MCE Model Member Handbook 2024:

Healthy Indiana Plan

Hoosier Care Connect

Hooser Healthwise

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Revision History

Version	Date	Reason for Revisions	Revisions Completed By
1.0	July 1, 2024	New handbook	FSSA and Gainwell

Table of Contents

Section 1: Introduction

1.1 MCE Model Member Handbook Purpose

The purpose of the managed care entities (MCEs) Model Member Handbook is to provide the minimum requirements and best practices for an MCE's member handbook for the following MCEs: Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC) and Hoosier Healthwise (HHW). The MCE shall utilize this MCE Model Member Handbook when creating and updating their own handbook. The MCE Model Member Handbook complies with 42 CFR 438.6(c) with Centers for Medicare & Medicaid Services (CMS).

1.2 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 handbook will provide you information on how your health plans work and important resources.

1.3 Contact Us

1.3.1 Mailing Address

<MCE list full mailing address>

1.3.2 Online

<MCE list website>

1.3.3 Hours of Operation

<MCE> is open for business Monday- Friday 8:00 AM 8:00 PM

<MCE> is closed on:

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

1.4 Working With Your Health Plan

Table 1-1: Health plan information

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, 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.
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 hours a day, 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 to your doctor appointments. Please see your health plan for more information regarding transportation services available to you.
Relay Indiana	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)	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	800-784-8669	Free phone-based service to help smokers quit
Program Helplines	Hoosier Care Connect (HCC) 866-963-7383 Hoosier Healthwise (HHW) 800-889-9949 Healthy Indiana Plan (HIP) 877-438-4479	If you don't know which health plan is best for you, call your program's helpline listed. 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.

Section 2: 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 PMP 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 benefit you most. You can also call this number if you want to change or switch your health plan.

2.1 Program Helplines

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

2.2 How to Choose Your Primary Medical Provider

If you are enrolled in the Healthy Indiana Plan, Hoosier Healthwise, or Hoosier Care Connect, you will need to choose a 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:

- Advanced Practice Nurses
- Endocrinologists (if primarily engaged in internal medicine)
- General Practitioners
- Gynecologists

- Internal Medicine Physicians
- Obstetricians
- Pediatrician
- Physician Assistants

You can choose your PMP or have one assigned to you. If you do not have a PMP, your health plan will assign one 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 may not be able to pay for any services you use through them. If your doctor would like to become a Medicaid provider, suggest they visit the Indiana Medicaid Provider website. If you have questions, contact your health plan directly.

2.2.1 Member Identification

You will receive a member identification card from your health plan. The type of card received will depend on the IHCP program in which you are enrolled. You will be assigned a 12-digit Member ID number also referred to as a MID. The Member ID is assigned by the FSSA DFR through the automated Indiana Eligibility Determination and Services System (IEDSS).

2.2.2 Member Cards

Your health plan will send you a member ID card. Your member ID card is very important. Your ID card will have your member ID, your cost-sharing responsibilities, and important health plan phone numbers on it. If you lose your card, contact your health plan to request a new one.

If you do not have your ID card at the time of your appointment, you can still be seen by the doctor once your Medicaid eligibility is verified. Medicaid eligibility can be verified if you can provide one of the following for the individual receiving services:

- Member ID
- Social Security number and date of birth
- First and last name

2.2.3 Provider Directory

Each Managed Care Program provides members with an up-to-date provider directory to assist you with finding a provider 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. <<insert MCE provider directory website and instructions on how to request a paper copy of the provider directory>>

The provider directory includes the following:

- Primary care physicians, specialists and hospitals
- Name, location and telephone number of providers

- Non-English language spoken by providers
- Provider web sites, if applicable
- Accommodations for people with physical disabilities, if available
- Pharmacies and behavioral health providers
- Providers that are not accepting new patients

2.2.4 Health Plan Updates

Your health plan will publish any updates to the provider network no less than 30 calendar 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.

2.3 How to Change Your PMP

You can call your health plan Member Services phone number to change your PMP. Member Services can assist you in finding your new PMP if:

- 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
- You have been disrespected while receiving care
- Your doctor does not return your calls
- You have trouble getting the care you want, or your doctor says you need

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.

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

2.3.1 Member Services Phone Numbers

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

2.4 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 others 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

2.5 Medically Frail for Healthy Indiana Plan

If you have a complex physical or behavioral health condition or a combination of such health conditions, your health plan may determine that you are "medically frail." Medically frail HIP members can get additional benefits through the HIP State Plan. Please call Member Services or see section 3.3 Healthy Indiana Plan.

