS03 = 021, indicates a new Fast Track Eligible member. 27 – When sent with INS03 = 024, indicates member is moving to HIP conditional. 29 – Will be sent along with INS03 = 024 to indicate a member is moving to HIP Fully Eligible. 33 – Indicates a change to one or more of the indicators reported in Loop 2700 – Additional Reporting Categories. 43 – Indicates the member's address, phone number, secondary phone number, case number, email address has changed. XN – Sent along with INS03 = 030 for all monthly audit records.
51	2000	INS05	Benefit Status Code			IHCP only sends data for active Medicaid members
51	2000	INS06-01	Medicare Plan Code			**HHW/CS/HCC/PEPW/PACE *PEPW will be phased out beginning in 2018** E - member is no longer covered by Medicare

						Null - member is not currently enrolled in Medicare
52	2000	INS08	Employment Status Code	FT TE		IHCP sends the member's status in their program FT – Full time TE – Terminated
56	2000	REF	Member Policy Number			**HHW/CS/HCC/PEPW/HPE – Adult/PACE *PEPW will be phased out beginning in 2018** Not sent in the Hoosier Healthwise or Presumptive Eligibility 834s. **HIP** Always sends this segment in Loop 2000 since Loop 2300 is not sent for conditionally eligible members.
56	2000	REF02	Reference Identification			**HIP** Sends value of "HIP"
57	2000	REF	Member Supplemental Identifier			**HHW/CS/HCC/PACE** Three segments are possible with case number, case worker ID or companion case number. A maximum of two additional REF segments may be sent with linked IHCP member IDs, listed most recent to least recent. **PEPW *PEPW will be phased out beginning in 2018** Two segments are sent with case number and caseworker ID. A maximum of two additional REF segments may be sent with linked IHCP member IDs, listed most recent to least recent. **HIP** Sent where applicable with case number, companion case number or spouse IHCP member ID. A maximum of two additional REF segments may be sent with linked IHCP member IDs, listed most recent to least recent. FTE Application ID is sent in this segment. **HPE – Adult** A maximum of two additional REF segments may be sent with linked IHCP member IDs, listed most recent to least recent. **FTE** Application ID is sent in this segment. A maximum of two additional REF segments may be sent with linked IHCP member ID's, listed most recent to least recent.

57	2000	REF01	Reference Identification Qualifier			**HHW/CS/HCC/PACE** Possible codes and descriptions: 3H – represents the case number ZZ – represents the case worker number 23 – represents the companion case number Q4 – represents the linked IHCP member ID. Maximum of two, listed most recent to least recent When multiple REF segments are reported with “Q4”, the first iteration reports the active, linked Medicaid RID. The subsequent iteration reports the inactive, prior RID that is linked to the active RID reported in the first iteration. The maximum number of linked member IDs is two and is limited by the maximum number of five occurrences per the HIPAA IG. **PEPW *PEPW will be phased out beginning in 2018** The case number and caseworker number are always reported. A maximum of two additional REF segments may be sent with linked IHCP member IDs, listed most recent to least recent. **HIP** Possible codes and descriptions: 3H – represents the case number 23 – represents the companion case number 6O – FTE Application ID ZZ – represents the member’s spouse’s IHCP ID. Sent for conditionally eligible members only. Q4 – represents the linked IHCP member ID. Maximum of four, listed most recent to least recent. Sent for fully eligible members only. When multiple REF segments are reported with “Q4” in REF01, the first iteration reports the active, linked Medicaid RID. The subsequent iteration reports the inactive, prior RID that is linked to the active RID reported in the first iteration. **HPE – Adult** Possible codes and descriptions: Q4 – represents the linked IHCP member ID. Maximum of two, listed most recent to least recent. When multiple REF segments are reported with “Q4” in REF01, the first iteration reports the active, linked Medicaid RID. The second iteration reports the inactive, prior RID that is linked to the active RID reported in the first iteration. **FTE** Used to pass the Application ID 6O – Application ID Q4 – Linked IHCP Member ID
59	2000	DTP	Member Level			

			Dates			
59	2000	DTP01	Date/Time Qualifier			**HHW/HCC/PACE** 473 – MCE Plan Roll-Up Begin 474 – MCE Plan Roll-Up End The qualifiers 473 and 474 are used for reporting the member's MCE related Roll-up effective date and end date based upon the reported PMP effective date range segment. **CS** 473 – Medicaid Eligibility Begin 474 – Medicaid Eligibility End The qualifiers 473 and 474 are used for reporting the member's eligibility effective date and end date under a specific PMP. **PEPW *PEPW will be phased out beginning in 2018** 473 – MCE Plan Roll-Up Begin 474 – MCE Plan Roll-Up End The qualifiers 473 and 474 are used for reporting the member's MCE related Roll-up effective date and end date based upon the reported PE PMP effective date range segment. **HIP** 300 – Enrollment Signature Date 303 – Maintenance Effective 473 – MCE Plan Roll-Up Begin 474 – MCE Plan Roll-Up End Qualifier 300 is used for conditionally eligible members only. It will indicate the date the member became conditionally eligible. Qualifier 303 is used to indicate the date a change to a member's information becomes effective. For conditionally eligible members, it is also used for terminations. If INS04 = 33, then 303 = POWER effective date. If INS04 = 22 or AI, then 303 = benefit effective date. The qualifiers 473 and 474 are used for reporting the member's MCE related Roll-up effective date and end date based upon the reported PMP effective date range segment. HIP members have a finite benefit period, typically twelve months in duration. Benefit period dates are important for POWER account reconciliation. Note that a member can have multiple POWER account dates and obligations within a benefit period span. HIP fully eligible members effective as of January 1, 2018, will have benefit periods that begin January 1 and end December 31, regardless of their eligibility effective date or the dates of their subsequent redeterminations. HIP fully eligible members who are terminated from the

						program on or after January 1, 2018, will retain a benefit period end date of December 31st, regardless of the date of their termination from the HIP program. HIP members who have retroactive eligibility inserted in 2018 or after, for eligibility effective dates prior to 2018, will follow pre-2018 benefit period rules. **HPE – Adult** 303- Maintenance Effective 473 – MCE Plan Roll-Up Begin 474 – MCE Plan Roll-Up End Qualifier 303 is used to indicate the date a change to a member's information becomes effective. The qualifiers 473 and 474 are used for reporting the member's MCE related Roll-up effective date and end date based upon the reported PE PMP effective date range segment. **FTE** 300 – Enrollment Signature Date 303 – Maintenance Effective Qualifier 300 is used for the start date of a person FTE status. When INS03 = 001, qualifier 303 is used for the date a change to a person's information becomes effective. When INS03 = 024, it is used to report the termination end date.
65	2100A	PER	Member Communications Numbers			IHCP Note: This segment contains the member's home telephone number, e-mail address and alternate telephone number if available. A member may have any combination of these elements. For example, they may have two telephone numbers, but no email address. Or they may only have one phone number, or may only have an email address. This information may not be available for some members. The email address and alternate telephone number will not be sent for PE.
66	2100A	PER03	Communication Number Qualifier	TE EM HP		IHCP uses codes: TE - member's home phone number EM - member's e-mail address HP - member's alternate phone number
66	2100A	PER05	Communication Number Qualifier	TE EM HP		IHCP uses codes: TE - member's home phone number EM - member's e-mail address HP - member's alternate phone number

67	2100A	PER06	Communication Number			IHCP only sends on **HHW/HCC/PACE** and **HIP** 834s
67	2100A	PER07	Communication Number Qualifier	TE EM HP		IHCP uses codes: TE - member's home phone number EM - member's e-mail address HP - member's alternate phone number
67	2100A	PER08	Communication Number			IHCP only sends on **HHW/HCC/PACE** and **HIP** 834s
68	2100A	N3	Member Residence Street Address			IHCP Note: This segment contains the member's street address as submitted to DXC by ICES. DXC does not have system editing for addresses.
69	2100A	N4	Member City, State, ZIP Code			IHCP Note: This segment contains the member's city, state, ZIP Code and county code information as reported to DXC by ICES. DXC does not perform validation for City, State, ZIP, and county code mismatches. If the record is sent to DXC from ICES with a ZIP that doesn't match the city, it's reported as received and not "cleaned up."
70	2100A	N406	Location Identifier			IHCP Note: This is the county code of the member's residence. Members may be assigned to a region other than their home region. Capitation reimbursement is based on the member's home region, regardless of the region they are assigned to. Note: the county code is entered into ICES by DFR and passed to DXC. DXC does not validate county codes for mismatches.
71	2100A	DMG	Member Demographics			
72	2100A	DMG05	Composite Race or Ethnicity Information			**HIP/PEPW/HPE – Adult *PEPW will be phased out beginning in 2018** The race/ethnicity code will be sent when received from ICES
79	2100A	ICM	Member Income			**HIP/HHW/HCC** Member income is returned when received from ICES.
		ICM01	Frequency Code			**4-Monthly**
		ICM02	Monetary Amount			
81	2100A	AMT	Member Policy Amounts			**HHW/CS/HCC/PEPW *PEPW will be phased out beginning in 2018** Not sent in the Hoosier Healthwise or Presumptive Eligibility 834s.
81	2100A	AMT01	Amount Qualifier	B9		**HIP**

			Code	D2		B9 – Conditionally eligible - used to qualify the member's outstanding debt. D2 – Used to qualify the member's monthly POWER account contribution.
81	2100A	AMT02	Monetary Amount			**HIP** Will contain the dollar amount of the member's monthly POWER account contribution or outstanding debt amounts.
84	2100A	LUI	Member Language			
85	2100A	LUI02	Identification Code	SPA		IHCP only supports code SPA when the member's native language is Spanish
86	2100B	NM1	Incorrect Member Name			**HIP** Only sent on HIP 834s when applicable
89	2100B	DMG	Incorrect Member Demographics			**HIP** Only sent on HIP 834s when applicable
140	2300	HD	Health Coverage			**HHW/CS/HCC** A second situational loop provides the Hoosier Healthwise Open Enrollment status. This status indicates whether the member is in an open enrollment period or not. An open enrollment status of "O" means the member is allowed to change MCEs without cause. An open enrollment status of "C" requires a just cause to change MCEs. **HIP** A second situational loop provides the HIP Potential Plus status for fully eligible members. If present, indicates the member is eligible for the HIP Plus benefit. The member's Plus category, FPL, POWER account amount, and the effective date of the potential plus segment are specified. New and ongoing segments use code 030 and include the effective date of the potential plus segment (DTP 348) and the end date of potential plus segment (DTP 348). HIP Potential Plus Example for a new or ongoing potential plus segment: HD*030**HLT*RP110*IND~ DTP*348*D8*20150401~ AMT*P3*1~ HIP Potential Plus example for a termed potential plus segment: HD*024**HLT*RP110*IND~ DTP*348*D8*20150401~ DTP*348*D8*20150520~ AMT*P3* **FTE** Applicant is on fast track for eligibility determination in HIP or other aid category

