

Indiana Health Coverage Program Policy Manual

CHAPTER: 1600

CATEGORIES OF ASSISTANCE

SECTION: 1600

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Indiana Health Coverage Program Policy Manual	
CHAPTER: 1600 CATEGORIES OF ASSISTANCE	SECTION: 1600.00.00 CATEGORIES OF ASSISTANCE

1600.00.00 CATEGORIES OF ASSISTANCE

This chapter of the manual provides information regarding the Medicaid and Hoosier Healthwise program. It also defines each specific Medicaid category under which a person/family can qualify. Additionally, it explains the scope of coverage offered under each category.

The Medicaid program has categorical eligibility requirements which must be met in order to receive assistance. These requirements are discussed in detail in Chapter 2400 - Non-Financial Eligibility Requirements.

The main sections in this chapter are:

Categories of Assistance (Section 1600);

Medical Assistance for the Aged, Blind, & Disabled (Section 1605);

Hoosier Healthwise (Section 1610).

1600.05.00 MEDICAID ELIGIBILITY CATEGORIES SUMMARY

There are 35 categories under which individuals may be eligible for Medicaid coverage. The method used to determine income eligibility (Modified Adjusted Gross Income-MAGI/non-MAGI), the type of coverage (traditional fee-for-service or managed care), and the scope of the benefits provided all vary based on the category under which individuals are eligible. (See Chapters 3200 and 3400 for an explanation of MAGI methodology).

The following table lists all of the Medicaid coverage categories, eligibility criteria for each category, the type of benefit package provided, and whether MAGI methods are applied to determine income eligibility.

Indiana Medicaid Hierarchy

As of June 1, 2018

Aid Cat.	Eligibility Description	Age Limits	Income Limits	Fee For Service (FFS) <u>only</u> if one of these applies...	Otherwise, will be Risk-Based Managed Care (RBMC) in...	Coverage Level	Cost-Sharing Required? ¹	MAGI ²	HCBS Waiver Compatible?
MASI	Disabled members receiving SSI	N/A	N/A	-Retroactive month/s for new application -Level of Care is entered into Core -Medicare recipient	Hoosier Care Connect	Full	N/A	N	Y <i>No financial budget applied</i>
MA X	Newborns born to mother on Medicaid	< 1	N/A	-Retroactive month/s for new application -Level of Care is entered into Core	Hoosier Healthwise	Full	Exempt	N	Y <i>No financial budget applied</i>
MA Y	Newborns not in MA X	< 1	≤ 208% FPL	-Retroactive month/s for new application -Level of Care is entered into Core	Hoosier Healthwise	Full	Exempt	Y	Y <i>Normal financial budget applied</i>
MA Z	Children	1 - 5	≤ 141% FPL	-Retroactive month/s for new application -Level of Care is entered into Core	Hoosier Healthwise	Full	Exempt	Y	Y <i>Normal financial budget applied</i>
MA 2	Children	6 - 18	≤ 106% FPL	-Retroactive month/s for new application -Level of Care is entered into Core	Hoosier Healthwise	Full	Exempt	Y	Y <i>Normal financial budget applied</i>

MAGF	Parent or Caretaker Relative, not eligible for HIP	N/A	≤ MAGI-Converted Need Standard ³	-Level of Care is entered into Core -Medicare recipient -Refugee in first 8 months in the U.S.	N/A	Full	Yes, copays apply	Y	Y <i>Normal financial budget applied</i>
MAMA	Pregnancy & Postpartum	19 - 64	≤ 133% FPL (initial)	-Retroactive month/s for new application	HIP Maternity	HIP State Plan	Exempt	Y	N
MAGP	Pregnancy & Postpartum	N/A	≤ 208% FPL (initial)	-Retroactive month/s for new application -Level of Care is entered into Core -Medicare recipient -Undocumented Immigrant	Hoosier Healthwise Maternity	Full	Exempt	Y	N
MA O	Inpatient Psychiatric Facility	19-20	≤ MAGI-Converted Need Standard	Defaults to FFS	N/A	Full	Exempt	Y	N

