IHCP Model Enrollee Handbook 2022

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Model Enrollee Handbook Purpose

The purpose of the MCE Model Enrollee Handbook is to provide the minimum requirements and best practices for an MCE's member handbook. The MCE shall utilize this Model Enrollee Handbook when creating and updating their own handbook. The MCE Model Enrollee Handbook complies with 42 CFR 438.6(c) with Centers for Medicare & Medicaid Services (CMS).

Welcome to IHCP

The Indiana Family and Social Services Administration (FSSA) offers Medicaid services to eligible Hoosiers through the Indiana Health Coverage Programs (IHCP). This manual will provide you 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 <MCE to list times>

<MCE> is closed on: list observed holidays

Working With Your Health Plan

Service Area	Phone number	Information
Member Services	<MCE enter phone number> (TTY 711)	Hours: <MCE list hours> Call for questions about: ✓ Your health plan ✓ Behavioral Health ✓ Substance abuse services ✓ Pharmacy benefits ✓ Utilization management
24/7 Nurse line	<MCE enter phone number>	A nurse is available 24 hours a day/ 7 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, 7 days a week.
Dental Member Services	<MCE enter phone number>	Find a dentist in your area or learn more about changes like phone, address and income.
Utilization Management (UM)	<MCE enter phone number>	The prior authorization is requested by your doctor. UM customer service can answer general questions regarding your authorization.
Suicide and Crisis Hotline	988	Providing 24/7, free and confidential support for those experiencing a suicidal crisis or emotional distress.
		For calls to set up transportation to your doctor appointments.

Transportation Services	<MCE enter phone number>	Please see your health plan for more information regarding transportation services page 29 available to you.
Relay Indiana	1-800-743-333 (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 Services Administration (FSSA)	1-800-403-0864	Call this number to report any information changes like phone, address and 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
Program Helplines	Hoosier Care Connect (HCC) 1-866-963-7383 Hoosier Healthwise (HHW) 1-800-889-9949 Healthy Indiana Plan (HIP) 1-877-438-4479	If you don't know which health plan is best for you, call your program's helpline listed below. The people who work at the helpline will help you decide which health plan would help you most. You can also call this number if you want to change or switch your health plan.

Choosing a Health Plan

If you are a member of the Healthy Indiana Plan, Hoosier Healthwise, or Hoosier Care Connect, you will need to choose a health plan. 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 several health plans depending on your program. If you are a Hoosier Healthwise or Healthy Indiana Plan Member you can select Anthem, CareSource, MDwise, or MHS. If you are a Hoosier Care Connect Member you can select Anthem, MHS, or UnitedHealthcare.

After enrollment into your health plan is completed, a welcome packet will be sent to you. The welcome packet will provide more detail 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 doctor will also make referrals and help you with prior authorizations for services that are not always covered by Medicaid.

If you already have a doctor or other primary or specialty medical provider, when choosing your health plan, you will want to make sure that 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 your program’s helpline listed below. The people who work at the helpline will help you decide which health plan would help you most. You can also call this number if you want to change or switch your health plan.

Program Helplines

Hoosier Care Connect (HCC) - 866-963-7383
Hoosier Healthwise (HHW) - 800-889-9949
Healthy Indiana Plan (HIP) - 877-438-4479

How to Choose your PMP

Now that you have selected your health plan, the next step is choosing a Primary Medical Provider. If you are enrolled in the Healthy Indiana Plan (HIP), Hoosier Healthwise, or Hoosier Care Connect, you will need to choose a Primary Medical Provider (PMP) within your health plan. This is your main doctor that you will see for annual check-ups, routine sick or well visits and immunizations (shots).

Your PMP may be any of the following:

General Practitioners	Obstetricians
Internal Medicine Physicians	Pediatrician
Advanced Practice Nurses	Physician Assistants
Endocrinologists (if primarily engaged in internal medicine)	Gynecologists

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 on to you 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 doctor 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 doctor 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 DFR through the automated Indiana Eligibility Determination and Services System (IEDSS). Each member will receive a member identification card from the selected health plan. The type of card received depends on the IHCP program in which the member is enrolled.

Member Cards

Your health plan will send you a member ID card. 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. Your ID card will have your member ID on it.

Provider Directory

Each Managed Care Program provides members with an up-to-date Provider Directory to assist you with finding provider that are 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, specialty).