140	2300	HD01	Maintenance Type Code			**HHW/CS/HCC/PACE** Possible codes and descriptions: 001 – Change - represents a change to a member's active enrollment status and/or data specific to the member. 021 – Addition - represents a new member notification. 024 – Cancellation or Termination - represents a member termination notification. IHCP does not use Cancellation terminology. 030 – Audit or Compare - represents a verification file for the member Deletion code 002 is not used. A deletion is indicated when INS03 = 024 and INS04 = NULL. **PEPW *PEPW will be phased out beginning in 2018** Possible codes and descriptions: 001 – Change 002 - Delete 021 – Addition 024 – Cancellation or Termination 030 – Audit or Compare **HIP** Possible codes and descriptions: 001 – Change - indicates either a change to/from HIP plan, or a change to the member's plan (eligibility dates or capitation category) with the current insurer. The type of change will be specified in HD04. 021 – Addition 024 – Cancellation or Termination 030 – Audit or Compare **HPE - Adult** Possible codes and descriptions: 001 – Change 021 – Addition 024 – Cancellation or Termination 030 – Audit or Compare
141	2300	HD03	Insurance Line Code	HLT		IHCP uses code HLT
141	2300	HD04	Plan Coverage Description			With the exception of CS, concatenated information data is separated by a Pipe Delimiter character of | **HHW/CS/HCC** The plan coverage description is made up of the following concatenated information: VALID CAPITATION CODES - two characters A1 – Pkg A Preschool Ages 1-5 A6 – Pkg A Child Ages 6-12

						AF – MAGI Pkg A/B/P Adult Females Ages 19-above AM – MAGI Pkg A Adult Males Ages 19-above C1 – Pkg C Preschool Ages 1-5 C6 – Pkg C Child Ages 6-12 CN – Pkg C Newborns CT – Pkg C Teens Ages 13-18 D1 – HCC Adult Member 21 and over D2 – HCC Member under 21 D3 – HCC Member Dual Medicare D4 – DCS Involved Youths (MA 4,8,14,15) NB – Pkg A Newborns TN – MAGI Pkg A/B/P Teens Ages 13-18 U1 – Pkg A MA-U Preschool Ages 1-5 U6 – Pkg A MA-U Child Ages 6-12 UD – Pkg A MA-U Delivery Payment UF – Pkg A MA-U Females UM – Pkg A MA-U Males UN – Pkg A MA-U Newborns UT – Pkg A MA-U Teens Ages 13-20 TF – Pkg A Transitional Adult Females TM - Pkg A Transitional Adult Males PH – Pkg A Pregnancy **PACE** VALID CAPITATION CODES PA – PACE Non-Dual Eligible PB – PACE Pre-65 – Dual Eligible PC – PACE Post-65 – Dual Eligible Capitation category may be blank for Pkg C members if they turn 19 during the final month of enrollment. VALID BENEFIT PACKAGE INDICATORS - one character A – Standard Coverage B – Pregnancy Coverage C – Child Health Plan P – Presumptive Eligibility Coverage for Pregnant Women VALID AUTO ASSIGNMENT INDICATORS - one character Y – Yes N – N o Not applicable in this position for Hoosier Healthwise. See HHW Right Choices indicator location later in this section. Y – Yes N – No VALID AID CATEGORY CODES - two characters - one character codes are right justified.

						1 – Children age < 19 who meet TANF income stds 2 – Children ages 6-19 under 100% FPL 9 – Children age 1-19 up to 150% poverty (CHIP I) C – Low Income Families F – Transitional Medical Assistance GF – MAGI Parent/Caretaker of Relative ages 19-over GP – MAGI Pregnancy 208% or under FPL H – Ineligible for AFDC due to deemed income M – Pregnancy – Full Coverage N – Pregnancy - Related Coverage S – Ineligible for AFDC due to sibling income T – Children age18,19,20 living w/specified relative U – Ineligible for TANF due to SSI payments X – Newborn – infants born to Medicaid recipients Y – Children age<1 under 150% FPL Z – Children ages 1-5 under 133% FPL 10 – Hoosier Healthwise-Package C-Children's Health Plan AID CATEGORY CODES FOR HCC A – Aged B – Blind D – Disabled SI – Supplemental Social Security Income DI – Working Disabled MED Works Improved DW – Working Disabled MED Works Applicable AID Categories that have the option to Opt In to HCC 4 – Title IVE Foster Children under 18 8 – Children Receiving Adoption Assistance 14 – Former Foster Children (ages 18 < 21) < 200% FPL 15 – Former Foster Children (ages 18<26) AID CATEGORY CODES FOR PACE PA – PACE START REASON CODES - two characters STOP REASON CODES - two characters 01 Approved Change 02 New Eligible 03 6 Month PMP change 04 Newborn auto-assign change 05 Member Initiated – MCE Disenrollment 06 Redetermination 07 Death 08 Disenroll from Managed Care 09 Expired Managed Care Segment 10 PCCM Voluntary PMP Disenroll 11 MCE Voluntary PMP Disenroll 12 PCCM Mandatory PMP Disenroll 13 MCE Mandatory PMP Disenroll 14 MCE dsnrl – PMP moved to oth MCE plan

						15 MCE dsnrl – PMP moved to PCCM 16 MCE dsnrl – PMP dsnrl from program 17 MCE PMP moved to another MCE plan 18 MCE PMP moved to PCCM 19 PCCM PMP moved to an MCE plan 20 Auto Assigned – Newborn (Mom PMP) 21 Auto Assigned – Case Assignment 22 Auto Assigned – Previous PMP 23 Auto Assigned – Default Distance 24 Auto Assigned – PCCM PMP Disenrolled 25 Auto Assigned – MCE PMkP Disenrolled 26 Auto Assigned – Newborn Preselection 27 HHPD – Other 28 Auto Assigned – Redetermination 29 Auto Assigned – Lockin – Previous PMP 2A Auto Assigned – Newborn Case (Mom MCE) 2B Auto Assigned – Newborn Group (Mom MCE) 2C Auto Assigned – Newborn Distance (Mom MCE Network) 2D Auto Assigned – Newborn Other (Mom MCE Network) 2E Auto Assigned – Newborn County (Mom MCE Network) 2F Auto Assigned – Newborn Distance (Mom MCE) 2G Auto Assigned – Newborn Other (Mom MCE) 2H Auto Assigned – Newborn County (Mom MCE) 2I Auto Assigned – Default Other 2J Auto Assigned – Default County 2K Auto Assigned – Previous PMP Group Location 2L Auto Assigned – Previous PMP Other Location 2M Auto Assigned – Previous MCE Case PMP 2N Auto Assigned – Previous MCE Case Group-Mbr PMP 2O Auto Assigned – Previous MCE Network Distance 2P Auto Assigned – Previous MCE Network Other 2Q Auto Assigned – Previous MCE Distance 2R Auto Assigned – Previous MCE Other 2S Auto Assigned – Case Group Assignment 2T Auto Assigned – Lockin – Previous PMP Group 2U Auto Assigned – Lockin – Previous MCE 2V Auto Assigned – Lockin – Case Assignment 2W Auto Assigned – Lockin – Default 2X Previous PMP <2 month auto-assignment 30 Voluntary county enrollment 31 Aprvd. Chng. – Member Choice Auto Assignment 33 Aprvd. Chng. – Untimely Communication 35 Aprvd. Chng. – PMP Panel Full 3A Auto Assigned – Previous MCE 3B Auto Assigned – Companion Case ID 3C Auto Assigned – Previous RCP 3D Auto Assigned – Spouse (HIP) 3F Auto Assigned – Newborn (MOM MCE) 3G Auto Assigned – Member Choice 3Q HPE Dsnrl – MCE PMP Svc Location No Longer Active 3R HPE Dsnrl – Prov. Medicaid Eligibility Terminated 3S HPE Dsnrl – Group Medicaid Eligibility Terminated 3T HPE Dsnrl – PMP Service Location No Longer Active 3U HPE Dsnrl – PMP Group Svc Location No Longer Active

						3V HPE Dsnrl – PMP no longer practices at this Svc Loc 3W MCE Dsnrl – PMP no longer practices at this Svc Loc 3X MCE Dsnrl – PMP no longer contracted with MCE 3Y MCE Dsnrl – PMP not in managed care at this Svc Loc 3Z MCE Dsnrl – PMP deceased 40 Aprvd. Chng. – PCCM PMP Disenrolled 41 Aprvd. Chng. – MCE PMP Disenrolled 42 Aprvd. Chng. – Error in Assignment 43 Aprvd. Chng. – MCE Ancillary Service Access Issues 44 Aprvd. Chng. – PCCM Ancillary Svc Access Issues 45 Aprvd. Chng. – Quality of Service Issues 46 Aprvd. Chng. – Third Party Liability 47 Aprvd. Chng. – Network Limitations 50 Aprvd. Chng. – Inconvenient Location 51 Aprvd. Chng. – Member Moved 52 Aprvd. Chng. – Transportation Problems 53 Aprvd. Chng. – Appointment Delays 54 Aprvd. Chng. – Office Waiting Time 55 Aprvd. Chng. – Treatment by staff 56 Aprvd. Chng. – Unsatisfactory Communication 57 Aprvd. Chng. – Unsatisfactory quality of care 58 Aprvd. Chng. – Unsatisfactory emergency response 59 Aprvd. Chng. – Unable to obtain referral 60 Aprvd. Chng. – Insufficient after-hours coverage 61 Aprvd. Chng. – Physician no longer Medicaid 62 Aprvd. Chng. – Physician no longer in practice 63 Aprvd. Chng. – Physician Patient rltnshp unacpt 64 Aprvd. Chng. – Med condition not approp to pvdr 65 Aprvd. Chng. – Physician Requests Member Reassign 66 Aprvd. Chng. – Speclty not consistent with cond. 67 Aprvd. Chng. – Preg. Related – ante-partum change 68 Aprvd. Chng. – Preg. Related – post-partum change 69 Aprvd. Chng. – Other 70 Disenroll – ICES County Change 71 Disenroll – Residency Change 72 Disenroll – Third Party Liability Issues 73 Disenroll – Continuity of Care Issues 74 Disenroll – Member Determined to be Illegal Alien 75 Disenroll – Member Eligible for Waiver Program 76 Disenroll – Member Choice – Ward or Foster Child 77 Disenroll – Network Limitations 78 Disenroll – More than one RID # linked from ICES 79 Disenroll – Member became Eligible for Hospice 80 Disenroll – Member Ineligible Due To Age 81 Eligibility was Terminated 82 PMP DSNRL/REENR-Individ to Group loc 83 PMP DSNRL/REENR-Group to individ loc 84 PMP DSNRL/REENR-individ to diff individ loc 85 PMP DSNRL/REENR-group to diff group loc 86 Manual Reassignment 87 MCE Mass Change 88 JC-Lack of Medical Services 89 JC-MCO non-covered for moral or religious reasons

