INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Healthy Indiana Plan

Note: *For the latest information on cost-sharing, see Indiana Health Coverage Programs (IHCP) Bulletin BT202461, accessible from the IHCP Bulletins page at in.gov/medicaid/providers.*

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Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures beginning Feb. 1, 2015 Published: June 5, 2018	New document	FSSA and DXC
2.0	Policies and procedures as of July 1, 2019 Published: Nov. 10, 2020	Scheduled update	FSSA and Gainwell
3.0	Policies and procedures as of May 1, 2021 Published: Nov. 4, 2021	Scheduled update	FSSA and Gainwell
4.0	Policies and procedures as of Nov. 1, 2022 Published: March 15, 2023	Scheduled update	FSSA and Gainwell
5.0	Policies and procedures as of Oct. 1, 2024 Published: March 13, 2025	Scheduled update: • Edited text as needed for clarity • Updated the DFR fax number • Added note to *Cost-Sharing Information* section • Updated the note about PE in the *HIP Benefit Plans – Eligibility and Coverage* section and updated HIP Basic coverage for OMT in *Table 3 – Benefit Coverage Summary for HIP Benefit Plans* • Updated the categories in the *HIP State Plan Plus, HIP State Plan Basic and HIP Maternity* section • Updated the number of prescription supply days for *HIP Basic* in *Table 39 – Prescription Drugs* • Corrected text in *Table 42 – Prosthetics* (changed "abnormal growth" to "normal growth") • Updated *Table 64 – Osteopathic Manipulative Treatment (OMT)* to include covered for *HIP Basic* • Updated the *Billing and Reimbursement for Extended Nursing Facility Stays* section • Updated the *Reimbursement Rate* section and subsections • Updated the end date in the *Hospital Assessment Fee* section and updated the *HAF-Adjusted Reimbursement for Outpatient Hospital Services* subsection	FSSA and Gainwell

Table of Contents

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

Waiver/Authority

The Healthy Indiana Plan (HIP) operates under a 1115(a) Medicaid demonstration waiver that provides authority for the state of Indiana to provide healthcare coverage for adults between the ages of 19 and 64 through a managed care health plan and a consumer-directed model that provides an account, similar to a health savings account, called a Personal Wellness and Responsibility (POWER) Account. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the *Social Security Act*. The demonstration is operating statewide, and a waiver extension was approved for a 10-year period, from Jan. 1, 2021, through Dec. 31, 2030.

With this demonstration waiver, Indiana expects to achieve the following to support the objectives of Title XIX:

- Promoting increased access to healthcare services
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention and wellness
- Increasing quality of care and efficiency of the healthcare delivery system

HIP Program Overview

The HIP program is sponsored by the state of Indiana and provides an affordable healthcare choice to thousands of individuals throughout Indiana. Eligibility is limited to adults who meet all the following criteria:

- Between the ages of 19 and 64
- With income at or under 138% of the federal poverty level (FPL) (133% plus 5% disregard = 138%)
- Not on Medicare
- Do not qualify for any other Medicaid program

HIP is a managed care program with pharmacy and dental services, when applicable, carved into the managed care arrangement. Indiana offers HIP members a comprehensive benefit plan through a deductible health plan paired with a personal healthcare account called a POWER Account.

Under HIP, beneficiaries are served with specific benefit plans based on their aid category. The benefit plans are as follows:

- *HIP Plus*
- *HIP Basic*
- *HIP State Plan Plus*
- *HIP State Plan Basic*
- *HIP Maternity*
- *HIP State Plan Plus Copay*

See the *HIP Benefit Plans – Eligibility and Coverage* section for specific coverage and eligibility information related to each benefit plan.

Individuals accepted for HIP are not fully eligible, nor enrolled as IHCP members, until one of the following occurs*:

- Payment of their first POWER Account contribution (also referred to as a PAC)
- A $10 Fast Track payment to the selected health plan (if applicable and approved for HIP)
- For individuals at or below 100% FPL, the expiration of the 60-day payment period

HIP-accepted members who are still in the initial 60-day payment period and who have not yet paid their Fast Track payment or first POWER Account contribution are referred to as *conditionally eligible*. Members who are conditionally eligible do not have any benefits until they move into a fully eligible aid category.

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

Fast Track Enrollment

Fast Track is a payment option that allows eligible Hoosiers to expedite the start of their coverage in the *HIP Plus* program. Fast Track allows a $10 prepayment to be made while the application is being processed. The $10 prepayment goes toward the applicant's first POWER Account contribution. For applicants that make a Fast Track prepayment and are eligible for HIP, their *HIP Plus* coverage will begin the first of the month in which they made their Fast Track prepayment.

Coverage may occur in a different month from that in which payment was made in the following situations:

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

Individuals that do not make a credit card payment at the time of application will be invoiced by the managed care entity (MCE) to which they are assigned. From the date the Fast Track invoice was issued, individuals have 60 days to make either a Fast Track prepayment or their first POWER Account contribution to be able to begin *HIP Plus* coverage. For example, if an individual makes a Fast Track payment or initial POWER Account contribution in July, then the *HIP Plus* coverage will begin July 1. If the individual makes the contribution in August, *HIP Plus* coverage will begin Aug. 1. If the individual allows the 60-day payment period to expire in August without making either a Fast Track prepayment or POWER Account contribution, then one of the following occurs:

- If the individual's income is at or below 100% of the FPL, the coverage defaults to *HIP Basic* effective Aug. 1.
- If the individual's income is over 100% of the FPL, that individual would not receive coverage and would have to reapply for HIP.

Presumptive Eligibility Adult members are eligible to make a Fast Track prepayment only if they submit a full IHCP application before the end of their presumptive eligibility period and meet other applicable Fast Track criteria. Presumptively eligible members who submit a full application and make a Fast Track prepayment will begin *HIP Plus* coverage beginning the first of the following month after approval.

Prior Authorization for Individuals With Fast Track Prepayment

IHCP providers that assist individuals with a HIP Fast Track prepayment can also submit a retroactive PA request for services after the individual has been determined fully eligible for benefits. This process applies only to individuals age 19 years through 64 years who ***do not*** pursue temporary coverage through Presumptive Eligibility and did submit an IHCP application with a Fast Track prepayment.

Providers must use the following process for inpatient stays to ensure that they can properly submit a retroactive PA request for individuals utilizing a Fast Track prepayment:

1. The provider must assist an individual in completing an application for health coverage.
2. As part of the application process, the provider will assist the individual with submitting a Fast Track prepayment.
3. After assisting with the application for health coverage, the provider must complete a *Fast Track Notification Form* (available on the *Forms* page at in.gov/medicaid/providers) and fax the form to the managed care entity (MCE) selected on the application. This process must be completed within five days of the date of admission. To locate the fax number for the applicable MCE, see the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.
4. After eligibility has been established, the MCE will return a *Full Eligibility Notification Form* to the provider via fax. This form will contain the member's MCE assignment and IHCP Member ID (also known as RID). The notification will occur within seven days following eligibility discovery.
5. The provider will then be able to submit a PA request for the service rendered since the first day of the month of the Fast Track prepayment. ***Providers must submit the PA request within 60 days of receiving the Full Eligibility Notification Form.*** Providers must verify eligibility, using the IHCP Provider Healthcare Portal, prior to submitting the PA request.

If an individual is not determined fully eligible within 60 days of receiving the *Fast Track Notification Form*, the MCE receiving the information will stop tracking the individual's eligibility status.

Providers must agree not to submit a PA request or a claim for services rendered for the individual until the individual's full eligibility is determined by the state. Additionally, a Fast Track prepayment is not a guarantee of coverage or eligibility. All PA requests will continue to require all regular PA documentation standards.

Cost-Sharing Information

All nonexempt, HIP-eligible individuals are responsible for making financial contributions toward the cost of their healthcare coverage, whether it is through POWER Account contributions (also known as PACs) or through copayments assessed at the point of service:

- Members enrolled in *HIP Plus* or *HIP State Plan Plus* make monthly POWER Account contributions and have no additional cost-sharing responsibility, except for a copayment for nonemergency use of the emergency department (ED).
- Members enrolled in *HIP Basic* or *HIP State Plan Basic* are not required to make monthly contributions to their POWER Account, but **are** required to make copayments, which are assessed as indicated in the *Copayments* section.
- *HIP State Plan Plus Copay* members have the same copayment obligations as *HIP Basic* members, but also accrue debt for any unpaid monthly POWER Account payments.

HIP Maternity members, as well as all other pregnant HIP members, are exempt from all cost-sharing requirements (including copayments and POWER Account contributions) during pregnancy and the 12-month postpartum period.