You are considered medically frail if you have a:

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

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 can be found in the Appeals section.

When you are medically frail, you must make your POWER Account contribution to receive HIP State Plan Plus benefits. If you do not make your POWER Account contribution and are at or below 100% the federal poverty level (FPL), you will be in HIP State Plan Basic and will have copays.

Section 3: Programs and Services

3.1 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:

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

- Ride services to doctor visits, pharmacy, emergency care, and redetermination appointments
- Routine dental care
- Routine vision care
- Surgeries
- Urgent care
- Well-child checkups

3.2 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:

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

- Preventive care
- Primary care
- Prosthetic devices
- Renal dialysis
- Smoking cessation
- Specialty care
- Transportation

3.3 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.

Table 3-1 provides the benefits included in each HIP plan.

Table 3-1: Benefits in each HIP plan

HIP Plan	Benefits
HIP Basic	• Doctor Care • Physical exams • Primary care • 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 (limited to 100 days) • 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

HIP Plan	Benefits
	• Plus: o Non-emergency transportation o MRO ▪ Addiction Counseling ▪ Adult Intensive Rehabilitation Services ▪ Behavioral Health Level of Need Redetermination ▪ Case Management ▪ Child and Adolescent Resiliency Services ▪ Medication Training and Support ▪ Psychiatric Assessment and Intervention ▪ Psychosocial Rehabilitation (Clubhouse Services) ▪ Skills Training and Development
HIP Maternity	• All HIP State Plan benefits • Plus: o Enhanced smoking cessation services

Section 4: 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.

4.1 Behavioral Health Helplines

If you are having very negative thoughts, a crisis, feel like hurting yourself or someone else, or you are not sure what type of help you need call the national Suicide & Crisis Lifeline by dialing 988. If you have questions, please call your health plan's helpline.

<MCE enter phone number>\

Section 5: Care and Disease Management Services

5.1 Care Management

Care Management services are available for children and adults with complex health care 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 treatment. Care Management covers conditions including, but not limited to:

- ADHD
- Asthma
- Autism/Pervasive Developmental Disorder
- Chronic Kidney Disease
- Coronary Artery Disease
- Congestive Heart Failure
- COPD
- Depression
- Diabetes
- Hepatitis C
- HIV
- Pregnancy
- 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: 866-408-6131
- CareSource: 844-607-2829
- MDwise: 800-356-1204
- MHS: 877-647-4848
- UnitedHealthcare: 800-832-4643, TTY 711

5.2 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:

- ADHD
- Asthma
- Autism and disorders like it
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- Hepatitis C
- High Blood Pressure
- Human Immunodeficiency Virus (HIV)
- Pregnancy
- Substance Use Disorder

A person will be assigned to help you learn information about your condition, tests for your condition that you can talk to your doctors about, and steps you can take to 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 questions to make sure you are getting the best care.

Section 6: Right Choices Program

The Right Choices Program (RCP) is part of Indiana Medicaid. It is for members who need help with using their health coverage appropriately. Its goal is to make sure medical care is happening at the right time and place.

Common reasons for referral to the RCP include members being treated by several physicians for the same or similar medical condition, purchasing the same or similar medications from several different pharmacies, or frequently using the hospital emergency department for services that are not considered emergencies.

RCP members are assigned to one primary medical provider (PMP) and one pharmacy. These providers work with the member's medical services in a way that is in the best interest of the member. Any special doctors you see will need approval from your PMP.

Thirty to 60 days before the projected end of a member's enrollment in the program, the members health plan will review the case to determine the outcome of the member's performance in the program and an Exit Care Conference will be held.

The conference results in one of three decisions:

1. The member has been compliant and is removed from the RCP.
2. The member has not been compliant and will continue in the RCP (for up to an additional two years).
3. If the member is referred to law enforcement because of suspected fraudulent practices, this referral does not terminate the member from the program. The member will continue in the RCP for two years.