						90 JC-Member risk related serv not avail MCO network 91 JC-lack access provider for mbr health care need 92 JC-Poor quality of care 93 JC-Family member change 94 Annual Enrollment 95 JC Self Select <= 2 month break eligibility 98 Disenroll – Ineligible for Auto Assignment 99 Open A1 MCE Auto Assigned – Previous PMP A2 MCE Auto Assigned – Case ID PMP A3 MCE Auto Assigned – PMP in Previous Group A4 MCE Auto Assigned – Case ID in Previous Group A5 MCE Default Auto Assignment A6 MCE PMP Disenrolled A7 MCE Member Request A8 MCE PMP Initiated A9 MCE Approved Change – PMP Panel Full RA HHW Manual Retroactive Assignment Start RB HHW Manual Retroactive Assignment Stop RC HCC Manual Retroactive Assignment Start RD HCC Manual Retroactive Assignment Stop VALID RIGHT CHOICES PROGRAM INDICATORS FOR HOOSIER HEALTHWISE Y – Yes N – No PMP DIRECTORY INDICATOR Member wants a paper directory of providers. An N is reported for members who specify No directory, or for members who do not answer the directory question on the application. Y – Yes N – No MEMBER'S RESIDENCE REGION CODE The last digit of HD04 is the member's residence region code. HHW and HCC values used - 1 through 9 with the zero indicating that the member's residence region code is not available. PACE value used - 'S' FEDERAL POVERTY LEVEL – three character FPL percentage is sent when on file HOOSIER HEALTHWISE OPEN ENROLLMENT PERIOD STATUS – one character. Not applicable for HIP or PACE Value for HD04 in an additional 2300 loop O Open – Member is in their free-change period to change MCEs without cause C Closed – Member cannot change MCEs unless they have

						just-cause, as verified and approved by the Enrollment Broker HOOSIER CARE CONNECT FROM/TO MCE This code indicates the plan the member is transferring from when maintenance type and reason is 021/Null. The code indicates the plan the member is transferring to when maintenance type and reason code is 024/07. ANTH – Anthem MDWI – MDwise MHS – MHS **PEPW *PEPW will be phased out beginning in 2018** The plan coverage description is made up of the following concatenated information: Concatenated information data is separated by a Pipe Delimiter character of | Valid Capitation Codes - two characters A6 – Pkg A Child Ages 6-12 PH – Pkg A/B Adult Females TN – Pkg A/B Teens Ages 13-20 Valid Benefit Package Indicators - one character A – Standard Coverage B – Pregnancy Coverage C – Child Health Plan P – Presumptive Eligibility Valid Auto Assignment Indicators - one character N – No Limited to the value of N for Presumptive Eligibility, PE members must choose their plan immediately. Valid Aid category - two characters - one character codes are right justified M – Pregnancy – Full Coverage N – Pregnancy – Related Coverage PE – Presumptive Eligibility (This aid category will be phased out beginning in 2018) Start and Stop Reason Codes Start Reason Code, two characters Stop Reason Code, two characters 01 Approved Change 02 New Eligible 03 6 Month PMP change 04 Newborn auto-assign change

						05 Member Initiated – MCE Disenrollment 06 Redetermination 07 Death 08 Disenroll from Managed Care 09 Expired Managed Care Segment 10 PCCM Voluntary PMP Disenroll 11 MCE Voluntary PMP Disenroll 12 PCCM Mandatory PMP Disenroll 13 MCE Mandatory PMP Disenroll 14 MCE dsnrl – PMP moved to oth MCE plan 15 MCE dsnrl – PMP moved to PCCM 16 MCE dsnrl – PMP dsnrl from program 17 MCE PMP moved to another MCE plan 18 MCE PMP moved to PCCM 19 PCCM PMP moved to an MCE plan 30 Voluntary county enrollment 31 Aprvd. Chng. – Member Choice Auto Assignment 33 Aprvd. Chng. – Untimely Communication 35 Aprvd. Chng. – PMP Panel Full 40 Aprvd. Chng. – PCCM PMP Disenrolled 41 Aprvd. Chng. – MCE PMP Disenrolled 42 Aprvd. Chng. – Error in Assignment 43 Aprvd. Chng. – MCE Ancillary Service Access Issues 44 Aprvd. Chng. – PCCM Ancillary Svc Access Issues 45 Aprvd. Chng. – Quality of Service Issues 46 Aprvd. Chng. – Third Party Liability 47 Aprvd. Chng. – Network Limitations 50 Aprvd. Chng. – Inconvenient Location 51 Aprvd. Chng. – Member Moved 52 Aprvd. Chng. – Transportation Problems 53 Aprvd. Chng. – Appointment Delays 54 Aprvd. Chng. – Office Waiting Time 55 Aprvd. Chng. – Treatment by staff 56 Aprvd. Chng. – Unsatisfactory Communication 57 Aprvd. Chng. – Unsatisfactory quality of care 58 Aprvd. Chng. – Unsatisfactory emergency response 59 Aprvd. Chng. – Unable to obtain referral 60 Aprvd. Chng. – Insufficient after-hours coverage 61 Aprvd. Chng. – Physician no longer Medicaid 62 Aprvd. Chng. – Physician no longer in practice 63 Aprvd. Chng. – Physician Patient rltnshp unacpt 64 Aprvd. Chng. – Med condition not approp to pvdr 65 Aprvd. Chng. – Physician Requests Member Reassign 66 Aprvd. Chng. – Speclty not consistent with cond. 67 Aprvd. Chng. – Preg. Related – ante-partum change 68 Aprvd. Chng. – Preg. Related – post-partum change 69 Aprvd. Chng. – Other 70 Disenroll – ICES County Change 71 Disenroll – Residency Change 72 Disenroll – Third Party Liability Issues 73 Disenroll – Continuity of Care Issues 74 Disenroll – Member Determined to be Illegal Alien 75 Disenroll – Member Eligible for Waiver Program

						76 Disenroll – Member Choice – Ward or Foster Child 77 Disenroll – Network Limitations 78 Disenroll – More than one RID # linked from ICES 79 Disenroll – Member became Eligible for Hospice 80 Disenroll – Member Ineligible Due To Age 81 Eligibility was Terminated 82 PMP DSNRL/REENR-Individ to Group loc 83 PMP DSNRL/REENR-Group to individ loc 84 PMP DSNRL/REENR-individ to diff individ loc 85 PMP DSNRL/REENR-group to diff group loc 86 Manual Reassignment 87 MCE Mass Change 98 Disenroll – Ineligible for Auto Assignment 99 Open **MEMBER'S RESIDENCE REGION CODE** Not applicable for HIP. The last digit of HD04 is the member's residence region code. Values used - 0 thru 8 with the zero indicating that the member's residence region code is not available. **HIP** The plan coverage description is made up of the following concatenated information: Concatenated information data is separated by a Pipe Delimiter character of | **Conditionally Eligible** Member Aid Category **–** two character RP HIP Plus SP HIP Plus – State Plan RB HIP Basic SB HIP Basic – State Plan **Federal Poverty Level percentage** – three character FPL percentage **Fully Eligible** Member Aid Category **–** two character RP HIP Plus SP HIP Plus – State Plan RB HIP Basic SB HIP Basic – State Plan PC HIP Plus Co-Pay MA HIP Maternity VALID Capitation Code – 2 characters BZ MA-RB Male Age 18 R1 MA-RB Male Ages 19-24 R2 MA-RB Male Ages 25-34 R3 MA-RB Male Ages 35-44 R4 MA-RB Male Ages 45-54 R5 MA-RB Male Ages 55-64 BY MA-RB Female Age 18

						R6 MA-RB Female Ages 19-24 R7 MA-RB Female Ages 25-34 R8 MA-RB Female Ages 35-44 R9 MA-RB Female Ages 45-54 RX MA-RB Female Ages 55-64 RZ MA-RP Male Age 18 P1 MA-RP Male Ages 19-24 P2 MA-RP Male Ages 25-34 P3 MA-RP Male Ages 35-44 P4 MA-RP Male Ages 45-54 P5 MA-RP Male Ages 55-64 RY MA-RP Female Age 18 P6 MA-RP Female Ages 19-24 P7 MA-RP Female Ages 25-34 P8 MA-RP Female Ages 35-44 P9 MA-RP Female Ages 45-54 PX MA-RP Female Ages 55-64 SZ MA-SB Male Age 18 B1 MA-SB Male Ages 19-24 B2 MA-SB Male Ages 25-34 B3 MA-SB Male Ages 35-44 B4 MA-SB Male Ages 45-54 B5 MA-SB Male Ages 55-64 SY MA-SB Female Age 18 B6 MA-SB Female Ages 19-24 B7 MA-SB Female Ages 25-34 B8 MA-SB Female Ages 35-44 B9 MA-SB Female Ages 45-54 BX MA-SB Female Ages 55-64 PZ MA-SP Male Age 18 S1 MA-SP Male Ages 19-24 S2 MA-SP Male Ages 25-34 S3 MA-SP Male Ages 35-44 S4 MA-SP Male Ages 45-54 S5 MA-SP Male Ages 55-64 PY MA-SP Female Age 18 S6 MA-SP Female Ages 19-24 S7 MA-SP Female Ages 25-34 S8 MA-SP Female Ages 35-44 S9 MA-SP Female Ages 45-54 SX MA-SP Female Ages 55-64 FB-Medically Frail MASB FP-Medically Frail MASP DM – MAMA HIP Delivery Case Rate PM – MAMA Pregnancy MY – MAMA Pregnancy Female Age 18 PR-Regular HIP pregnancy indicator PS-State HIP pregnancy indicator Start Reason Codes – two characters Stop Reason Codes – two characters 07 – Death

