INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Healthy Indiana Plan

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures beginning February 1, 2015 Published: June 5, 2018	New document	FSSA and DXC
2.0	Policies and procedures as of July 1, 2019 Published: November 10, 2020	Scheduled update: • Reorganized and edited as needed for clarity • Updated links to IHCP website • Added note box with standard wording at beginning of module • Added note about DXC company name change • Updated the *Waiver/Authority* section with new waiver information • In the *HIP Program Overview* section, clarified coverage when a HIP member transfers to another IHCP program. • Added information about Presumptive Eligibility members in the *Fast Track Enrollment* section • Added the *Prior Authorization for Individuals with Fast Track Prepayment* section • Updated the *HIP Eligibility and Benefit Plans* section • Updated tables as needed per the new ABPs in the *HIP Plus, HIP Basic, and HIP Maternity Benefit Plans* section • Updated the *Presumptive Eligibility Adult (PE Adult)* section • In the *Managed Care Entities* section, updated information about members staying with MCEs during the calendar year they are enrolled and what they	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		need to do to change MCEs for the next calendar year • Deleted information about POWER Account debit cards and updated sample HIP member cards in the *MCE Welcome Packet and Member ID Cards* section • Updated *Table 72 – Pharmacy Services* • Added HIP Maternity to the *Medicaid Rehabilitation Option (MRO) Services* section • Updated the *Designated Drugs* section • Updated the contact information in the *Nursing Facility Placement* section • Update the contact information in the *Extended Nursing Facility Stays* section and added a note about a policy change • Updated the *Hospital Assessment Fee* section and subsections	

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Note:	*For updates to the information in this module, see IHCP Banner Pages and 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 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 new waiver was approved for a 3-year period, from February 1, 2018, through December 31, 2020.

Under the new waiver, Indiana is building on and changing its previous HIP program in multiple ways, including the following:

- *HIP Maternity* coverage for pregnant women
- Simplified POWER Account contribution calculation
- Implementation of a tobacco user surcharge
- Addition of some chiropractic coverage
- A substance use disorder (SUD) treatment program
- Member benefit period and MCE selection based on calendar year

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 Plus Copay*

See the *HIP Eligibility and Benefit Plans* 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
- 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.

If an individual does not make a credit card payment at the time of application, he or she will be invoiced by the managed care entity (MCE) to which the individual is assigned. From the date the Fast Track invoice was issued, the individual has 60 days to make either a Fast Track prepayment or his or her first POWER Account contribution to be able to begin *HIP Plus* coverage. For example, if the individual makes his or her Fast Track payment or first POWER Account contribution in July, then his or her *HIP Plus* coverage will begin July 1. If the individual makes the contribution in August, *HIP Plus* coverage will begin August 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 August 1.
- If the individual's income is over 100% of the FPL, he or she 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

Effective April 1, 2019, a new prior authorization (PA) process was established for IHCP providers that assist individuals with a HIP Fast Track prepayment. This process allows for a retroactive PA 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 5 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 Member ID (also known as RID). The notification will occur within 7 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.

HIP Eligibility and Benefit Plans

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.
- ***HIP Basic*** – This plan is for members with income at or below 100% FPL who fail to make a POWER Account contribution. *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 emergency room (ER) visit. *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* has a more limited formulary for pharmacy benefits.

- ***HIP State Plan Plus*** – This plan offers access to all benefits available under the 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 ER visit.
- ***HIP State Plan Basic*** – This plan offers access to all benefits available under the 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 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 postpartum coverage period is over.
- ***HIP Plus Copay*** – This plan offers the coverage of *HIP Plus* benefits but requires copayment for all services. Copayments match those for *HIP Basic* at $4, $8, or $75. 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*** *(MA HA) benefit plan. The benefits and copayment requirements of PE Adult mirror those of HIP Basic. However, PE Adult coverage is provided under the fee-for-service delivery system, rather than through an MCE. See the Presumptive Eligibility module for more information.*

Table 1 provides an overview of the benefits available under the HIP plans. For more detailed information about the specific services covered under *HIP Plus*, *HIP Basic*, and *HIP Maternity*, see Tables 2 through 71.