Health plan updates

Your health plan will publish any 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 doctor. 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 doctor or hospital cannot treat because of their moral or religious beliefs. If this happens, that doctor or hospital should tell you. Then,you can decide to go to a different doctor 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 doctor 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 doctor does not return your calls
- You have trouble getting the care you want, or your doctor says you need

Member Services Phone Numbers

Anthem: 1-866-408-6131, TTY 711
CareSource: 1-844-607-2829, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, TTY 711
UnitedHealthcare:1-800-832-4643, TTY 711

Open Enrollment Period

With the Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect programs, you must remain in your chosen health plan for a one-year period as long as you remain eligible. You may only change your health plan during certain times of the year or for certain reasons outlined below.

Open Enrollment Periods:

- Anytime during your first 90 days with a new health plan
- Annually during your open enrollment period
- Anytime you file a grievance with your health plan and the State finds that you have a good reason to change health plans. Another name for good reason to change health plans is “just cause:” This is when you have concerns over the quality of care being provided by your health plan. You must first contact your health plan so they can attempt to resolve your concern. Please see page 30 for “just cause” reasons.

Pregnant Women

If you become pregnant, call us right away. If you are a HIP member, you will be enrolled in the HIP Maternity plan. You will be enrolled in the HIP Maternity plan the first of the month after you tell your health plan and until 12 months after you give birth. You will have continuous eligibility, meaning you will not be disenrolled during pregnancy and 12- month postpartum period regardless of change in your situation that would normally result in loss of coverage.

With HIP Maternity, you have no copays or POWER Account payments. If you are still eligible for HIP at the end of the postpartum coverage period, you will be enrolled in HIP Basic. If you make your POWER Account payment within 60 days, you will receive HIP Plus benefits.

All programs cover the same benefits for pregnant women, including vision, dental, and chiropractic services. They also cover non-emergency transportation and enhanced smoking cessation services.

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.
- Sterilization services
- HIV and sexually transmitted infection (STI) testing, treatment and counseling
- Screenings for cancer and other related conditions

Medically Frail for Healthy Indiana Plan

If you have a complex physical or behavioral health condition, it is called “medically frail.” Medically frail HIP members can get additional benefits through the HIP State Plan. Please call Member Services or go online to www.in.gov/fssa/hip/ for information on these additional benefits.

You are considered medically frail if you have a:

- Disabling mental disorder
- Chronic substance use disorder
- Serious and complex medical condition
- Physical, intellectual or developmental disability that significantly impairs the individual’s ability to perform one or more activities of daily living
- Disability determination from the Social Security Administration

We may contact you to confirm that you are medically frail. This is decided based on the medical care you get. You or your PMP may also call Member Services to tell us you have a condition that qualifies you as medically frail. If we determine that you do not qualify, you have the right to appeal. Instructions on how to appeal are on page 39.

When you are medically frail, you must make your POWER Account payments to receive HIP State Plan benefits without copays. If you do not make your POWER Account payments, you will be in HIP State Plan Basic and will have copays.

Programs and Covered Services

Hoosier Care Connect

Hoosier Care Connect is a health care program for people who are blind, disabled, or aged 65 years and older and are not eligible for Medicare.

Hoosier Care Connect covers these services:

- Doctor visits
- Well-child checkups
- During and after pregnancy care
- Prescriptions and medication therapy management
- Medical supplies/equipment
- Diagnostic tests
- Labs and x-rays
- Referrals to specialists
- Routine dental care
- Routine vision care
- Chiropractic services
- Psychiatric services
- Behavioral health (mental health, substance abuse, chemical dependency
- Foot care
- Authorized therapies (physical, speech, occupational, respiratory)
- Hospital stays
- Urgent care
- Emergency services
- Family planning
- Home health care
- Hospice care
- Surgeries
- Post-stabilization services
- Orthotics
- Diabetes strips, blood sugar monitoring
- Hearing aids (every five years)
- Developmental delay evaluation and treatment
- Diabetes self-management
- Ride services to doctor visits, pharmacy, emergency care, and redetermination appointments
- Immunizations (shots)

Hoosier Healthwise

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

Hoosier Healthwise includes two plans, called Package A and Package C. Package A covers children and pregnant women. Package C covers children in the Children's Health Insurance Program, which is also called CHIP. CHIP is for children up to age 19 whose families have slightly higher incomes. CHIP members must pay a low monthly premium for coverage as well as copays for certain services.

Hoosier Healthwise Packages A and C cover these services:

- Doctor care
- Physical exams
- Primary care
- Preventive care
- Prenatal care
- Specialty care
- Immunizations (shots)
- Health care screenings and diagnosis
- Home health care
- Physical, speech, respiratory, and occupational therapy
- Renal dialysis
- Smoking cessation
- Transportation
- Hospital care
- Inpatient services
- Outpatient services
- Diagnostic studies
- Lab tests and X-rays
- Post-stabilization services
- Prescriptions
- Durable medical equipment
- Leg braces and orthopedic shoes
- Hearing aids
- Prosthetic devices

Healthy Indiana Plan

The Healthy Indiana Plan is a health care program for adults ages 19 to 64 and pregnant women who meet income requirements. It covers medical care like doctor visits, prescriptions, and hospital stays. It can even provide vision and dental coverage.