Cost-sharing obligations are capped at a set percentage of household income.

> *Note: Members who are American Indian/Alaska Natives, or who are pregnant or within the postpartum period, are not required to make copayments or financial contributions to a POWER Account. See the Cost-Sharing Limitations and Exemptions section of the Member Eligibility and Benefit Coverage module for more information.*

The following sections provide details about POWER Account and copayment responsibilities and cost-sharing caps for HIP members.

Personal Wellness and Responsibility Account

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

The POWER Account comprises a monthly member contribution plus a state contribution. Members pay a monthly contribution for *HIP Plus* and *HIP State Plan Plus* coverage. HIP POWER Account contribution amounts are tiered and based on FPL percentage ranges and will not exceed 5% of the member's annual household income. When it is determined that a *HIP Plus* member has met their 5% cost-share limit for the quarter, their POWER Account Contribution will be reduced to $1 for the remainder of the quarter (or $1.50 if there is a tobacco surcharge).

The maximum combined total annual amount of the POWER Account is $2,500 and is used to pay the initial eligible expenses or the deductible to participating providers. If a POWER Account is not fully funded, the MCE is still required to pay all claims. A member's monthly POWER Account contribution is determined using the criteria shown in Table 1.

Table 1 – Member's Monthly POWER Account Contribution Requirements Based on Income

Yearly Income	Monthly PAC for Single Individual	Monthly PAC for Spouses (Each)
Up to and including 22% of the FPL	$1.00	$1.00
Above 22% of the FPL and up to and including 50% of the FPL	$5.00	$2.50
Above 50% of the FPL and up to and including 75% of the FPL	$10.00	$5.00
Above 75% of the FPL and up to and including 100% of the FPL	$15.00	$7.50
Above 100% of the FPL and up to and including 133% of the FPL	$20.00	$10.00

Note: Members may be assessed a 50% tobacco use surcharge in addition to the POWER Account tier amounts listed in this table.

All preventive services set forth in federal regulations will be administered free of cost sharing and will not be debited from the POWER Account. If additional preventive services are offered, the first $500 of these services do not require member contributions from the POWER Account.

Copayments

Table 2 provides information about copayment requirements for members under each of the HIP benefit plans.

Table 2 – HIP Copayment Amounts

Service	Copayments for: *HIP Basic,* *HIP State Plan Basic,* and *HIP State Plan Plus Copay*	Copayments for: *HIP Plus* and *HIP State Plan Plus*	Copayments for: *HIP Maternity*
Outpatient services, including office visits	$4	None	None
Inpatient services, including hospital stays	$75	None	None
Preferred drugs	$4	None	None
Nonpreferred drugs	$8	None	None
Nonemergency ED visit	$8	$8	None

When it is determined that a member has met their 5% cost-share limit for the quarter, they will not have to pay copayments for any services for the remainder of the quarter.

Services Exempt From Copay

The following services are **exempt** from copayment requirements for all HIP members:

- Preventive care services
  - For applicable procedure codes, see *Preventive Care Services Excluded From Cost Sharing for Healthy Indiana Plan*, accessible from the *Code Sets* page at in.gov/medicaid/providers.
- Tobacco cessation drugs
- Family planning services
  - For applicable procedure codes, see *Family Planning Eligibility Program Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.
- Services provided for an emergency health condition (nonpharmacy services only)
  - Professional claims must include an emergency indicator at the detail level; outpatient claims must include an emergency diagnosis code; and inpatient claims must have admission type 1 or 5 or be a transfer with an admission source of 4.

HIP Benefit Plans – Eligibility and Coverage

HIP members receive coverage under one of the following benefit plans:

- ***HIP Plus*** – This plan is available for all members enrolled in HIP who choose to make affordable monthly contributions to their individual POWER Account. Members enrolled in *HIP Plus* receive a more generous benefit package, including vision, dental and additional chiropractic services. Other than the monthly contribution, the members in *HIP Plus* have no additional cost-sharing responsibility except for a copayment for nonemergency use of the emergency department (ED), which is currently set at $8.
- ***HIP Basic*** – This plan is for members with income at or below 100% FPL who fail to make a POWER Account contribution. *HIP Basic* has a more limited benefit package and does not cover vision or dental services unless the dental is for accident or injury. *HIP Basic* also has a more limited formulary for pharmacy benefits. *HIP Basic* requires the member to make copayments at the point of service for each service received from a provider. Copayments for services received are $4 or $8 for most services and prescriptions. There is a $75 copayment for inpatient hospitalization and an $8 copayment for a nonemergency ED visit. For details about these copayment amounts, as well as a list of exempt services, see the *Copayments* section.
- ***HIP State Plan Plus*** – This plan offers access to all benefits available under the Indiana Medicaid State Plan. Members with this benefit plan have the same cost-sharing requirements as *HIP Plus*, must make monthly POWER Account contributions, and do not have copayments for services, except for an $8 copayment for a nonemergency ED visit.
- ***HIP State Plan Basic*** – This plan offers access to all benefits available under the Indiana Medicaid State Plan. Members with this benefit plan have the same cost-sharing requirements and copayments for all services as *HIP Basic* members.
- ***HIP Maternity*** – This plan offers access to all benefits available under the Indiana Medicaid State Plan, with no cost-sharing requirements, for pregnant women who are enrolled in or determined eligible for HIP. HIP members with income at or below 138% FPL who become pregnant while in HIP will be covered under the *HIP Maternity* benefit plan beginning the first of the month following notification of pregnancy and will continue under that benefit plan until their 12-month postpartum coverage period is over.
- ***HIP State Plan Plus Copay*** – This plan offers the coverage of *HIP State Plan Plus* benefits but requires copayment for all services. Copayments match those for *HIP Basic* at $4, $8 or $75 (depending on service). This limited-enrollment plan is reserved for members who are above 100% FPL but are medically frail and therefore do not lose benefits for failure to pay POWER Account contributions.

> *Note: Members who go through the Presumptive Eligibility (PE) process and are found presumptively eligible based on HIP eligibility criteria are assigned to the **Presumptive Eligibility – Adult** (PE Adult) benefit plan. The benefits of PE Adult mirror those of HIP Basic, but without cost-sharing requirements. Additionally, PE Adult coverage is provided under the fee-for-service delivery system, rather than through an MCE. For the duration of their PE period, claims (and prior authorization requests, when applicable) for PE Adult members must be submitted to Gainwell Technologies (or, for pharmacy services, to Optum Rx). See the Presumptive Eligibility module for more information.*

Table 3 provides an overview of the benefits available under the HIP benefit plans. For more detailed information about the specific services covered under *HIP Plus* and *HIP Basic*, see Tables 4 through 70.

Table 3 – Benefit Coverage Summary for HIP Benefit Plans

Benefit	***HIP Basic***	***HIP Plus***	***HIP Maternity***	***HIP State Plan***
Ambulatory Patient Services	X	X	X	X
Urgent Care	X	X	X	X
Home Health Services	X	X	X	X
Emergency Services	X	X	X	X
Hospitalization	X	X	X	X
Hospice Services	X	X	X	X
Maternity Care	X	X	X	X
Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment	X	X	X	X
Prescription Drugs	X	X	X	X
Rehabilitative and Habilitative Services and Devices (including hearing aids – one per member every five years)	X	X	X	X
Laboratory Services	X	X	X	X
Preventive and Wellness Services and Chronic Disease Management	X	X	X	X
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services	X	X	X	X
Vision*		X	X	X
Dental*		X	X	X
Limited Dental – Accident/Injury Only	X	X	X	X
Temporomandibular Joint (TMJ) Disorder Treatment		X	X	X
Bariatric Surgery		X	N/A	X
Osteopathic Manipulative Treatment (OMT)	X	X	X	X
Residential Treatment		X	X	X
Chiropractic Spinal Manipulations		X	X	X
Medicaid Rehabilitation Option			X	X
Nonemergency Transportation			X	X

** Note: The EPSDT benefit includes dental and vision benefits for all 19- and 20-year-old members, including those enrolled in HIP Basic.*

HIP State Plan Plus, HIP State Plan Basic and HIP Maternity

HIP State Plan Plus and *HIP State Plan Basic* benefits are available to HIP members who are determined to meet criteria under one of the following categories:

- Medically frail
- Low-income parents and caretaker relatives
- Low-income 19- and 20-year-old dependents
- Eligible for transitional medical assistance

HIP Maternity benefits are available to HIP-eligible members during pregnancy and 12 months postpartum.