Table 1 – Benefit Coverage Summary for HIP Benefit Plans

Benefit Category	HIP Basic	HIP Plus	HIP Maternity	HIP State Plan
Ambulatory Patient Services	X	X	X	X
Emergency Services	X	X	X	X
Urgent Care	X	X	X	X
Hospitalization	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	X	X	X	X
Laboratory Services	X	X	X	X
Preventive and Wellness Services and Chronic Disease Management	X	X	X	X
Pediatric Services Including Oral and Vision Care	X	X	X	X
Adult Vision		X	X	X
Adult Dental		X	X	X

Benefit Category	HIP Basic	HIP Plus	HIP Maternity	HIP State Plan
Adult 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
Residential Treatment		X	X	X
Chiropractic Spinal Manipulations		X	X	X
Medicaid Rehabilitation Option			X	X
Nonemergency Transportation			X	X

HIP Plus, HIP Basic, and HIP Maternity Benefit Plans

HIP 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. The *HIP Maternity* benefit plan offers enhanced services for *HIP Plus* or *HIP Basic* members during pregnancy. For specific billing and coding information, refer to the member's assigned MCE for directions.

Ambulatory Patient Services

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

Table 2 – Primary Care Physician (PCP) Services – Office Visits

HIP Plus, HIP Basic, and HIP Maternity	
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 3 – Specialty Physician Visits

HIP Plus, HIP Basic, and HIP Maternity	
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 4 – Home Health Services

HIP Plus, HIP Basic, and HIP Maternity	
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 hospice services • Home health aides • Laboratory services, drugs, and medicines prescribed by a physician in connection with home health care • Medical social services Home hospice services are considered a separate service. 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 5 – Outpatient Surgery

HIP Plus, HIP Basic, and HIP Maternity	
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 6 – Allergy Testing

HIP Plus, HIP Basic, and HIP Maternity	
HIP Plus, HIP Basic, and HIP Maternity Coverage	**Authorization Requirements**
Includes allergy procedures and administration of serum. **Amount/Duration Limit**: None **Scope Limit**: None	None

Table 7 – Intravenous (IV) Infusion Services

HIP Plus, HIP Basic, and HIP Maternity	
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 8 – Chemotherapy – Outpatient

HIP Plus, HIP Basic, and HIP Maternity	
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 9 – Radiation Therapy – Outpatient

HIP Plus, HIP Basic, and HIP Maternity	
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 10 – Dialysis – Outpatient

HIP Plus, HIP Basic, and HIP Maternity	
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 11 – Outpatient Services

HIP Plus, HIP Basic, and HIP Maternity	
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 12 – Clinical Trials for Cancer Treatment

HIP Plus, HIP Basic, and HIP Maternity	
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 Protection • 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 13 – Dental – Limited Covered Services – Accident/Injury

HIP Plus, HIP Basic, and HIP Maternity	
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 1 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 14 – Urgent Care/Walk-Ins

HIP Plus, HIP Basic, and HIP Maternity	
Coverage and Limits	**Authorization Requirements**
Coverage includes after-hours care. **Amount/Duration Limit**: None **Scope Limit**: None	None

Table 15 – Routine Foot Care

HIP Plus, HIP Basic, and HIP Maternity	
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 16 – Voluntary Sterilization for Males

HIP Plus, HIP Basic, and HIP Maternity	
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*, *HIP Basic*, and *HIP Maternity* members.

Table 17 – Emergency Department Services

HIP Plus, HIP Basic, and HIP Maternity	
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 18 – Emergency Transportation: Ambulance/Air Ambulance

HIP Plus, HIP Basic, and HIP Maternity	
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*, *HIP Basic*, and *HIP Maternity* members.

