Indiana PathWays for Aging Model Enrollee Handbook 2026

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Member Model Handbook Purpose

The purpose of the MCE Member Model Handbook is to provide the minimum requirements and best practices for an MCE's member handbook. The MCE can utilize this Member Model Handbook when creating and updating their own handbook. The Handbook complies with 42 CFR 438.6(c) with Centers for Medicare & Medicaid Services (CMS). MCEs are responsible for ensuring all documentation including their final Member Handbook comply with the information requirements at 42 CFR 438.10. All enrollment notices, informational and instructional materials must be provided in a manner and format that is easily understood. This means written materials shall not exceed a fifth grade reading level and be in plain language. All written materials for members or potential members shall be in a font size no smaller than 12-point.

Please note that this Member Model Handbook was *not* verified to show compliance with the fifth grade reading level requirement as defined in the Scope of Work (SOW).

Welcome to Indiana PathWays for Aging

The Indiana Family and Social Services Administration (FSSA) offers Medicaid services for individuals aged 60 and older to eligible Hoosiers through Indiana PathWays for Aging (PathWays). *The Indiana PathWays for Aging* program helps the State to achieve the ability to ensure more Hoosiers can choose to age at home and simplify access to Home and Community-Based Services (HCBS), appropriately divert individuals from long-term nursing facility stays in accordance with a person-centered approach, improve quality outcomes and consistency of care across the delivery systems, leverage data to make informed program and care decisions, and promote caregiver support. This manual will provide you with information on how your health plan works and important resources.

Contact Us

Mailing Address: <MCE list full mailing address>

Online: <MCE list website>

Hours of Operation

<MCE> is open for business Monday- Friday, 8am to 8pm

<MCE> is closed on:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas

Working With Your Health Plan

Service Area	Phone number	Information
Member Services	<MCE enter phone number> (TTY 711/TTD)	Hours: <MCE list hours> Call for questions about: ✓ Your health plan coverage ✓ Behavioral Health ✓ Service Coordinator ✓ Pharmacy benefits ✓ Utilization management
24/7 Nurse line	<MCE enter phone number>	A nurse is available 24 hours a day, seven days a week.
Behavioral Health Crisis Hotline	<MCE enter phone number>	Speak to a licensed behavioral health professional when you are going through a mental health or substance use crisis. You can call 24 hours a day, seven days a week.
Dental Member Services	<MCE enter phone number>	Find a dentist in your area or learn more

Service Area	Phone number	Information
		about dental benefits available to you.
Utilization Management (UM)	<MCE enter phone number>	The prior authorization is requested by your provider. UM customer service can answer general questions regarding your authorization.
Suicide and Crisis Hotline	988	Providing 24/7, seven days a week, free and confidential support for those experiencing a suicidal crisis or emotional distress nationwide.
Transportation Services	<MCE enter phone number>	For calls to set up transportation for your medical appointments. Please see your health plan for more information regarding transportation services available to you.
Relay Indiana	1-800-743-3333 (TTY 711)	For members with hearing or speech loss, a trained person will help them speak to someone using a standard phone.
Vision Member Services	<MCE enter phone number>	Member services is available to help you find information about your vision benefits and how to find a provider in your area.
Indiana Family and Social	1-800-403-0864	Call this number to report any

Service Area	Phone number	Information
Services Administration (FSSA)		information changes such your telephone number, address, family size, and/or income.
Dental Member Services	<MCE enter phone number>	Find a dentist in your area or learn more about dental benefits available to you.
Indiana Tobacco Quitline	1-800-784-8669	Free phone-based service to help smokers quit
PathWays Enrollment Broker Helpline	1-877-284-9294	Provides education and counseling for new applicants and existing members on how to select or change an MCE. This includes open enrollment.
State Long-Term Care Ombudsman Program	Information/complaint line: 800-622-4484 or 317-232-7134 Fax number: 317-972-3285 Email: LongTermCareOmbudsman@ombudsman.IN.gov Website: https://www.in.gov/ombudsman/long-term-care-ombudsman/	Advocates for residents of long-term care facilities, which includes nursing facilities and licensed assisted living facilities with the primary purpose of promoting and protecting the resident rights guaranteed to residents under federal and state law.

Service Area	Phone number	Information
Adult Protective Services (APS)	State hotline: 800-992-6978 Website: https://www.in.gov/fssa/ddars/bba/adult-protective-services/	Receives and investigates reports regarding adults within the state of Indiana who may be endangered and, as appropriate, to coordinate a proper response to protect endangered adults who are victims of abuse, neglect, or exploitation.
Member Support Services (MSS) is Maximus	1-877-738-3511 Website: https://indianapathwaysmss.com/en/home	Supports members after enrollment. May serve as a mediator between MCE and the member. Educates and supports members with grievances and appeals.

Choosing a Health Plan

You will need to choose a health plan (MCE) unless you are a non-excluded individual enrolled in *Indiana PathWays for Aging*. A health plan is a health insurance company. Each health plan includes a group of health care providers (doctors, specialists, home health care providers, pharmacies, therapists, and more). This is called a "network" of providers. For most health care services, you must use the providers who are in your health plan.

You have the choice between three health plans in *Indiana PathWays for Aging*. You can select.

Anthem, Humana, or United Healthcare. If you come into *Indiana PathWays for Aging* with no current Medicaid coverage, health plan assignment will be effective on the date of eligibility approval. Medicaid coverage may be effective up to three (3) months retroactively from your application date. Retroactive coverage will be in the State's fee for service (FFS) program. The managed care assignment will not be retroactive. For individuals transitioning from an existing Medicaid Managed Care program or FFS, the MCE assignment will be effective the first day of the month following the notice of change in eligibility.

Plan selection can be made by calling the enrollment broker within ninety (90) days of the start of coverage. If you do not select a plan, there will be an assignment process in place directed

by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the current provider of the member (if applicable).

After enrollment into your health plan is completed, a welcome packet will be sent to you. The welcome packet will provide more details on your plan as well as additional resources. When you are enrolled in a managed care program, you will choose a Primary Medical Provider (PMP). Your PMP will work with you and be your primary contact when making medical decisions. Your PMP will also make referrals and help you with prior authorizations (PA) for services that are not always covered by Medicaid.

If you already have a PMP or other primary or specialty medical provider, when choosing your health plan, you will want to make sure that your provider is part of the health plan's network. If you do not have a PMP, your health plan will work with you to choose one.

If you don't know which health plan is best for you, call *the Indiana PathWays for Aging* helpline at 1-877-284-9294. The staff who work at the helpline will support you in deciding which health plan would help you most. You can also call this number if you want to change or switch your health plan.

American Indian/Alaska Native Process to opt out of Managed Care

American Indian/Alaska Native members may elect to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State. Individuals who are American Indians, as verified by FSSA's Department of Family Resources (DFR), will be voluntarily enrolled in *Indiana PathWays for Aging*. If you are verified, you will have the opportunity to voluntarily enroll in the PathWays program through an opt-in process at any time. If you do not choose to opt-in, you will remain in fee-for-service (FFS) through the Health and Wellness program of FSSA's Division of Disability and Rehabilitative Services (DDRS).

How to Choose your PMP

Now that you have selected your health plan, the next step is choosing a Primary Medical Provider (PMP). If you are enrolled in the *Indiana PathWays for Aging* program, you will need to choose a Primary Medical Provider (PMP) within your health plan. This is your main provider that you will see for your annual check-ups, routine sick or well visits, and immunizations (shots).

Your PMP may be any of the following:

General Practitioners	Geriatricians
Internal Medicine Physicians	Family medicine physicians
Gynecologists	Physician Assistants

Endocrinologists (if primarily engaged in internal medicine)	Advanced practice nurse (APN) practitioners, a/k/a Nurse Practitioner (NP)

You can choose your PMP, or you can have one assigned to you. If you do not have a PMP, your health plan will assign you one based on where you live and if the PMP is taking new patients.

Please call your health plan's member services helpline if you need help selecting a PMP, or you can visit the Find a Provider Portal at https://www.in.gov/medicaid/members/114.htm. You can also use this link to see if your current provider (PMP) is a Medicaid provider. If they are not, your health plan will not be able to pay for any services you use through them. If your provider would like to become a Medicaid provider, suggest that they visit the Indiana Medicaid Provider website.