These are the benefits included in each HIP plan.

HIP Plan	Benefits
HIP Basic	• Doctor Care • Physical exams • Primary care

HIP Plan	Benefits
	• Preventive care • Specialty care • Health care screenings and diagnosis • Home health care • Physical, speech, respiratory and occupational therapy services • Renal dialysis • Smoking cessation • Disease management • Lead screening • Hospice services • Skilled nursing facility • Transportation for pregnant members • Inpatient services • Outpatient services • Diagnostic services • Lab tests and X-rays • Post-stabilization services • Prescriptions • Durable medical equipment • Hearing Aids (one every five years)

HIP Plus	• All HIP Basic benefits
	• Plus:
	  ○ Dental services
	  ○ Vision services
	  ○ Chiropractic services
	  ○ TMJ services
	  ○ Bariatric surgery

HIP State Plan	• All HIP Plus benefits • Plus: ○ Non-emergency transportation
HIP Maternity	• All HIP State Plan benefits • Plus: ○ Enhanced smoking cessation services

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 Hoosier Care Connect, Hoosier Healthwise, and Healthy Indiana Plan packages include mental health and substance use disorder services. You may see any in-network doctor without a referral for outpatient treatment. **If you are having very negative thoughts or feel like hurting**

yourself or someone else, call 988 for help. If you have questions, please call your health plan's helpline below.

Behavioral Health Helplines

Anthem: 1-866-408-6131
CareSource: 1-844-607-2829
MDwise: 1-800-356-1204
MHS: 1-877-647-4848, then press *
UnitedHealthcare: 1-800-832-4643, TTY 711

Care and Disease Management Services

Care Management

Care Management services are available for children and 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 doctor recommends it, you ask for it, or they see you have a health issue they could help you with. Care Management covers conditions including, but not limited to:

- Asthma
- Depression
- Pregnancy
- ADHD
- Autism/Pervasive Developmental Disorder
- COPD
- Coronary Artery Disease
- Chronic Kidney Disease
- Congestive Heart Failure
- HIV
- Hepatitis C
- Diabetes
- Sickle Cell Disease

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.

Anthem: 1-866-408-6131
CareSource: 1-844-607-2829
MDwise: 1-800-356-1204
MHS: 1-877-647-4848
UnitedHealthcare: 1-800-832-4643, TTY 711

Disease Management

There are special programs for members with certain health conditions. Disease Management can help you learn more about your condition. It can help you when you talk with your doctor. The Disease Management program includes conditions like:

- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Diabetes
- Heart Disease
- Depression
- High Blood Pressure
- Hepatitis C

- Human Immunodeficiency Virus (HIV)
- Heart Failure
- Autism and disorders like it
- ADHD
- Pregnancy
- Chronic Kidney Disease

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

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, also called a PMP. You will be assigned one pharmacy. Any special doctors you see need will need approval from your PMP.

Pharmacy Information

Your health plan covers necessary medicines. Your doctor must prescribe them to you. You can go to any pharmacy that accepts your health plan.

Hoosier Care Connect

Hoosier Care Connect members have copays of $3.00 for each generic medication and brand-name medication.

Hoosier Healthwise

Hoosier Healthwise Package C members have copays of $3.00 for each generic medication and $10.00 for each brand-name medication.

Healthy Indiana Plan

HIP Plus, HIP State Plan Plus, and HIP Maternity members do not have copays for prescription medicines. HIP Basic and HIP State Plan Basic members have a $4 copay for each generic medication and an $8 copay for each brand-name medication.

Prior Authorization

Some prescription drugs, including some mental health drugs, for safety reasons, need approval from your doctor before you get them. This is called prior authorization. If your doctor does not get prior authorization when it is needed, your health plan will not pay for the prescription.

Cost-Sharing and Co-Payments

Cost-Sharing

Cost-sharing means you and your health plan share the cost of a service. Your health plan pays most of the cost and you pay your share through co-payments.

Co-Payments

Co-payments, or "copays," are set amounts of money you pay for a medical service. Some health plans do not have copays. In others, you may pay copays for doctor visits, prescriptions, transportation, and other services.

You will not have copays if you are:

- Under 18 years old
- Pregnant
- American Indian or Alaskan Native
- Receiving services related to pregnancy or family planning
- Have paid 5% of your income or more in copays during each quarter

Hoosier Care Connect Co-payments

Hoosier Care Connect	
Emergency Room	$3 for each non-emergent* date of service
Pharmacy	$3 for each prescription
Transportation	$1 for each one-way trip

*Non-emergent means not life-threatening. Life-threatening means if you do not get care right away, your life may be at risk.