Table 19 – General Inpatient Hospital Care

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 20 – Inpatient Physician Services

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 21 – Inpatient Surgical Services

HIP Plus, HIP Basic, and HIP Maternity	
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 71 – Bariatric Surgery* for *HIP Plus* benefit) • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) (see *Table 67 – TMJ Treatment Services* for *HIP Plus* and *HIP Maternity* benefit) • 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. • 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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 22 – Noncosmetic Reconstructive Surgery

HIP Plus, HIP Basic, and HIP Maternity	
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 1 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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 23 – Mastectomy – Reconstructive Surgery

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 24 – Transplants

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 25 – Congenital Abnormalities

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 26 – Anesthesia

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 27 – Hospice Care

HIP Plus, HIP Basic, and HIP Maternity	
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 6 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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
Note Home hospice services are considered a separate service; see Table 4 – Home Health Services.	

Table 28 – Medical Social Services

HIP Plus, HIP Basic, and HIP Maternity	
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 29 – Dialysis – Inpatient

HIP Plus, HIP Basic, and HIP Maternity	
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 30 – Chemotherapy – Inpatient

HIP Plus, HIP Basic, and HIP Maternity	
Coverage and Limits	**Authorization Requirements**
Includes coverage for inpatient chemotherapy 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 31 – Radiation Therapy – Inpatient

HIP Plus, HIP Basic, and HIP Maternity	
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*, *HIP Basic*, and *HIP Maternity* members.

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

Table 32 – Obstetric Care

HIP Plus, HIP Basic, and HIP Maternity	
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 • 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*, *HIP Basic*, and *HIP Maternity* members.

Table 33 – Mental/Behavioral Health – Inpatient

HIP Plus, HIP Basic, and HIP Maternity	
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. These services are not provided through institutions of mental disease (IMDs). **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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
Note: Effective January 1, 2020, coverage of acute inpatient stays in facilities that qualify as IMDs is 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 34 – Mental/Behavioral Health – Outpatient

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 35 – Substance Abuse Inpatient Treatment

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 36 – Substance Abuse Outpatient Treatment

HIP Plus, HIP Basic, and HIP Maternity	
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 • 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*, *HIP Basic*, and *HIP Maternity* members.

Table 37 – Prescription Drugs

HIP Plus, HIP Basic, and HIP Maternity	
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 30 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 • 90-day prescription supplies • Mail order pharmacy benefit • Medication Therapy Management (MTM) services • No copayment for any filled prescription *HIP Maternity* prescription coverage mirrors that of *HIP State Plan Plus.* 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*, *HIP Basic*, and *HIP Maternity* members.

Table 38 – Physical Therapy, Occupational Therapy, and Speech Therapy – Outpatient

HIP Plus, HIP Basic, and HIP Maternity	
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. • *HIP Maternity*: Coverage mirrors State Plan benefits. **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 67 – TMJ Treatment Services* for *HIP Plus* and *HIP Maternity* benefit.)	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • 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 members under 21 years of age, habilitative services are covered on a case-by-case basis subject to PA.	

Table 39 – Durable Medical Equipment (DME)

HIP Plus, HIP Basic, and HIP Maternity	
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 5 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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 40 – Prosthetics

HIP Plus, HIP Basic, and HIP Maternity	
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 abnormal 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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 41 – Corrective Appliances

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 42 – Cardiac Rehabilitation– Outpatient

HIP Plus, HIP Basic, and HIP Maternity	
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. • *HIP Maternity*: Coverage mirrors State Plan benefits **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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 43 – Medical Supplies

HIP Plus, HIP Basic, and HIP Maternity	
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 44 – Pulmonary Rehabilitation – Outpatient

HIP Plus, HIP Basic, and HIP Maternity	
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. • *HIP Maternity*: Coverage mirrors State Plan benefits **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 Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 45 – Skilled Nursing Facility (SNF)

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 46 – Autism Spectrum Disorder Services

HIP Plus, HIP Basic, and HIP Maternity	
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. • *HIP Maternity*: Coverage mirrors State Plan benefits **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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 47 – Hearing Aids

HIP Plus, HIP Basic, and HIP Maternity	
Coverage and Limits	**Authorization Requirements**
Amount/Duration Limit: One per member every 5 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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 48 – Home Health – Medical Supplies, Equipment, and Appliances

HIP Plus, HIP Basic, and HIP Maternity	
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 Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 49 – Cardiac Rehabilitation – Inpatient

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 50 – Rehabilitation Therapy – Inpatient

HIP Plus, HIP Basic, and HIP Maternity	
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 • 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 members under 21 years of age, 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*, *HIP Basic*, and *HIP Maternity* members.