If you have questions, you should contact your health plan directly.

Member Identification

You will have a 12-digit Member ID number (also referred to as MID). The Member ID is assigned by the FSSA Division of Family Resources (DFR) through the automated Indiana Eligibility Determination and Services System (IEDSS).

Member Cards

Each member will receive a member identification card from the selected health plan with the assigned MID. Your member ID card is very important. You must have one to use your health plan. You must give your ID card to the medical staff before you use any service or see your PMP.

Provider Directory

Each Managed Care Program provides members with an up-to-date Provider Directory to assist you with finding a provider that is in your health plan network. The directory can be found on your health plan website and is ready for you to search based on your criteria (some examples include location and specialty). Member Services of your health plan can also assist you with provider directory look-up.

Health Plan Network Updates

Your health plan will publish updates to the provider network no less than 30 days prior to the effective date of the change. This means if there is a change that could impact your care, the health plan will provide the information to you within 30 business days.

How to Change your PMP

You can call your health plan Member Services phone number to change your PMP. They may ask you why you want to change your provider. If there comes a time that you want or need to change your PMP, please call your health plan for assistance.

Your health plan does not make coverage decisions based on moral or religious beliefs. You may have a health need that a certain provider or hospital cannot treat because of their moral or religious beliefs. If this happens, that provider or hospital should tell you. Then, you can decide to go to a different provider or hospital to get care.

Changing your Primary Medical Provider

Member Services can assist you in finding your new PMP when:

- You have moved
- Your PMP has moved or no longer belongs to your health plan
- You are not happy with the care you are receiving from your health plan
- Someone in your health plan treated you rudely
- Your PMP does not return your calls
- You have trouble getting the care you want, or your PMP says you need

Plan Selection Period/Changing Health Plans

With *Indiana PathWays for Aging*, you must remain in your chosen health plan for a one-year period if you remain eligible. You may only change your health plan during certain times of the year or for certain reasons outlined below.

Plan Selection Periods:

Plan selection can be made by calling the enrollment broker within ninety (90) days of coverage start. If you do not select a plan, there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the PMP of the member (if applicable).

You will have the chance to change your health plan:

1) within ninety (90) days of starting coverage,
2) at any time, your Medicare and Medicaid plans become unaligned (e.g., member disenrolls from one MA plan to another during quarterly Special Enrollment Period (SEP),
3) once per calendar year for any reason,
4) at any time using the just cause process; and
5) during a plan selection period which will be aligned with the Medicare open enrollment window (mid-October to mid-December) to be effective the following calendar year.

- Medicare Election
    - A prospective member who is eligible for Medicare must:
        - Enroll in and remain enrolled in all parts of Medicare for which the prospective member is eligible (Medicare Part A, Part B, and/or Part D); or
        - Obtain all Medicare Part A, Part B, and Part D benefits, if eligible, from the MCE's Special Needs Plan.
    - If you become Medicare-eligible after enrollment, you must enroll in all parts of Medicare for which you are eligible.

Coordination of Medicare and Medicaid Services

Your health plan will coordinate all your Medicare and Medicaid services. To the greatest extent possible, this will include all reasonable efforts to coordinate care for you regardless of your Medicare service delivery system or Medicare plan benefit package. This includes traditional Medicare, unaligned Medicare Advantage plans, Chronic Conditions Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

Your health plan will ensure that services covered and provided in *Indiana PathWays for Aging* are delivered without charge and as a dually eligible member for Medicare and Medicaid services. Your health plan is responsible for providing medically necessary Medicaid covered services to you, even when you are also eligible for Medicare, if the service is not covered by Medicare. Your health plan will engage with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits you receive. They coordinate with all relevant State and social service agencies and community-based organizations (CBOs) as needed to better identify and address both your medical and social needs.

Family Planning Services

You can go to any family planning provider or clinic that accepts Indiana Medicaid and offers family planning services. You do not need a referral from your PMP for family planning services. Family planning services include:

- Birth control
- Birth control devices such as IUDs, implantable contraceptive devices, and other that are available with a prescription.
- HIV and sexually transmitted infection (STI) testing, treatment, and counseling
- Screenings for cancer and other related conditions
- Sterilization services

Care Coordination and Service Coordination

As a state, Indiana strives to make sure everyone who receives long-term services and supports (LTSS) can live, learn, work, and enjoy life in the most integrated setting. The goal is for people to lead lives that are meaningful to them. To do this, we must have a person-centered support system that helps people:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life

Based on your eligibility you may select or be assigned a care coordinator and/or a service coordinator that will assist you with care coordination and/or service coordination to meet your health needs. Your service plan must not prioritize your provider's preferences over your own preferences. If your provider is not willing or able to provide services in a way that aligns with your needs, preferences, and goals then alternate service plan options should be examined. The plan must be reviewed and revised every 12 months and any time there is a reassessment of functional need, when your circumstances or needs change significantly, or at your request.

Ongoing monitoring of the service plan takes place throughout the year through use of the monthly monitoring tool and service notes. As new information is learned, the plan will be updated and revised as needed. The plan should always document whether the support setting where HCBS services are delivered was selected by the individual and is integrated in and supports full access to the greater community.

You should complete a health needs screenings (HNS) to allow your health plan to gather results for a more detailed comprehensive health assessment that identifies your needed medical and behavioral health services. Your health plan will work with you to ensure you are receiving appropriate services and ensure you are not at risk of over-utilizing or under-utilizing services.

In addition, with the appropriate consent, your care coordinator and/or service coordinator will notify your integrated care team if you are hospitalized or receive emergency treatment including behavioral health issues, such as substance use disorder. This notification will occur within five (5) calendar days of the hospital admission or emergency treatment.

By engaging in person-centered practices throughout your service plan development and implementation, you can be assured of the opportunity to fully engage in your community to the extent you desire.

Programs and Covered Services

As your health plan for *Indiana PathWays for Aging* coverage, we can provide two different State benefits packages to our members. The first is State Plan Medicaid, which includes the nursing facility, home health, and hospice care. The second, State Plan Medicaid plus Home and Community Based Services (HCBS), is available to all who have been determined to meet the Level of Care. State Plan Medicaid services include at a minimum, all benefits and services deemed "medically reasonable and necessary" and covered by Indiana Medicaid and included in the Indiana Administrative Code and under the Contract with the State.

The health plan delivers covered services sufficient in amount, duration, or scope to reasonably expect that the provision of such services would achieve the purpose of the furnished services. Coverage may not be arbitrarily denied or reduced, and it is subject to certain limitations in accordance with CFR 438.210(a)(4), which specifies when health plans may place appropriate limits on services:

Service[1]	Limitations/Coverage
Adult Mental Health and Habilitation (AMHH) – 1915(i) (405 IAC 5-21.6)	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Services include: • Adult day services; • HCB habilitation; • Respite • Therapy and behavioral support services; • Addiction counseling; • Peer support services; • Supported community engagement services; • Care coordination; and • Medication training and support.
Behavioral and Primary Healthcare Coordination (BPHC) – 1915(i) (405 IAC 5-21.8)	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Includes coordination of healthcare services to manage the healthcare needs of the recipient including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case and linkage to appropriate services. Limited to forty-eight (48) units per six (6) months.

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Service[1]	Limitations/Coverage
Care Conferences	Coverage of procedure code 99211 with the SC modifier for PathWays care conferences, payment of $40 reimbursement to the provider.
Chiropractors* (405 IAC 5-12)	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five (5) visits and fifty (50) therapeutic physical medicine treatments per member per year.
Dental Services (405 IAC 5-14)	Coverage for medically necessary, covered dental services with no annual dollar limit applied. Reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs and emergency treatment. Full mouth series or panorex are limited to one (1) set per recipient every three (3) years, one (1) set per recipient every twelve (12) months for bitewing radiographs. Comprehensive detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider, with an annual limit of two (2) per recipient. A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient. Topical fluoride is not covered for recipients twenty-one (21) years of age or older. Prophylaxis is limited to one unit every twelve (12) months for non-institutionalized recipients over age (21). Periodontal surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Payment for office visits is not covered; reimbursement is only available for covered services actually performed.
Diabetes Self-Management Training Services* (405 IAC 5-36)	Limited to sixteen (16) units per member per year. Additional units may be prior authorized.