A member may be removed from RCP by the health plan before the end of the member's enrollment period for the following reasons:

- The member has been assigned to hospice care. When a member is approved for hospice care, the hospice PA analyst must notify the RCP Administrator so that the member can be removed from the RCP.
- The member appealed and received a judgment in favor of the appellant. The member's enrollment in the RCP ends when the RCP Administrator receives the notification from the FSSA Office of Administrative Law Professionals (for FFS members) or from the MCE (for managed care members). Details regarding RCP appeal processes are provided to members in their initial RCP notification letter and the accompanying booklet.
- The member receives Medicare benefits in addition to IHCP Medicaid benefits.
- The member is deceased.
- The member is placed in a 590 Program facility

Section 7: Cost Sharing and Co-Payments

7.1 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, monthly premiums, or monthly POWER Account Contributions (PACs).

Copayments, or "copays," are set amounts of money you pay to the provider for a medical service. Some health programs do not have copays. In others, you may pay copays for doctor visits, prescriptions, transportation, and other services. Copayments may be made at the time you receive the service, or your provider may send you a bill so you can pay it later (except for copayments for prescriptions, which must be paid at the time you pick them up from the pharmacy). A provider cannot refuse to see you if you are unable to pay a copayment at the time of service.

Monthly Premiums are required for CHIP-Package C and MEDWorks members. They will receive a bill in the mail from Gainwell Premium Vendor and must make their first payment in order for their health coverage to start.

POWER Account Contributions (PACs) are required for some HIP members. A bill is sent to the member from their health plan. Ongoing coverage might be impacted if monthly PACs are not paid. There is a 60-day grace period for payment--as long as payment is made within 60 days of the due date, coverage will continue.

Cost Sharing Exemptions: Even if your health coverage program has copayments, there are some types of services that are not allowed to charge a copay. Services that are exempt from copays are:

- Emergency Services
- Family Planning Services
- Pregnancy related services
- Preventive care services for children and treatment for any conditions identified via EPSDT screening (EPSDT)
- Preventive care services for HIP

There are some groups of people who do not have to participate in cost sharing at all. You will not have copays or premiums if you are:

- Pregnant or in your 12-month postpartum coverage period
- American Indian or Alaskan Native
- Have paid 5% of your income or more in copays during each quarter (or for the year, for CHIP-Package C)

> ***Note:*** *HIP members who meet their 5% cost share limit for the quarter will have their monthly PAC amount reduced to $1 for the rest of the quarter, or $1.50 if they have a tobacco use surcharge.*

7.1.1 Hoosier Healthwise Co-Payments and Cost-Sharing

Table 7-1: Hoosier Healthwise

Hoosier Healthwise		
Package A	Package C (CHIP)	
No Copays	Prescriptions (Generic *)	$3
	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.

7.1.2 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.

Table 7-2: Package C premiums

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
176 – 200%	$33.00	$50.00
201– 225%	$42.00	$53.00
226 – 250%	$53.00	$70.00

7.2.4 Late Payments and Disenrollment for CHIP

If you are enrolled in CHIP, you will have monthly premiums. If you are determined eligible for CHIP, you will be made conditionally eligible pending a premium payment. You may be eligible for coverage of services provided on or after the first day of the month in which you applied; however, your enrollment does not become effective until the first required monthly premium has been paid. Your premium is due by the date listed on your monthly invoice from the premium vendor. If you do not pay your premium by that day, you have 60 days to make your payment before you are considered to have missed a payment for that month. You could lose your health coverage at the end of your benefit period if you miss premium payments during the year.

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.

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.

7.2.4.1 Payment Options

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

P.O. Box 3127

Indianapolis, IN 46206-3127

By Phone: 855- 765-8672

Online: Hoosier Healthwise Package C & MEDWorks Premium Portal

7.2.5 Healthy Indiana Plan Co-Payments

Table 7-3: HIP 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

7.3 POWER Account Contributions

Table 7-4: POWER account contributions

Federal Poverty Level (FPL)	Monthly PAC Single Individual	Monthly PAC with Tobacco Surcharge	Monthly PAC Spouses (each)	Spouse PAC when one has a tobacco surcharge	Spouse PAC when both have a tobacco surcharge (each)
<22%	$1.00	$1.50	$1.00	$1.00 & $1.50	$1.50
23-50%	$5.00	$7.50	$2.50	$2.50 & $3.75	$3.75
51-75%	$10.00	$15.00	$5.00	$5.00 & $7.50	$7.50

Federal Poverty Level (FPL)	Monthly PAC Single Individual	Monthly PAC with Tobacco Surcharge	Monthly PAC Spouses (each)	Spouse PAC when one has a tobacco surcharge	Spouse PAC when both have a tobacco surcharge (each)
76-100%	$15.00	$22.50	$7.50	$7.50 & $11.25	$11.25
101-138%	$20.00	$30.00	$10.00	$10.00 & $15.00	$15.00