Table 51 – Lab Tests

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 52 – X-Rays

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 53 – Imaging – Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), and Positron Emission Tomography (PET)

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 54 – Pathology

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 55 – Radiology

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 56 – Electrocardiogram (EKG or EEG)

HIP Plus, HIP Basic, and HIP Maternity	
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 • 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*, *HIP Basic*, and *HIP Maternity* members.

Table 57 – Preventive Care Services

HIP Plus, HIP Basic, and HIP Maternity	
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 58 – 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 59 – Diabetes Self-Management Training

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 60 – Health Education

HIP Plus, HIP Basic, and HIP Maternity	
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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
**Note: See Table 70 for HIP Maternity smoking cessation coverage.*	

Pediatric Services Including Oral and Vision Care

The following table summarizes coverage of pediatric services, including oral and vision care, for *HIP Plus*, *HIP Basic*, and *HIP Maternity* members.

Table 61 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

HIP Plus, HIP Basic, and HIP Maternity	
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*, *HIP Basic*, and *HIP Maternity* members.

Table 62 – Osteopathic Manipulative Treatment (OMT)

HIP Plus, HIP Basic, and HIP Maternity	
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 63 – Residential Treatment

HIP Plus, HIP Basic, and HIP Maternity	
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 64 – Chiropractic Services

HIP Plus and HIP Maternity*	
Coverage and Limits	**Authorization Requirements**
HIP Plus: 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. *HIP Maternity:* Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions. **Amount/Duration Limit**: • *HIP Plus:* One visit per day/six visits per covered benefit year • *HIP Maternity:* Limits equivalent to State Plan **Scope Limit**: • *HIP Plus:* Annual limit of six spinal manipulation visits per covered person per benefit year. One visit per day. • *HIP Maternity:* None	*HIP Plus:* None *HIP Maternity:* MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
**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 65 – Dental

HIP Plus and HIP Maternity*	
Coverage and Limits	**Authorization Requirements**
HIP Plus: 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 5 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) *HIP Maternity:* Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits. **Amount/Duration Limit**: • *HIP Plus:* See above • *HIP Maternity:* Limits equivalent to State Plan **Scope Limit**: • *HIP Plus:* Limited to basic commercial package • *HIP Maternity:* None	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 13 – Dental – Limited Covered Services – Accident/Injury* • *Table 61 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services*	

Table 66 – Vision

HIP Plus and HIP Maternity*	
Coverage and Limits	**Authorization Requirements**
HIP Plus: The vision benefits include: • Routine exam (one every 2 years) • Eyeglasses, including frames and lenses (one pair every 5 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) Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference. *HIP Maternity:* Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The benefits include State Plan equivalent benefits. **Amount/Duration Limit**: • *HIP Plus:* See above • *HIP Maternity:* Limits equivalent to State Plan **Scope Limit**: • *HIP Plus:* None • *HIP Maternity:* 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 61 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services table.*	

Table 67 – TMJ Treatment

HIP Plus and HIP Maternity*	
Coverage and Limits	**Authorization Requirements**
HIP Plus: State Plan benefit. Coverage includes treatment of temporomandibular joint (TMJ) disorder. *HIP Maternity:* Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage includes treatment of TMJ disorder. **Amount/Duration Limit**: None **Scope Limit**: None	For authorization, MCEs may require prior authorization requirements such as: • General member information • Documentation of nonsurgical treatment and duration prior to surgery • 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 68 – Nonemergency Transportation Services

HIP Maternity*	
Coverage and Limits	**Authorization Requirements**
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions. **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 • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment
**Note: Nonemergency transportation is not included in HIP Plus or HIP Basic.*	

Table 69 – Medicaid Rehabilitation Option (MRO)

HIP Maternity*	
Coverage and Limits	**Authorization Requirements**
Benefit is only offered to women who become pregnant while enrolled in HIP and includes State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. MRO services are designed to assist in the rehabilitation of the consumer‘s optimum functional ability in daily living activities. **Amount/Duration Limit:** None **Scope Limit**: None	
**Note: MRO services are not included in HIP Plus or HIP Basic.*	