Service[1]	Limitations/Coverage
Legend Drugs (405 IAC 5-24)	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid. The following drugs are carved out of the Pathways program (full rating period): • Hepatitis C drugs (GPI 125350 or 123599) • Hemophilia Agents (GPI 8510) • Spinal Muscular Atrophy Treatments (GPI 7470) • Muscular Dystrophy Treatments (GPI 7460) • CAR-T Therapies (GPI 21651010 and 21651075) • Durable Genetic Therapy (GPI 8637) • Cystic Fibrosis Agents (GPI 453020 and 453099) • Sickle Cell Agents (GPI 828050 and 828070) • FDA approved SARS Coronavirus Vaccines and Administration
Non-legend Drugs (405 IAC 5-24)	Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available via a link from the IHCP website at https://inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp
Emergency Services (IC 12-15-12-15 & 12-15-12-17)	Emergency services are covered subject to the prudent layperson standard of an Emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an Emergency medical condition are covered.
Eye Care, Eyeglasses and Vision Services (405 IAC 5-23)	Coverage for the initial vision care examination will be limited to one (1) examination every two (2) years for a recipient twenty-one (21) years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair every five (5) years for members twenty-one (21) years and older.
Family Planning Services and Supplies	Family planning services include limited history and physical examination, pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.

Service[1]	Limitations/Coverage
Federally Qualified Health Centers (FQHCs) (405 IAC 5-16-5)	Coverage is available for medically necessary services provided by licensed health care practitioners.
Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services Inpatient* (405 IAC 5-17)	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital Services Outpatient* (405 IAC 5-17)	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Home Health Services** (405 IAC 5-16)	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.
Hospice Care** (405 IAC 5-34)	Hospice is available under Medicaid if the recipient is expected to die from illness within six (6) months. Coverage is available for two (2) consecutive periods of ninety (90) calendar days followed by an unlimited number of periods of sixty (60) calendar days. This also includes hospice in an institutional setting.
Laboratory and Radiology Services (405 IAC 5-18; 405 IAC 5-27)	Services must be ordered by a physician or other practitioner authorized to do so under state law.
Long Term Acute Care Hospitalization	Long term acute care services are covered. Prior authorization is required. An all-inclusive per diem rate is paid based on level of care.
Medical supplies and equipment (include prosthetic devices, implants, hearing aids, dentures, etc.)** (405 IAC 5-19)	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.

Service[1]	Limitations/Coverage
Mental health/Behavioral health services-Inpatient (State Psychiatric Hospital)** (405 IAC 5-20-1)	PathWays members are disenrolled from the Contractor when admitted to a State psychiatric hospital.
Mental health/Behavioral health services-Inpatient** (405 IAC 5-20)	Covered.
Mental health/ Behavioral health services-Outpatient (405 IAC 5-20-8)	Coverage includes partial hospitalization services, Clinic Option services, mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Prior authorization is required for services that exceed twenty (20) units, per recipient, per provider, per rolling twelve (12) months.
Medicaid Rehabilitation Option (MRO) - Community Mental Health Centers (405 IAC 5-21)	Services provided by community mental health centers (CMHCs). Service packages are assigned based on level of need, as determined by an individualized assessment conducted by CMHCs, and qualifying behavioral health diagnosis. Additional units can be prior authorized when determined medically necessary. Services include: • Adult intensive rehabilitation services (AIRS) addition counseling; • Addiction counseling; • Behavioral health counseling and therapy; • Behavioral health level of need redetermination; • MRO case management; • CAIRS; • Medication training and support; • Psychiatric assessment and intervention; and • Skills training and development.
Nurse-midwife services (405 IAC 5-22-3)	Coverage is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioners (405 IAC 5-22-4)	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

Service[1]	Limitations/Coverage
Nursing Facility Services (Long-term)** (405 IAC 5-31-1)	Requires pre-admission screening for level of care determination. Coverage includes room and board; nursing care; medical and nonmedical supplies and equipment; durable medical equipment; medically necessary and reasonable therapy services; transportation to vocational/habilitation service programs.
Nursing Facility Services (Short-term) (405 IAC 5-31-1)	Services for members in a nursing facility setting on a short-term basis, i.e., for fewer than thirty (30) calendar days.
Occupational Therapy** (405 IAC 5-22)	Services must be ordered by an M.D. or D.O. and provided by qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. Prior authorization is not required for initial evaluations, services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge. Prior authorization is required for therapy more than thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary modality of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.
Organ Transplants (405 IAC 5-3-13)	Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike. Prior authorization is required.
Orthodontics**	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.

Service[1]	Limitations/Coverage
Out-of-state Medical Services** (405 IAC 5-5)	Medicaid reimbursement is available for the following services provided outside Indiana: acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies; hospice services, subject to the conditions in 405 IAC 5-34-3; and diagnostic services, including genetic testing. All out-of-state services are subject to the same limitations as in-state services. Prior authorization is required except for Emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization). Services may be obtained in the following designated out-of-state cities subject to the prior authorization requirements for in-state services: Louisville, Kentucky; Cincinnati, Ohio; Harrison, Ohio; Hamilton, Ohio; Oxford, Ohio; Sturgis, Michigan; Watseka, Illinois; Danville, Illinois; and Owensboro, Kentucky. Recipients may obtain services in Chicago, Illinois if the recipient's physician determines the service is medically necessary, transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family, the service is not available in the immediate area, the recipient's physician complies with all of the criteria set forth in accordance with the state plan and 42 CFR 456.3. Prior authorization will not be approved for the following out of state services: nursing facilities, ICFs/IID, or home health agency services; or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.
Physician Assistant (IC 25-27.5)	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified Physician Assistant within the scope of the applicable license and certification.
Physicians' Surgical and Medical Services* (405 IAC 5-25)	Covers reasonable services provided by an M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits are limited to a maximum of thirty (30) per calendar year per member per provider without prior authorization. New patient office visits are limited to one (1) per recipient, per provider within the last three (3) years.

Service[1]	Limitations/Coverage
Physical Therapy** (405 IAC 5-22)	Services must be ordered by an M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge, and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy more than thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Podiatrists (405 IAC 5-26)	Reimbursement provided for podiatric services performed within the scope of the practice of the podiatric profession. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders. Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six (6) routine foot care visits per year are covered for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Proof must be submitted of patient visit to a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six (6) month period prior to the rendering of routine foot care services. Prior Authorization is required for inpatient hospital stays and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.
Rehabilitative Unit Services - Inpatient** (405 IAC 5-32)	The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function or self-care activities.
Residential Substance Use Disorder (SUD) Services	Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria: • ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services • ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

Service[1]	Limitations/Coverage
Respiratory Therapy* (405 IAC 5-22)	Services must be ordered by an M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, Emergency, and oxygen equipment and supplies necessary for the delivery of oxygen, therapy within thirty (30) calendar days (up to thirty (30) units) following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large **private or small ICF/IID,** which are included in the facility's established per diem rate. Prior authorization is required for therapy more than thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Rural Health Clinics (405 IAC 5-16-5)	Coverage is available for services provided by a physician, physician assistant nurse practitioner, a clinical psychologist or a clinical social worker. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those clinics that are located in an area that has a shortage of home health agencies as determined by Medicaid.

Service[1]	Limitations/Coverage
Smoking Cessation and Tobacco Dependence Treatment Services (405 IAC 5-37)	Treatment may include prescription of any combination of smoking cessation and tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. Providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself. The IHCP does not require prior authorization for reimbursement for smoking cessation and tobacco dependence treatment products or counseling. The IHCP reimburses pharmacy providers for smoking cessation and tobacco dependence treatment products, including over-the counter products, only when a licensed practitioner prescribes them for a member, including utilization of the statewide standing order for tobacco cessation products. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may want to have the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment. Providers must perform tobacco dependence counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within the course of treatment. IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.

Service[1]	Limitations/Coverage
Speech, Hearing and Language Disorders* (405 IAC 5-22)	Services must be ordered by an M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by physician prior to discharge or following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy more than thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Transportation - Emergency* (405 IAC 5-30)	Coverage has no limit or prior authorization requirement for Emergency ambulance or trips to/from hospital for inpatient admission/discharge, transportation for patients on renal dialysis or those residing in nursing homes, accompanying parent or recipient attendant (or both) or for a return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.
Transportation – Non-emergency medical (405 IAC 5-30)	Non-emergency medical travel is available when another alternative is not available.
Urgent Care Services	Urgent Care Services are covered if they are medically necessary. Urgent Care is needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.