Aid Cat.	Eligibility Description	Age Limits	Income Limits	Fee For Service (FFS) <u>only</u> if one of these applies...	Otherwise, will be Risk-Based Managed Care (RBMC) in...	Coverage Level	Cost-Sharing Required ?	MAGI	HCBS Waiver Compatible ?
MA 15	Former Indiana Foster Children	18 - 25	N/A	Defaults to FFS	Can opt into Hoosier Care Connect	Full	N/A	N	Y <i>No financial budget applied</i>
MA 14	Former Foster Children (not Indiana)	18 - 20	≤ 210% FPL	Defaults to FFS	Can opt into Hoosier Care Connect	Full	Yes, copays apply	Y	Y <i>Normal financial budget applied</i>
MA R	RCAP Room & Board Assistance members	N/A	≤ 100% FPL	Defaults to FFS	N/A	Full	N/A	N	N
MA 9	Children M-CHIP (<i>Medicaid-funded</i>)	≤ 18	≤ 158% FPL	- Retroactive month/s for new application -Level of Care is entered into Core	Hoosier Healthwise	Full	Exempt	Y	Y <i>Normal financial budget applied</i>
MA Q	Refugee Medical Assistance (RMA) 1 st 8 months in the U.S.	N/A	≤ MAGI-Converted Need Standard	Defaults to FFS	N/A	Full	Exempt	N	N
MAN A ⁴ <i>HIP Opt-Out</i>	Verified Native American	19 – 64	≤ 133% FPL	Defaults to FFS	N/A (<i>not a HIP category</i>)	Full	Exempt	Y	N
MAPC <i>Frail No-Pay</i>	HIP PLUS State Plan w/copays	19 – 64	101% - 133% FPL	N/A	Healthy Indiana Plan	HIP State Plan	Yes, copays apply and contributions accrue	Y	N
MARB	HIP Regular Basic	19 – 64	≤ 100% FPL	N/A	Healthy Indiana Plan	HIP ABP ⁵	Yes, copays apply	Y	N
MASB <i>Frail or LIPCT</i>	HIP State Plan Basic	19 – 64	≤ 100% FPL	N/A	Healthy Indiana Plan	HIP State Plan	Yes, copays apply	Y	N

MARP	HIP Regular Plus	19 – 64	≤ 133% FPL	N/A	Healthy Indiana Plan	HIP ABP + added benefits ⁶	Yes, contributions apply	Y	N
MASP <i>Frail, LIPCT, or TMA</i>	HIP State Plan Plus	19 – 64 or older if LIPCT	≤ 133% FPL ⁷	N/A	Healthy Indiana Plan	HIP State Plan	Yes, contributions apply	Y	N
<i>Adult</i>									
MA F <i>eligibility lost b/c of job income increase</i>	Transitional Medical Assistance (TMA)	≤ 18	Months 1-6: N/A ----- Months 7-12: ≤ 185% FPL	N/A <i>Disabled or MAX children will stay in other ongoing category rather than move to MA F</i>	Hoosier Healthwise	Full	Exempt	N	Y <i>Normal financial budget applied</i>
MA A	Aged, <u>not</u> Long-Term Care (LTC ⁸)	≥ 65	≤ 100% FPL	Retroactive month/s for new application -Medicare recipient	Hoosier Care Connect	Full	Yes, copays apply	N	N/A <i>See ↙ MA A LTC</i>
MA A LTC	Aged, HCBS Waiver or Institution	≥ 65	300% Current Max SSI	Defaults to FFS	N/A	Full	Exempt	N	Y <i>SIL⁹ rules apply</i>

Aid Cat	Eligibility Description	Age Limits	Income Limits	Fee For Service (FFS) <u>only</u> if one of these applies...	Otherwise, will be Risk-Based Managed Care (RBMC) in...	Coverage Level	Cost-Sharing Required?	MAGI	HCBS Waiver Compatible?
MA B	Blind, <u>not</u> LTC	N/A	≤ 100% FPL	-Retroactive month for new application -Medicare recipient	Hoosier Care Connect	Full	Yes, copays apply	N	N/A See ↙ MA B LTC
MA B LTC	Blind, HCBS Waiver or Institution	N/A	300% Current Max SSI	Defaults to FFS	N/A	Full	Exempt	N	Y SIL rules apply
MA D ¹⁰	Disabled, <u>not</u> LTC	≤ 65	≤ 100% FPL	-Retroactive month for new application -Medicare recipient	Hoosier Care Connect	Full	Yes, copays apply	N	N/A See ↙ MA D LTC
MA D LTC	Disabled, HCBS Waiver or Institution	≤ 65	300% Current Max SSI	Defaults to FFS	N/A	Full	Exempt	N	Y SIL rules apply
MAD W	MEDWorks Working Disabled	N/A	≤ 350% FPL	-Retroactive month/s for new application (after first premium has been paid) -Medicare recipient	Hoosier Care Connect	Full	Yes, premiums and copays apply	N	Submit to PAL (Policy Answer Line) to determine if correct
MAD I	Previous MADW, Medically Improved	N/A	≤ 350% FPL	-Level of Care is entered into Core -Medicare recipient	Hoosier Care Connect	Full	Yes, premiums and copays apply	N	Submit to PAL (Policy Answer Line) to determine if correct
MA L	QMB Qualified Medicare Beneficiary	N/A	≤ 150% FPL	Medicare Savings Program Only – may or may not have coverage in another FFS category	N/A	Medicare Parts A & B premium, deductible, & co-insurance	N/A	N	N May receive in another full coverage category if dual-eligible
MA J	SLMB Special Low-Income Medicare Beneficiary	N/A	151% - 170% FPL	Medicare Savings Program Only – may or may not have coverage in another FFS category	N/A	Medicare Part B Premiums	N/A	N	N May receive in another full coverage category if dual-eligible
MA I	QI Qualified Individual	N/A	171-185% FPL	Medicare Savings Program Only – cannot have coverage in any other category	N/A	Medicare Part B Premiums	N/A	N	N Cannot be dual-eligible
MA G	QDW Qualified Disabled Worker <i>lost free Part A coverage due to employment</i>	N/A	≤ 200% FPL	Medicare Savings Program Only – cannot have coverage in any other category	N/A	Medicare Part A Premiums	N/A	N	N Cannot be dual-eligible