						50 – ICES Termination 81 – Eligibility was Terminated 99 – Open 3Q – HPE Dsnrl-MCE PMP Svc Location No Longer Active 3R – HPE Dsnrl-Prov. Medicaid Eligibility Terminated 3S – HPE Dsnrl-Group Medicaid Eligibility Terminated 3T – HPE Dsnrl – PMP Svc Location No Longer Active 3U – HPE Dsnrl-PMP Group Mbr Location No Longer Active 3V – HPE Dsnrl-PMP No Longer Practices at this Svc Location 3W – MCE Dsnrl-PMP No Longer Practices at this Svc Location 3X – MCE Dsnrl-PMP No Longer Contracted With MCE 3Y – MCE Dsnrl-PMP not in Managed Care at this Svc Location 3Z – MCE dsnrl-PMP deceased A1 – MCE Auto Assigned-Previous PMP A2 – MCE Auto Assigned-Case ID PMP A3 – MCE Auto Assigned-PMP in Previous Group A4 – MCE Auto Assigned-Case ID in Previous Group A5 – MCE Default Auto Assignment A6 – MCE PMP Disenrolled A7 – MCE Member Request A8 – MCE PMP Initiated A9 – MCE Approved Change-PMP Panel Full AA – Auto Assign-Default AB – Auto Assign-Previous Insurer HIP AC – Auto Assign-Previous Insurer HHW AD – Auto Assign-Spouse HIP AE – Auto Assign-Spouse HHW AF – Auto Assign-Case HIP AG – Auto Assign-Case HHW AH – Auto Assign-Companion Case HHW AP – Auto Assigned-Previous Insurer AR – Auto Assigned-Rotation AS – Auto Assigned-Spouse CS – COVID19 Eligibility (Start Code) CT – COVID19 Eligibility (Stop Code) EB – Enrollment Broker Assisted EC – Eligibility Change ER – Eligibility Restored with Retro Date ET – Eligibility Terminated F1 – Failure To Cooperate In Verifying Income F2 – Failure To Provide All Required Information F3 – Unable To Locate Assistance Group F4 – Failure To Verify Indiana Residency F5 – Failure To Cooperate In Verifying Age Composition F6 – Failure To Cooperate With Dfr In Obtaining Med Info F7 – Failure To Apply For Benefits To Which You May Be Entitled F8 – Fail To Complete Req Personal Interview On Non-Magi App F9 – Failure To Provide Required Proof Citizenship FA – Failure To Cooperate In Verifying The Value Of

						FB – Mail Sent To Last Known Address Returned as Undeliverable FR-Member Failed Redetermin FX – Fixed Record GS – HIP GTW Suspension HA – HIP Reassign Current Year Lock In (For System-use only) HB – HIP Bridge Eligibility HJ – HIP Lock-in Just Cause Transfer (For EB-use only) HL– HIP Lock-in Current Calendar Year (For System-use only) HP – HIP Lock-in Prior Calendar Year (For System-use only) HT – HIP Current Year Lock-in Transfer (For EB-use only) JA – Non-Payment of a Conditional-Term JG – Member Redetermination Same Plan JH – Member Redetermination Different Plan JL – HIP LINK Employer-Sponsored Insurance Status Terminated JM – Individual Not Eligible for Employer-Sponsored Insurance MA – Moved to Active Enrollment MM – TMA Member with Potential Rollover MP-Member Did Not Return Packet for Processing MS-Member Selection on Application MT – HIP Member moving to TMA NF – Non-Payment of Fast Track NP – Non Payment OA – Over Age Limit OH – Other Health Insurance Obtained OI – Member Over Income OS – Out of State Relocation PC – Plan Change – With Cause PP – Plan Change for Payment VW – Voluntary Withdrawal XA – Appeal Federal Poverty Level percentage - three character percentage sent when present Right Choices Program Indicator Y – Yes N – No PMP DIRECTORY INDICATOR Member wants a paper directory of providers Y – Yes N – No An N is reported for members who specify No directory, or for members who do not answer the directory question on the application. Plan or aid category changing from/to: CTG CHG-DIS – Member terminated from HIP and moved to Disability aid category.

						CTG CHG-PREG – Member terminated from HIP and moved to Pregnancy aid category. NEW DATES – Member's eligibility start and/or end date has changed during their benefit period. New dates will be sent in the subsequent DTP segments. NEW CAP – Member's capitation category has changed during their benefit period. FPL – Member's federal poverty level has changed during their benefit period. RE-FAILS REDETERM – Member did not successfully redeterm. ELIG CHANGE – Member's HIP eligibility is retro replaced, usually by another Medicaid program. DEATH – Member is retro termed from HIP due to date of death precedes HIP eligibility. The following will have the abbreviated four character plan name with a space preceding: * ANTH – Anthem * MDWI – MDwise * MANA - MHS * CARE - CareSource RE-PLAN2PLAN – Member is changing from one HIP plan to another during redetermination period. RE-SAME PLAN – Member successfully redetermed PLAN2PLAN – Member is changing from one HIP plan to another during their benefit period. HIPLINK – Member is moving to HIP 2 From HIP LINK HCC PLAN2PLAN – Member is changing from one HCC plan to another HIP Potential Plus Loop (second HD segment on a fully eligible) Member Plus Aid Category – two character RP HIP Plus SP HIP Plus – State Plan Federal Poverty Level percentage – three character FPL percentage **HPE – ADULT** The plan coverage description is made up of the following concatenated information: Concatenated information data is separated by a Pipe Delimiter character of | **Valid Aid category – two characters** HA – Hospital Presumptive Eligibility Adult XX – HPE Zero Capitation **Valid Capitation Codes - two characters**

						AP – HPE Adult HX – MA-XX Members Valid Auto Assignment Indicators – one character N – No **Start and Stop Reason Codes** **Reason Codes, two characters** HS – HPE Adult – MCE Self Selection HR – HPE Adult – MCE Rotational Assignment 81 – Eligibility Terminated 99 – Open EC – Eligibility Change ET – Eligibility Terminated **FTE** FTE – Fast Track Eligible
142	2300	HD05	Coverage Level Code			**HHW/CS/HCC/PACE** Possible codes and descriptions: IND – always the coverage level code value for the first 2300 loop. **PEPW/FTE *PEPW will be phased out beginning in 2018** Possible code and description: IND – Individual **HIP** Possible code and description: IND – always the coverage level code value for the first 2300 loop. **HPE – ADULT** Possible code and description: IND – always the coverage level code value for the first 2300 loop.
143	2300	DTP	Health Coverage Dates			**HHW/CS/HCC/PACE** 1. This segment contains the dates of health coverage for the IHCP member and the corresponding network. 2. The second situational segment provides the Hoosier Healthwise Open Enrollment dates. **PEPW *PEPW will be phased out beginning in 2018** This segment contains the dates of health coverage for the IHCP member and the corresponding PMP. **HIP** 1. This segment contains the dates of health coverage for the IHCP. 2. A second situational Health Coverage Loop provides the Potential Plus status dates.

						HPE – ADULT This segment contains the dates of health coverage for the IHCP. **FTE** This segment contains the date for fast track eligibility status
143	2300	DTP01	Date/TimeQualifier			**HHW/HCC/PACE** 303 – Maintenance Effective, not applicable for PACE 1st set of positional date ranges are for PMP Assignment: Qualifier pairs 348/348 - used as date ranges for additions and changes. Qualifier pairs 348/349 - used as date ranges for terminations and deletions. 2nd set of positional date ranges are for Aid Category Eligibility: Qualifier pairs 348/348 - used as date ranges for additions and changes. Qualifier pairs 348/349 - used as date ranges for terminations and deletions 1. Qualifier 303 is used when the Benefit Package Indicator has changed. Indicates the date the newly reported benefit package becomes effective. This typically applies to members who change from Package C to Package A/B. The effective date of the change is based on a change to the member's aid category, and can be retroactive. 2. Qualifiers 303 and 348 could exist at the same time for changes only. OPEN ENROLLMENT (OE) STATUS LOOP ONLY (Open Enrollment does not apply to HIP) 1st 348 = beginning of OE period for the member (Effective date of when the member is allowed to change MCEs without cause) 2nd 348 = end of OE for the member (Last date the member can change their MCE without cause) 3rd 348 = end of annual OE period (End date of the member's enrollment period with their current MCE) **CS** 303 – Maintenance Effective 348 – Benefit Begin 349 – Benefit End 1. Qualifier 303 is used when the Benefit Package Indicator has changed. Indicates the date the newly reported benefit package becomes effective. This typically applies to members who change from Package C to Package A/B. The effective date of the change is based on a change to the member's aid category, and can be retroactive. 2. Qualifier 348 is used for additions and changes. 3. Qualifier 349 is used for terminations and deletions. 4. Qualifiers 303 and 348 could exist at the same time for changes only.

						PEPW *PEPW will be phased out beginning in 2018 1st set of positional date ranges are for PMP Assignment. Qualifier pairs 348/348 – used as date ranges for additions and changes. Qualifier pairs 348/349 – used as date ranges for terminations and deletions. 2nd set of positional date ranges are for Aid Category Eligibility: Qualifier pairs 348/348 – used as date ranges for additions and changes. Qualifier pairs 348/349 – used as date ranges for terminations and deletions. **HIP** Conditionally Eligible Qualifier 348 – used for eligible start date Qualifier 348/349 – used for eligible date range on terms (HD01 = 024) Fully Eligible 1st set of positional date ranges are for PMP Assignment. Qualifier pairs 348/348 – used as date ranges for additions and changes. Qualifier pairs 348/349 – used as date ranges for terminations and deletions. 2nd set of positional date ranges are for Aid Category Eligibility: Qualifier pairs 348/348 – used as date ranges for additions and changes. Qualifier pairs 348/349 – used as date ranges for terminations and deletions. 3rd set of positional date ranges are for Benefit Period Qualifier pairs 348/348 – used as date ranges for additions and changes. Qualifier pairs 348/349 – used as date ranges for terminations and deletions. The 348/348 date range for a member's PMP Assignment dates reflects initially the MCE/placeholder assignment effective date to be reported. The transaction will then report any subsequent PMP assignment effective date ranges. POTENTIAL PLUS LOOP Qualifier 348 = ICES authorization date Qualifier 349 = end date of Potential Plus status. Only sent when HD01 = 024 **HPE - ADULT** 1st set of positional date ranges are for PMP Assignment. Qualifier pairs 348/348 – used as date ranges for additions and changes.