Service[1]	Limitations/Coverage
HCBS Services for those with HCBS LOC determination **Included HCBS PathWays Waiver**	Refer to the most current version of the Indiana Health Care Provider manual for the most updated covered services and their respective service definitions for those eligible for HCBS in the 1915(c) Managed Care Medicaid Waiver. Current list below: Adult Day Services Attendant Care Home and Community Assistance Skilled Respite Adult Family Care Assisted Living Caregiver Coaching Community Transition Home Delivered Meals Home Modifications and Assessments Integrated Health Care Coordination Nutritional Supplements Personal Emergency Response System Pest Control Specialized Medical Equipment and Supplies Structured Family Caregiving Transportation Vehicle Modifications

Self-Referral Services

Indiana PathWays for Aging includes some benefits and services that are available to you on a self-referral basis. These self-referral services do not require a referral from your PMP or authorization.

Your health plan and/or your PMP may direct you to seek the services of the self-referral providers contracted in the health plan's network. Your health plan cannot require that you receive such services from their network providers, unless otherwise noted.

You may only self-refer to a provider who is enrolled as an Indiana Medicaid provider (IHCP).

The following services are considered self-referral services.

- Chiropractic services may be provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider.
- Eye care services, except surgical services may be provided by any licensed vision provider.
- Routine dental services may be provided by any in-network licensed dental provider.
- Podiatric services (foot care) may be provided by any licensed podiatry provider.
- Psychiatric services may be provided by any licensed behavioral health provider.
- Family planning services require a freedom of choice of providers and access to family planning services and supplies. (Additional information above)
- Emergency services are covered without the need for prior authorization or the existence of a health plan contract with the emergency care provider. Emergency services shall be available twenty-four (24)-hours-a-day, seven (7)-days-a-week and are subject to the "prudent layperson" standard of an emergency medical condition.
- Urgent care services are covered for members on a self-referral basis.
- Immunizations (shots) are self-referral to any IHCP-enrolled provider.
- Diabetes self-management services may be utilized if rendered by a self-referral provider enrolled in IHCP.
- Behavioral health services are self-referral if rendered by an in-network provider. You may self-refer within your health plan's network for behavioral health services not provided by a psychiatrist. This includes mental health, substance abuse and chemical dependency services rendered by mental health specialty providers.

The mental health and addiction providers to which the member may self-refer within network are:

- Outpatient mental health clinics;
- Community mental health centers (CMHC);
- Psychologists;
- Licensed psychologists;
- Health services providers in psychology (HSPPs);
- Licensed social workers (LSW);
- Licensed clinical social workers (LCSW);
- Psychiatric nurses;
- Independent practice school psychologists;
- Advanced practice nurses (APN) under IC 25-23-1-1(b), credentialed in psychiatric or mental health nursing (applicable education and board certification), and
- Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option).

Behavioral Health and Substance Use Disorder

Behavioral health is about how you feel and act. It is also called mental health. Your mental health is very important. All *Indiana PathWays for Aging* members can receive mental health and substance use disorder services. You may see any in-network provider without a referral for outpatient treatment. **If you are having very negative thoughts or feel like hurting yourself or someone else, call 988 immediately for help.** If you have questions about services, please call your health plan's helpline below.

Behavioral Health Helplines

{MCE insert Behavioral Health Number and TTY}

Outreach and Education Regarding Critical Incidents

Your health plan must include in its welcome packet and on its member website information about all types of critical incidents (CI), including but not limited to:

- The types of critical incidents:
  - A detailed description of HCBS critical incidents and instructions about how to report an HCBS critical incident
  - Brief descriptions of all other critical incidents and links to the pertinent state entity for reporting each
- A description of what you should expect if you submit a critical incident report to them or if one is submitted on your behalf
- Member rights related to the reporting, management and mitigation of all critical incident types

- A description of your role in mitigating future critical incidents
- Information about how to report a complaint about a health care facility, as set forth at: https://www.in.gov/health/long-term-carenursing-homes/reporting-a-complaint-about-a-health-care-facility/

In addition, your health plan must conduct ongoing outreach and education to inform you about reporting, management, and mitigation of all types of critical incidents and to communicate with your providers about trends and issues identified through critical incident data analysis. Your health plan shall communicate with you via a variety of mechanisms, such as but not limited to:

- Alerts and messages via member portals, websites, text messaging and other mechanisms to spread awareness to individuals involved in your care, family, unpaid caregivers, and other stakeholders to inform them about proactive measures that can mitigate future risks
- Social media campaigns on key topics distributed through a variety of channels
- Use of short online videos to deliver information about incident reporting, management and prevention

Care and Disease Management Services

Care Management

Care Management is the foundational Care Coordination level of service that shall be made available to all Indiana Pathways for Aging members and is intended to provide members with assistance with care coordination activities, making preventive care appointments, and/or accessing care for needed health or social services to address the member's chronic health condition(s). Care Management entails a purposeful plan to reach members and impact their health and health care utilization and to coordinate all services provided to members.

Care Management services include coordination of care across providers and direct consumer contacts to assist members with scheduling needed services, location of specialists and specialty services, intellectual and developmental disability services, transportation needs, twenty-four (24)-hour nurse call line use, general preventive (e.g. mammography) and disease specific reminders, pharmacy refill reminders, tobacco cessation and education regarding use of primary care and emergency services.

Care Managers want to learn more about you. Then they can help you learn self-care and how to get help from others. Care Managers may meet with your PMP and other health resources to make sure they are working together. Care Managers work to make sure you have all the services you need, including non-medical services like food and housing. If you think you need Care Management, call your health plan. Care Managers work with your Service and Care Coordinators to ensure continuity of care.

Complex Case Management

Complex Care Management services are available for adults with complex healthcare needs. Nurses and social workers will work with you to meet your health care needs. These staff members may contact you if your provider recommends it, you ask for it, or they see you have a health issue they could help you with.

Complex Case Management is for members who are at risk of an acute or catastrophic episode in the future or for members with one or more of the following:

- two (2) or more "uncontrolled" disease states which are defined as disease states requiring immediate attention, for which the member is not currently receiving disease-appropriate screening, follow-up appointments, care, therapy, and/or medication
- an active cancer diagnosis or the “uncontrolled”/ “uncompensated” disease states of heart failure or COPD or diabetes with an A1C of greater than 9.0%
- serious mental illness (SMI)
- substance use disorder (SUD)
- significant cognitive impairment, including Alzheimer’s disease and related dementias (ADRD)
- an unplanned inpatient stay or more than two (2) ER visits in the last ninety (90) days
- high dollar medical claims of over fifty thousand $50,000 dollars (>$50,000) in six (6) months (excludes HCBS claims)
- an NFLOC determination and are receiving HCBS in a home or community-based setting
- self-referral to the Contractor’s Care Coordination program
- provider referral for the member
- unstable housing that may exasperate health conditions

The Contractor must provide Complex Case Management services for members discharged from an inpatient psychiatric or substance use disorder hospitalization, for no fewer than ninety (90) calendar days following the inpatient hospitalization. The Contractor must also provide Complex Case Management services for any member at risk for inpatient psychiatric, drug overdose, or substance abuse re-hospitalization.

A person will be assigned to help you. You will learn basic information about your condition. They will teach you about tests for your condition that your providers may not have done. They can also teach you how to make sure you stay healthy. Learning more about your physical and/or behavioral health condition and your needs will help keep you healthy and out of the emergency room. Always go to your provider visits and ask questions to make sure you are getting the best care.

Complex Case Management and Service Coordination

In addition to Complex Case Management, members who are determined Nursing Facility Level of Care (NFLOC) and receive HCBS shall receive HCBS-specific Service Coordination. Service Coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic LTSS and related environmental and social needs of everyone. Your Service Coordinator would be responsible for the development and implementation of the HCBS-specific person-centered support plan ("Service Plan") and for assisting you in gaining access to long term services and supports, as well as medical, social, housing, educational, and other services, regardless of the funding source for the services, to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for institutional placement. Your Service Coordinator shall collaborate with your Care Coordinator and provide for the regular review and modification of your HCBS-specific Service Plan. With your consent, your caregivers and your interdisciplinary care team (ICT) may participate in your care plan.