MA10	Children S-CHIP <i>(Separately funded)</i>	≤ 18	≤ 250% FPL	-Retroactive month/s (after first premium has been paid)	Hoosier Healthwise	Compr e- hensive	Yes, premiums and copays apply.	Y	N
MA E	Family Planning Only	N/A	≤ 141% FPL	Defaults to FFS	N/A	Limited	Exempt	Y	N

Aid Cat.	Eligibility Description	Age Limits	Income Limits	Fee For Service (FFS) <u>only</u> if one of these applies...	Otherwise, will be Risk-Based Managed Care (RBMC) in...	Coverage Level	Cost-Sharing Required?	MAGI	HCBS Waiver Compatibility
MA 4	IV-E Foster Children	≤ 18	N/A	Defaults to FFS	Can opt into Hoosier Care Connect	Full	Exempt	N	Y <i>No financial budget ap</i>
MA 8	Children in Adoption Assistance Program	≤ 18	N/A	Defaults to FFS	Can opt into Hoosier Care Connect	Full	N/A	N	Y <i>No financial budget ap</i>
MA 12	ISDH Breast and Cervical Cancer Program	N/A	≤ 200% FPL	Defaults to FFS	N/A	Full	Exempt	N	N
ESO Coverage Looks like another category but that will only be a “shell” category		Income & other rules of “shell” category apply Must always be FFS			Covers “Emergency Services Only” (due to Immigration Status); Can temporarily expand to cover pregnancy through postpartum		Exempt from cost-sharing (cannot be MA10, MADW/I, or HIP) Not HCBS compatible		

¹ Costs (copays, premiums, contributions) *imposed by the Medicaid program* are limited to 5% of countable income per calendar quarter. This does not apply to any/all healthcare spending by the family or individual, nor does it apply to waiver liability or patient liability.

² MAGI budgets give a disregard of 5% FPL in the budget, if needed to pass in any MAGI category. The disregard should not be applied when simply determining in which MAGI category a person qualifies, (e.g., MA 2 or MA 9) for low-income flags, or for the HIP Basic threshold.

³ The MAGI-Converted Need Standard is based on Temporary Aid to Needy Families (TANF) income limits, which are independent of current FPL and do not change each year. There is not a consistent FPL % that the amount can be converted to for various household sizes, and it decreases each year that the FPL is raised. As of 2018, the equivalent FPL % for the MAGI-Converted Need Standard ranges between 15% and 17% FPL (ex., \$373.00 a month for a family of 4). This is also the Low-Income Parent/Caretaker standard used for HIP categories.

⁴ Members with verified Native American/Alaskan Native status are exempted from cost-sharing in any category.

⁵ ABP = The Alternative Benefit Plan is a benefit package with lesser coverage than State Plan benefits. The ABP is benchmark coverage per 42 U.S.C. 1396u-7, and covers Essential Health Benefits as required by the Affordable Care Act.

⁶ HIP Regular Plus coverage is the ABP, with some additional services such as vision, dental, and chiropractic.

⁷ All Transitional Medical Assistance (TMA) for adults is given in HIP State Plan Plus. The income limit does not apply for the first 6 months, and is 185% FPL for the second 6 months.