Members with *HIP State Plan Plus*, *HIP State Plan Basic* or *HIP Maternity* receive Indiana Medicaid State Plan level benefits, including MRO, nonemergency medical transportation, dental, vision and chiropractic care. The full list of services is available on the Indiana Medicaid member website at in.gov/medicaid/members (see Package A information on the *What Is Covered by Indiana Medicaid* page).

The cost-sharing requirements for *HIP State Plan Plus* and *HIP State Plan Basic* mirror those of *HIP Plus* and *HIP Basic*, respectively. *HIP Maternity* members are exempt from cost sharing requirements.

Medically Frail Individuals

Within the HIP-eligible population, the IHCP identifies those members who may be medically frail and provides enhanced coverage for those individuals who meet the medically frail criteria. HIP-eligible medically frail individuals are enrolled in one of the *HIP State Plan* options and receive comprehensive Indiana Medicaid State Plan benefits equivalent to Package A benefits, including nonemergency transportation to medical appointments.

Federal regulation *42 CFR 440.315(f*) defines the *medically frail* as individuals with one or more of the following:

- Disabling mental disorder
- Chronic substance abuse disorder
- Serious and complex medical condition
- Physical, intellectual or developmental disability that significantly impair the individual's ability to perform one or more activities of daily living
- Disability determination based on Social Security Administration (SSA) criteria

Each MCE is responsible for identifying and verifying all its members who are medically frail. However, members with a disability determination based on SSA criteria or members who are confirmed by the Indiana Department of Health to have human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) are automatically confirmed medically frail by the state. The MCE is not responsible for verifying the medically frail designation of the members identified as such by the state, and these HIP members automatically qualify for enrollment into *HIP State Plan* benefits.

MCEs verify through claims or supplemental information using the Milliman Medical Underwriting Guidelines to determine whether members qualify as medically frail. Members with a qualifying condition will be assessed by their MCE to verify that the condition is active and to determine how well the condition is controlled, as well as to identify any complicating comorbidities. Those members designated medically frail as a result of the MCE's assessment will be enrolled in the *HIP State Plan* option the first day of the following month after the assessment is sent to the state.

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

Pregnant Applicants

Pregnant applicants with a family income at or below 138% of the FPL and who meet all other HIP eligibility criteria will be enrolled in the *HIP Maternity* benefit plan, which provides full Indiana Medicaid State Plan benefits, free of cost-sharing obligations.

> *Note: Pregnant applicants with income **above** 138% of the FPL and eligible for IHCP services will be enrolled in **Hoosier Healthwise**, with **Package A – Standard Plan** coverage, which provides the same benefits as **HIP Maternity**.*

If members are already enrolled in HIP when they become pregnant, their coverage will be converted to the *HIP Maternity* benefit plan beginning the first of the month following notification of pregnancy and will continue under that benefit plan until their postpartum coverage period is over. The postpartum coverage period lasts at least 12 months from pregnancy termination date. HIP members retain coverage through the HIP program, under their existing MCE, during pregnancy and at redetermination as long as they continue to meet eligibility requirements.

Pregnant applicants enrolling in HIP may also be determined eligible for retroactive coverage for up to three months prior to their application date. If the applicant is eligible for retroactive coverage, the IHCP EVS will indicate *Package A – Standard Plan* as the member's coverage during the retroactive time period, with no enrolling MCE indicated. Retroactive coverage is paid through the FFS delivery system.

HIP Plus and HIP Basic Benefit Plans

Individuals who meet the eligibility criteria for HIP enrollment, as outlined in the *HIP Program Overview* section, and who do not qualify for *HIP Maternity* or one of the *HIP State Plan* packages, may be enrolled under *HIP Plus* or *HIP Basic*. Those who make monthly contributions to their POWER Account are enrolled under *HIP Plus*. Those who fail to make POWER Account contributions and who have income at or below 100% FPL are enrolled under *HIP Basic*, which has more limited coverage and is subject to copayment requirements as described in the *Copayments* section.

Benefits for *HIP Plus* and *HIP Basic* are based on approved alternative benefit plans. *HIP Plus* and *HIP Basic* are distinct benefit plans with different coverage, limitations and prior authorization (PA) requirements. For specific billing and coding information, refer to the member's assigned MCE for directions.

> *Note: The information in this section does not apply to HIP Maternity, HIP State Plan Plus and HIP State Plan Basic. Members enrolled in those plans receive the same level of benefits as in the Indiana Medicaid State Plan. For information about those plans, see the HIP State Plan Plus, HIP State Plan Basic and HIP Maternity section.*

Ambulatory Patient Services

The following tables summarize coverage of ambulatory patient services for *HIP Plus* and *HIP Basic* members.

Table 4 – Primary Care Physician (PCP) Services – Office Visits
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Office visit services include supplies for treatment of the illness or injury, medical consultations, procedures performed in the physician's office, second opinion consultations and specialist treatment services provided by the member's PCP. **Amount/Duration Limit**: None **Scope Limit**: None	For second opinion consultations, the MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 5 – Specialty Physician Visits
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Referral physician office visits are included. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 6 – Home Health Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Services include: • Skilled medical services • Nursing care given or supervised by a registered nurse • Nutritional counseling furnished or supervised by a registered dietician • Home health aides • Laboratory services, drugs and medicines prescribed by a physician in connection with home health care • Medical social services Within the benefit, training of family members to provide home health services is noncovered. **Amount/Duration Limit**: 100 visits per year **Scope Limit**: Services are covered only if not considered custodial care and are prescribed in writing by a participating physician as medically necessary, in place of inpatient hospital care or convalescent nursing home, and services provided under physician's care.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 7 – Outpatient Surgery
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Outpatient medical and surgical hospital services are covered when medically necessary. Includes diagnostic invasive procedures that may or may not require anesthesia. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 8 – Allergy Testing
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Includes allergy procedures and administration of serum. **Amount/Duration Limit**: None **Scope Limit**: None	None

Table 9 – Intravenous (IV) Infusion Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Includes coverage for outpatient infusion therapy. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 10 – Chemotherapy – Outpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Includes outpatient therapeutic injections that are medically necessary and may not be self-administered. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 11 – Radiation Therapy – Outpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Includes coverage for outpatient services. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 12 – Dialysis – Outpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Coverage provided for outpatient (including home) dialysis services provided by a participating provider. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 13 – Outpatient Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty and referral for all physician services in an outpatient facility. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 14 – Clinical Trials for Cancer Treatment
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
The clinical trial must be approved or funded by one of the following: • National Institutes of Health (NIH) • Cooperative group of research facilities that have an established peer review program that is approved by an NIH institute or center • Food and Drug Administration (FDA) • U.S. Department of Veterans Affairs • U.S. Department of Defense • Institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institute of the Office for Human Research Protections • Research entity that meets eligibility criteria for a support grant from an NIH center Coverage provided for routine care costs that are incurred in the course of a clinical trial. **Amount/Duration Limit**: None **Scope Limit**: Items and services that are not routine care costs or unrelated to the care method will not be covered.	MCEs may establish PA requirements such as: • General member information • Review of clinical trial to ensure qualified • Review of routine costs related to clinical trial • A justification of services rendered for the medical needs of the member

Table 15 – Dental – Limited Covered Services – Accident/Injury
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Injury to sound and natural teeth, including teeth that have been filled, capped or crowned. **Amount/Duration Limit**: Treatment complete within one year from initiation **Scope Limit**: Coverage not provided for: • Orthodontia • Dental procedures • Repair of injury caused by an intrinsic force (such as the force of the upper and lower jaw in chewing) • Repair of artificial teeth, dentures or bridges • Other dental services (limit applies to *HIP Basic* only)	MCEs may establish PA requirements such as: • General member information • Reporting injury to insurer and receiving follow-up care within specified time frame • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 16 – Urgent Care/Walk-Ins
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Coverage includes after-hours care. **Amount/Duration Limit**: None **Scope Limit**: None	None

Table 17 – Routine Foot Care
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases. **Amount/Duration Limit**: Six visits per year **Scope Limit**: Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions and calluses.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 18 – Voluntary Sterilization for Males
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Amount/Duration Limit: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Emergency Services

The following tables summarize coverage of emergency services for *HIP Plus* and *HIP Basic* members.

Table 19 – Emergency Department Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Emergency room included. **Amount /Duration Limit**: None **Scope Limit**: Medical care outside the United States is not covered.	None

Table 20 – Emergency Transportation: Ambulance/Air Ambulance
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways, and transfer from a hospital to a lower level of care) is covered. **Amount/Duration Limit**: None **Scope Limit**: None	For other medically necessary transportation, authorization may be required in which the MCEs may require: • Other details, such as general member information • Contacting the PCP for other types of transportation-related services • A justification of services rendered for the medical needs of the member

Hospitalization

The following tables summarize coverage of hospitalization services for *HIP Plus* and *HIP Basic* members.