						Qualifier pairs 348/349 – used as date ranges for terminations and deletions. 2nd set of positional date ranges are for Aid Category Eligibility: Qualifier pairs 348/348 – used as date ranges for additions and changes. Qualifier pairs 348/349 – used as date ranges for terminations and deletions. **FTE** Qualifier 348 – used for eligible start date status Qualifier 348/349 – used for eligible date range status on terms (HD01=024)
145	2300	AMT	Member Policy Amounts			**HIP** Sent on situational second HD loop that indicates Potential Plus status.
145	2300	AMT01	Amount Qualifier Code	FK P3		**HIP** FK – Potential Plus - Member Income P3 – Potential Plus POWER account member contribution
145	2300	AMT02	Monetary Amount			Will contain the dollar amount of the member's monthly POWER account contribution and income
146	2300	REF	Health Coverage Policy Number			IHCP sends up to two identifiers. 1. If the PMP provider is atypical, then the LPI will be presented in the first segment. Otherwise, the PMP provider tax ID will be present in the first segment. 2. If a PMP exists as part of a group, then the group's provider identifier will be presented in the second REF segment. PMP values, including placeholders, are reported on additions, changes and terminations.
146	2300	REF01	Reference Identification Qualifier	1L ZZ		IHCP uses codes 1L and ZZ
147	2300	REF02	Reference Identification			IHCP Note: 1. When an NPI has been reported for the member's PMP, their tax ID is sent with the "1L" qualifier. Note: When the tax ID is not on file, 999999999 is sent. 2. When a PMP has not yet been assigned to the member, 999999990 is sent. 3. When an NPI has been reported for the PMP group, their NPI is sent with the "ZZ" qualifier. 4. Health care PMP groups not reporting an NPI will receive the message "NOGROUPNPI" along with the "ZZ" qualifier. 5. When the group provider is atypical and an NPI is not reported, the LPI will be present.
152	2310	LX	Provider Information			

152	2310	LX01	Assigned Number			An IHCP member is assigned to only one PMP
153	2310	NM1	Provider Name			
153	2310	NM101	Entity Identifier Code	P3		IHCP only sends code P3 - Primary Care Provider
154	2310	NM102	Entity Type Qualifier	2		IHCP only sends code 2 - Non-Person Entity
155	2310	NM109	Identification Code			IHCP Note: 1. When an NPI has been reported for the member's PMP, their NPI is sent along with the "XX" qualifier. 2. When an NPI has not been reported for the member's PMP, the message "NO_PMP_NPI" is sent along with the "XX" qualifier. 3. Atypical providers that have not reported an NPI will receive their Social Security number or federal taxpayer ID. Note: When an ID is not on file, 999999999 is sent along with the "FI" qualifier.
164	2320	COB	Coordination of Benefits			**HHW/CS/HCC/PEPW/PACE *PEPW will be phased out beginning in 2018** IHCP sends the five most current policies if more than five exist. Not sent if a member does not have third party liability in *Core*MMIS. **HIP/HPE – Adult** Not sent in the Healthy Indiana Plan 834s
166	2320	REF	Additional Coordination of Benefits Identifiers			**HIP/HPE – Adult** Not sent in the Healthy Indiana Plan 834s
168	2320	DTP	Coordination of Benefits Eligibility Dates			**HIP/HPE – Adult** Not sent in the Healthy Indiana Plan 834s
169	2330	NM1	Coordination of Benefits Related Entity			**HIP/HPE – Adult** Not sent in the Healthy Indiana Plan 834s
176	2700	LS	Additional Reporting Categories			**HIP/HHW/FTE**
177	2710	LX	Member Reporting Categories			**Loop repeats for each of the indicators noted below.**
178	2750	N1	Reporting Category			

178	2750	N101	Entity Identifier Code	75		
178	2750	N102	Name			**HHW** **Indicator** Threshold PregnancyExpectedDueDate Pregnancy Ethnicity CurrentCapitationCode CurrentAssignmentStartCode CurrentAssignmentStopCode CurrentIncome FutureIncome Redetermination **HCC** **Indicators** Threshold NativeAmerican PregnancyExpectedDueDate Pregnancy CostShare FamilySize Ethnicity CurrentCapitationCode CurrentAssignmentStartCode CurrentAssignmentStopCode CurrentIncome FutureIncome Redetermination **HIP** **Indicators** **Conditional & Fully Eligible** MedicallyFrailStatus MedicallyFrail PregnancyExpectedDueDate Pregnancy BasicThreshold **Fully Eligible Only** NativeAmerican 19and20YearOld TransitionalMedicalAssistance LowIncomeParentorRelativeCaretaker CaretakerorNonCaretaker Appeal FutureAidCategory Power Account (current and future amounts, along with

						effective and end dates, when a member POWER account is about to change) RollOverDiscAmount RollOverDiscPercent CostShare Redetermination Tobacco (This indicator will be reported on every HIP fully eligible change record, as well as on the HIP fully eligible Audit file) FamilySize Ethnicity CurrentCapitationCode CurrentAssignmentStartCode CurrentAssignmentStopCode CurrentIncome FutureIncome **HPE – ADULT** **Indicators** EPSDT Refund FTEDifferentPlan ***Reporting Category Name*** EnrollingProvider EnrollingProviderZipPlus4 **FTE** **Indicators** Refund FTEDifferentPlan
178	2750	REF	Reporting Category Reference			
		REF01	Reference Identification Qualifier	ZZ 9V		**ZZ – Mutually Defined**
		REF02	Reference Identification			**HHW Indicator Codes** Ethnicity 00 – Not Hispanic or Latino 01 – Hispanic or Latino 09 – Unknown Capitation Codes See Plan Coverage section for values Assignment Start and Stop Codes

						See Plan Coverage section for values **HCC Indicator Codes** NativeAmerican Y – Yes N – No CostShare Y – CostShare / Copay Threshold has been met / Off N – CostShare / Copay Threshold has not been met / On Others Y – Yes N – No FamilySize A default value of zero ‘0’ will be reported for FamilySize if there is no Case ID Ethnicity 00 – Not Hispanic or Latino 01 – Hispanic or Latino 09 – Unknown Capitation Codes See Plan Coverage section for values Assignment Start and Stop Codes See Plan Coverage section for values **HIP Indicator Codes** FutureAidCategory RP – Regular Plus SP – State Plan Plus RB – Regular Basic SB – State Plan Basic PC – Plus Copay Caretaker or NonCaretaker C – Caretaker N – Non Caretaker U – Unknown Medically Frail Y – Confirmed Frail N – Confirmed Not Frail U – Unconfirmed Frail NativeAmerican Y – Yes

						N – No CostShare Y – CostShare / Copay Threshold has been met / Off N – CostShare / Copay Threshold has not been met / On Tobacco (A change to the Tobacco data alone will generate a change record) Y - Yes N – No R – Refused to answer U – Unknown (If there is no Tobacco data for the member, the 834 program will report a default of "U" with no corresponding dates) FamilySize A default value of zero '0' will be reported for FamilySize if there is no Case ID Ethnicity 00 – Not Hispanic or Latino 01 – Hispanic or Latino 09 – Unknown Others Y – Yes N – No Capitation Codes See Plan Coverage section for values Assignment Start and Stop Codes See Plan Coverage section for values **HPE – ADULT** Refund X – Default Y – Yes N – No FTEDifferentPlan X – Default – When the member is FTE only S – Same – When the member is both HPE and FTE and is assigned to the same MCE in both situations D – Different – When the member is both HPE and FTE and is assigned to different MCE's ***Reporting Category Name*** EnrollingProviderNPI EnrollingProviderZipPlus4

						NO_ENR_NPI – If NPI information is not found when doing the crosswalk, the "No Enrolling NPI Found" code will be returned **FTE** Refund X – Default Y – Yes N – No FTEDifferentPlan X – Default – When the member is FTE only S – Same – When the member is both HPE and FTE and is assigned to the same MCE in both situations D – Different – When the member is both HPE and FTE and is assigned to different MCE's **HHW** Pregnancy Indicator Y – Yes N - No
181	2750	DTP	Reporting Category Date			
181	2750	DTP01	Date/Time Qualifier	007		
181	2750	DTP02	Date Time Period Format Qualifier	D8 RD8		D8 is used with Pregnancy Expected Due Date, Medically Frail Status, Medically Frail, Future Aid Category and Redetermination Date. If there is no redetermination date for a member, a default date of 22991231 will be reported. A change to the redetermination date alone will generate a change record. RD8 is used with other indicators. The Tobacco indicator effective date may precede the effective date of the HIP member's eligibility. **HPE – Adult** **No dates will be sent** **FTE** **Dates are not applicable for FTE indicator(s)**
182	2750	DTP03	Date Time Period			

4 TI Additional Information

4.1 Business Scenarios

Not applicable

4.2 Payer Specific Business Rules and Limitations

All references to the IHCP in this Companion Guide refer to *Indiana Health Coverage Programs*.

All references to the IHCP provider number in this Companion Guide refer to the Indiana Health Coverage Programs Provider Identifier.

4.2.1 Hoosier Healthwise (HHW) / Hoosier Care Connect (HCC) / Program for All-inclusive Care for the Elderly (PACE)

4.2.1.1 Change File

4.2.1.1.1 Available daily – 7 days a week.

4.2.1.1.2 Change files represent updates to active member enrollment status and/or updates to member data since the last change file was provided.