Right Choices Program (RCP)

The Right Choices Program is part of Indiana Medicaid. It is for members who need help with using their health coverage appropriately. Its goal is to make sure your medical care is happening at the right time and place. If you are placed in the Right Choices Program, it can help you learn to use your health coverage the right way.

If you are enrolled in the Right Choices Program, you will still have all your benefits. You will have one Primary Medical Provider (PMP). You will be assigned one pharmacy. Any special providers you see will need approval from your PMP.

State Ombudsman

The Indiana Long-Term Care Ombudsman Program advocates for residents of long-term care facilities, which includes nursing facilities and licensed assisted living facilities. The primary purpose is to promote and protect the Resident Rights guaranteed to residents under federal and state law. Certified long-term care ombudsmen are trained to receive complaints and assist residents to resolve problems in situations involving quality of care, use of chemical or physical restraints, transfer and discharge, abuse and other aspects of resident rights.

Your ombudsman will:

- Advocate for your rights as a resident living in a long-term care facility
- Resolve concerns about your quality of life and quality of care received
- Work with you, your family or friends, and facility staff to meet your needs
- Negotiate on your behalf

- Provide education on how to self-advocate
- Provide education about long-term care facilities as well as other service options in the community
- Help you establish a resident or family council

Adult Protective Services (APS)

The Adult Protective Services program was established to receive and investigate reports regarding adults within the state of Indiana who may be endangered and, as appropriate, to coordinate a proper response to protect endangered adults who are victims of abuse, neglect, or exploitation.

APS is required to screen all reports of abuse, neglect, and exploitation of vulnerable adults aged 18 years and older. When a report meets the qualifications of an endangered adult, APS will assess the allegations. Reports that do not meet the qualifications of an endangered adult, but may need to be reviewed by other agencies, are referred to the appropriate agency.

Your health plan has a designated staff person to serve as a member advocate and liaison between APS, any relevant State ombudsman and you to assist staff working in developing your service options.

Pharmacy Information

Your health plan covers necessary medicines. You can go to any pharmacy that accepts your health plan. Prescription drugs including injections and infusions, certain over-the-counter drugs, and pharmacy supplements are benefits under the PathWays program.

In the first year of the program, your health plan will provide for ninety (90) days of continuity of care for all pre-existing drug regimens for new members. This will allow time for the health plan pharmacy to work with your prescribing provider to negotiate future drug regimens.

Prior Authorization

Some covered drugs may be subject to utilization management (UM) and require a prior authorization (PA) before you are able to get them. This includes certain prescription drugs, such as some behavioral health drugs, that for safety reasons need approval from your provider before you get them. If your provider does not get prior authorization when it is needed, your health plan will not pay for the prescription.

Medicare Part D

Medicare Part D drug benefit plans cover prescription drugs as approved by the Centers for Medicare and Medicaid Services (CMS). For full benefit dual eligible members, Indiana Medicaid covers medically necessary, federally and State reimbursable prescription drugs that are excluded from coverage for Medicare Part D benefit plans. Drugs eligible for coverage under Medicare Part D will not be covered under Medicaid if the member refuses Part D coverage.

What if I Receive a Bill from My Provider?

Your health plan only pays your provider for the covered services you get. Other than copays, your provider can't charge you, your family, or others for covered services.

Your provider can only bill you for non-covered services. The provider must tell you if your health plan does not cover a service before they provide it to you. They may only charge you for the non-covered service if they told you in advance that it was not covered before providing it and you agreed to pay for it in writing.

If you get a bill for a service, you should take care of it right away. If you do not, it could be sent to a collection agency. To handle a bill, you should:

- Call your doctor/provider and make sure they know you are a Medicaid member.
- Check to make sure the bill is not for your copayment. If you have copayments, you can be billed for those amounts. If you aren't sure what copayments you have, please see the section on Copayments and Cost-Sharing.
- If the bill is not your copayment or the copayment is wrong, contact your health plan. Have the bill in your hand. Your health plan will assist you with how to handle the bill.

How to Access Care

A PMP is a primary medical provider. Your PMP is your health partner. You will call them first when you need health care. They will work with you on your health care needs. Your PMP will usually be able to help you with whatever you need. If your PMP is unable to treat your health issue, they will refer you to another place to get care.

Your PMP can be a(n):

- General practitioner (a doctor who treats people of all ages)
- Internal Medicine or Internist (a doctor who treats adults)
- Gynecologist (OB/GYN) (a doctor who deals with the female health)
- An Endocrinologist (if primarily engaged in internal medicine)
- Family medicine providers
- Physician Assistants
- Advance Practice Nurses (a nurse with additional training such as Nurse Practitioner)

Seeing a Specialist

Your PMP may send you to a specialist for special care or treatment. They will help you choose a specialist to give you the care you need. You may need permission from your health plan to see a specialist or receive certain care. Your PMP knows when to ask for permission.

Your PMP's office staff can help you get an appointment with a specialist. Make sure to tell your PMP and specialist as much about your health as you can. If your specialist or any other provider is not in your health plan, they must get permission from your health plan before they can give you care. You may also need a referral from your PMP before you go to a specialist.

If you have questions about your care plan, you may want to ask for a second opinion. Asking for a second opinion can help make sure your care plan is right for you. To get a second opinion, call your PMP's office or call the member services number for your health plan.

Member Services Phone Numbers

{MCE insert Member Services Number and TTY}

How to Make an Appointment

To make an appointment, call your PMP's office and request one. Make sure to have your member ID card in your hand when you call. Tell them you are a Medicaid member and give them your member ID card information.

When you see your PMP, they will help you understand your medical needs. At your first appointment, your PMP will:

- Ask you questions about your current health and your medical history
- Give you information on how to maintain your health
- Schedule any tests and preventive care services you need

Preventive Care

Preventive Care for Adults

Seeing your PMP for preventive care is very important. Preventive care includes medical services you use to check your health to prevent and catch early symptoms of illness. It helps keep you healthy, especially as you get older.

All preventive care is paid for by your health plan. You are encouraged to use all preventive care services.

See the chart below for preventive care services for adult men and women.

Preventive Care Service	Women 50+	Men 50+
Annual Physical Exam	X	X
Blood Glucose Testing	X	X
Cholesterol Testing	X	X
Flu Shot	X	X
Pneumococcal Vaccine	X	X
Tetanus-Diphtheria Booster	X	X
Colorectal Cancer Screening	X	X
Pap Smear	X	
Screening Mammogram	X	
Dental Exams	X	X
Eye Exams	X	X

Immunizations

Immunizations are shots that protect the body from disease and illness. Some immunizations require follow-up shots or "boosters." Check with your PMP to make sure you have all the recommended shots for your age. These are the recommended adult immunizations:

- DTaP (diphtheria, tetanus, pertussis)
- Flu
- Hib (Haemophilus influenzae type B)
- Hepatitis B
- Tdap (tetanus, diphtheria, pertussis booster)
- Shingles
- Pneumococcal conjugate vaccine (PCV15 or PCV20)

MCE TO INSERT PERIODICITY IMMUNIZATION SCHEDULE

These shots are given to you at certain times. It may seem like there are several shots, but the shots are needed to prevent disease or worsen conditions for your health. If you're not sure if you have all your recommended shots, talk to your PMP right away.

When and Where to Go for Care

It is important to know when and where to go for the medical care you need. Sometimes it may seem difficult to decide where you should go when you or a family member doesn't feel well. Your health plan has many options for care. The chart below shows some options for care and when they are the best option for you to use.

Primary Medical Provider (PMP)	Check-ups and physicals; immunizations; minor aches and pains
Telehealth	For minor problems when you cannot see your provider in-office. Telehealth is seeing your provider remotely, usually by a video or audio call on your phone. Check with your provider to see if they offer telehealth.
Convenience Care Clinic	For minor problems when your PMP is unavailable
Urgent Care	For problems that could become emergencies if left untreated for 24 hours
Emergency Room (ER)	Life-threatening emergencies

Access to Care

The chart below provides you with a time expectation of when you may be able to obtain an appointment with your provider.