Hoosier Healthwise Co-Payments and Cost-Sharing

Hoosier Healthwise		
Package C (CHIP)		Package A
Prescriptions (Generic *)	$3	No Copays
Prescriptions (Brand name)	$10	
Emergency Ambulance Transportation	$10	

†"Brand-name" means the medicine has a name given to it by a company. Some medicines have many brand names. For example, Tylenol is a brand-name pain medication.
*Generic medicines do not have a brand name. Usually, the medicine is named after the active ingredient. For example, acetaminophen is a generic version of Tylenol. Acetaminophen has the same active ingredient, but is not sold under a brand name.

Any medication given to you in an emergency does not have a copay.

Hoosier Healthwise Package C (CHIP) Premiums

Package C has small monthly premiums for its members. How much you pay is based on your family income and how many children in your family are in the program.

Hoosier Healthwise Package C (CHIP) Premiums		
Income (as percent of federal poverty level)	One Child	Two Children or More
150 – 175%	$22.00	$33.00
175 – 200%	$33.00	$50.00
200 – 225%	$42.00	$53.00
225 – 250%	$53.00	$70.00

Late Payments and Disenrollment for CHIP

If you are enrolled in CHIP, you must pay your monthly premiums. Your premium is due by the date listed on your monthly invoice from the State. If you do not pay your premium by that day, you have 60 days to make your payment before you lose your coverage.

If you are disenrolled due to not making payments, you can reapply for coverage. You must pay for any missed payments in the past and the current month to be eligible.

You will not be charged for the time between the day you lost coverage and the date that your coverage begins again. However, any services used in that time will not be covered.

Payments can be made using a credit card, debit card, or electronic check when calling or paying online. Your premium account number will need to be given for payment to be accepted. This can be found on your monthly voucher statement.

By Mail

Package C Premium (make charges payable to "Children's Health Insurance")

P.O. Box 3127

Indianapolis, IN 46206-3127

By Phone 1-855- 765-8672

Online Hoosier Healthwise Package C & M.E.D. Works Premium Portal

Healthy Indiana Plan Co-Payments

Healthy Indiana Plan			
HIP Basic		HIP Plus	
Outpatient Services (including office visits)	$4	Outpatient Services (including office visits)	No copay
Inpatient Services (including hospital stays)	$75	Inpatient Services (including hospital stays)	No copay
Preferred Drugs	$4	Preferred Drugs	No copay
Non-Preferred Drugs	$8	Non-Preferred Drugs	No copay
Non-Emergency ER Visits	$8	Non-Emergency ER Visits	$8

Healthy Indiana Plan POWER Account

Healthy Indiana Plan members have a POWER Account. POWER Account stands for "Personal Wellness and Responsibility" Account. The POWER Account is a special savings account designed to encourage members to stay healthy and use services in a cost-efficient manner. It is set up with $2,500 in your name. The state contributes most of the amount. If you are required to make a payment, depending on your eligibility status, your payments go towards the $2,500 as well. The amount of your contribution amount is based on your income.

You will receive monthly statements showing how much money is left in your POWER Account. However, covered services are still paid for by your health plan even after all the money in your POWER Account has been used. If you manage your health and your POWER Account wisely and receive preventive care, you may have money left in your account at the end of the year that can be used to lower your payments for the next year.

Members in the HIP Basic plan also have a POWER Account, but since they do not make contributions, the reward for receiving preventive care is different. When your eligibility is determined after each year of coverage, if you are in HIP Basic, you will have the opportunity to upgrade to HIP Plus coverage by making your POWER Account contributions. If you received preventive care last year and didn't use all your POWER Account funds, your required monthly POWER Account contribution may be less.

How do I monitor my POWER account?

Members receive monthly statements that show how much money is remaining in the POWER account. Members who manage their health and POWER accounts wisely could still have money in their accounts after a year of coverage. These remaining funds can be used to lower POWER account contributions for the next year of coverage. Every calendar year, members get a new $2500 POWER account to pay for HIP coverage medical expenses.

Healthy Indiana Plan Payment Cost Share Limits

There are limits to what you might have to pay. Your total cost-sharing for healthcare can't be more than 5% of your family's income for each quarter of the year. If you reach the limit, your cost sharing will be less or stopped for that quarter and you will not have to pay copays. Your health plan keeps track of your payments.

What if I Receive a Bill From My Doctor?