⁸ Long-Term Care (LTC) = approved for Home and Community Based Services Waiver services and open in a compatible Medicaid category, or living in a Medicaid-certified institution such as a nursing home.

⁹ The SIL, or Special Income Limit, allows for disregard of parental income and resources for children, spousal impoverishment budgeting when married to a spouse not in LTC, establishment of a Miller Trust for excess income; and can require patient liability or waiver liability.

¹⁰ MA B/D/DW/DI are effectively above HIP in the hierarchy when a non-LTC member is verified as disabled by the Social Security Administration and has income and resources below the regular MA D limits. A blind or disabled member may receive coverage in

HIP if income and resources exceed the MA D standards or if they fail to comply with MA D eligibility determination, but HIP passes

1610.00.00 MEDICAL ASSISTANCE FOR THE AGED, BLIND & DISABLED (MED 1, MED 4)

Medicaid coverage is available to individuals who are aged, blind, or disabled. The scope of coverage varies depending upon the specific category under which an individual qualifies. The categories and scope of coverage are explained in the following sections.

As of April 2015, individuals eligible in MED 1 categories who are not in an institution or on a waiver and who are not eligible for Medicare will be enrolled in Hoosier Care Connect (HCC), a coordinated health care program. Hoosier Care Connect members will have to select a managed care entity (MCE) that will help coordinate care with the member's providers. Care coordination is individualized based on a member's assessed level of need determined through a health screening.

Individuals in MED 1 who are eligible for Medicare and those who reside in institutions or are on a HCBS Waiver will receive Traditional fee-for-service coverage.

1610.02.00 SSI ELIGIBLE INDIVIDUALS (MED 1)

This category is identified in ICES as MASI.

To be eligible for MASI Medicaid an individual must be determined eligible by the Social Security Administration. When determined SSI disabled and receiving SSI payments, the proper category of assistance is MASI. MASI is based on categorical eligibility and does not have a budget or redetermination. It is a full coverage category with no cost sharing and is at the top of the Medicaid hierarchy, therefore, it should not be replaced with any other category of medical coverage.

MASI should be given only based on information received via data exchange from the Social Security Administration. This can be seen by the "disability verification" column of

the payment status code table. Payment status code appears on the data exchange screen/s which shows SSA information in the Eligibility System.

“Y” means SSA has determined approval for MASI eligibility, regardless of current SSI payments being released or held. MASI would be the appropriate category.

- Payment status codes: C01, E01, E02, S06, S07, S08, S09, S10

“P” means SSI payments are not being made, but the disability status has not necessarily changed – in this instance, if no longer showing disability DE verified, an MRT determination would be appropriate. MA D would be the proper category, if approved.

- Payment status codes: C32, H10, H20, H30, H40, H50, H60, H70, H80, H90, M01, M02, N01, N02, N03, N04, N05, N06, N09, N10, N11, N12, N13, N14, N17, N18, N19, N20, N22, N23, N24, N25, N52, N53, N54, N55, N56, P01, S01, S05, S20, S21, S90, S91, T01, T20, T22, T30, T31, T32, T33, T50, T51

“T” means SSI disability status has ended, and an MRT determination may not overrule this determination unless there is a verified appeal or re-application with SSA in progress.

- N07, N08, N15, N16, N27, N30, N31, N32, N33, N34, N35, N36, N37, N38, N39, N40, N41, N42, N43, N44, N45, N46, N47, N48, N49, N50, N51, S04

The SS MED ELIG CODES on the SSA/SSI DAILY FILE DISPLAY screen in the eligibility system summarizes what the detailed payment status code means for MASI budgeting. In the section: SS MED ELIG CODE, the first line is the most current. Only the below codes are eligible for MASI:

– C = FEDERALLY ADMINISTERED MEDICAID COVERAGE SHOULD BE CONTINUED REGARDLESS

OF PAYMENT STATUS CODE - 1619B PARTICIPANT

– G = GOLDBERG/KELLY PAYMENT CONTINUATION

– N = ELIGIBLE FOR MEDICAID - N24 PAYMENT STATUS ONLY

– Y = ELIGIBLE FOR MEDICAID - 1634 STATES ONLY

All the remaining listed codes are not eligible for MASI budgeting:

– A = REFUSED TO ASSIGN RIGHTS TO TPL

– B = DEEMING WAIVED, CHILD UNDER A STATE HOME CARE PLAN

– D = REFERRED TO THE STATE FOR MEDICAID DETERMINATION DUE TO ENTITLEMENT OR

INCREASE IN DAC BENEFITS UNDER T2

– E = ELIGIBLE UNDER STATE DETERMINATION (OBSOLETE)