7.4 Healthy Indiana Plan POWER Account

A POWER Account is a special savings account that you can use to pay for health care. Every HIP member has a POWER Account. The POWER Account is used to pay for the first $2,500 in health care costs. For those who make POWER Account Contributions (PACs), this account is where those payments are held. The state of Indiana funds the rest of the $2,500 in the POWER account. Your contribution amounts are between $1 and $20 but may be higher if you use tobacco and do not cease use for a full calendar year of HIP coverage. Help quitting is available via the Indiana Quit Line and there are no copayments for tobacco cessation treatments your doctor prescribes.

7.4.1 Healthy Indiana Plan Co-Payments

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 $2,500 POWER account to pay for HIP coverage medical expenses.

7.4.2 What if I Receive a Bill From My Doctor?

Your health plan only pays your provider for the services that are covered under your health coverage program. 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 coverage program 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 so that they can bill your health plan instead if you were not expecting to receive a bill for the service(s).
- 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 and have the bill in your hand. Your health plan will assist you with how to handle the bill.

Section 8: 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):

- Advance Practice Nurses (a nurse with additional training)
- Endocrinologist (if primarily engaged in internal medicine)
- Clinic doctor (at a health department, health center, or rural health clinic)
- 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)
- Pediatrician (a doctor who takes care of members under age 19)

8.1 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.

8.1.1 Member Services Phone Numbers

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

8.2 How to Make a PMP 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 (HIP, Hoosier Healthwise, or Hoosier Care Connect) 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

8.3 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. However, 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 in Table 8-1.

Table 8-1: Services received from any IHCP provider without a referral

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 in Table 8-2.

Table 8-2: Services receive without a referral that must be provided by a doctor in your health network

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

Section 9: Preventive Care

9.1 Introduction

Preventive care are routine health services that help prevent illnesses, diseases, and other health problems. Rather than treating a condition after it has already occurred or worsened, preventive care aims to keep people healthy by identifying potential issues early on. Preventive care will depend on your age and personal health history. Some common preventive services include:

- Annual physical examination
- Chlamydia Screening
- Dental examination
- Eye examination
- Flu Shot
- Mammogram
- Pap Smear

9.1.1 HIP Basic/ HIP State Plan Basic Members

HIP Basic and HIP State Plan Basic members who get their preventive 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.

9.1.2 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.

9.1.3 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)
- 15 months
- 18 months
- 24 months (2 years)
- 30 months
- Yearly ages 4–20

9.1.4 Early and Periodic Screening, Diagnosis, and Treatment Program

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is for children and adolescents under the age of 21. The EPSDT program ensures the early identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. These check-ups help ensure your child grows up healthy. If the doctor finds a problem, a referral may be made for diagnosis and treatment. EPSDT services and transportation to and from are covered for Hoosier Healthwise, Hoosier Care Connect, and Healthy Indiana Plan members under 21.

It is very important that children go to all their EPSDT appointments. When your child goes for an EPSDT check-up, the doctor may cover the following areas depending on their age.

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

9.1.5 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.

9.2 Immunizations

Immunizations are shots that protect the body from disease and illness. 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.

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. A doctor can help get your child up to date on their shots.

MCE TO INSERT PERIODICITY IMMUNIZATION SCHEDULE

Section 10: 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 do not feel well. Your health plan has many options for care. The table below shows some options for care and when they are the best option for you to use.

Table 10-1: Options for care

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.

10.1 Access to Care

Some medical appointments may have to be scheduled farther in advance due to availability while other medical appointments may be easier to schedule. The table below will provide you with an estimate of when you can expect to get an appointment with your provider.

Table 10-2: Appointment estimates

Provider Type	Appointment Category	Appointment Standards
PMP	Routine	Not to exceed 30 calendar days
	Urgent	Within 48 hours
	Emergency	24 hours a day/ seven 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/ seven days a week

Provider Type	Appointment Category	Appointment Standards
Behavioral Health	Non life-threatening emergency	Not to exceed six hours
	Urgent	Not to exceed 48 hours
	Emergency	24 hours a day/ seven 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 seven days following discharge for the inpatient behavior health hospitalization
Prenatal and Postpartum visits	First Trimester	14 days of request
	Second Trimester	Within seven days of request
	Third Trimester	Within three business days of request or immediately if an emergency
	High-risk pregnancy	With three business days of request or immediately if an emergency
	Postpartum Exam	Between three to-eight weeks after delivery

10.2 After-hour Coverage

PMP after-hour coverage is available to you 24 hours a day, seven days a week. Your health plan maintains standards your PMP must follow. Your PMP (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.