4.2.1.2 Audit File

4.2.1.2.1 Available twice a month.

4.2.1.2.2 Includes Presumptive Eligibility (PE) members.

4.2.1.2.3 Consists of audit records only – INS03 with a value of 030.

4.2.1.2.4 The audit file is meant to be a verification file for the MCEs to compare data they received on change files.

4.2.1.3 Term Change File

4.2.1.3.1 The new HHW and HCC 834 Term Change File naming convention will be *TPID.834CT.DDD.HHMMSS.01.01.dat*

4.2.1.3.2 The new HHW AND HCC 834 Term Change File will generate on the 20th of every month.

4.2.1.3.3 The new HHW AND HCC 834 Term Change File will report the same data elements as the corresponding HHW and HCC Daily Files

4.2.1.3.4 The Term Change File will only include all termination types. It will NOT include voided termination (024/06).

4.2.1.3.5 PACE does not have a Term Change file

4.2.1.4 Term Audit File

4.2.1.4.1 The new HHW and HCC 834 Term Audit File naming convention will be *TPID.834AT.DDD.HHMMSS.01.01.dat*

4.2.1.4.2 The new HHW and HCC 834 Term Audit Files will generate on the 5th of every month.

4.2.1.4.3 The new HHW and HCC 834 Term Audit Files will include the same data elements as the HHW and HCC 834 Daily Term Records

4.2.1.4.4 The Term Audit Files will include all types of Termination and Void records.

4.2.1.4.5 PACE does not have a Term Audit file

4.2.1.5 File Naming Standard

Audit and change files will be differentiated by a letter code in the file name. The file naming standard is as follows:

- Node 1 – contains the receiver's IHCP trading partner ID
- Node 2 – contains the transaction ID (834) and type code.
  - A – Monthly audit file
  - C – Daily change file
  - CT – Monthly term change file
  - AT – Monthly term audit file
- Node 3 – File Creation Julian Date in DDD format
- Node 4 – File creation timestamp in HHMMSS format
- Node 5 – File Number

  Example: a change file for trading partner MCE1, created at 6:30pm on January 15th would be named MCE1.834C.015.183000.01.01.dat

4.2.2 Presumptive Eligibility for Pregnant Women (PEPW) *PEPW will be phased out beginning in 2018

4.2.3.1 Change File

4.2.3.1.1 Available daily – 7 days a week.

4.2.3.1.2 Change files represent updates to active member enrollment status and/or updates made to member data since the last change file was provided.

4.2.3.2 File Naming Standard

The file naming standard is as follows:

- Node 1 – contains the receiver's IHCP trading partner ID
- Node 2 – contains the transaction ID (834) and type code.
  - PEC – Daily change file
- Node 3 – File Creation Julian Date in DDD format
- Node 4 – File creation timestamp in HHMMSS format
- Node 5 – File Number

  Example: a file for trading partner MCE1, created at 1:30pm on January 10th would be named MCE1.834PEC.010.133000.01.01.dat

4.2.3 Healthy Indiana Plan (HIP)

4.2.4.1 Change File

4.2.4.1.1 Available daily – 7 days a week.

4.2.4.1.2 Separate change files are created for conditionally and fully eligible members.

4.2.4.1.3 Contains new members, withdrawn/terminated members and members whose information has changed since the last Change file was provided.

4.2.4.2 Audit File

4.2.4.2.1 Available once a month.

4.2.4.2.2 Consists of audit records only – INS03 with a value of 030.

4.2.4.2.3 Contains a current snapshot of the insurer's plan members.

4.2.4.2.4 The audit file is meant to be a verification file for the MCEs to compare data they received on change files.

4.2.4.3 Term Change File

4.2.4.3.1 The new HIP 834 Term Change File naming convention will be *TPID.834CT.DDD.HHMMSS.01.01.dat*

4.2.4.3.2 The new HIP 834 Term Change File will generate on the 20th of every month.

4.2.4.3.3 The new HIP 834 Term Change File will report the same data elements as the HIP Daily File

4.2.4.3.4 The Term Change File will only include all termination types. It will NOT include voided termination (024/06).

4.2.4.4 Term Audit File

4.2.4.4.1 The new HIP 834 Term Audit File naming convention will be *TPID.834AT.DDD.HHMMSS.01.01.dat*

4.2.4.4.2 The new HIP 834 Term Audit File will generate on the 5th of every month.

4.2.4.4.3 The new HIP 834 Term Audit File will include the same data elements as a HIP 834 Daily Term Records

4.2.4.4.4 The Term Audit File will include all types of Termination and Void records.

4.2.4.5 File Naming Standard

Audit and change files will be differentiated by a letter code in the file name. The file naming standard is as follows:

- Node 1 – contains the receiver's IHCP trading partner ID
- Node 2 – contains the transaction ID (834) and type code.
  - S – Daily change file – conditionally eligible members
  - T – Daily change file – fully eligible members
  - U – Monthly audit file – conditionally eligible members
  - V – Monthly audit file – fully eligible members
  - CT – Monthly term change file – fully eligible members
  - AT – Monthly term audit file – fully eligible members
- Node 3 – File Creation Julian Date in DDD format
- Node 4 – File creation timestamp in HHMMSS format
- Node 5 – File Number

  Example: a conditional change file for trading partner HIP1, created at 6:30pm on January 15th would be named HIP1.834S.015.183000.01.01.dat

4.2.4 Hospital Presumptive Eligibility for Adults (HPE Adult)4.2.4.1 Change File

4.2.5.1.1 Available daily – 7 days a week.
4.2.5.1.2 Change files represent updates to active member enrollment status and/or updates made to member data since the last change file was provided.

4.2.5.2 Audit File

4.2.5.2.1 Available once a month.
4.2.5.2.2 Consists of audit records only – INS03 with a value of 030.
4.2.5.2.3 Contains a current snapshot of the insurer's plan members.
4.2.5.2.4 The audit file is meant to be a verification file for the MCEs to compare data they received on change files.

4.2.5.3 File Naming Standard

The file naming standard is as follows:

- Node 1 – contains the receiver's IHCP trading partner ID
- Node 2 – contains the transaction ID (834) and type code.
  - HPC – Daily change file – fully eligible members
  - HPA – Monthly audit file – fully eligible members
- Node 3 – File Creation Julian Date in DDD format
- Node 4 – File creation timestamp in HHMMSS format
- Node 5 – File Number

  Example: a change file for trading partner MCE1, created at 1:30pm on January 10th would be named MCE1.834HPC.010.133000.01.01.dat

NOTE: HPE managed care will be phased out beginning 1/1/2019

4.2.5 Fast Track Eligibility (FTE) 4.2.6.1 Change File

4.2.6.1.1 Available daily – 7 days a week.
4.2.6.1.2 Contains new members, members who are being terminated, and members whose information has changed since the last Change file was provided.

4.2.6.2 Audit File

4.2.6.2.1 Available once a month.
4.2.6.2.2 Consists of audit records only – INS03 with a value of 030.
4.2.6.2.3 Contains a current snapshot of the insurer's plan members.
4.2.6.2.4 The audit file is meant to be a verification file for the MCEs to compare data they received on change files.

4.2.6.3 File Naming Standard

The file naming standard is as follows:

- Node 1 – contains the receiver's IHCP trading partner ID.
- Node 2 – contains the transactions ID (834) and type code.
  - Q – Daily Change file
  - R – Monthly Audit file
- Node 3 – File Creation Julian Date in DDD format
- Node 4 – File creation timestamp in HHMMSS format.
- Node 5 – File Number

Example: a change file for trading partner MCE1, created at 1:30pm on January 10th would be named MCE1.834Q.010.133000.01.01.dat

4.2.6 834 Summary Report

4.2.6.1 Available Daily – 7 days a week.
4.2.6.2 Contains summary of 834 transactions submitted for previous day.
4.2.6.3 File Naming Standard
The file naming standard is as follows:

- Node 1- contains the receiver's IHCP trading partner ID
- Node 2 – contains the transaction ID (834) and type code
  - RPT – Daily report file
- Node 3 – File creation Julian Date in DD format
- Node 4 – File creation timestamp in HHMMSS format

4.2.7 Interchange Control Header

4.2.7.1 Interchange Sender ID (ISA06) – Value is IHCP.
4.2.7.2 Interchange Receiver ID (ISA08) – This is the four-byte sender ID assigned by the IHCP.

4.2.8 Functional Group Header

4.2.8.1 Application Sender Code (GS02) – Value is IHCP.
4.2.8.2 Application Receiver's Code (GS03) – This is the four-byte sender ID assigned by the IHCP

4.3 Frequently Asked Questions

Not applicable

4.4 Other Resources

This section lists other references or resources.

DXC EDI Solutions
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204
Fax: (317) 488-5185
INXIXTradingPartner@dxc.com

Indiana Medicaid for Providers website
https://www.in.gov/medicaid/providers/index.html

Electronic Data Interchange (EDI) Solutions
https://www.in.gov/medicaid/providers/697.htm

IHCP Provider Manual
https://www.in.gov/medicaid/providers/453.htm

News, Bulletins and Banner pages
https://www.in.gov/medicaid/providers/737.htm

5 TI Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).

Version	CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed by
2.0			Jan 2013	Implemented	CAQH CORE format	Systems
2.1	2225	ACA Section 2001: MAGI Phase II	Jan 2014	Implemented	CO 2225 update	Systems
2.2	2433	HIP 2.0 Conversion New Applicant	July 2014	Implemented	CO 2433 HIP 2.0	Systems
3.0	2445	Hoosier Care Connect Aged Blind (HCC)	Feb 2015	Implemented	Pg. 4. Added Hoosier Care Connect (HCC) to 4.2.1 in Table of Contents Pg. 9. Added HCC to Legend Added 'HCC' to following segments: BGN02, REF02, INS03, INS04, INS06-01, REF, DTP01, PER06, PER08, ICM, AMT, HD, HD01, HD04, HD05, DTP loop2300, COB, N102 Added HCC Capitation Codes for segment HD04: D1, D2, D3, D4 Added HCC Aid Category Codes for segment HD04: A, B, D, SI, DI, DW Pg. 42. Added 'HCC' to 4.2.1	Systems
3.0	2453	HIP 2.0 Native Americans & FTE	Feb 2015	Implemented	Pg. 4. Added Fast Track Eligibility (FTE) to 4.2.6 in Table of Contents Pg. 9. Added FTE to Legend Added FTE headers to BGN02, REF02, INS03, HD05, DTP, LS INS04 – Added 'Add Maintenance Reason Codes' REF01, loop2000 – Added Reference ID Qualifier – 'ZZ' DTP01, loop2000 – Added 300 and 303 codes HD04 – Added FTE – Fast Track Eligible DTP01, loop2300 – Added 348 and 348/349 qualifier N1 – Added FTE Indicators Refund DTP, loop 2750 – Added 'Dates are not applicable for FTE indicator(s) Pg. 46 – Added Additional Information: 4.2.6	Systems
3.1	2453	HIP 2.0 Native Americans & FTE	Feb 2015	Implemented	Pg. 36. REF02, loop2750 – Added FTE Header, added 'X' as a default value for Add records and 'Y' and 'N' for Term records	Systems
3.2	2453	HIP 2.0 Native Americans & FTE	March 2015	Implemented	Pg. 14. INS04 – Update Maint. Reason Code '14' to state 'to indicate a member who has been denied.' Pg. 14. INS04 – Added Maint Reason Code '27' – When sent with INS03 = 021, indicates a new Fast Track Eligible member. Pg. 14. INS04 – Added Maint Reason Code '27' – When	Systems