– F = TITLE VIII SPECIAL VETERANS BENEFIT RECIPIENT

– I = INELIGIBLE PER STATE DETERMINATION (OBSOLETE)

– P = DRUG ADDICITON AND/OR ALCOHOLISM (OBSOLETE)

– Q = MEDICAID QUALIFYING TRUST MAY EXIST

– R = REFERRED TO STATE FOR DETERMINATION (1634 STATES) - FEDERAL

DETERMINATION NOT POSSIBLE

– S = STATE DETERMINATION - NOT SSA RESPONSIBILITY

– W = WIDOW(ER) - 1634 STATES

If the worker questions whether MASI is the correct category, they should contact Helpdesk/PAL rather than open MASI without the correct SSA determination.

If a person has deemed SSI eligibility but is not receiving payments because another SSA benefit amount is more than the maximum SSI amount, these members should be determined for MED 1 eligibility under normal income and resource rules. The maximum SSI payment amount should be entered as SSI income, and any excess above that amount should be entered as Social Security income. This will cause the income to be properly counted in the budget for all programs. This would apply to some widow/ers (see 2414.10.20) and Disabled Adult Children (see 2414.10.10).

1610.05.00 AGED INDIVIDUALS (MED 1)

This category is identified in ICES as MA A.

To be eligible in this category an individual must be age 65 or older.¹ A person is categorically eligible for MA A beginning with the month they turn age 65.

The full range of Medicaid covered services is available to recipients in the MA A category except for aliens who are eligible for emergency services only.

1610.10.00 BLIND INDIVIDUALS (MED 1)

This category is identified in ICES as MA B.

To be eligible in this category an individual must meet the definition of blindness set forth in State regulation. The definition is the same as that of the SSI program.²

The full range of Medicaid covered services is available to recipients in the MA B category, except for aliens who are eligible for emergency services only.

1610.20.00 DISABLED INDIVIDUALS (MED 1)

This category is identified in ICES as MA D.

To be eligible under this category, individuals must be substantially impaired as set forth in the definition of disability in State law.³

The full range of Medicaid covered services is available to receipts in the MA D category except for aliens who are eligible for emergency services only.

610.25.00 RCAP ELIGIBLE INDIVIDUALS (MED 1)

This category is identified in ICES as MA R.

To be eligible for Residential Care Assistance Program -related Medicaid an individual must¹:

Be approved for Room and Board Assistance (RBA);

Be aged, blind, or disabled. The aged, blind, and disabled requirements for RCAP-related Medicaid are the same as those for RCAP.

The full range of Medicaid covered services is available to recipients in the MA R category.

1610.26.00 EMPLOYEES WITH DISABILITIES (MED 1)

M.E.D. Works – Medicaid for Employees with Disabilities – consists of two categories identified in ICES as MADW and MADI.

A federal law, known as the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIA) added two new optional Medicaid categories designed to remove barriers to employment for persons with disabilities by providing access to health care. Effective July 1, 2002, Indiana’s Medicaid Program was expanded to cover these categories with the enactment of P.L. 287-2001.

MADW is the basic MED Works category for individuals who meet the Medicaid definition of disability without regard to the person’s employment. MADI is the medically improved category for persons who lose eligibility in the basic category because of an improvement in their medical condition which although is not a medical recovery, is improved to the extent that the Disability definition for the basic category is no longer met.²

To be eligible, individuals must be age 16-64. Depending on their income, some MED Works members must pay premiums. All members pay the regular Medicaid co-payments.

1610.30.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

This category is identified in ICES as MA L.

To be eligible in this category an individual must be entitled to Medicare Part A.³ There is no other blindness or disability requirement for the QMB category.

Medicaid coverage under QMB is limited to payment of:⁴

The monthly premium for Medicare Part B;

The monthly premium for Premium Hospital Insurance under Medicare Part A for individuals not entitled to free Part A; and

Medicare Parts A and B deductibles and co-insurance.

An individual can be simultaneously eligible for QMB and any other full coverage MA.

1610.35.00 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (MED 4)

This category is identified in ICES as MA J.

To be eligible in this category an individual must be entitled to Medicare Part A.⁵ There is no other blindness or disability requirement for the Specified Low-Income Medicare Beneficiary (SLMB) category.

Medicaid coverage under SLMB is limited to payment of the Medicare Part B premium.⁶

An individual can be simultaneously eligible for SLMB and any other full coverage MA category.