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. They may only charge you for the non-covered service if they told you 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 all 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):

- Family physician or general practitioner (a doctor who treats people of all ages)
- Internist (a doctor who treats adults)
- Obstetrician or gynecologist (OB/GYN) (a doctor who deals with the female reproductive system.
- Clinic doctor (at a health department, health center, or rural health clinic)
- Advance Practice Nurses (a nurse with additional training)
- Pediatrician (a doctor who takes care of members under age 19)
- An Endocrinologist (if primarily engaged in internal medicine)

Seeing a Specialist

Your PMP may send you to a specialist for special care or treatment. They will help 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.

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

Anthem: 1-866-408-6131, TTY 711
CareSource: 1-844-607-2829, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, TTY 711
UnitedHealthcare: 1-800-832-4643, TTY 711

How to Make a Doctor's 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

Self-Referral Services

For most services you need to go to a <MCE Name> provider. For some services, you can go to any Indiana Medicaid provider without a referral from your PMP. These services are called self-referral services. If you get these services, please let your doctor know. This helps them take care of you. For most self-referral services, you can go to any Indiana Medicaid provider. But, for some services, the provider must also be in your health plan's network.

The services you can receive from any IHCP provider without a referral from your PMP are below.

Service	Hoosier Care Connect	Hoosier Healthwise	HIP Basic	HIP Plus	HIP State Plan	HIP Maternity
Chiropractic Services	X	X			X	X
Diabetes Self-Management	X	X	X	X	X	X
Emergency Services	X	X	X	X	X	X
Family Planning	X	X	X	X	X	X
Immunizations (Shots)	X	X	X	X	X	X
Podiatry (Foot) Care	X	X			X	X
Psychiatric Services	X	X	X	X	X	X
Routine Vision Care	X	X		X	X	X

The services you can receive without a referral, but that must still be provided by a doctor in your health plan's network, are below.

Service	Hoosier Care Connect	Hoosier Healthwise	HIP Basic	HIP Plus	HIP State Plan	HIP Maternity
Behavioral Health (Mental Health, Substance Use, Chemical Dependency)	X	X	X	X	X	X
Routine Dental Care	X	X		X	X	X

Preventive Care

Preventive Care for Adults

Seeing your doctor 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 (19-20)	Men (19-20)	Women (21-34)	Men (21-34)	Women (35-49)	Men (35-49)	Women 50+	Men 50+
Annual Physical Exam	X	X	X	X	X	X	X	X
Blood Glucose Testing*	X	X	X	X	X	X	X	X
Cholesterol Testing*					45+	X	X	X
Flu Shot*	X	X	X	X	X	X	X	X
Pneumococcal Vaccine*	X	X	X	X	X	X	X	X
Tetanus-Diphtheria Booster	X	X	X	X	X	X	X	X
Colorectal Cancer Screening							X	X
Pap Smear*	X		X		X		X	
Screening Mammogram*							X	
Chlamydia Screening	X		Under 25					
HPV Vaccine	X	X	Under 27					
Dental Exams**	X	X	X	X	X	X	X	X
Eye Exams**	X	X	X	X	X	X	X	X

*These services are usually provided annually or as otherwise recommended by your doctor.
**For HIP members, if these services are included in your HIP plan.

HIP Members

HIP Plus members who have money remaining in their POWER Account at the end of the benefit year may roll over the portion that they contributed. By getting preventative care, they may qualify to double that amount to reduce their future contributions.

HIP Rollover credit

The Healthy Indiana Plan offers incentives for members who seek preventative care. Referred to as the HIP Rollover, members who get certain preventative care services may have the opportunity to lower future POWER Account contributions. The chart listed above provides a list of preventive care services. These services will not take money from your POWER Account balance. HIP members need to receive one of the preventative services from the list to be considered for the rollover credit.

HIP Members

HIP Plus members who have money remaining in their POWER Account at the end of the benefit year may roll over the portion that they contributed. By getting preventative care, they may qualify to double that amount to reduce their future contributions. HIP preventative services may be updated yearly by October 1st, and any age and gender appropriate preventative doctor visit may qualify a member for rollover to apply for the following year's POWER Account contribution. You may receive preventative service reminders from your health plan including monthly POWER Account statements and redetermination information.

HIP Basic/ HIP State Plan Basic members

HIP Basic members who get their preventative care may be able to move up to HIP Plus at a discount when they are determined eligible for another benefit period and continue with HIP. The discount may reduce monthly POWER Account contributions up to 50 percent.

If you are in HIP Basic or HIP State Plan Basic and get preventive care each year, the money left that you contributed to your POWER Account will roll over to the next year. This could lower your payments. If you do not get preventive care, this money will not roll over to the next year.