					sent with INS03 = 024, indicates member is moving to HIP conditional. Pg. 14. INS04 – Added Maint Reason Code ‘29’ – Will be sent along with INS03 = 024 to indicate a member is moving to HIP Fully Eligible. Pg. 14 REF, loop2000 – Added ‘FTE’ header and text: Application ID is sent in this segment. A maximum of two additional REF segments may be sent with linked IHCP member IDs, listed most recent to least recent. Pg. 15 REF01, loop2000 – Replace ‘ZZ’ qualifier with ‘6O’ for Application ID – *Note 6-number O-letter for 6O qualifier* Pg. 15 REF01, loop2000 – Added ‘Q4’ qualifier – ‘Linked IHCP Member ID’	
3.3	2463	HIP 2.0 Fast Track Elig PE	April 2015	Implemented	Pg. 14. INS04 Loop2000 – Added Maint Reason Code ‘22’ - When sent with INS03=24, indicates a member being terminated due to a plan change to another FTE plan. When sent with INS03=21, indicates a member coming from another FTE plan.	Systems
3.4	2462	HIP 2.0 Fast Track Credit Card	May 2015	Implemented	Pg. 14-15 REF Loop2000 – Added under HIP ‘FTE Application is sent in this segment’ Pg. 15 REF01 Loop2000 – Added under HIP – 6O-FTE Application ID Pg. 27 HD04 Loop2300 – Added HIP/Fully Eligible Member Aid Category: PC HIP Plus Co-Pay Pg. 35-36 N102 Loop2750 – Added HPE-Adult Indicators ‘Refund’ and ‘FTEDifferentPlan’ Added Title ‘Reporting Category Name’ and ‘EnrollingProvider’, ‘EnrollingProviderZipPlus4’ Pg. 35-36 REF02 Loop2750 – Added HPE-Adult Indicator Codes: Refund: X-Default, Y-Yes, N-No FTEDifferentPlan: X-Default, S-Same, D-Different Added Title ‘Reporting Category Name for HPE-Adult’ and ‘EnrollingProviderNPI’, ‘EnrollingProviderZipPlus4’ Pg. 35-36 N102 Loop2750 – Added FTE Indicator ‘FTEDifferentPlan’ Pg. 35-36 REF02 Loop2750 – Added FTE Indicator Codes: FTEDifferent Plan: X-Default, S-Same, D-Different	Systems
3.5	2462	HIP 2.0 Fast Track Credit Card	May 2015	Implemented	Pg. 37 REF02, loop2750 – Under FTE Header, removed ‘X’ as a default value for Add records and ‘Y’ and ‘N’ for Term records – (All values are sent for adds and terms)	Systems
3.6	2462	HIP 2.0 Fast Track Credit Card	May 2015	Implemented	Pg. 37 REF02, Loop2750 – Added descriptions for HPE and FTE ‘FTEDIFFERENTPLAN’ indicators	Systems
3.7	2462	HIP 2.0 Fast Track Credit Card	May 2015	Implemented	Pg. 29 HD04, Loop2300 – Added HIP Fully Eligible Plan Coverage Description: ‘PP-Plan Change for Payment’ Pg. 37 REF02, Loop2750 – Added Reporting Category Name for HPE-ADULT: ‘NO_ENR_NPI – If NPI is not found when doing the crosswalk, the “No Enrolling NPI Found’ code will be returned’	Systems

3.8	2459	HCC	June 2015	Implemented	Pg. 25 – HD04, Loop 2300 – Added text: **Hoosier Care Connect (HCC)** This code indicates the plan the member is transferring from when maintenance type and reason is 021/22. The code indicates the plan the member is transferring to when maintenance type and reason is 024/22. ANTH – Anthem MDWI – MDwise MHS – MHS	Systems
3.9		Correction	July 2015	Implemented	Pg. 13 INS04, Loop2000 – Corrected Maintenance Reason Code 06 -HPE Adult - FULLY ELIGIBLE MEMBERS: When sent with INS03 = 024, indicates a member's eligibility was replaced or deleted from the HIP program. The HD04 segment will contain ELIG CHANGE or DEATH Pg. 13 INS04, Loop2000 – Added Maintenance Reason Code 06 – HPE Adult: When sent with INS03 = 024, indicates a member's eligibility was replaced or deleted from the HIP program	Systems
3.10	2466 IRT38b	HIP 2.0 Data Discrepancies	August 2015	Implemented	Pg. 36 N102, Loop2750 – Added 'FutureAidCategory' for HIP Fully Eligible Only Pg. 37 REF02, Loop2750 – Added 'FutureAidCategory' for HIP Indicator Codes Pg. 37 DTP02, Loop2750 – Added 'D8 is used with Pregnancy Expected Due Date, Medically Frail Status, Medically Frail, and **Future Aid Category**'	Systems
3.11	IRT#113		Sept 2015	Implemented	Pg. 12 INS04 Loop2000 – Added under HIP – Maintenance Reason Code 22 - When sent with INS03 = 001, indicates a change to the member's aid category, income, capitation category or FPL. The type of change will be indicated in HD04. Pg. 36 N102 Loop 2750 – Added 'Power Account' under Fully Eligible Only	Systems
3.12	2452/ 2467	HIP Link - Release III / HIP 2 Power Account - PRF	Oct 2015	Implemented	Pg. 13 – INS04 Loop2000 – For code 22 added 'HIP Link eligibility' verbiage. Pg. 29 – HD04 Loop 2300 – Added new codes, JL, JM, JA, JG, JH, OI, NF, F3, FB, F1, F2, F9, FA, F4, F5, F6, F7, F8 Pg. 30 – HD04 Loop 2300 – Added 'HIPLINK – Member is moving to HIP 2 from HIP LINK'	Systems
3.13	2467	HIP 2 Power Account - PRF	Nov 2015	Implemented	Pg. 29 – HD04 Loop2300 – For HIP Fully Eligible Members, added new start reason code: 'ER-Eligibility Restored with Retro Date	Systems
3.14	2494	HCC Copay – CR 46314	Feb 2016	Implemented	Pg. 36-37 – N102 Loop2750 – Separated HHW/HCC Indicators. Added HCC Indicators: Threshold, NativeAmerican, Pregnancy and PregnancyExpectedDueDate	Systems
3.15	2489	HIP2 -PRF-Rpts/834/820/Roll over	Apr 2016	Implemented	Pg 30 – HD04 Loop2300 – Added new start reason codes for HIP Fully Eligible Members: MT, MM and FX Pg 37 – N102 Loop2750 – Added new HIP Conditional/Fully Eligible Indicators: RollOverDiscAmount and RollOverDiscPercent	Systems

					Pg 38 – Added new Reporting Category Qualifier: 9V-Payment Category	
3.16	2489	HIP2 -PRF-Rpts/834/820/Rollover	Apr 2016	DRAFT	CORRECTION from v3.15 - Pg 38 – Removed Reporting Category Qualifier: 9V-Payment Category	Systems
3.17	2466	HIP2 – IRT203	June 2016	Implemented	Pg. 31-31- HD04 Loop2300 – Added HPE Adult aid category 'XX' and HPE Adult capitation code 'HX'	Systems
3.18	2489	HIP2 -PRF-Rpts/834/820/Rollover	July 2016	DRAFT	Pg.37 Remove the following two indicators from the HIP Indicators Conditional and Fully Eligible List.and add them to the HIP Indicators Fully Eligible Only List : RollOverDiscAmount and RollOverDiscPercent	Systems
3.19	2518	2518 - 5% Cost Share MCE Inclusion	Aug 2016	Implemented	Pg. 38 REF02 Loop2750 – Add NativeAmerican indicators for HCC and HIP *AIM only, changes are not reflected in this DDI version	Systems

CoreMMIS Change Summary

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed by
	9538	45796 - HPE Rebranding - EDI Forms	Mar. 2016	Implemented	Throughout document - Changed Hewlett Packard (HP) to Hewlett Packard Enterprise (HPE).	Systems
	12227	834 Companion Guide Updates for CR 50001 - 5% Max Cost share – MCE Inclusion	Oct. 2016	Implemented	Pg. 38 – N102 Loop 2750 – Added CostShare to HCC and HIP Indicators Pg. 39 – REF02 Loop 2750 – Added HCC and HIP Indicator Codes for Cost Share	Systems
	CR 31755	Program of All-Inclusive Care of the Elderly (PACE)	Oct. 2016	Implemented	Pg. 4 Added Program for All-inclusive Care for the Elderly (PACE) to 4.2.1 in Table of Contents Pg. 9 Added PACE to Legend Added PACE to the following segments: BGN02, REF02, INS03, INS04, INS06-01, REF, DTP01, PER06, PER08, HD01, HD04, HD05, DTP loop2300, COB Pg. 21, HD04 Loop 2300 – Added PACE capitation codes 'PA', 'PB', 'PC' Pg. 23, HD04 Loop 2300 – Added note for aid category codes for PACE Pg. 42. Added 'PACE' to 4.2.1	Systems
4.0	n/a		Dec. 2016	Pending	Indiana *Core*MMIS Implementation	Systems
4.1	n/a	End-to-End testing	Jan. 2017	Implemented	Pg. 20, HD04 Loop 2300 - Added clarifications for the Potential Plus segment, and a Term example. Pg. 13, INS04 Loop 2000 - Added a clarification to maintenance reason 33 that it is the default reason when nothing else matches in the HIP hierarchy. Pg. 33, HD04 Loop 2300 - Added HPE-Adult stop reason 81 - Eligibility Terminated Pg. 32, HD04 Loop 2300 - Added Caresource as a plan abbreviation Pg. 38, N102 Loop 2750 - Added clarification that there could be a current and future	Systems