Provider Type	Appointment Category	Appointment Standards
PMP	Routine	Not to exceed 30 calendar days
	Urgent	Within 48 hours
	Emergency	24 hours a day/ 7 days a week
	Routine Gynecological Exam/new patient	30 calendar days
	Annual Physical Exam	90 calendar days
Specialist	Routine	Not to exceed 60 calendar days
	Urgent	Within 48 hours
	Emergency	24 hours a day/ 7 days a week

Behavioral Health	Non-life-threatening emergency	Not to exceed 6 hours
	Urgent	Not to exceed 48 hours
	Emergency	24 hours a day/ 7 days a week
	Initial visit for routine care	Not to exceed 10 business days
	Follow-up routine care	Not to exceed 30 calendar days based off the condition
	Outpatient follow-up appointment	Within 7 days following discharge for the inpatient behavior health hospitalization
Prenatal and Postpartum visits	First Trimester	14 days of request
	Second Trimester	Within 7 days of request
	Third Trimester	Within 3 business days of request or immediately if an emergency
	High-risk pregnancy	With 3 business days of request or immediately if an emergency
	Postpartum Exam	Between 3-8 weeks after delivery

After-hour

Primary Medical Provider after-hour coverage is available to you 24 hours a day, 7 days a week. Your health plan maintains standards your Primary Medical Provider must follow. Your Primary Medical provider (or designated provider) will answer your phone call after normal business hours in English and Spanish. After hour coverage for your PMP may include an answering service or a shared-call service with other medical providers.

Emergency Services

An emergency is a medical condition with severe symptoms that may be life threatening or cause serious damage to you. Examples of health problems needing emergency treatment include:

- Uncontrolled bleeding, major burns, seizures/convulsions
- Fainting, shortness of breath, severe chest pain, severe vomiting
- Miscarriage/pregnancy with vaginal bleeding, cases of rape or molestation
- Poisoning
- A serious accident
- Broken bones

When seeking emergency care, you have the right to use any hospital or other setting for emergency care. Emergency room visits do not require a prior authorization for emergency services.

For emergency services, call 911 or go to the nearest emergency room (ER). Do not call your health plan prior to calling 911 for emergencies.

If you are not sure if you are having an emergency, please call your Primary Medical Provider (PMP). If you cannot reach your PMP's office, you can call your health plan's 24-hour nurse phone number.

[MCE Insert 24-hour nurse phone number and TTY]

The nurse can help you:

- Decide if you need to see your doctor or other medical practitioner
- Decide if you should go to the emergency room
- Answer general questions about your health

Behavioral Health Crisis Line

If you are experiencing a mental health crisis, call your health plan Behavioral Health Crisis line. Clinicians are available 24 hours a day, 7 days a week to talk with you.

Or dial 988 for Suicide and Crisis Lifeline.

Transportation

PathWays include transportation (rides) benefits. Check your health plan's benefits and coverage to understand limitations. Rides to the locations listed below are included in these plans.

- Any medical visit or health care appointment
- Urgent (upon approval) and recurring health care appointments
- Eligibility redetermination appointments with the State (DFR)

Please schedule a ride at least two business days before your appointment. Remember, if you have an emergency, please call 911 or go directly to the nearest emergency room. If you have questions, please call your health plan's Member Service line.

When using ride services, please follow these rules:

- Wait for the driver at the curbside pick-up and drop-off site. The driver is only allowed to wait **<insert MCE standard>** of minutes. If they wait too long, they will leave, you will not be able to get a ride.
- If you must cancel your ride, you must call at least two hours before your pick-up time.

After you get care, ask the medical office to call the ride company for your return trip home. If you need to have a prescription filled in at the office before leaving, work with your provider to do so before calling your driver for the trip home. Your driver will need to be told if a stop at the pharmacy is needed when scheduling the trip home.

Transportation Phone Numbers

{MCE insert Transportation Number and TTY}

Language Assistance

If English is not your main language, your health plan can provide you with an interpreter at no cost to you. To request assistance, please call your health plan Member Services.

If you are deaf or hard of hearing, your health plan can provide you with an American Sign Language Interpreter at no cost to you. To request assistance, please call your health plan Member Services. You can get help in your preferred language, including sign language, when you go to your medical appointment.

Your health plan can give you reading materials in your language. If you need your member handbook and other health plan information in other ways let us know. For example, if you need the information in another language, larger print, Braille or in audio format, call your health plan Member Services. Your health plan will answer your questions in your language.

Tell your provider's office when making your appointment if you need a certain language for your medical visits.

Language Help Phone Numbers

{MCE insert Language Helpline Number and TTY}

Hearing and Speech Assistance

If you need hearing and speech help, you can call the Indiana Relay Service at 1-800-743-3333 or TTY 711 for TDD/TTY service. This number can be used anywhere in Indiana. Ask the operator to connect you to your health plan's number.

How to Change Health Plans

At certain times each year, you can choose to change your health plan. You can stay with your current health plan, or you can switch to a different one. You can only switch health plans during your plan selection time-period. Right Choices Program members are not eligible to change plans.

PathWays members have plan selection for the first 90 days they are eligible for coverage.

Members may not move to another MCE except for reasons that meet the standard of just cause.

Just Cause Grievances

There might be a time when you want to change your health plan but are not in your plan selection time. You may be able to due to certain reasons called "just cause." If you have one of these reasons, you need to file a just cause grievance with your health plan to see if you can change plans. Just cause reasons include:

"Just Cause" Reasons:

The following are the "just cause" reasons for switching health plans during the year for the PathWays program:

- Receiving poor quality of care
- The plan does not, because of moral or religious objections, cover the service sought
- Failure of the health plan to provide covered services
- Failure of the health plan to comply with established standards of medical care administration
- Significant language or culture barriers
- Corrective action levied against the health plan for FSSA
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs
- The member's primary healthcare provider disenrolls from the member's current MCE and re-enrolls with another PathWays MCE; or
- Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

If you have a just cause grievance, call your health plan. They will answer your questions and review your request.

{MCE insert Member Services Number and TTY}

You may also call Member Support Services (Maximus) if you need help filing a grievance or changing your health plan at 1-877-738-3511.

Redetermination

To continue receiving Medicaid health coverage you must renew your benefits. This is called a redetermination. Depending on your income at the end of each year of your coverage, you may have to show you are still eligible. Prior to your health coverage ending, a letter will be mailed to you from Family and Social Services Administration (FSSA). The letter is called "Notice of Renewal". Be sure to carefully read the directions that come with your renewal form. You may be required to sign the form and return it with some information. Contact the Division of Family Resources (DFR) to ask questions. It can take about 45 days to complete your redetermination process. You will receive a notice from the DFR and your health plan to remind you about redetermination.

Your health plan may assist you in redetermination process. However, it is important to keep your address and phone number updated so you receive DFR notices. If your phone number or address changes, contact the Division of Family Resources (DFR).

Update Information or Eligibility Questions

Call: DFR: 1-800-403-0864

FSSA Benefits Portal: FSSAbenefits.in.gov

MCE Member Services

{MCE insert Member Services Number and TTY}

Moving to Medicare

If you become eligible for a Medicare program, you must apply for Medicare. This includes if you are over 65 years old or have a disability. Medicare will help you apply as you get closer to your 65th birthday. If you become disabled, there is also Medicaid Disability. Your current health plan will help you apply for Medicaid Disability coverage.

When you move from your current health plan to a disability or Medicare program, your start date may be in the past (retroactive). When your coverage changes you may receive different benefits. Plan selection can be made by calling the enrollment broker within ninety (90) days of coverage start. If you do not select a plan there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the PMP provider of the member (if applicable).

How and When to Report Changes

Your health plan keeps your information on file for many reasons. It is important that your information is always up to date. Whenever you have a change of information, you need to report it to your health plan. In some cases, you will also need to report your changes to the Department of Family Resources (DFR).