Table 21 – General Inpatient Hospital Care
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Services include: • Semiprivate room and board (private room provided when medically necessary) • Intensive care unit/coronary care unit • Inpatient cardiac rehabilitation and inpatient rehabilitation therapy • General nursing care • Use of operating room or delivery suite • Surgical and anesthesia services and supplies • Ordinary casts • Splints and dressings • Drugs and oxygen used in hospital • Laboratory and X-ray examinations • Electrocardiograms • Special duty nursing (when requested by a physician and certified as medically necessary) • Inpatient specialty pharmaceuticals **Amount/Duration Limit**: None **Scope Limit**: Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.	MCEs may establish PA requirements such as: • General member information • Review of medical necessity • Authorization by acting physician • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 22 – Inpatient Physician Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit includes PCP, specialty and may require a referral for physician services in the hospital. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 23 – Inpatient Surgical Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Surgical hospital services are covered when medically necessary. Services include: • Semiprivate room and board (private room provided when medically necessary) • Intensive care unit/coronary care unit • General nursing care • Use of operating room or delivery suite • Surgical and anesthesia services and supplies • Ordinary casts • Splints and dressings • Drugs and oxygen used in hospital • Laboratory and X-ray examinations • Electrocardiograms • Special duty nursing (when requested by a physician and certified as medically necessary) • Inpatient specialty pharmaceuticals Surgical operations may include replacement of diseased tissue removed while a member. **Amount/Duration Limit**: None **Scope Limit**: Benefit does **not** include: • Bariatric surgery (see *Table 70 – Bariatric Surgery* for *HIP Plus* benefit) • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) (see *Table 69 – TMJ Treatment* for *HIP Plus* benefit) • Personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products • Room and board when temporary leave permitted	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 24 – Noncosmetic Reconstructive Surgery
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Surgical hospital services are covered when medically necessary and approved by physician. Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident. **Amount/Duration Limit**: Services begin within one year of the accident **Scope Limit**: Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 25 – Mastectomy – Reconstructive Surgery
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Surgical hospital services are covered when medically necessary and approved by physician. Covered services include reconstruction of the breast upon which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas. **Amount/Duration Limit**: None **Scope Limit**: Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 26 – Transplants
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Human organ and tissue transplant services for both the recipient and the donor when the recipient is a member. No coverage is provided for the donor or the recipient when the recipient is not a member. Specialty care physician (SCP) provides pretransplant evaluation. Nonexperimental, noninvestigational organ and other transplants are covered. The donor's medical expenses are covered if the person receiving the transplant is a member and the donor's expenses are not covered by another issuer. Transportation and lodging services for the donor are a noncovered benefit. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 27 – Congenital Abnormalities
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Surgical hospital services are covered when medically necessary and approved by physician. **Amount/Duration Limit**: None **Scope Limit**: Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 28 – Anesthesia
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Coverage includes anesthesia services and supplies. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 29 – Hospice Care
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
This benefit may be provided in hospitals, skilled nursing facilities and freestanding hospice centers. Covered services include semiprivate room; private room provided when medically necessary. Hospice care is provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is six months or less. Concurrent care is provided to children (19 and 20 years old). **Amount/Duration Limit**: None **Scope Limit**: Room-and-board services are not covered when temporary leave permitted.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
Note: Home hospice services are covered under HIP. Providers should contact each MCE for authorization instructions.	

Table 30 – Medical Social Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Hospital services to assist member and family in understanding and coping with the emotional and social problems affecting health status **Amount/Duration Limit**: None **Scope Limit**: None	None

Table 31 – Dialysis – Inpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Inpatient dialysis services provided by a participating provider. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 32 – Chemotherapy – Inpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Includes coverage for inpatient services. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 33 – Radiation Therapy – Inpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Includes coverage for inpatient services. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Maternity and Newborn Care

The following table summarizes coverage of maternity services for *HIP Plus* and *HIP Basic* members, which mirrors the maternity coverage available under *HIP Maternity*, *HIP State Plan Plus* and *HIP State Plan Basic*.

> *Note: This table does not include all covered services available to pregnant HIP members. Members enrolled in the HIP Maternity benefit plan receive the full range of Indiana Medicaid State Plan benefits during their pregnancy and for 12 months postpartum.*

Newborn coverage is not included in HIP. Newborns born to members will be covered through Medicaid for children.

Table 34 – Obstetric Care
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Coverage is provided from the State Plan under the physician benefit and includes various obstetrical services, such as antepartum and postpartum visits, laboratory and X-ray (ultrasound) services and other services as medically necessary and appropriate. The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services include two visits within 60 days of delivery. **Amount/Duration Limit**: Limits equivalent to State Plan **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment

The following tables summarize coverage of mental health and substance use disorder (SUD) services, including behavioral health treatment services, for *HIP Plus* and *HIP Basic* members.

Table 35 – Mental/Behavioral Health – Inpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefits include evaluation and treatment in a psychiatric day facility and electroconvulsive therapy. Coverage may also include partial hospitalization depending on the type of services provided. **Amount/Duration Limit**: None **Scope Limit**: Benefit does not include: • Hypnotherapy, behavioral modification or milieu therapy, when used to treat conditions that are not recognized as mental disorders • Personal comfort items • Room and board when temporary leave available	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
Note: Effective Jan. 1, 2020, coverage of acute inpatient stays in facilities that qualify as institutions of mental disease (IMDs) was extended to include members 21 through 64 years of age who are diagnosed with serious mental illness (SMI). PA is required for all inpatient stays. Length of stay will be authorized based on medical necessity. The IHCP will be required to achieve a statewide average length of stay of no greater than 30 days, and reimbursement will not be available for inpatient stays longer than 60 days.	

Table 36 – Mental/Behavioral Health – Outpatient (HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Coverage applies to individual therapy and group therapy sessions. Benefit may also include partial hospitalization depending on the type of services provided. **Amount/Duration Limit**: None **Scope Limit**: Coverage does not include: • Self-help training or other related forms of nonmedical self-care • Marriage counseling • Hypnotherapy, behavioral modification or milieu therapy, when used to treat conditions that are not recognized as mental disorders	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 37 – Substance Abuse Inpatient Treatment (HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit does not include: • Services and supplies for the treatment of codependency or caffeine addiction • Personal comfort items • Room and board when temporary leave permitted Benefit includes detoxification for alcohol or other drug addiction. Coverage may also include partial hospitalization depending on the type of services provided. **Amount/Duration Limit**: Up to 15 days in a calendar month **Scope Limit**: Members 21 through 64 years of age in facilities that qualify as IMDs. Members can be authorized for up to 15 days in a calendar month.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

*Note: The limit of 15 days per month applies **only** for stays in an IMD (psychiatric facility with more than 16 beds) and **only** to members ages 21–64. There is **no** set limit on the length of a substance-abuse stay in a facility that is **not** in an IMD (such as an acute care hospital or psychiatric hospital with 16 beds or fewer), nor is there a fixed limit for length of stay in an IMD for IHCP members under age 21 or over age 64.*

Table 38 – Substance Abuse Outpatient Treatment
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Coverage includes detoxification for alcohol or other drug addiction. Benefit may also include partial hospitalization depending on the type of services provided. **Amount/Duration Limit**: None **Scope Limit**: Benefit does not include services and supplies unrelated to mental health for the treatment of codependency or caffeine addiction.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Prescription Drugs

The following table summarizes coverage of prescription drugs for *HIP Plus* and *HIP Basic* members.

Table 39 – Prescription Drugs
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
The prescription drug benefit will cover at least one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. The *HIP Basic* formulary must support the coverage and noncoverage requirements for legend drugs by Indiana Medicaid, found in *405 IAC 5-24-3*. Prescription supply is limited to 90 days. The *HIP Plus* formulary includes the coverage for all the drugs in the *HIP Basic* formulary and provides additional enhanced benefits that include the following: • Access to many brand-name drugs without prior authorization requirements • Mail-order pharmacy benefit • Medication Therapy Management (MTM) services • No copayment for any filled prescription The exact drugs covered under the formularies may vary by MCE. **Prescription Drug Limits**: Limit on days supply, limit on number of prescriptions, limit on brand drugs, other coverage limits, preferred drug list.	MCEs may establish PA requirements such as: • General member information • A justification of need for prescription related to the medical needs of the member • A planned course of treatment, if applicable, as related to the number of prescriptions provided and duration of treatment PA requirements for prescription drugs may vary by MCE but will comply with Mental Health Parity requirements. MCEs will be required to have a process in place to allow drugs that are medically necessary but not included on the formulary to be accessed by members.