					POWERACCOUNT loop for members who have a new POWER account segment Pg. 26, HD04 Loop 2300 – Corrected the “reason” code portion of the maintenance/reason code pairs. Pg. 32, HD04 Loop 2300 – Added HCC – PLAN2PLAN Pg. 23, HD04 Loop 2300 – Added PACE aid category ’PA’ Pgs. 44 – 45, section 4, Additonal Information – Added bullets 4.2.4.2.4, 4.2.5.2.4, and 4.2.6.2.4 for additional audit file information.	
4.2	n/a	Corrections	Jan. 2017	Implemented	Pg. 26, HD04 Loop 2300 - MEMBER'S RESIDENCE REGION CODE - Removed references to Care Select (obsolete program) and HIP (should not be included in 'blue' section); specified values for HHW and HCC as 0 thru 8; added PACE region code 'S' Pg. 42, 43, 44, 45 – Added ‘.dat’ file extension to examples of File Naming Standard for all programs.	Systems
4.3	12784	PEPW for HHW Plan Coverage Description does not match 834 Companion Guide	Jan. 2017	Implemented	Pg. 27, HD04 Loop 2300 - Removed PEPW Capitation Code 'AF', added 'PH'	System
4.4		Corrections Rebranding	April 2017	Implemented	Pg. 20, Loop 2300 HD - Revised description of second situational loop for HIP Potential Plus status; revised HIP Potential Plus example for a termed potential plus segment. Pg. 38, Loop 2750 N102 - Revised HIP Indicators moving the 'CostShare' indicator to Fully Eligible Only. Updated throughout document Hewlett Packard Enterprise (HPE) to DXC Technology	Systems
4.5			June 2017	Implemented	Pg. 12, Loop2000 INS04 – PEPW - Added ‘NULL – Deletion only when INS03 = 024 without a reason code’. Pg. 14, Loop2000 INS04 – HPE Adult – Added ’43 – Indicates the member’s address, phone number, secondary phone number, case number, email address has changed.’ Pg. 14, Loop 2000 INS04 – FTE – Added ’03 – Will be sent along with INS03 = 024 to indicate a member who has passed away.’ Pg. 42 TI Additional Information: -Modified Availability timeframe from Tuesday-Saturday to 7 days a week for all programs -Removed ‘Not available the day after a State holiday’ 4.2.2 – Removed Care Select (CS) program information	Systems
4.6		CR55453	July 2017	Implemented	Pg. 16. Loop2000 DTP01 – Added text: HIP fully eligible members effective as of January 1, 2018, will have benefit periods that begin January 1 and end December 31, regardless of their eligibility effective date or the dates of their subsequent redeterminations. HIP fully eligible members who are terminated from the program on or after January 1, 2018, will retain a	Systems

					benefit period end date of December 31st, regardless of the date of their termination from the HIP program. HIP members who have retroactive eligibility inserted in 2018 or after, for eligibility effective dates prior to 2018, will follow pre-2018 benefit period rules. Pg.29-30, Loop2300 HD04 – Added HIP codes – HA, HJ, HL, HP, HT Pg. 39, Loop2750 DTP02 – Added Text: D8 is used with Pregnancy Expected Due Date, Medically Frail Status, Medically Frail, and Future Aid Category, and Redetermination Date. If there is no redetermination date for a HIP member, a default date of 22991231 will be reported. A change to the Redetermination date alone will generate a HIP fully eligible change record. The Tobacco indicator effective date may precede the effective date of the HIP member's eligibility.	
		CR55448			Pg 28, Loop2300 HD04 – Added code to HIP Fully Eligible: 'MA'	
		CR55678			Pg. 32, Loop2300 HD04 – Added code to HPE Adult Valid Aid Category: 'PN'	
		CR55451			Pg. 37, Loop2750 N102 – Added text under Fully Eligible Only: Redetermination (This indicator will be reported on every HIP fully eligible change record, as well as on the HIP fully eligible Audit file) Tobacco (This indicator will be reported on every HIP fully eligible change record, as well as on the HIP fully eligible Audit file) Pg.38, Loop2750 REF02 – Added text under HIP Indicator Codes: Tobacco (A change to the Tobacco data alone will generate a change record) Y - Yes N – No U – Unknown (If there is no Tobacco data for the member, the 834 program will report a default of "U" with no corresponding dates)	
4.7		CR55451 CR55678 Office Hours Meeting 8/3/17	August 2017	Implemented	Pg. 38, Loop2750 REF02 – Added value 'R' under HIP Indicator Codes-Tobacco Pg. 32, Loop2300 HD04 – Removed Valid Aid Category 'PN'. Pg. 29, Loop2300 HD04 – Added value '81' under Start/Stop Reason Codes	Systems

4.8		CR55448 CR55453 CR55678 CR52057	October 2017	Implemented	Pg. 29, Loop2300 HD04 – Added Values DM and PM Pg. 38, Loop 2700 N102 – Removed additional verbiage for 'Redetermination' - (This indicator will be reported on every HIP fully eligible change record, as well as on the HIP fully eligible Audit file) Tobacco (This indicator will be reported on every HIP fully eligible change record, as well as on the HIP fully eligible Audit file) Multiple Pages – Added text where appropriate for PEPW '*PEPW will be phased out beginning in 2018' Pg. 8, BGN02 – Region codes will no longer be used, added 'A' as the one-character sent with the MCE ID Pg. 42-44 Section 4.2 – Updated all 834 File Naming Standards	Systems
4.9		CR52057/58376	August 2018	Implemented	Pg 45 - Added 4.2.6 – 834 Summary Report Information	Systems
5.0		CR43916 CR52057 IM105733 CR57446 CR58114	September 2018 August 2018 September 2018 September 2018 December 2018	Implemented Implemented Implemented Implemented Implemented	Pg 37 – Loop 2750, N102 Name - Added FamilySize Indicator under HCC Pg 38 - Loop 2750, N102 Name - Added FamilySize Indicator under HIP Fully Eligible Only Pg 39 – Loop 2750, REF02 Reference Identification - Under HCC Indicator Codes, Added FamilySize – A default value of zero '0' will be reported for FamilySize if there is no Case ID Pg 40 - Loop 2750, REF02 Reference Identification - Under HIP Indicator Codes, Added FamilySize – A default value of zero '0' will be reported for FamilySize if there is no Case ID Pg 25 – Loop 2300, HD04, MEMBER'S RESIDENCE REGION CODE – changed HHW and HCC values used – 1 through 9 Pg 18/19 – Loop 2100A AMT01 – Amount Qualifier Code - replace C1 qualifier with B9 to match code Pg 25 - Four new Start/Stop Reason Codes for HHW and HCC. Pg. 44 - added Note: HPE managed care will be phased out beginning 1/1/2019	Systems
5.1	CR59230 CR58112	Load pregnancy dates from CDEE file regardless of Pregnancy indicator from CDEE record 834 File Modifications and Creation of 834	July 2019 July 2019	Implemented Implemented	Pg. 37 Loop 2750 N102 Added HHW Indicators – Pregnanccy and PregnancyExpectedDueDate Pg 42 Loop 2750 REF02 Added HHW section with Pregnancy Indicator Y – Yes and N - No Pg. 37 Loop 2750 N102 Name – added HHW Indicators Ethnicity, CurrentCapitationCode, CurrentAssignmentStartCode,	Systems Systems

		Inactive Member Audit File			CurrentAssignmentStopCode,CurrentIncome, FutureIncome,Redetermination Pg. 38 Loop 2750 N102 Name - added HCC Indicators Ethnicity, CurrentCapitationCode, CurrentAssignmentStartCode, CurrentAssignmentStopCode,CurrentIncome, FutureIncome,Redetermination Pg. 38 Loop 2750 N102 Name – added HIP Indicators Ethnicity, CurrentCapitationCode, CurrentAssignmentStartCode, CurrentAssignmentStopCode,CurrentIncome, FutureIncome Pg. 39 Loop 2750 REF02 – added HHW Indicator Codes : Ethnicity, 00 – Not Hispanic or Latino, 01 – Hispanic or Latino, 09 – Unknown; Capitation Codes – See Plan Coverage section for values; Assignment Start and Stop Codes – See Plan Coverage section for values Pg. 40 Loop 2750 REF02 – added to HCC Indicator Codes: Ethnicity, 00 – Not Hispanic or Latino, 01 – Hispanic or Latino , 09 –Unknown; Capitation Codes – See Plan Coverage section for values; Assignment Start and Stop Codes – See Plan Coverage section for values Pg. 41 Loop 2750 REF02 – added to HIP Indicator Codes: Ethnicity, 00 – Not Hispanic or Latino, 01 – Hispanic or Latino, 09 – Unknown; Capitation Codes – See Plan Coverage section for values; Assignment Start and Stop Codes – See Plan Coverage section for values Pg. 42 Loop 2750 DTP02 – changed sentences to read If there is no redetermination date for a member, a default date of 22991231 will be reported and A change to the redetermination date alone will generate a change record. Pg. 43 Under HHW/HCC Added Section 4.2.1.3 Term Change File and Section 4.2.1.4 Term Audit File Pg. 44 Added to File Naming Standards - CT – Monthly term change file and AT – Monthly term audit file Pg. 45 Under HIP Added Section 4.2.4.3 Term Change File and Section 4.2.4.4 Term Audit File Pg. 46 Added to File Naming Standards – CT – Monthly term change file – fully eligible members and AT-Monthly term audit file – fully eligible members	

5.1	CR 61058	GTW Inactive Assignments For Suspended Members	December 2019	Implemented	Pg. 30 Added MCE stop reason code GS – HIP GTW Suspension.	Systems
5.2	CR 60161 CR 61921	HIP Bridge COVID-19 Updates	March 2020	Implemented Implemented	Pg. 30 Added MCE stop reason code HB – HIP Bridge Eligibility Pg. 30 Added COVID-19 start reason code CS and stop reason code CT	Systems
5.3	CR61200	Align Cap For HIP Elig For Cap Pay	June 2020	Implemented	Pg 28 and 29 Added HIP capitation categories for 18 year olds	Systems