To Your Health Plan

Your health plan should be updated with your contact information. This can be things like:

- Name
- Address
- Phone number
- Change in insurance (such as getting another insurance)

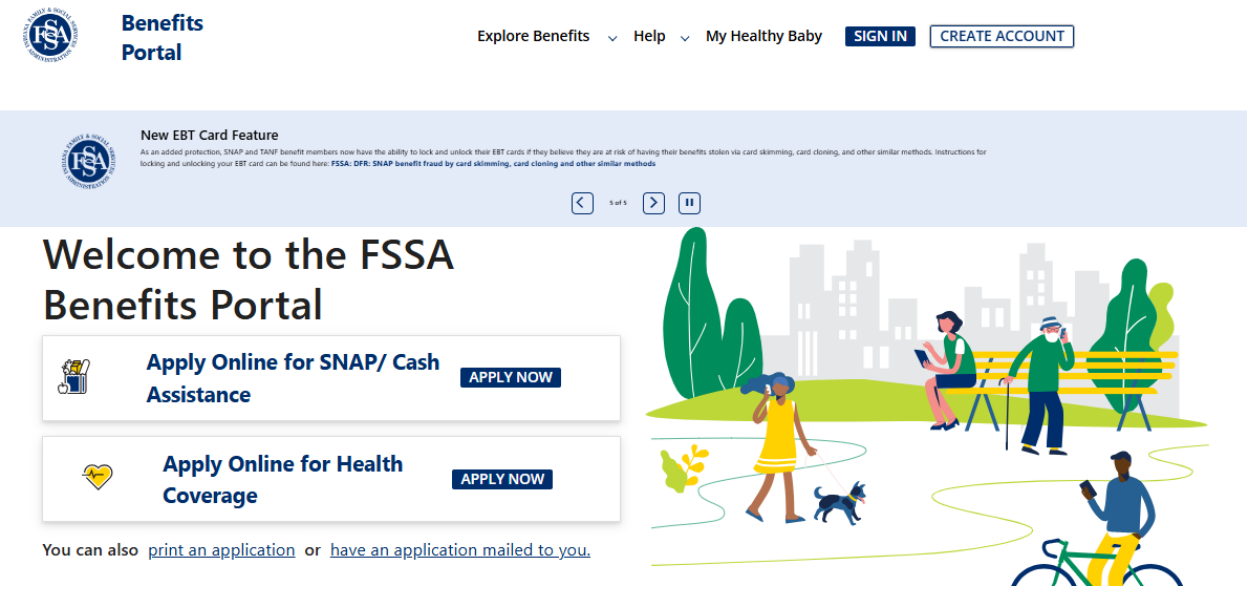
To the Division of Family Resources (DFR)

The Division of Family Resources should be updated on all your general information. If you have a change in any of these, you must let DFR know. You can call 800-403-0864 to report your changes to DFR:

- Name
- Address
- Phone number
- Change in household (the family members who live and/or file taxes with you)
- Change in income

Manage Your Benefits

Another option to report any changes is through the FSSA Benefits Portal. FSSA has developed an online tool that will allow you to manage your benefits, report changes, print proof of eligibility, and view your notices/correspondence. The Benefits Portal can be found: https://fssabenefits.in.gov/bp/#/.



Member Rights

As a member, you have the RIGHT to:

- Receive information on your medical benefits and plan information
- Be treated with dignity and respect when getting health services
- The right to say no to treatment or therapy. If you say no, the health care provider or health plan must talk to you about what could happen, and a note must be placed in your medical record about the treatment refusal.
- Receive information on available treatment options and alternatives, presented in a way that is right for your condition and that you can understand
- Be given easy-to-understand explanations of your medical problems and treatment choices
- Stay involved in decisions about your treatment choices
- Free from any restrictions on freedom of choice among network providers
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations. This means a provider cannot make you do something you do not want to do. A provider cannot try to get back at you for something that you may have done.
- Be given privacy for you and your medical records
- Request and receive a copy of your medical records and request that they be changed or corrected
- Get access to care 24 hours a day, seven days a week
- Get timely answers to your complaints or appeals
- Appeal decisions made about health care you receive
- Use buildings and services that meet the standards of the Americans with Disabilities Act (ADA). This means that persons with disabilities or physical problems can get into medical buildings and use important services.
- Get a second opinion from a different provider
- For members receiving HCBS services, the right to have and review your service plan

Member Responsibilities

As a member, you have the RESPONSIBILITY to:

- Tell your provider (PMP) about your medical conditions to the best of your ability
- Call your medical provider (PMP) for all your medical care
- Keep all your appointments, if you cannot keep an appointment, call to cancel or reschedule as soon as you can
- Tell your provider if you do not understand what he or she tells you about your condition, care, or what you need to do
- Call your provider if you are not sure you are having a true emergency

- Follow the rules of your medical provider's office
- Get regular checkups

Privacy Notices

This notice describes how health information about you may be legally used and shared. If your information is used, your health plan must follow the State and federal rules. You have the right to know what was shared.

Rights

You have rights as an IHCP/Medicaid member. Your health plan must follow rules about your rights. Your rights include the ability to:

- Get a copy of your health and claims records
- Ask to fix your health and claims records if you think they are wrong or not complete
- Ask for private communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Give your health plan consent to speak to someone on your behalf
- File a complaint if you feel your rights are violated.
    - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by
        - Sending a letter to **200 Independence Avenue, S.W. Washington, D.C. 20201.**
        - Calling the office at **1 877-696-6775.**
        - Visiting their website at **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

Choices

You can choose what information we share and with whom we share it. You may have to give written permission to share.

If you can't choose, such as while being unconscious, your health plan may share information if they believe it to be in your best interest.

Your health plan may not be able to share your information with family, caregiver, or friend unless you give written consent.

Uses

Your health plan uses your information for different things. They use it to help get you better care, to do research, and to follow the law.

Responsibilities

Your information is protected in many ways. This includes your information that is written, spoken, or available online. Your health plan is trained on how to protect your information.

Very few people can access your information. Your health plan is required by law to keep the privacy and security of your health information. If a breach occurs, your health plan will let you know quickly.

Your health plan must follow the duties and privacy practices described in this notice. They must give you a copy of it. Your health plan will not use or share your information other than as listed here unless you agree with them in writing.

You may change your mind at any time. Let your health plan know in writing if you change your mind.

How to Get Help

It is important that you receive the best care from your health plan and your providers. If you have a concern or question, you can call Member Services. Member Services can help you with things like:

- Finding a provider
- Finding care and treatment
- Understanding how your health plan works
- Answering questions about any part of your health care

You will not be treated any differently if you call with a complaint or grievance.

Member Services:

{MCE insert Member Services Number and TTY}

Grievances and Appeals

Grievances

If you have a complaint or problem with the care you are getting, you can file a grievance with your health plan. A grievance can be a written letter or a phone call. A grievance must be filed at any time

You can first talk to your doctor or provider if you have any questions or concerns about your care. They can work with you on fixing the problem. If the problem isn't fixed, you can call your health plan.

If you have questions or concerns about not getting the care you need, you will file an appeal with your health plan. You can file an appeal in writing or by calling your health plan's member services line.

Member Services: {MCE insert Member Services Number and TTY}

Grievance Process

- Your health plan will send an acknowledgment letter within three business days after receiving your grievance.
- The grievance will be reviewed quickly, no later than within thirty (30) days following receipt.
- If your grievance is a result of a health crisis, please request an expedited (faster) review within 48 hours.
- Once a decision has been made, your health plan will mail you letter in your preferred language.

Appeals

If you disagree with any action that denies or delays your care, you can file an appeal. An appeal is asking for a review because you do not agree with a decision the State or your health plan has made. You have the right to file an appeal if you disagree with the decision. You do not have to pay to file an appeal. You can also appeal if Medicaid or your plan stops providing or paying for all or part of a health care service, supply, or prescription drug you think you still need.

- If you are on Medicaid and want to appeal a decision made about your health care, you can appeal in writing or over the phone to your health plan.
- If you are on the PathWays program, you should contact your health plan and work through their appeal process. You have 60 calendar days from the date of the problem to appeal.
- If you file an appeal, you will continue to get any services you were already getting as long as you filed the appeal quickly. You must file an appeal within 60 calendar days

from the date of the Notice of Adverse Benefit Determination letter. If the appeal is not decided in your favor, you may have to pay for the services you received during the appeal process.