HIP Plus/ HIP State Plan Plus members

If you are in HIP Plus or HIP State Plan Plus and get preventive care, the money you contributed to your POWER Account will roll over to the next year and will also be doubled. This could lower or cover your payments. If you do not get preventive care, some of your money will be rolled over but will not be doubled.

Preventive Care for Children

Children require more frequent check-ups. Your child should receive check-ups at these ages:

- 3 – 5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months (1 year)
- 14 months
- 18 months
- 24 months (2 years)
- 30 months
- 3 years
- Yearly ages 4–20

EPSDT

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a program for children and adolescents under the age of 21. Members eligible for EPSDT services may be The EPSDT program makes sure children are receiving care from early on and as they grow. These check-ups help make sure your child grows up healthy. If the doctor finds a problem, it will be treated and watched. EPSDT program services are also covered for HIP members ages 19 – 20. EPSDT services are covered for Hoosier Healthwise and Hoosier Care Connect members under 21.

It is very important that children go to all of their EPSDT appointments. When your child goes for an EPSDT check-up, the doctor will cover these areas:

- Medical history and physical exam
- Development checks (personal, social, motor, and language skills)
- Vision screening
- Hearing screening
- Dental screening
- Nutrition and diet
- Mental health and substance abuse
- Immunizations (shots)
- Lab testing (including blood lead levels)
- Health education for parents
- Referrals for diagnosis and/or treatment if needed

Schedule an EPSDT Visit With Your PMP

You must schedule EPSDT visits for your child so your PMP can find any health problems early. Some services may require a prior authorization from your PMP. The prior authorization is a request that your PMP will send to your health plan to approve a service or procedure.

Immunizations

Immunizations are shots that protect the body from disease and illness. Most immunizations require follow-up shots or "boosters." Children will receive shots during some of their EPSDT visits. They must have all their shots before going to school. Check with your child's doctor to make sure your child has all the shots they need. These are the recommended childhood and adolescent immunizations:

- DTaP (diphtheria, tetanus, pertussis)
- Flu
- HIB (Haemophilus influenzae type B)
- Hepatitis A
- Hepatitis B
- HPV (human papilloma vaccine)
- IVP (polio)
- MCV4 (meningococcal)
- MMR (measles, mumps, rubella)
- PCV/PPSV (pneumococcal)
- RV (rotavirus)
- Tdap (tetanus, diphtheria, pertussis booster)
- VAR (chicken pox)

MCE TO INSERT PERIODICITY IMMUNIZATION SCHEDULE

These shots are given to your child over time. It may seem like there are a lot of shots, but the shots are needed to prevent disease. Shots help prevent disease for your child as well as other children. If you're not sure if your child has all their shots, talk to your child's doctor right away. Their doctor can also help if your child missed a shot.

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 don'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 PMP in-office. Telehealth is seeing your doctor remotely, usually by a video or audio call on your phone.
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 below chart will provide you with an expectation of when you can expect to obtain an appointment with you 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. t 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, the enrollee/member has 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 care, call 911 or go to the nearest emergency room (ER). Do not call your health plan prior to calling 911.

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]

The nurse can help you:

- Decide if you or your child needs to see your doctor
- Decide if you or your child 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 you health plan Behavioral Health Crisis line. Clinicians are available 24 hours a day, 7 days a week to talk with you.

Anthem: 1-833-874-0016, TTY 711
CareSource: 1-833-227-3464, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, then press * TYY 711
UnitedHealthcare: 1-800-832-4643, TTY 711

National Suicide Prevention – Dial 988

Transportation

HIP Maternity, HIP State Plus/Basic, Hoosier Care Connect and Hoosier Healthwise plans include transportation (ride) benefits. Check your health plan's benefits to see if you have a copay for rides and if non-emergent transportation is offered. Rides to the locations listed below are included in these plans.

- Any doctor visit or health care appointment
- Your local Women, Infants and Children (WIC) office
- Eligibility redetermination appointments with the state

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 Member Services.

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 set 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 at the office before leaving, work with your doctor to do so before calling your driver for the trip home. Your driver will need to be told about a stop at the pharmacy when scheduling the trip home.

Transportation Phone Numbers

Anthem: 1-844-772-6632, TTY 711
CareSource: 1-855-475-3163, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, TTY 711
UnitedHealthcare:1-800-832-4643, TTY 711

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 language or sign language when you go to the doctor.

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 doctor if you need a sign language interpreter for your medical visits.

Language Help Phone Numbers

Anthem: 1-866-408-6131, TTY 711
CareSource: 1-844-607-2829, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, TTY 711
UnitedHealthcare: 1-800-832-4643, TTY 711

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.