Rehabilitative and Habilitative Services and Devices

The following tables summarize coverage of rehabilitative and habilitative services and devices for *HIP Plus* and *HIP Basic* members.

Table 40 – Physical Therapy, Occupational Therapy and Speech Therapy – Outpatient (HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Amount/Duration/Limit: • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and pulmonary rehabilitation. • *HIP Plus*: As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and pulmonary rehabilitation. **Scope Limit**: Rehabilitative and habilitative services are offered at parity and have distinct benefit limits. *HIP Basic* coverage does not include nonsurgical treatment of TMJ. (See *Table 69 – TMJ Treatment* for the *HIP Plus* benefit.)	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
Note: Habilitative services are not covered for members 21 years of age and older. For 19- and 20-year-old HIP members, habilitative services are covered on a case-by-case basis subject to PA.	

Table 41 – Durable Medical Equipment (DME)
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit includes but is not limited to: • Wheelchairs • Crutches • Respirators • Traction equipment • Hospital beds • Monitoring devices • Oxygen-breathing apparatus • Insulin pumps Training for use of DME and applicable rental fees are also covered. Covered services are only for the basic type of DME necessary to provide for medical needs and do not include nondurable supplies that are not an integral part of the DME setup. **Amount/Duration/Limit**: 15-month rental cap; one every five years per member – replacement **Scope Limit**: DME does not include: • Corrective shoes • Arch supports • Dental prostheses • Deluxe equipment • Common first-aid supplies • Nondurable supplies Other noncovered services include but are not limited to equipment not suitable for home use.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 42 – Prosthetics
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
A prosthetic device means an artificial arm or leg or any portion thereof. Orthotic devices are also covered under this benefit as custom-fabricated braces or supports designed as a component of an artificial arm or leg. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in physical condition or body size due to normal growth. **Amount/Duration/Limit**: None **Scope Limit**: Benefit does not include: • Foot orthotics • Devices solely for comfort or convenience • Devices from a nonaccredited provider	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 43 – Corrective Appliances
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit includes but is not limited to: • Hemodialysis equipment • Breast prostheses • Back braces • Artificial eyes • One pair eyeglasses due to cataract surgery • Ostomy supplies • Prosthetics (all prosthetics except prosthetic limbs) Appliance must be medically necessary and used to restore function or to replace body parts. Coverage is not intended for nondurable appliances. **Amount/Duration/Limit**: None **Scope Limit**: Items not included by the benefit include but are not limited to: • Artificial or prosthetic limbs • Cochlear implants • Dental appliances • Dentures • Foot orthotics • Corrective shoes • Arch supports for plantar fasciitis, flat feet, fallen arches or corns	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 44 – Cardiac Rehabilitation – Outpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit includes services for the improvement of cardiac disease or dysfunction. **Amount/Duration Limit:** • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation. • *HIP Plus*: As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation. **Scope Limit**: Rehabilitative services are offered at parity and share the same, comparable benefit limits.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 45 – Medical Supplies
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit includes casts, dressings, splints and other devices used for reduction of fractures and dislocations. **Amount/Duration Limit**: None **Scope Limit**: Benefit does not include nondurable supplies and/or convenience items.	None

Table 46 – Pulmonary Rehabilitation – Outpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit consists of services that are for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia or hypercapnia. Rehabilitative services are offered at parity and share the same, comparable benefit limits. **Amount/Duration Limit**: • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy and cardiac rehabilitation. • *HIP Plus*: As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy and cardiac rehabilitation. **Scope Limit**: Benefit does not include formalized and predesigned rehabilitation programs for pulmonary conditions.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 47 – Skilled Nursing Facility (SNF)
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Covered services include: • Semiprivate room (private room provided when medically necessary) • Drugs • Specialty pharmaceuticals • Medical social services • Short-term physical, speech and occupational therapies (subject to limits) • Other services generally provided **Amount/Duration Limit**: 100 days per benefit period **Scope Limit**: An SNF does not include any institution or portion of any institution that is primarily for rest, the aged, nonskilled care or care of mental diseases or substance abuse. Room-and-board services are not covered when temporary leave permitted.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Note: For more information about drug reimbursement for nursing facility stays, see the Billing and Reimbursement for Extended Nursing Facility Stays section.

Table 48 – Autism Spectrum Disorder Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit, formerly known as Pervasive Development Disorder (PDD), is a state mandate that must be covered as outlined in the Indiana insurance code. Benefit provides coverage for Asperger's syndrome and autism. Coverage is for services provided as prescribed by the treating physician in accordance with the treatment plan. **Amount/Duration Limit**: • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and pulmonary rehabilitation. • *HIP Plus:* As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and pulmonary rehabilitation. **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 49 – Hearing Aids
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Amount/Duration Limit: One per member every five years **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 50 – Home Health – Medical Supplies, Equipment and Appliances
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefits include medical supplies in connection with home health care. **Amount/Duration Limit**: None **Scope Limit**: Benefit does not include nondurable supplies and/or convenience items.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 51 – Cardiac Rehabilitation – Inpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit includes services for the improvement of cardiac disease or dysfunction. **Amount/Duration Limit**: 90 days annual maximum **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 52 – Rehabilitation Therapy – Inpatient
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning. **Amount/Duration Limit**: 90 days annual maximum **Scope Limit**: Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Note: Habilitative services are not covered for members 21 years of age and older. For 19- and 20-year-old HIP members, habilitative services are covered on a case-by-case basis subject to PA.

Laboratory Services

The following tables summarize coverage of laboratory services for *HIP Plus* and *HIP Basic* members.

Table 53 – Lab Tests
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit provided as outpatient services when medically necessary. **Amount/Duration/Limit**: None **Scope Limit**: Coverage does **not** include lab expenses related to physical exams when provided for employment, school, sports programs, travel, immigration, or administrative or insurance purposes.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 54 – X-Rays
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit provided as outpatient services when medically necessary. **Amount/Duration Limit**: None **Scope Limit**: Coverage does **not** include X-ray expenses related to physical exams when provided for employment, school, sports programs, travel, immigration, or administrative or insurance purposes.	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 55 – Imaging – Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) and Positron Emission Tomography (PET)
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit provided as outpatient services when medically necessary. Coverage also includes magnetic resonance angiography (MRA) and single-photon emission computerized tomography (SPECT) scan. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 56 – Pathology
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit provided as outpatient services when medically necessary. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 57 – Radiology
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit provided as outpatient services when medically necessary. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 58 – Electrocardiogram (EKG or EEG)
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit provided as outpatient services when medically necessary. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Preventive and Wellness Services and Chronic Disease Management

The following tables summarize coverage of preventive and wellness services and chronic disease management for *HIP Plus* and *HIP Basic* members.

HIP preventive care services may be updated at any time, and any age- and gender-appropriate preventive care service can be obtained to qualify a member for rollover.

For procedure codes that are exempt from copayment, see *Preventive Care Services Excluded From Cost Sharing for Healthy Indiana Plan*, accessible from the *Code Sets* page at in.gov/medicaid/providers. These services are also not deducted from POWER Accounts.

Table 59 – Preventive Care Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services and routine immunizations. The following are included: • All preventive items or services that have a rating of "A" or "B" by the United States Preventive Services Task Force (USPSTF) • Immunizations recommended for the individual's age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) • For infants, children, adolescents and adults, preventive care and screenings included in the Health Resources and Services Administration (HRSA) Bright Futures comprehensive guidelines • Preventive screenings for women as recommended by the Institute of Medicine (IOM) **Amount/Duration Limit**: None **Scope Limit**: None	None

Table 60 – Routine Prostate-Specific Antigen (PSA) Test
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Amount/Duration Limit: None **Scope Limit**: One test annually for an individual who is at least 50 years old, or less than 50 years old if at high risk for prostate cancer	None

Table 61 – Diabetes Self-Management Training
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Covered services are limited to physician-authorized visits: • After receiving a diagnosis of diabetes • After receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management • For reeducation or refresher training **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 62 – Health Education
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Benefit provided by the primary care physician (PCP) as part of preventive health care and other health education classes approved by the insurer. **Amount/Duration Limit**: Three visits **Scope Limit**: Classes in nutrition or smoking cessation will be approved up to three visits when referred by the member's physician	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Early and Periodic Screening, Diagnostic and Treatment Services

The following table summarizes coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for *HIP Plus* and *HIP Basic* 19- and 20-year-old members.

For more information about EPSDT services, (including vision and dental services), see the *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services* module.