State Fair Hearing

Once a decision is made on your appeal, a Notice of Appeal Resolution letter will be sent to you. This letter will tell you the reason for the decision. If you feel the decision is not correct, you may request a State Fair Hearing. You can write a letter telling the State why you think a decision is wrong. Please make sure to also include your name and other important information, like the dates of the decision, which is in the letter. Send your appeal to:

Family and Social Services Administration
Office of Administrative Law Proceedings-FSSA Hearings
402 West Washington Street, Room E034
Indianapolis, IN 46204

Fax: 317-232-4412
Email: fssa.appeals@oalp.in.gov

Appeals regarding eligibility decisions can be sent to the local DFR office. To find a DFR office near you, go to http://in.gov/fssa/dfr/2999.htm.

If you file an appeal, you must do it within 120 calendar days after your problem happened or is set to happen. If your appeal is about a service you are still using, like in-home healthcare, you will get at least 10 days' notice before your service is stopped.

At your appeal hearing, you can speak for yourself or have help, or representation, from legal counsel, a friend, relative, or someone you trust to speak on your part. You will be shown your entire medical case file. You will be shown all materials used by FSSA, your county office, or the provider or health plan that relates to your appeal and used to make the original decision.

External Review by Independent Review Organization

If you do not agree with the appeal decision, you may also request an External Review by an Independent Review Organization (IRO). You or your authorized representative must request the IRO review in writing within 120 calendar days of receiving your appeal decision letter. The IRO will be conducted at no cost to you. The IRO will decide within 15 business days. The decision by the IRO is binding, meaning your health plan must obey their decision. To request the External Review by Independent Review Organization, reach out to your health plan Member Services.

Information to include when requesting an External Review:

- Name

- Member ID number
- Phone number where you can be reached
- Reason for your appeal
- Any information you feel is important to your appeal request (examples include documents, medical records, or provider letters)

Inquiry
Your health plan must resolve your inquiries by the close of the next business day after receipt. If an inquiry is not resolved in this timeframe, it becomes a grievance.

Fraud, Waste, and Abuse

Fraud, waste, and abuse means breaking the rules for a personal gain. Fraud can be committed by providers, pharmacies, or members. Examples of provider fraud, waste and abuse include doctors or other health care providers who:

- Prescribe medicine, equipment or services that are not medically necessary
- Don't provide patients with medically necessary services due to lower reimbursement rates
- Bill for tests or services that were not provided
- Use wrong medical coding on purpose to get more money
- Schedule more frequent return visits than are medically necessary
- Bill for more expensive services than provided
- Prevent members from getting covered services, resulting in underutilization of services

Examples of pharmacy fraud, waste, and abuse include:

- Not dispensing drugs as written
- Submitting claims for a more expensive brand-name drug that costs but giving a generic drug that costs less
- Dispensing less than the prescribed quantity and then not letting the member know how to get the rest of the drug

Examples of member fraud, waste, and abuse include:

- Inappropriately using services, such as selling prescribed narcotics or trying to get controlled substances from more than one provider or pharmacy
- Changing or forging prescriptions
- Using medications that you do not need
- Sharing your ID card with another person
- Not disclosing that you have other health insurance coverage
- Getting unnecessary equipment and supplies
- Receiving services or medicines under another person's ID (identity theft)
- Giving wrong symptoms and other information to providers to get treatment, drugs, etc.
- Visiting the ER repeatedly for problems that are not emergencies

Medicaid members who are proven to have abused or misused their covered benefits may:

- Be required to pay back any money we paid for services which were determined to be a misuse of benefits
- Be prosecuted for a crime and go to jail
- Lose their Medicaid benefits

Reporting Fraud, Waste, or Abuse

If you think your provider, pharmacy, or a member is committing fraud, waste, or abuse, you must tell your health plan. You can call your health plan's fraud reporting line, send an email, or fill out and mail a form. You do not have to tell them your name if you call or write. If you do

not give your personal information, your health plan will not be able to call for other information. Do not send any sensitive personal information through email. Your report will be kept confidential to the extent permitted by law.

Fraud Reporting Lines

Call toll-free: 800-403-0864, Monday to Friday, 8 a.m. to 4:30 p.m.
Select option 5. When prompted, enter your zip code.

Fax: 317-234-2244

Email: ReportFraud@fssa.IN.gov

Fraud Reporting Mailing Addresses:

FSSA Compliance Division
Room E-414
402 W. Washington St.
Indianapolis, IN 46204

Advance Directives

Advance directives are instructions you give about your future medical care in case there is a time you can't speak or make decisions for yourself. By having an Advance Directive in place this will not take away your right to decide your current health care choices. The Advance Directive also allows you to name a person to make decisions on your health care. They help your family and physician understand your wishes. With advance directives, you can:

- Let your provider or medical office know if you would or would not like to use life-support machines
- Let your provider or medical office know if you would like to be an organ donor
- Give someone else permission to say "yes" or "no" to your medical treatments

Advance directives are only used if you can't speak for yourself. It does not take away your right to make a different choice if you later become able to speak for yourself. You can make an advance directive by:

- Talking to your provider and family
- Choosing someone to speak or decide for you, known as a health care representative
- Creating a Power of Attorney and/or Living Will

Type of Advance Directives Recognized in Indiana

- Health Care Representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Organ and tissue donation
- Out of Hospital Do Not Resuscitate Declaration and Order Physician Orders for Scope of Treatment (POST)
- Power of Attorney
- Psychiatric advance directives

For more information on Advance Directives and to find forms available to you, please visit Indiana Health Care Quality Resource Center https://www.in.gov/isdh/25880.htm

Words and Acronyms used in this manual

Advance Directives or Living Will	A written explanation of a person's wishes about medical treatments. This often is called a living will. This makes sure wishes are done if a person cannot tell a provider.
Annual Physical	Visits to a Primary Medical Provider (PMP) each year to check your health. This is often referred to as a wellness visit, preventive health exam or checkup.
Appeal	A written or verbal request for a decision to be reversed. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received.
Benefit	Coverage of a health care service that a Medicaid member receives for the treatment of illness, injury, or other conditions allowed by the State.
Case Management	Program for members with special health conditions that help members manage their conditions by routine contact and help from their health plan.
Copayment	A form of cost sharing. Copayments or "co pays" refer to a specific dollar amount that an individual will pay for a particular service, regardless of the price charged for the service. The payment may be collected at the time of service or billed later.
Covered Service	Services covered under Indiana Medicaid. Some are mandatory medical services required by CMS and optional medical services approved by the State that are paid for by Medicaid. Examples of covered services are prescription drug coverage and physician office visits.
Division of Family Resources (DFR)	A Division of the Family and Social Services Administration. The State agency that offers help with job training, public assistance, supplemental nutrition assistance, and other services.
Eligible Member	Person certified by the State as eligible for medical assistance.
Explanation of Benefits (EOB)	A statement of an explanation of services rendered by your provider and any payments made toward those expenses.
Family and Social Services Administration (FSSA)	An umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction and the Division of Disability & Rehabilitative Services.
Grievance	A complaint about the health plan (MCE) or providers.
Health Needs Screening (HNS)	A questionnaire members must complete so your health plan is aware of any healthcare conditions. This allows the health plan to match the members with the right programs and services.

Indiana Health Coverage Programs (IHCP)	The name used to describe all of Indiana's public health assistance programs, such as Medicaid, PathWays, and CHIP.
In Network	When a doctor, hospital or other provider accepts your health insurance plan that means they are in network. We also call them participating providers.
Managed Care Entity (MCE)	Insurance organizations or health plans that oversee the overall care of a patient to ensure cost-efficient quality health care to its members.
Medicaid Identification Number (MID)	The unique, state assigned numbers issued to a member who is eligible for Medicaid services. This number can be found on the front of your Member ID card.
Medically Necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Non-Participating Provider	A licensed health care professional who has not signed a contract to provide services (out-of-network) within a health plan. This could be a doctor, hospital or other provider.
Primary Medical Provider (PMP)	A physician, advanced practice nurse, or physician assistant that devote the majority of their practice to internal medicine, family/general practice, and/or pediatrics. An obstetrician/gynecologist may be considered a primary medical provider.
Prior Authorization (PA)	A pre-authorization required to receive certain services. The MCE and/or State medical consultants review the PA for medical necessity, reasonableness, and other criteria. The PA must be obtained prior to the service for benefits to be provided and within a certain time period, except in certain allowed instances.