Hoosier Care Connect and Hoosier Healthwise members have plan selection for the first 90 days they are eligible for coverage. HIP members have plan selection for the first 60 days of their eligibility, or until they make their first POWER Account payment, whichever is sooner. HIP members also have plan selection from November 1 through December 15 each year.

On a yearly basis Hoosier Care Connect and Hoosier Healthwise members can change their plan. Look out for a notice for your specific plan selection time period.

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 Hoosier Healthwise and Hoosier Care Connect programs:

- Receiving poor quality of care
- The plan does not, because of moral or religious objections, cover the service sought
- Failure of the Contractor to provide covered services
- Failure of the Contractor to comply with established standards of medical care administration
- Significant language or culture barriers
- Corrective action levied against the Contractor 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 Hoosier Care Connect MCE; or
- Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

The following are the "just cause" reasons for switching health plans during the year for the Healthy Indiana Plan:

- Receiving poor quality care
- The plan does not, because of moral or religious objections, cover the service sought.
- Failure of the insurer to provide covered services
- Failure of the insurer to comply with established standards of medical care administration
- Lack of access to providers experienced in dealing with the member's health care needs
- Significant language or culture barriers
- Corrective language levied against the insurer by the office

- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence.
- A determination that another insurer's formulary is more consistent with a new member's existing health care needs.
- Other circumstances determined by the office 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. They will review your request.

Anthem: 1-866-408-6131, TTY 711
CareSource: 1-844-607-2829, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, TTY 711
UnitedHealthcare: 1-800-832-4643, TTY 711

Call the program phone number if you want help filing a grievance or changing your health plan.
Hoosier Care Connect (HCC) - 866-963-7383
Hoosier Healthwise (HHW) - 800-889-9949
Healthy Indiana Plan (HIP) - 877-438-4479

Redetermination

To continue receiving 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 Division of Family Resources and your health plan to remind you about redetermination.

It is important to keep your address and phone number updated so you receive notices. If your phone number or address changes, contact the Division of Family Resources (DFR).

Division of Family Resources Toll-Free Line

DFR: 1-800-403-0864

Moving to Medicare

If you become eligible for a Medicare program, you have to apply for Medicare. This includes if you're 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. T When your coverage changes you may have new copays. You will be responsible for paying your copays. When you become eligible for Medicare, your current health coverage will end. There are two parts to Medicare: Medicare Part A and Medicare Part B.

Medicare Part A and Medicare Part B have different start dates. It is important to know when your current health plan ends and Medicare begins. You can pick a Medicare plan that best fits your needs. It is also important to look into "Medigap" coverage. Medigap coverage is extra health coverage that can help pay for things that Medicare may not cover. In some cases, you may need an extra Medigap policy to help fill in any coverage needed and help with things you may have to pay, such as copays or deductibles.

SHIP (State Health Insurance Program)

The State Health Insurance Program (SHIP) can give you information about Medicare. SHIP does not sell you insurance. SHIP can answer your questions about Medicare, supplemental insurance, prescription drug cost help, long-term care insurance, and low-income help. SHIP can also:

- Give you educational reading materials
- Help you understand Medicare
- Teach you about how Medicare claims are filed
- Tell you your rights as a member
- Refer you to providers that can help you with other needs

You can go to https://www.medicare.gov or https://www.in.gov/ship for more information about Medicare and other federal programs. You can also call SHIP at 1-800-452-4800 for help.

How and When to Report Changes

Your health plan keeps your information on file for many reasons. It is important that your information is 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 on your contact information. This can be things like:

- Name
- Address
- Phone number
- Change in insurance (such as getting another insurance)
- The beginning and end of a pregnancy

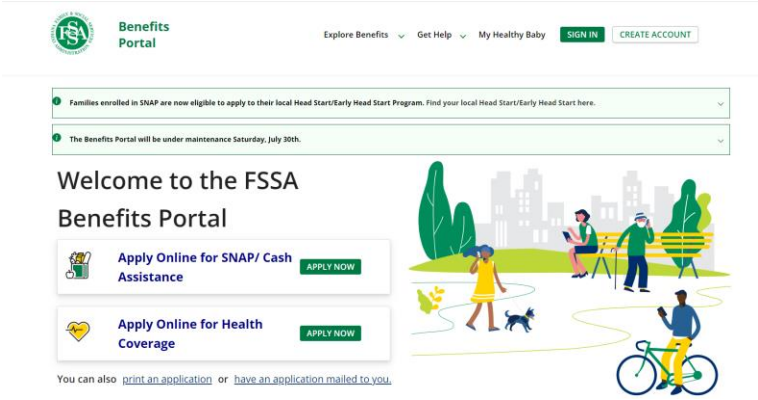
To the Division of Family Resources (DFR)