Table 63 – EPSDT Services
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment. In accordance with CMS regulation, individuals covered under EPSDT are not subject to the IMD exclusion. **Amount/Duration Limit**: None **Scope Limit**: EPSDT is required for 19- and 20-year-old members.	None

Other Covered Benefits

The following tables summarize other covered benefits for *HIP Plus* and *HIP Basic* members.

Table 64 – Osteopathic Manipulative Treatment (OMT)
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
State Plan benefit. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs and circumstances of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 65 – Residential Treatment
(HIP Plus and HIP Basic)

Coverage and Limits	Authorization Requirements
Services provided to individuals in IMDs with a substance use disorder (SUD) diagnosis when determined medically necessary by the MCE utilization review staff and in accordance with an individualized service plan. Room-and-board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the *Social Security Act*. **Scope Limit**: Statewide average length of stay of 30 calendar days, based on medical necessity	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs and circumstances of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 66 – Chiropractic Services
(HIP Plus)

Coverage and Limits	Authorization Requirements
Benefit offered to *HIP Plus* and included in State Plan. Self-referral, a provider referral is not required. No prior authorization is needed. Coverage available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. **Amount/Duration Limit**: One visit per day/six visits per covered benefit year **Scope Limit**: Annual limit of six spinal manipulation visits per covered person per benefit year. One visit per day.	None

Note: HIP Basic does not cover chiropractic manipulation services. Chiropractors can be reimbursed for covered rehabilitation and habilitation-related physical medicine treatments and therapies as well as office visits for HIP Basic members, subject to the limits stated elsewhere for those services.

Table 67 – Dental
(HIP Plus)

Coverage and Limits	Authorization Requirements
The dental benefits include: • Evaluations and cleanings (two per person per benefit year) • Bitewing X-rays (four X-rays per person per benefit year) • Comprehensive X-rays (one complete set every five years) • Minor restorative or corrective services, such as fillings or extractions (four combined per person per benefit year) • Major restorative services, such as crowns (one per person per benefit year) **Amount/Duration Limit**: See above **Scope Limit**: Limited to basic commercial package	The dental insurer may establish PA requirements, such as: • General member information • A justification for the type of dental services rendered based on the medical needs of the member

Note: HIP Basic does not include dental benefits, except as described in the following tables:

- *Table 15 – Dental – Limited Covered Services – Accident/Injury*
- *Table 63 – EPSDT Services*

Table 68 – Vision
(HIP Plus)

Coverage and Limits	Authorization Requirements
The vision benefits include: • Routine exam (one every two years) • Eyeglasses, including frames and lenses (one pair every five years if there is not a sufficient change in prescription [vision], loss, irreparable damage or theft) ➢ Frames include but are not limited to plastic or metal. ➢ Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference. • Replacement eyeglasses (covered when medical necessity guidelines met or due to loss, theft or damage beyond repair) • Contact lenses (covered for medical necessity, such as facial deformity or allergy to frame prevents wearing eyeglasses) • Vision surgeries (covered for medical necessity) • Vision training therapies (covered for medical necessity) **Amount/Duration Limit**: See above **Scope Limit**: None	The vision insurer may establish PA requirements, such as: • General member information • A justification for the type of vision services rendered based on the medical needs of the member or the dollar amount of the service

Note: HIP Basic does not include vision benefits, except as described in Table 63 – EPSDT Services.

Table 69 – TMJ Treatment
(HIP Plus)

Coverage and Limits	Authorization Requirements
State Plan benefit. Coverage includes treatment of temporomandibular joint (TMJ) disorder. **Amount/Duration Limit**: None **Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • Documentation of nonsurgical treatment and duration prior to surgery • A justification of services rendered for the medical needs and circumstances of the member

Note: HIP Basic coverage does not include surgical or nonsurgical treatment of TMJ disorder.

Table 70 – Bariatric Surgery
(HIP Plus)

Coverage and Limits	Authorization Requirements
State Plan Benefit. To be eligible for bariatric surgery benefits, the *HIP Plus* member must meet one of the following criteria: • Have morbid obesity that has persisted for at least five years' duration, and physician-supervised nonsurgical medical treatment has been unsuccessful for at least six consecutive months • Successfully achieved weight loss after participating in physician-supervised nonsurgical medical treatment but has been unsuccessful at maintaining weight loss for two years (> 3 kg [6.6 lb.] weight gain) **Amount/Duration/Scope Limit**: None **Scope Limit:** Benefit does **not** include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.	MCEs may establish PA requirements such as: • General member information • Physician documentation • Documentation of attempt to follow nonsurgical treatment and duration prior to surgery • Documentation of pre- and post-operative expectations • Behavioral health evaluation • Consultation reports from other specialists Justification of services rendered for the medical needs and circumstances of the member
Note: Bariatric surgery is not a covered benefit in HIP Basic.	

Managed Care Entities

All HIP beneficiaries are enrolled to receive services through an MCE under contract to the state of Indiana. The MCEs that manage HIP are as follows: Anthem, CareSource, Managed Health Services (MHS) and MDwise.

The MCEs are subject to the federal laws and regulations as specified in *Code of Federal Regulations 42 CFR Part 438*. The HIP beneficiary will be given an opportunity to select an MCE at the time of application. A HIP beneficiary who does not make an MCE selection at the time of application may be auto-assigned to a HIP MCE by the state. Except in cases of presumptive eligibility, auto-assignment may occur after the date on which the state made the eligibility determination.

The state may adjust the auto-assignment methodology. The state may consider assignment to one of the following:

- Lowest-cost MCE
- MCEs that demonstrate higher quality scores or better health outcomes
- MCEs on a rotating basis

Any change to the auto-assignment methodology must be approved by the CMS before implementation. New beneficiaries will be advised both at the time of application, and upon receiving an initial invoice, of the auto-assignment and their right to change MCEs prior to making their first POWER Account contribution. The notice to beneficiaries will include information on the process to change MCEs.

The state contracts with an enrollment broker, MAXIMUS, to assist interested applicants with their MCE selection so they can make an informed decision. The enrollment broker will provide the applicant with

appropriate counseling on the full spectrum of available MCE choices and will address any questions the applicant may have. After an MCE has been selected and the beneficiary has made either their Fast Track prepayment or first POWER Account contribution, or has begun coverage in *HIP Basic* after nonpayment, the beneficiary is required to remain with that MCE for the calendar year, even if they leave the HIP program and return. Beneficiaries may change their MCE for the following calendar year during MCE selection period between Nov. 1 and Dec. 15 by calling MAXIMUS at 877-GET-HIP-9 (877-438-4479).

MCE Welcome Packet and Member ID Cards

Within five calendar days of a new member's full enrollment, the MCE will send the new member a Welcome Packet. The Welcome Packet will include a new member letter, explanation of where to find information about the MCE's provider network, a copy of the member handbook and the member's ID card.

The member ID card must include the member's IHCP Member ID (also known as RID), as well as the applicability of cost-sharing. Specifically, at minimum, the card must indicate emergency services copayments and other copayments that may apply and direct the provider to call the MCE for specific amounts.

The Welcome Packet must also include educational materials about unique features of the program, including but not limited to the following:

- POWER Account
- Member required cost-sharing
- Nonpayment penalties
- POWER Account rollover, including the recommended preventive care services for the member's benefit year
- If applicable, general information regarding the importance of timely completion of the comprehensive health assessment for members initially identified on the application as potentially medically frail

Figures 1 through 4 show a sample HIP member card for each MCE.