1610.40.00 QUALIFIED DISABLED WORKER (MED 4)

This category is identified in ICES as MA G.

To be eligible in this category an individual must have lost or will lose premium-free Medicare Part A coverage due to his employment status.⁷

Medicaid coverage under this category is limited to payment of the monthly premium for Medicare Part A.⁸

An individual is not eligible under this category if he is eligible for Medicaid under any other category.

1610.45.00 QUALIFIED INDIVIDUALS (MED 4)

This category is identified in ICES as MA I.

To be eligible in this category, an individual must be entitled to Medicare Part A.⁹ There is a capped amount available for QIs each year.

MA I pays the Medicare Part B premium.¹⁰

An individual eligible under any other Medicaid category cannot be eligible as a QI.

1610.50.00 PREGNANT WOMEN WHOSE INCOME INCREASES (MED 1, 4)

When a pregnant woman receives an increase in income, her Medicaid eligibility must continue without change.¹¹ She remains eligible in the same category regardless of an income increase.

The income that the member has, when she reports the pregnancy, determines if the member will go into MAMA or MAGP. Once the pregnancy coverage is open the category will not change until after the post-partum ends.

1620.00.00 HOOSIER HEALTHWISE (MED 3)

Medical coverage is available to certain parents/caretakers, infants and children, former foster children up to age 21, former foster children ages 18 to 26 who were enrolled in Indiana Medicaid on their 18th birthday, and pregnant women under the Hoosier Healthwise Program. Additionally, medical coverage under the Healthy Indiana Plan (HIP) is available to adults between ages 19 and 64, effective February 1, 2015.

Hoosier Healthwise is funded by Title XIX-Medicaid and by the Children's Health Insurance Program-Title XXI and is composed of three benefit packages. Coverage under these packages is generally comprehensive, with a few exceptions, which are noted below. The packages are as follows:

Package A (Standard Plan) provides comprehensive healthcare coverage to some eligible parents and other caretaker adults, infants and children, former foster children ages 18 to 26 who were enrolled in Indiana Medicaid on their 18th birthday, and pregnant women. There are no premiums or co-payments for children under age 18. ICES category codes under this package are, MA F, MAGP, MA X, MA Y, MA Z, MA 2, MA 9, and MA 15.

Package C (Children's Health Plan) provides comprehensive healthcare coverage to children under age 19. Although comprehensive, some services are subject to limits and some services covered under Package A are not covered under Package C. This package includes a premium (based on income and family size) and co-payments for certain services. The ICES category code under this package is MA 10.

Package E (Emergency Services Only) provides coverage for serious medical emergencies to some immigrants and certain visitors to the U.S. who meet all other categorical and financial requirements. There is no specific ICES category for this benefit package. ICES designate whichever category is appropriate to the individual's circumstances.

Children who are wards of the State, children in the Adoption Assistance Program, foster children and former foster children (MA 4, MA 8, MA 14, MA 15) may opt out of Traditional Medicaid FFS and voluntarily enroll in Hoosier Care Connect, a coordinated care program (see 1610.00.00 for a description of the Hoosier Care Connect program).

HIP is funded through a Section 1115 demonstration waiver with the CMS, Indiana's existing cigarette tax revenues, and from a Hospital Assessment Fee.¹² HIP coverage is available to adults aged between 19 and 64 years, who do not have Medicare, have income equal to or less than 133% of the FPL, and are not eligible for any other Medicaid category excluding:

- Low-Income parents / caretakers;
- Transitional Medical Assistance;

Under HIP, a person will qualify for either State Plan Benefits or Regular Plan Benefits. Within each plan exists Plus and Basic. Please, refer to IHCPPM 3500.00 to see the difference in benefits and cost sharing between HIP Plus and HIP Basic. To receive coverage under either HIP State Plan Plus (MASP) or HIP Regular Plan Plus (MARP), a person must make financial contributions towards a Personal Wellness and Responsibility (POWER) account that is based on their income and the FPL percentage range that the member falls in, but can be no less than \$1 per month, regardless of a person's income. To receive coverage under either HIP State Plan Basic (MASB) or HIP Regular Plan Basic (MARB), the income standard is 100% of the FPL.

HIP State Plan Plus (MASP) benefits, refer to **3520.10.00**

HIP State Plan Basic (MASB) benefits, refer to **3520.15.00**

HIP Regular Plan Plus (MARP) benefits, refer to **3520.25.00**.

HIP Regular Plan Basic (MARB) benefits, refer to **3520.30.00**

A woman who is a member of any HIP category who becomes pregnant will be moved into the MAMA category, unless income increases at the same time. If this happens, they should go into MAGP.