10.2.1 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:

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

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 PMP or the 24-hour nurse line.

[MCE Insert 24-hour nurse phone number]

The nurse can help you:

- Answer general questions about your health

- Decide if you or your child needs to see your doctor
- Decide if you or your child should go to the emergency room

Section 11: 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.

Please schedule a ride 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, and 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.

Family members, close friends, or able-bodied members may enroll in the IHCP as drivers for your nonemergency medical transportation. All transportation provided by family member or associate drivers must be managed through the Medicaid member's transportation broker. After you are successfully enrolled with the IHCP as a family member or associate driver, the Medicaid member's transportation broker will contact you to finalize any paperwork needed so that you can begin scheduling trips and submitting claims for reimbursement.

11.1 Transportation Phone Numbers

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

Section 12: 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 the Member Services helpline.

Your health plan can give you any document you receive in your language.

If you need your member handbook and other health plan information in another preferred language, let us know. For example, if you need the information in another language, larger print, Braille or in audio format, call Member Services. Your health plan will answer your questions in your language or conduct a three-way call with an interpreter.

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

12.1 Language Help Phone Numbers

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

12.2 Hearing and Speech Assistance

If you need hearing and speech help, you can call the Indiana Relay Service at 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.

Section 13: 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 or for certain reasons referred to as “just cause”. Right Choices Program members are not eligible to change plans.

13.1 MCE Selection for Healthy Indiana Plan

Applicants may select an MCE on the application or one will be auto-assigned, if not already assigned for the current calendar year. HIP members are able to change their MCE selection any time before making their first POWER Account contribution or within 60 days of assignment to an MCE, whichever comes first. After payment, HIP members are not able to make MCE changes until the annual open enrollment period (November 1 through December 15), unless they have an unresolved just-cause issue, as described in section 13.4 Just Cause Grievances. Members who change MCEs during the open enrollment period will start with their newly selected MCE the first day (January 1) of the following year.

13.2 MCE Selection for Hoosier Care Connect

Hoosier Care Connect members pick an MCE and a PMP. The MCE assists members in coordinating their health care benefits and tailoring the benefits to individual needs, circumstances and preferences. Hoosier Care Connect members receive full Indiana Medicaid State Plan benefits, in addition to care coordination services and other FSSA-approved enhanced benefits developed by the MCEs.

Hoosier Care Connect members may change their MCE selection during the first 90 days of enrollment or during the annual redetermination period. Outside of those periods, members may not move to another MCE except for reasons that meet the standard of just cause.

13.3 MCE Selection for Hoosier Healthwise

Hoosier Healthwise members may change their MCE selection during the first 90 days of enrollment or during the annual redetermination period. Outside of those periods, members may not move to another MCE except for reasons that meet the standard of just cause. See section 13.4 Just Cause Grievances for details.

13.4 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.

13.4.1 “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 health care provider disenrolls from the member's current MCE and re-enrolls with another Hoosier Care Connect MCE
- Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.
- Lack of access to providers experienced in dealing with the members health care needs
- Lack of access to necessary services covered under the contractor's contract with the state
- Related services are required to be performed at the same time and not all related services are available within the contractor's network, and the members provider determines that receiving the services separately will subject the member to unnecessary risk

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 Contractor 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

- Lack of access to medically necessary services covered under the contractor's contract with the state
- Related services are required to be performed at the same time and not all related services are available within the contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk.
- The member's primary health care provider disenrolls from the member's current MCE and reenrolls with another MCE. The enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider and, as a result, would experience a disruption in their residence or employment.

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

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

Section 14: 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.

13.1 Redetermination Process

It can take about 45 days to complete your redetermination process. Contact the Division of Family Resources (DFR) to ask questions. It is important to keep your address and phone number updated so you receive notices. If your phone number or addresses changes, contact the DFR Toll-Free Line:

- Division of Family Resources: 800-403-0864
- FSSA Benefits Portal: FSSAbenefits.in.gov

Section 15: Moving to Medicare

If you become eligible for a Medicare program, you must apply for Medicare in order to continue using Medicaid coverage. This includes people who are 65 or older, have a disability or End-Stage Renal Disease. There are two main parts to Medicare: Medicare Part A and Medicare Part B. Additionally, you have the option to add more coverage to receive extra benefits. Some people get Medicare automatically; others must actively sign up.