Figure 1 – Sample Anthem HIP Member Card

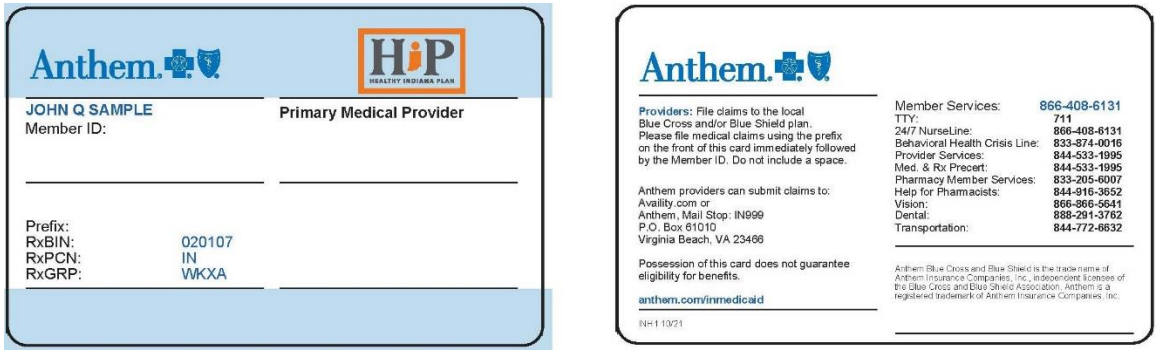

Figure 2 – Sample CareSource HIP Member Card

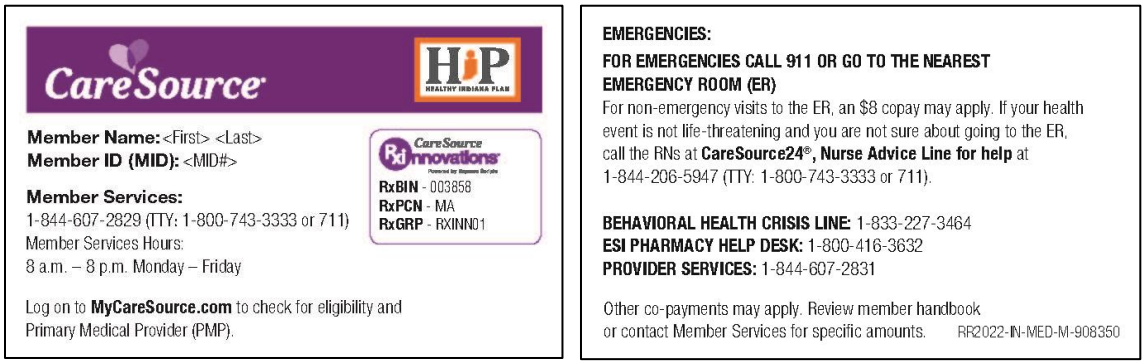

Figure 3 – Sample MHS HIP Member Card

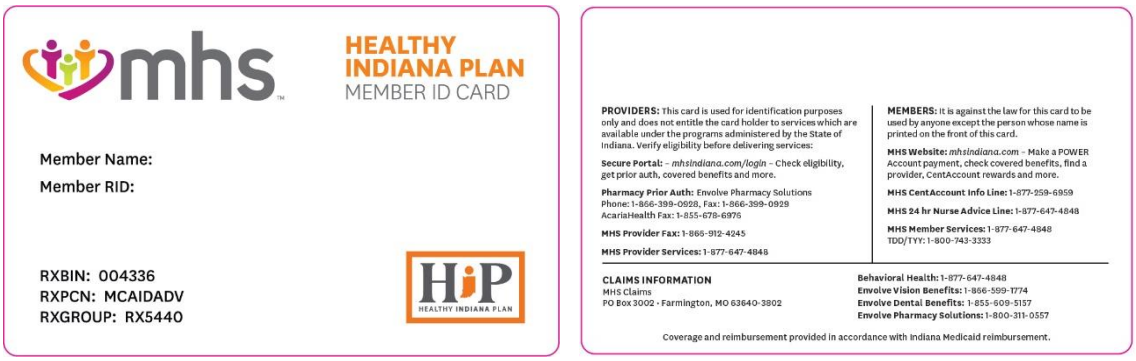

Figure 4 – Sample MDwise HIP Member Card

Carved-In Services

All covered HIP services other than those described in the *Carved-Out Services* section are reimbursed under the managed care delivery system. Claim processing (and prior authorization, when applicable) for these services is performed by the MCE with which the member is enrolled or by a third-party benefit manager contracted by the MCE.

The following sections provide additional information about three specific carved-in services: dental, vision and pharmacy services.

Dental Services

Dental services are covered for *HIP Plus* members who are making monthly contributions to their POWER Account, *HIP State Plan* (*Plus* or *Basic*) members and *HIP Maternity* members. Additionally, limited dental coverage is available as follows:

- Limited accident/injury-related dental services are covered for **all** HIP members under the Ambulatory Patient Services benefit category
- Routine dental screenings and preventive care, as well as necessary treatment services identified as a result of those screenings, are covered for **all 19- and 20-year-old** HIP members through the EPSDT Services benefit category

Dental benefits are provided by the MCE and may be subcontracted to a dental benefit manager (DBM). See the MCE website for the appropriate DBM.

Vision Services

Vision services are covered for *HIP Plus* members who are making monthly contributions to their POWER Account, *HIP State Plan* (*Plus* or *Basic*) members and *HIP Maternity* members. Additionally, routine vision screenings, as well as necessary treatment services identified as a result of those screenings, are covered for all 19- and 20-year-old HIP members through the EPSDT Services benefit category.

Vision benefits are provided by the MCE and may be subcontracted to a vision services provider. See the MCE website for the appropriate information.

Pharmacy Services

Pharmacy benefits are provided by the MCE and may be subcontracted to a pharmacy benefit manager (PBM). The MCEs are responsible for managing this vendor and coordinating the benefits. Each MCE has its own contract with the PBM of their choice. See the *IHCP Quick Reference Guide* for each MCE's pharmacy contact information.

Designated drugs may be carved out (see the *Carved-Out Services* section).

Carved-Out Services

Certain services are carved out of the HIP managed care program, meaning that they are the financial responsibility of the state. For carved-out services, providers should follow fee-for-service (FFS) procedures for PA and billing as specified in the *Prior Authorization* and *Claim Submission and Processing* modules.

Carved-out services include the following:

- Services provided by a school corporation as part of a student's Individualized Education Program (IEP)
- First Steps services
- Designated drugs (see the *Designated Drugs* section)
- Coronavirus disease 2019 (COVID-19) vaccination services
- Crisis intervention services
- Medicaid Rehabilitation Option (MRO) services (see the *Medicaid Rehabilitation Option (MRO) Services* section)

- 1915(i) State Plan Home- and Community-Based Services (HCBS), provided through the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA), including:
  - Adult Mental Health and Habilitation (AMHH) services
  - Behavioral and Primary Healthcare Coordination (BPHC) services
  - Child Mental Health Wraparound (CMHW) services
- Comprehensive environmental lead investigation (initial and follow-up services) provided by a county health department to members with a confirmed elevated blood lead level

Designated Drugs

Certain drugs (such as all covered hepatitis C drugs) are carved out of the managed care medical and/or pharmacy benefit and reimbursed as FFS for all IHCP members, including those enrolled in HIP.

For a complete list of drugs that are carved out of managed care for **medical claims**, see *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group*, accessible from the *Code Sets* page at in.gov/medicaid/providers. Medical claims for these drugs (and PA requests, if applicable) should be submitted to Gainwell.

For a complete list of drugs that are carved out of managed care for **pharmacy claims**, see *Drug Therapies Carved-Out of the Managed Care Pharmacy Benefit*, accessible from the Carved-out Drug Benefits quick link on the Optum Rx Indiana Medicaid website. Pharmacy claims for these drugs (and PA requests, if applicable) should be submitted to Optum Rx, the FFS pharmacy benefit manager.

> *Note: Pharmacy providers should refer to the Statewide Uniform Preferred Drug List (SUPDL) for information regarding preferred status and PA requirements for hepatitis C agents and other carved out drugs. The FFS PDL and PA criteria are available on the Optum Rx Indiana Medicaid website, accessible from the Pharmacy Services page at in.gov/medicaid/providers.*

Medicaid Rehabilitation Option (MRO) Services

The IHCP covers MRO services provided to HIP members receiving *HIP State Plan (Plus* or *Basic*) or *HIP Maternity* benefits. These services are carved out of managed care and reimbursed to community mental health centers (CMHCs) under the FFS delivery system. MCEs are not responsible for claim reimbursement for such services. However, the MCEs are responsible for ensuring care coordination with physical and other behavioral health services for individuals receiving MRO services. The MCE must provide all medically necessary community-based, partial hospital and inpatient hospital behavioral health services.

HIP State Plan Basic member copayment obligations are deducted automatically during claim adjudication; CMHCs are reminded to collect copayments at the time of service.

Nursing Facility Placement

When a HIP member moves into a nursing facility, it is a reported change (also referred to as a verified or positive change). Any nursing facility admission or discharge of an IHCP member enrolled in HIP must be reported to both the Division of Aging and the Division of Family Resources (DFR) within **10 days** of the event.

Nursing facilities must report the admission of a HIP member as follows:

- **To the Division of Aging** by completing the Preadmission Screening and Resident Review (PASRR) process and reporting the member's level of care (LOC) using the Path Tracker tool at assessmentpro.com.
- **To the DFR** via the online FSSA Benefits Portal at fssabenefits.in.gov, by faxing 888-436-9199 or by mail to the local DFR office. To find your DFR office contact information, visit the *Find My Local DFR Office* page at in.gov/fssa/dfr. The following information must be provided:
  - Member's full name
  - Medicaid Member ID (also known as RID)
  - Social Security number
  - Date of birth
  - Admission date
  - Name and address of the nursing facility

A HIP member can be admitted to a nursing facility and remain enrolled in the HIP program; however, coverage of skilled nursing care for HIP members is limited to 100 days. Stays beyond this limit will require the member's enrollment to be transitioned from HIP to an FFS aid category and benefit plan, as described in the following section, to continue Medicaid coverage.