Table 70 – Health Education – Smoking Cessation

HIP Maternity*	
Coverage and Limits	**Authorization Requirements**
For *HIP Maternity*, the benefit includes up to 12 weeks in a smoking cessation course providing treatment and counseling. Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. **Duration/Scope Limit**: 12-week course	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member
**Note: See Table 60 for smoking cessation coverage for HIP Plus and HIP Basic members.*	

Table 71 – 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 5 years' duration, and physician-supervised nonsurgical medical treatment has been unsuccessful for at least 6 consecutive months • Successfully achieved weight loss after participating in physician-supervised nonsurgical medical treatment but has been unsuccessful at maintaining weight loss for 2 years (> 3 kg [6.6 lb.] weight gain) **Duration/Scope Limit**: None	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 • A justification of services rendered for the medical needs and circumstances of the member 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), or room and board when temporary leave permitted.
**Note: Bariatric surgery is not a covered benefit in HIP Basic.*	

HIP State Plan Plus and HIP State Plan Basic

Members with *HIP State Plan Plus* or *HIP State Plan Basic* will receive Indiana State Plan level benefits, including MRO, nonemergency 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 these members mirror those of the *HIP Plus* or *HIP Basic* program.

Presumptive Eligibility Adult (PE Adult)

PE Adult members determined presumptively eligible on or after January 1, 2019, have their services reimbursed under the FFS delivery system for the duration of their PE period. Providers must submit *PE Adult* claims (and prior authorization requests, when applicable) to DXC Technology. The *PE Adult* benefit plan mirrors the *HIP Basic* benefit. Individuals who receive *PE Adult* will have copayments that mirror the amounts that must be paid when enrolled in *HIP Basic*. For more information, see the *Presumptive Eligibility* module.

> *Note: On October 1, 2020, the name of the IHCP fiscal agent changed from DXC Technology to Gainwell Technologies.*

Managed Care Entities

All HIP beneficiaries are enrolled to receive services through an MCE under contract to the State. 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 are able to change their MCE for the following calendar year during MCE selection period between November 1 and December 15 by calling MAXIMUS at 1-877-GET-HIP-9 (1-877-438-4479).

MCE Welcome Packet and Member ID Cards

Within 5 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 some sample HIP member cards for each MCE.