1620.05.00 LOW INCOME PARENTS / CARETAKERS

This category is identified in the Eligibility System as MAGF.

The category consists of parents and caretaker relatives of dependents less than 18 years of age and is reserved for members who do not qualify for HIP coverage due to Medicare, a waiver or refugee status. A parent includes biological, adopted, and step-parent. For the definition of a caretaker relative, please, refer to IHCPPM 2420.00.00. This category also consists of low income parent and caretaker refugees for the first eight months after arriving in the United States.

For more information regarding MAGF coverage, see IndianaMedicaid.com or refer members to call the information number on the back of their Medicaid Card.

1620.05.15**TRANSITIONAL MEDICAL ASSISTANCE**

This category is identified in ICES as MA F. Although MA F is considered Hoosier Healthwise, MA F is not considered a MED 3 category. Nor is it considered MED 2. Please, refer to IHCPPM Chapter 3800 for more specific information on MA F.

Up to 12 months of full medical coverage under the Transitional Medical Assistance (TMA) category is available to parents/caretaker relatives who have been discontinued from or are denied Medicaid because of the earnings of a caretaker relative who was eligible for and received Medicaid, with the Low Income Parent/Caretaker (LIPCT) designation, in Indiana in three of the preceding six months. TMA is also available to certain dependents. Please, refer to Chapter 3800. (NOTE: The LIPCT designation eligibility in the retro period for a new application counts towards the three of six months.) To qualify for TMA, the AG must be ineligible for Medicaid for being over 133% FPL (plus the 5% disregard) for one of the following reasons:¹³

New or increased earnings of a parent or caretaker relative who is a participating member of the AG;

New or increased earnings of a MA sanctioned parent or caretaker relative who is a non-participant due to a sanction; or

The effective date of TMA corresponds to the date of discontinuance or the date, on which the AG first becomes ineligible, whichever is earlier.¹⁴

1620.35.00**RESERVED****1620.35.05****NATIVE AMERICAN/ALASKA NATIVE HIP (MED 3)**

Native Americans and Alaska Natives who qualify for HIP will automatically be placed into HIP State Plan. Additionally, Native American and Alaskan Native HIP members will not be required to make any financial contributions to a POWER Account or make any required co-pays.

If a Native American and Alaska Native chooses to be covered by fee-for-service, rather than managed care, the person will then have eligibility under the MANA category.

1620.36.00**HIP STATE PLAN PLUS (MED 3)**

This category is identified in ICES as MASP.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age and have income equal to or less than 133% of the FPL, unless the person qualifies for TMA. The upper age limit is waived for Low-Income Parent/Caretakers. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program. Participants included are:

- Low Income parents and caretaker relatives;

- TMA eligible individuals; or
- Individuals that qualify as medically frail.¹⁵

HIP Plus State Plan requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MASP members, who are American Indian/Alaska Natives, are not required to make a financial contribution to a POWER Account.

1620.37.00 HIP BASIC-STATE PLAN (MED 3)

This category is identified in ICES as MASB.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age (upper age limit is waived for Low-Income Parent/Caretakers). They must have income at or below 100% FPL. They will be enrolled in HIP Basic State Plan if they fail to make financial contributions toward a POWER account and fall into one of the following groups:

- Low-income parents and caretaker relatives; or
- Individuals that qualify as medically frail.¹⁶

1620.38.00 HIP STATE PLAN PLUS WITH CO-PAYS (MED 3)

This category is identified in ICES as MAPC.

- To be eligible in this category an adult must have been eligible under MASP, while being determined medically frail, having income between 100% FPL and 133% FPL, and fail to make ongoing financial contributions to a POWER account.
- If an MAPC member's income decreases to below 100% FPL, they will be moved into the State Plan Basic category.

1620.39.00 HIP REGULAR PLAN PLUS (MED 3)

- This category is identified in ICES as MARP.
- To be eligible in this category an adult must at least 19 years of age and less than 65 years of age. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible for any other Medicaid category.¹⁷ The income standard is 133% FPL. HIP Regular Plus requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department.

1620.39.05 HIP REGULAR BASIC (MED 3)

This category is identified in ICES as MARB.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age with income at or below 100% FPL and will be enrolled in HIP Basic after failing to make financial contributions to a POWER account. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible under any other Medicaid category.¹⁸ The HIP Basic benefit package applies co-payments to services. The “HIP Basic” Plan maintains essential benefits, but incorporates reduced benefit coverage, has a more limited pharmacy benefit, does not include dental, and does not include vision benefits.