All nursing facility stays for HIP members require PA. If a member's stay is expected to extend beyond the time frame originally prior authorized by the MCE, the provider should request an extension of the PA from the MCE before the original PA expires to allow time for assessment and possible transition to FFS coverage. If the member is ultimately approved for FFS coverage, that coverage may be backdated to the first of the month after the admission was reported (assuming that the provider reported the admission within the required 10-day time frame).

> *Note: Providers should understand that reporting admission of a HIP member to the nursing facility will not automatically change the aid category and benefit plan for the member.*

Transitioning to FFS for Extended Nursing Facility Stays

To be transitioned from HIP to FFS Traditional Medicaid, HIP members must be determined as disabled per the definition used by the Social Security Administration and must qualify under the income and resource limits associated with FFS benefits under the applicable aid category.

After the Social Security Administration or Medical Review Team (MRT) completes a disability determination, the member's coverage can be transitioned from the managed care delivery system to the FFS delivery system effective on the first day of the month following the DFR's receipt of the report of admission.

The following steps outline the process that providers, members and authorized representatives should follow to transition a member from HIP to FFS coverage:

1. The provider submits written notice of the nursing facility admission within 10 days of the admission to both of the following agencies:
   - To the Division of Aging through the Path Tracker tool at assessmentpro.com.
   - To the DFR via the online FSSA Benefits Portal at fssabenefits.in.gov, by faxing 888-436-9199 or by mail to the local DFR office. To find your DFR office contact information, visit the *Find My Local DFR Office* page at in.gov/fssa/dfr.
2. The member or authorized representative contacts the DFR to request the transition to FFS coverage and request an eligibility interview. *(This step should occur at the same time as the provider performs step 1.)*

3. After the transition process has been completed and the member has been awarded FFS coverage, the member and authorized representatives will receive a benefit award letter indicating the start date for the FFS coverage.

The following additional steps may be required to backdate the FFS start date:

4. If the benefit award letter indicates that FFS coverage will begin the month following the *disability determination*, the nursing facility may need to call the DFR to request that the FFS coverage start date be backdated to the month following the *report of admission* (that is, to the first day of the month after the DFR received the reported change from the nursing facility).

> *Note: If a member's admission to a nursing facility was not reported to the Division of Aging and the DFR within 10 days, the FFS start date cannot be backdated.*

5. After the start date has been backdated, the DFR will send a second benefit award letter indicating the new FFS coverage start date.
6. If a new award letter verifying the revised start date is not received within three weeks of the nursing facility requesting the coverage be backdated, the provider should email the appropriate DFR regional mailbox to escalate the issue.
7. If the coverage is not appropriately backdated after an additional three weeks, the provider can contact the Office of Medicaid Policy and Planning (OMPP) Provider Relations team at OMPPProviderRelations@fssa.in.gov.

Billing and Reimbursement for Extended Nursing Facility Stays

While awaiting a resident's transition from HIP to FFS, providers should bill the member's MCE for nursing facility days that the MCE prior authorized. For days beyond what the MCE authorized, providers should wait until after the transition to FFS is complete, and then submit claims for those dates to Gainwell. If waiting for FFS coverage causes the claim to exceed timely filing limits, the provider must enter a claim note indicating: "**Retroactive eligibility – FFS eligibility was backdated**."

If the FFS coverage gets backdated to include dates that have already been billed to the MCE, providers should refund what the MCE paid and then rebill those dates to Gainwell.

> *Note: Drug coverage is not included in per diem rates, and MCEs must provide reimbursement for all covered outpatient drugs (including those typically requiring administration by a licensed healthcare provider) and covered over-the-counter (OTC) drugs to all IHCP enrolled pharmacy providers servicing members admitted to nursing facilities, until the member is transitioned to FFS.*

Reimbursement Rate

The HIP reimbursement rate is the amount of reimbursement MCEs pay to providers participating in HIP.

Professional Reimbursement Rates

In 2024, under the IHCP HIP Rate Equalization Project, the IHCP began aligning its fee-for-service (FFS) Professional Fee Schedule with 100% of the prior year's Medicare rates. Additionally, the IHCP Professional Fee Schedule was implemented as a minimum fee schedule for all managed care plans, requiring MCEs to reimburse providers at or above the fee schedule rates for services covered under the member's benefit plan.

As a result, in 2024, the Hoosier Healthwise, Hoosier Care Connect and FFS rates for professional services that have a Medicare rate were all increased to 100% of the 2023 Medicare rates. However, because HIP reimbursement rates had previously been aligned with the *current* year's Medicare rates, the HIP rates for professional services that have a Medicare rate remained the same in 2024 as they were in 2023. For professional services *without* a Medicare rate, such as dental services, rates under HIP and other managed care programs were changed, as necessary, to pay according to the rate established within the current year's IHCP Professional Fee Schedule.

The IHCP Professional Fee Schedule is accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Institutional/Facility Reimbursement Rates

Under HIP, hospitals, ambulatory surgical centers (ASCs), rehabilitation facilities, outpatient mental health clinics and end-stage renal disease (ESRD) clinics are reimbursed at 100% of the current year's Medicare rates or 130% of the IHCP rate if no Medicare rate is available, for services covered under the member's benefit plan.

See the *Billing and Reimbursement for Extended Nursing Facility Stays* section for special information about HIP reimbursement rates for nursing facility stays.

Note: As part of the HIP Rate Equalization Project, and to be compliant with the Centers for Medicare & Medicaid Services (CMS), the rates for certain institutional providers are being revised, effective for dates of services on or after Jan. 1, 2025. For covered services under both FFS and all managed care programs, the rate factors described in IHCP Bulletin BT2024178 will be applied to a base rate of 100% of the IHCP rate. for the following providers:

- *Rehabilitation hospitals (freestanding)*
- *Long-term acute care (LTAC) hospitals*
- *Acute care hospitals – Out-of-state only*
- *Psychiatric hospitals – Out-of-state only*
- *ASCs*
- *Rehabilitation facilities*
- *Outpatient mental health clinics*
- *ESRD clinics*

Hospital Assessment Fee

HIP is funded in part through Indiana's existing cigarette tax revenues as well as through funds from the Hospital Assessment Fee (HAF). The HAF program began in 2011 and was extended to include HIP in 2016. The fee is currently in place through July 31, 2025.

The HAF is assessed against all licensed acute hospitals and private psychiatric hospitals. The HAF was designed to increase hospital inpatient and outpatient reimbursement to align with the level of payment that would be paid under the federal Medicare program. The state also maintains a share of the HAF assessment to cover costs related to the Medicaid program. MCEs are responsible for maintaining their own list of HAF-eligible facilities.

The HAF payment distributions include increased reimbursement to eligible hospitals for services provided to IHCP members, including presumptively eligible members. HIP MCEs apply HAF adjustment factors accordingly when adjudicating claims. Non-HAF-eligible hospitals continue to be reimbursed applying current rates and methodologies. For more information and for adjustment factors for inpatient and outpatient rates, see the *Hospital Assessment Fee* module.

HAF-Adjusted Reimbursement for Inpatient Hospital Services

HAF-eligible hospitals are reimbursed for inpatient hospital services rendered to all HIP members using the Medicaid All-Patient Refined Diagnosis-Related Group (APR-DRG) or LOC methodology, as appropriate, with the HAF adjustment factors applied. Indiana Medicaid Medical Education payments are paid separately.

HAF-Adjusted Reimbursement for Outpatient Hospital Services

HAF-eligible hospitals are reimbursed for outpatient hospital services rendered to all HIP members using the Medicaid rate methodology with the HAF adjustment factors applied directly to the claim payment.

Due to federal payment limitations, the HAF reimbursement increase does not apply to the following procedure codes billed on an outpatient claim:

- Laboratory services, defined as the procedure codes listed on the Medicare Clinical Laboratory Fee Schedule, available from the *Clinical Laboratory Fee Schedule* page at cms.gov
- Drug procedure codes linked to revenue code 636 – *Pharmacy (Extension of 025X) – Drugs Requiring Detailed Coding*
- DME procedure codes linked to revenue code 274 – *Medical/Surgical Supplies and Devices – Prosthetic/Orthotic Devices*

The HAF adjustment factor applies to outpatient hospital claim detail lines.