Figure 1 – Sample Anthem HIP Member Card

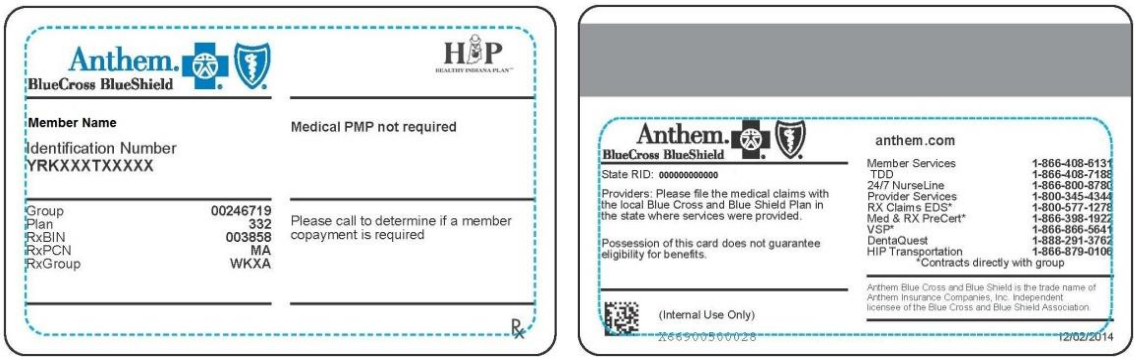

Figure 2 – Sample MDwise HIP Member Card

Figure 3 – Sample MHS HIP Member Card

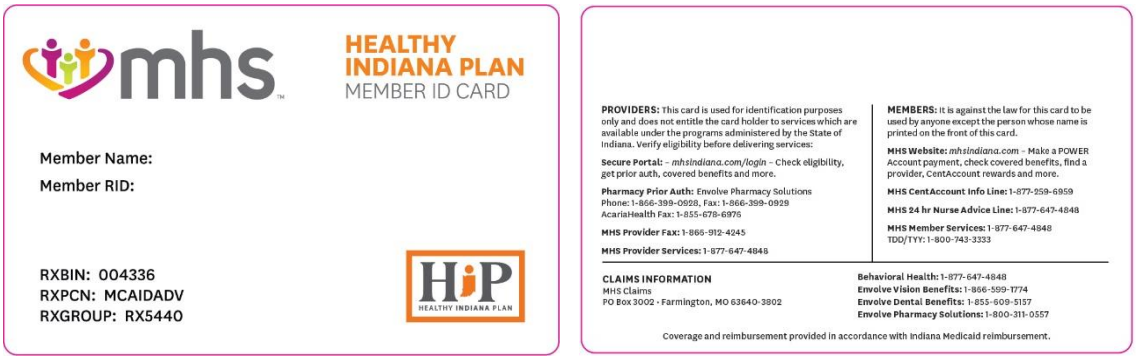

Figure 4 – Sample CareSource HIP Member Card

Carved-In Services

Pharmacy services, as well as vision and dental services, when applicable, are carved into the HIP managed care arrangement.

Dental Services

Dental services are provided only to *HIP Plus* members who are making monthly contributions to their POWER Account, *HIP State Plan* (*Plus* or *Basic*) members, and *HIP Maternity* members. 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 provided only to *HIP Plus* members who are making monthly contributions to their POWER Account, *HIP State Plan* (*Plus* or *Basic*) members, and *HIP Maternity* members. 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. Select pharmacy services may be carved out (see the *Carved-Out Services* section).

Table 72 – Pharmacy Services

Anthem	MHS	MDwise	CareSource
Pharmacy Information PBM: IngenioRx Claims: 1-833-205-6007 PA: 1-844-533-1995 PA Fax (Retail Pharmacy): 1-844-864-7860 PA Fax (Medical Injectable): 1-888-209-7838 Help for Pharmacists: 1-833-236-6191	Pharmacy Information PBM Claims: CVS Health PBM PA: US Script Claims: 1-800-311-0557 PA: 1-866-399-0928 PA Fax: 1-866-399-0929 (standard) PA Fax: 1-855-678-6976 (specialty)	Pharmacy Resources PBM: MedImpact Claims: 1-844-336-2677 PA: 1-800-788-2949 PA Fax: 1-858-790-7100	Pharmacy Information PBM Claims: CVS Health Claims: 1-800-342-5441 PA: 1-844-607-2831 PA Fax: 1-844-432-8924

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.

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.

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 DXC.

> *Note: On October 1, 2020, the name of the IHCP fiscal agent changed from DXC Technology to Gainwell Technologies.*

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 Pharmacy Benefit Drugs quick link on the OptumRx Indiana Medicaid website. Pharmacy claims for these drugs (and PA requests, if applicable) should be submitted to OptumRx, the FFS pharmacy benefit manager.

> *Note: Pharmacy providers should refer to the Indiana Medicaid Preferred Drug List (PDL) 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 OptumRx Indiana Medicaid website, accessible from the Pharmacy Services page at in.gov/medicaid/providers.*

Nursing Facility Placement

Any nursing facility admission or discharge of an IHCP member enrolled in HIP must be reported to both the Division of Aging (DA) and the Division of Family Resources (DFR) within **10 days** of the event:

- Providers should report the event to the DA through the Path Tracker tool at assessmentpro.com.
- Reports should be made to the DFR via the online FSSA Benefits Portal, by faxing 1-800-403-0864, or by mail to the local DFR office. To find your DFR office contact information, visit the *DFR Benefits Information* page at in.gov/fssa/dfr.

Extended Nursing Facility Stays

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. A HIP member can be admitted to a nursing facility and remain enrolled in the HIP program; however, coverage of skilled nursing care for most 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 to continue Medicaid coverage. In order to transition, HIP members must qualify under the income and resource limits associated with FFS benefits. Specific steps must be taken by the nursing facility to facilitate the member's transition:

1. All nursing facility stays for HIP members require PA. If a member's stay is expected to extend beyond the original PA time frame, the provider should request an extension of the PA from the enrolling MCE before the original PA expires to allow time for assessment and possible transition to FFS coverage.
2. The nursing facility must complete the Preadmission Screening and Resident Review (PASRR) process and report the member's level of care (LOC) to the DA using the Path Tracker tool. If appropriate, the nursing facility must notify the enrolling MCE of the intent to extend a member's stay and the need to transition the member to FFS coverage.
3. The nursing facility must notify DFR of the need to move the member to an aid category for FFS coverage. Notice should be made via the online FSSA Benefits Portal, by faxing 1-800-403-0864, or by mail to the local DFR office. 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

The nursing facility is expected to complete the transition steps within the first 60 days of a HIP member's admission. After 60 calendar days, if the member remains in the facility, the member's assessment and LOC determination has not been initiated, and the member continues to be enrolled with the MCE, the nursing facility may be liable for any costs associated with the member's long-term stay. The time limit is established to ensure the appropriate reimbursement (managed care versus FFS) for services rendered without interrupting the care being delivered to the member.

> *Note: The IHCP updated its eligibility policy so that when a HIP member moves into a nursing facility, it is now a reported change (also referred to as verified or positive change). This policy update is effective for reported dates of admission on or after October 1, 2019.*
>
> *After the Social Security Administration (SSA) or Medical Review Team (MRT) completes a disability determination, this policy change allows a member's coverage to transition from the managed care delivery system to the FFS delivery system, on the first day of the month following the reported change.*

Billing for Extended Nursing Facility Stays for HIP Members

When a HIP member in a nursing facility is transitioning from HIP to FFS, it is the nursing facility's responsibility to meet the assessment and notification obligations in a timely manner. When completing this process, nursing facilities are reminded that aid category changes are prospective; therefore, changes are effective on the first of the month following the date the request is made. Nursing facilities must work with the MCE on the submission of PA requests and claims for the dates of service during the transition period. If the facility has met the required notice and assessment obligations but a request for PA or a claim is denied by the MCE, the provider must exhaust all grievances and appeals processes with the MCE to resolve the issue.

If the nursing facility cannot resolve the issue with the MCE, the facility may request a retroactive transition date for the member's disenrollment from managed care and enrollment in FFS from DFR. Requests must include the following:

- A provider-generated claim (or copy of same) that clearly shows that the claim was denied by the enrolling MCE
- Verification that all grievances with the MCE have been exhausted
- An explanation of the situation

All requests will be reviewed on a case-by-case basis; approval of a retroactive transition date is not guaranteed.

> *Note: These requests should not be made to the Office of Medicaid Policy and Planning (OMPP) or to the IHCP provider representative.*

Questions about IHCP managed care member services should be directed to the MCE with which the member is enrolled.

Reimbursement

The reimbursement rate is the amount of reimbursement MCEs pay to providers participating in HIP. This amount is established by the FSSA secretary and is based on a Medicaid reimbursement formula, which is comparable to one of the following:

- The federal Medicare reimbursement rate for the service provided
- One hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate

Hospital Assessment Fee

HIP is funded in part through Indiana's existing cigarette tax revenues that support the current HIP program, as well as funds from the Hospital Assessment Fee (HAF). The HAF program began in 2011 and was extended to include HIP in 2016. The HAF program is currently effective through June 30, 2021.

The HAF is assessed against all licensed acute hospitals and private psychiatric hospitals, and 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 (AP-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 HIP members as follows:

- HIP expansion population: Reimbursement is based on Medicare rates.
- HIP low-income parent and caretaker population: Reimbursement is based on 130% of Medicaid rates.

A separate payment is made to account for the difference between the initial base reimbursement and the enhanced HAF-adjusted amount. 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. Reimbursement for outpatient laboratory services, defined as the procedure codes listed on the Medicare Clinical Laboratory Fee Schedule, are not subject to the HAF increase due to federal payment limitations. The HAF adjustment factor applies to outpatient hospital claim detail lines.