If you are already getting benefits from Social Security, you will automatically get Part A and Part B starting the first day of the month you turn 65 (if your birthday is on the first day of the month, Part A and Part B starts the first day of the prior month). If you are under 65 and have a disability, you will automatically get Part A and Part B after getting 24 months of disability benefits.

If you are close to 65 but not getting Social Security benefits, you will need to sign up for Medicare by visiting SSA.gov/medicare or by contacting your Social Security office to schedule an appointment.

It is important to understand your Medicare options and to choose 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.

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.

13.1 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
- Refer you to providers that can help you with other needs
- Teach you about how Medicare claims are filed
- Tell you your rights as a member

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

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Section 16: 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 should report it to your health plan. In some cases, you will also need to report your changes to the Department of Family Resources (DFR).

16.1 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

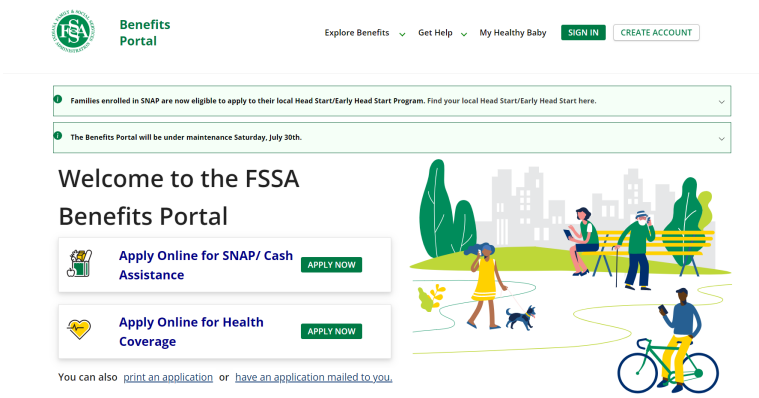
16.2 Division of Family Resources (DFR)

The DFR should be updated on all your general information. If you have a change in any of these, you should let DFR know. You can call **800-403-0864 to report your changes to DFR or go online to** https://www.in.gov/fssa/dfr/**.**

- Name
- Address
- Phone number
- Change in household (the family members who live and/or file taxes with you)
- Change in income
- The beginning and end of a pregnancy

16.3 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. You can access the benefit portal at https://fssabenefits.in.gov/bp/#/


Benefits Portal
Explore Benefits
Get Help
My Healthy Baby
SIGN IN
CREATE ACCOUNT
Families enrolled in SNAP are now eligible to apply to their local Head Start/Early Head Start Program. Find your local Head Start/Early Head Start here.
The Benefits Portal will be under maintenance Saturday, July 30th.
Welcome to the FSSA Benefits Portal
Apply Online for SNAP/ Cash Assistance
APPLY NOW
Apply Online for Health Coverage
APPLY NOW
You can also print an application or have an application mailed to you.

Section 17: 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, 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 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.
- 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.

17.1 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
- Get regular checkups for you and or your children

Section 18: 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.

18.1 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 have shared information
- Get a copy of the 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 **877-696-6775**
        - visiting their website at https://www.hhs.gov/hipaa/filing-a-complaint/

18.1.1 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 are unable to 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.

18.1.2 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.

18.1.3 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.

Section 19: 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.

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Section 20: Grievances and Appeals

20.1 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 can 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 is not 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 plans member services line.

20.2 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.

20.3 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.

20.4 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 https://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 health care, 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.

20.5 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 conducted at 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 IRO, 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)

Section 21: 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

21.1 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.

21.1.1 Fraud Reporting Options

- **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 Address:**

  FSSA Compliance Division

  Room E-414

  402 W. Washington St.

  Indianapolis, IN 46204

Section 22: 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

22.1 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 at https://www.in.gov/isdh/25880.htm

Appendix

Terms

Term	Description
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.

Term	Description
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 health care 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 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 they have 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.

Term	Description
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 $2,500 in health care costs. The state of Indiana pays for most of the $2,500 in the POWER account, but the member is responsible for a fixed monthly payment depending on their 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.