The Division of Family Resources should be updated on all of 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 on go online

- Name
- Address
- Phone number
- Change in family size
- Change in income
- The beginning and end of a pregnancy

Manage Your Benefits

Another option to report any changes is through the benefit 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. https://fssabenefits.in.gov/bp/#/



Member Rights

As a member, you have the RIGHT to:

- Be treated with dignity and respect when getting health services
- Be given information on your medical benefits and plan information
- Be given privacy for you and your medical records
- Be given easy-to-understand explanations of your medical problems and treatment choices
- Stay involved in decisions about your treatment choices
- Get care 24 hours a day, 7 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 doctor
- Request and receive a copy of your medical records and request that they be changed or corrected
- 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 place in your medical record about the treatment refusal.
- 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 doctor cannot make you do something you do not want to do. The doctor cannot try to get back at you for something that you may have done.
- Free from any restrictions on freedom of choice among network providers.
- Receive information on available treatment options and alternatives, presented in a way that is right for your condition and that you can understand.

Member Responsibilities

As a member, you have the RESPONSIBILITY to:

- Tell your doctor (PMP) about your medical conditions to the best of your ability
- Call your personal doctor (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 doctor if you do not understand what he or she tells you about your condition, care, or what you need to do
- Get all childhood shots for your children
- Call your doctor if you are not sure you are having a true emergency
- Follow the rules of your doctor's office

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 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 **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 people unless you give written consent. These may be people like a family member or close friend who pays for your care.

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 tell them they can 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 are receiving 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 doctor
- 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:

Anthem: 1-866-408-6131, TTY 711
CareSource: 1-844-607-2829, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, TTY 711
UnitedHealthcare: 1-800-832-4643, TTY 711

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 no more than 60 days after a problem happens.

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 would file an appeal with your health plan. You can file an appeal in writing or by calling your health plan.

Member Services:

Anthem: 1-866-408-6131, TTY 711
CareSource: 1-844-607-2829, TTY 711
MDwise: 1-800-356-1204, TTY 711
MHS: 1-877-647-4848, TTY 711
UnitedHealthcare: 1-800-832-4643, TTY 711

Grievance Process

- Your health plan will send an acknowledgment letter within three business days after reporting a grievance
- The grievance will be reviewed quickly, no later than within thirty (30) days following receipt of the grievance.
- 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 primary 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 Healthy Indiana Plan, Hoosier Healthwise, or Hoosier Care Connect, 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 file 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 on 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

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 contractor that relate 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 days of receiving your appeal decision letter. The IRO will be conductedat no cost to you. The IRO will make a decision 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)

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 doctor, 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 option5. 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 doctor know if you would or would not like to use life-support machines
- Let your doctor 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 doctor 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

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

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.
Benefit	Health care service coverage 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
Children's Health Insurance Program (CHIP)	An expansion of Hoosier Healthwise that extends coverage to children up to age 19 years old whose family meet the eligibility requirements.
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.
Cost Sharing	The costs a member is responsible for paying for health services when covered by health insurance.
Covered Service	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.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment Services. These are a series of tests your child needs to receive from birth to age 21 to help them to keep from getting sick or to detect potential health problems early.
Explanation of Benefits (EOB)	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.
Federal Poverty Level (FPL)	Individual and family income guidelines set by the federal government for the administration of social service benefits. The state-specific guidelines are adjusted for the cost of living in each state. Financial eligibility for social service programs is often based on a percentage of FPL.
Grievance	A compliant about the health plan 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	The name used to describe all of Indiana's public health assistance programs, such as Medicaid, HIP 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 (MCE)	Organizations that oversee the overall care of a patient so as to ensure cost-efficient quality health care to its members.
Medically Frail	Individuals who are determined to be medically frail receive coverage for some additional benefits including non-emergency transportation and chiropractic services. An individual is medically frail if he or she has one or more of the following: • Disabling mental disorder • Chronic substance abuse disorder • Serious and complex medical condition • Physical, intellectual or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living or disability determination from the Social Security Administration
Medicaid number	The unique number assigned 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 give services. This could be a doctor, hospital or other provider.
POWER Account	Every HIP member has a POWER Account. The POWER Account is used to pay for the first $2500 in health care costs. The state of Indiana pays for most of the $2500 in the POWER account, but the member is responsible for a fixed monthly payment depending on the income.
Primary Medical Provider (PMP)	A physician or advanced practice nurse, the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary medical provider.
Prior Authorization	An authorization required for the delivery of certain services. The Medical Services Contractor and State medical consultants review PA for medical necessity, reasonableness, and other criteria. The PA must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances.