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## Guide to Indiana Medicaid

Indiana's Medicaid program, collectively referred to as the Indiana Health Coverage Programs (IHCP), provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant, or meet other eligibility requirements. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). In Indiana, the Family and Social Services Administration (FSSA) administers the IHCP. The IHCP receives federal and state funds in order to operate the program and reimburse providers for reasonable and necessary medical care for eligible members.

### Healthy Indiana Plan

The Healthy Indiana Plan (HIP) is a health insurance program for certain qualified adults. The plan is offered by the State of Indiana. It pays for medical costs for members and can even provide vision and dental coverage. It also rewards members for taking better care of their health. HIP covers Hoosiers ages 19 to 64 who meet specific income levels.

HIP Plus - The initial plan selection for all members is HIP Plus which offers the best value for members. HIP Plus has comprehensive benefits including vision, dental, and chiropractic. The member pays an affordable monthly POWER account contribution based on income. There is no copayment required for receiving services with one exception: using the emergency room where there is no true emergency.

HIP Basic - HIP Basic is an option for members with a household income less than or equal to 100 percent of the federal poverty level (FPL) who don't make their POWER account contributions. For HIP basic, essential health benefits are covered, but vision and dental services are not. The member is also required to make a copayment each time he or she receives a health care service—such as going to the doctor, filling a prescription, or being admitted to a hospital. These payments may range from \$4 to \$8 per doctor visit or prescription fill and can reach \$75 per hospital stay.

### Hoosier Care Connect

Hoosier Care Connect (HCC) is a health care program for individuals who are 65 years and older; blind or disabled; and are not eligible for Medicare. The HCC program is operated within the managed care delivery system. Contracted managed care entities (MCEs) arrange, administer,



and pay for the delivery of healthcare services to members enrolled in their health plan. All services, except Medicaid Rehabilitation Option (MRO) services, are provided through the MCEs, including dental and pharmacy services.

## **Hoosier Healthwise & CHIP**

Hoosier Healthwise (HHW) is a health care program for pregnant women and children up to age 19. The program covers medical care like doctor visits, prescription medicine, mental health care, dental care, hospitalizations, and surgeries at little to no cost to the member or the member's family.

The Children's Health Insurance Program (CHIP) falls under the Hoosier Healthwise program. CHIP is for children up to age 19 whose families have slightly higher incomes. CHIP members are required to pay a low monthly premium for coverage, as well as copays for certain services.

## **Traditional Medicaid**

Traditional Medicaid provides full health care coverage to individuals with low income. Eligibility is based on the member's aid category. Members in the following categories will be covered by traditional Medicaid:

- Members eligible for home and community-based services.
- Members who are dually eligible for Medicare and Medicaid.
- Members in nursing homes, intermediate care facilities for the intellectually disabled, and state-operated facilities.

## **Home and Community Based Services**

Home and Community Based Services (HCBS) allow Medicaid programs to pay for services that are provided in a person's home or other community setting, rather than a Medicaid-funded facility or institution. Persons must qualify for institutional level of care in order to be eligible for home and community-based services. HCBS programs can be used along with federal, state, and local programs, such as Medicaid State Plans and Administration on Aging grants.

### **1915(c)**

The Division of Disability and Rehabilitative Services (DDRS) oversees the Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Waiver programs. The Division of Aging oversees the Aged & Disabled (A&D) Waiver and Traumatic Brain Injury (TBI) Waiver programs. OMPP facilitates the waivers' contractual obligations with CMS.

- **Aged & Disabled Waiver**
  - The A&D Waiver provides an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide

services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities return to community settings, such as their own homes, apartments, assisted living, or adult family care.

▪ **Traumatic Brain Injury Waiver**

- The goal of the TBI Waiver is to ensure that individuals with a traumatic brain injury receive appropriate services based on their needs and the needs of their families.
- Indiana defines a traumatic brain injury as a trauma that has occurred as a closed- or open-head injury caused by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are mechanical, or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function that is not degenerative or congenital in nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability. Indiana’s definition of TBI does not include birth trauma-related injury.

▪ **Community Integration and Habilitation Waiver**

- The CIH Waiver provides Medicaid HCBS to participants in a range of community settings as an alternative to care in an intermediate care facility (ICF) for individuals with intellectual disabilities (IID). The CIH Waiver serves individuals with an intellectual/developmental disability, autism spectrum disorder, or related conditions who have substantial functional limitations, as defined in 42 CFR 435.1010. However, entrance into services under the CIH Waiver occurs only when an applicant has been determined by DDRS to meet priority criteria of one or more federally approved reserved waiver capacity categories; a funded slot is available; and, in some instances, DDRS determines that other placement options are neither appropriate nor available.
- When priority access has been deemed appropriate and a priority waiver slot in the specific reserved waiver capacity category met by the applicant remains open, participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop a Person-Centered Individualized Support Plan (PCISP) using a person-centered planning process guided by an individual support team (IST). The IST is composed of the participant, their case manager, and anyone else of the participant’s choosing—typically family, friends, and service providers. The participant with the IST

selects services, identifies service providers of their choice, and develops a plan of care (POC) or cost comparison budget (CCB) that must be approved by DDRS and reflect services to be purchased through the waiver.

- The goal of the CIH Waiver is to provide access to meaningful and necessary home and community-based services and supports, seeks to implement services and supports in a manner that respects the participant's personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participants independent living.

#### ▪ **Family Supports Waiver**

- The FSW program provides Medicaid HCBS to participants in a range of community settings as an alternative to care in an intermediate care facility (ICF) for individuals with intellectual disabilities (IID) or autism, who have substantial functional limitations. Participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop a PCISP using a person-centered planning process guided by an IST. The IST consists of the participant, the participant's case manager, and anyone else of the participant's choosing—typically family, friends, and service providers. The participant with the IST selects services, identifies service providers of their choice, and develops a plan of care (POC) or cost comparison budget (COB) within an annual waiver services cap of \$17,300 that must be approved by DDRS and reflect services to be purchased through the waiver.
- The FSW provides access to meaningful and necessary home and community-based services and supports, implements services and supports in a manner that respects the participant's personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participant's independent living.

### **1915(i)**

The Department of Mental Health and Addiction (DMHA) oversees the three programs: Adult Mental Health Habilitation (AMHH), and Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW). OMPP facilitates the contractual obligations with CMS.

- **Adult Mental Health Habilitation**
  - The Adult Mental Health Habilitation program is designed to help people with serious mental illnesses (SMI). AMHH services help support an individual in restoring and maintaining their best possible functioning level while allowing individuals to live in their community. AMHH offers a variety of services, such as therapy, behavioral support, addiction counseling, care coordination, supported community engagement, and adult day services.
  
- **Behavioral and Primary Healthcare Coordination**
  - The Behavioral and Primary Healthcare Coordination program was designed to help individuals with serious mental illness (SMI) and co-occurring physical healthcare needs manage their care by providing logistical support, advocacy, and education. In coordinating these needs, the goal is to empower BPHC consumers to remain integrated in the community. The BPHC program is targeted to individuals who meet the BPHC eligibility criteria and who will not otherwise qualify for Medicaid or other third-party reimbursement for the intense level of services needed to function safely in the community. The primary function of the program is to provide a gateway to Medicaid benefits for individuals who meet the BPHC eligibility criteria.
  - Individuals who qualify for Medicaid without this program do not need to apply because they will be able to access Medicaid services to meet their healthcare needs without this program.
  
- **Child Mental Health Wraparound**
  - The Children’s Mental Health Wraparound program is targeted to address the needs of youth with complex mental health challenges and/or at risk of out-of-home placement. CMHW is designed to support families and youth in their communities. CMHW is utilized when nothing else has worked, so children can receive intensive mental health services and support to stay at home with their families and in their schools.

## **Division of Family Resources**

The Division of Family Resources (DFR) is responsible for establishing eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF) benefits. The division also manages the timely and accurate delivery of SNAP and TANF benefits. DFR also provides employment and training services to some SNAP and TANF recipients.

## Health Acronyms and Definitions

ACA	Affordable Care Act: 2010 federal health care reform legislation that is sometimes referred to as ACA. <i>See also PPACA.</i>
ACO	Accountable Care Organization: A network of health care providers that together manages and coordinates care for patients along the continuum of care. The network is held accountable for the quality and cost of care.
A&D	Aged and Disabled Waiver
ADL	Activities of Daily Living such as bathing, dressing, eating
AMHH	Adult Mental Health Habilitation Waiver
ASC	Ambulatory Surgical Center
AWP	Average Wholesale Price: Used when compiling rebates for prescription drugs.
BCCP	Breast and Cervical Cancer Treatment Program
BPHC	Behavioral and Primary Health Coordination Waiver
CCB	Cost Comparison Budget
CCRC	Continuing Care Retirement Community
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program; sometimes referred to as S-CHIP for federal authorization program
CHOICE	Community and Home Options to Institutional Care for the Elderly and disabled program
CIH	Community Integration and Habilitation Waiver
CMS	Center for Medicare and Medicaid Services: A federal government agency responsible for the Medicaid and Medicare programs.
CON	Certificate of Need: A regulation that requires state approval of medical care facility construction, usually nursing home beds or hospital beds.

CPT	Current Procedural Terminology: Coding system for billing for health care services.
DDRS	Division of Disability and Rehabilitative Services (within FSSA)
DFR	Division of Family Resources (within FSSA)
DMHA	Division of Mental Health and Addiction (within FSSA)
DA	Division of Aging (within FSSA)
DSH	(pronounced “dish”) Disproportionate Share Hospitals: Payments for hospitals that provide care to a disproportionate share of uninsured individuals.
EPSDT	Early Periodic Screening Diagnosis and Treatment: Preventive care services required by Federal law to be given to children under 21 for early detection.
EHR/EMR	Electronic Health Record/Electronic Medical Record
ERISA	Employee Retirement Income Security Act: A federal law governing group health insurance plans.
FSSA	Family and Social Services Administration
FFP	Federal Financial Participation: The federal government financing for services in a program.
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FSW	Family Support Waiver
HAF	Hospital Assessment Fee: The HAF is used, in part, to increase reimbursement to eligible hospitals for services provided in IHCP fee-for-service and managed care programs, and as the State’s share of disproportionate share hospital (DSH) payments. The HAF reimbursement increases and collection of the assessment fees will continue through the duration of the HAF program.
HCBS	Home and Community Based Services: Services provided that would help an individual stay at home instead of being institutionalized.

HCI	Health Care for the Indigent hospital program
HHS	United States Department of Health and Human Services
HIE	Health Information Exchange
HIP	Healthy Indiana Plan: HIP is a Medicaid waiver program that provides additional health care coverage for the uninsured.
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
ICF	Intermediate Care Facility
IID	Individuals with Intellectual Disabilities
IGT	Intergovernmental Transfer
MCO	Managed Care Organizations: A group of health care providers who offer managed care health plans. Indiana Medicaid has four MCO's-Anthem, CareSource, MDwise and Managed Health Services (MHS).
OMPP	Office of Medicaid Policy and Planning: Division of FSSA that administers the Medicaid program as well as other human services programs.
PACE	Program of All-Inclusive Care for the Elderly
PBM	Pharmacy Benefit Manager
POC	Plan of Care
POST	Physician Order for Scope of Treatment
PPACA	Patient Protection and Affordable Care Act of 2010: Federal law that was signed into U.S. law on March 23, 2010. This Act and the Health Care and Education



Reconciliation Act of 2010 (signed into law on March 30, 2010) make up the Health Care Reform Act of 2010. *See also the Affordable Care Act (ACA).*

PPO	Preferred Provider Organization
RBMC	Risk-Based Managed Care
RUGs	Resource Utilization Groups: The classifications for payment rates in nursing homes.
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families: A federally funded program for caretakers and children under 18 that meet certain eligibility requirements.
TBI	Traumatic Brain Injury
TPA	Third Party Administrator
UPL	Upper Payment Limit: Methodology for additional reimbursement for DSH hospitals that takes the difference between Medicare and Medicaid reimbursement.
Waiver	A deviation from the normal Medicaid program where the state asks for an exception to certain federal Medicaid rules to allow states flexibility in operating the state's Medicaid program.
WIC	Supplemental Nutrition Program for Women, Infants, and Children