1620.40.00 CHILDREN IN PSYCHIATRIC FACILITIES (MED 3)

This category is identified in ICES as MA O.

To be eligible in this category a child must be under age 21, an inpatient of a Medicaid certified psychiatric facility, and meet MAGF eligibility requirements (except the age 18 limitations) as if they were living at home.¹⁹ A recipient who is approved for MA O prior to his 21st birthday remains eligible until age 22 as long as he remains in the psychiatric facility.

1620.45.00 REFUGEE MEDICAL ASSISTANCE (MED 2)

This category is identified in ICES as MA Q.

Individuals receiving or eligible to receive Refugee Cash Assistance (RCA) are eligible for Medicaid under these categories. This is the category of last resort, after all other categories have been explored.

A MA Q AG that becomes ineligible for assistance due solely to new or increased earnings may receive continued Medicaid until the end of the eight month eligibility period. In cases where a member of the AG obtains private medical coverage, it is imperative to code it properly on AEFMC. A refugee may not receive Medicaid under this provision once his initial eight month eligibility period ends

Low-income Parent/Caretaker refugees who are within their first 8 months in the country will be placed into MAGF instead of MA Q. These members will remain in MAGF for the first 8 months. At the end of the 8 months the State Eligibility system will explore all other eligible categories for the member, including HIP.

1620.50.00 PREGNANT WOMEN - FULL COVERAGE (MED 3)

These categories are identified in ICES as MAMA and MAGP.

To be eligible for these categories a woman must have an attestation of pregnancy and have income less than or equal to 208% of the Federal Poverty Level. These categories are calculated with MAGI methodology and must be found income eligible in the month of application to be eligible for retro and ongoing coverage. (42 CFR 435.831(1) & 42 CFR 435.603).²⁰ There are no resource eligibility requirements for these categories.

If a pregnant woman receiving coverage under either of these two categories receives an increase in income which causes her countable income to exceed the standard, she remains eligible for pregnancy-related coverage through the end of the 60 day postpartum period, as explained in Section 1610.50.00.²¹

The 60 day postpartum period is available to a woman who:

Applies for Medical Assistance while pregnant and is eligible on the date pregnancy ends (by birth or other means); or

Applies for Medical Assistance after the child is born (or the pregnancy is terminated by other means) and is found to have been eligible for Medical Assistance in the application month.

For a pregnant woman who was eligible and enrolled on the date her pregnancy ends, the agency must provide coverage described through the last day of the month in which the 60-day postpartum period ends. (Citation: **42 CFR §435.170**).²²

1620.60.00 CHILDREN UNDER AGE 1 (MED 3)

This category is identified in ICES as MA Y.

To be eligible in this category a child must be under the age of one.²¹

The income standard for this category is less than or equal to 208% of the Federal Poverty Level and there are no resource requirements.

1620.65.00 CHILDREN AGE 1 - 5 (MED 3)

This category is identified in ICES as MA Z.

To be eligible in this category a child must be at least one year of age, but not six years old. Income standards are based on 141% of the Federal Poverty Level and there are no resource requirements.²¹

1620.70.00 CHILDREN AGE 6 - 18 (MED 3)

This category is identified in ICES as MA 2.

To be eligible in this category a child must be at least age six (6), but under age nineteen (19).²⁰ The income standard is based on 106% of the Federal Poverty Level and there are no resource requirements.

1620.71.00 CHILDREN AGE 1 - 19 (MED 3)

This category is identified in ICES as MA 9.

This category is an eligibility expansion effective July 1, 1998. It is funded under the federal "Children's Health Insurance Program" (CHIP) enacted in the Balanced Budget Act of 1997. To be eligible in this category:

- A child must be age 1 through age 5 with income between 141% - 158% of the federal poverty level; or
- Age 6 through 18 with income between 106% - 158% of the federal poverty level, and not eligible in any other Medicaid category.

There are no resource requirements.

1620.72.00 CHILDREN'S HEALTH PLAN (MED 3)

This category of Hoosier Healthwise is designated as MA 10 on ICES.

Effective January 1, 2000, comprehensive medical coverage, under an eligibility expansion funded through the federal Children's Health Insurance Program (CHIP), is available to Indiana children under the age of nineteen.²¹ Under this category, also known as Package C, the income limit was 200% of the federal poverty guidelines at implementation and increased to 250% of the federal poverty guidelines, as of October 1, 2008. (Refer to IHCPPM Section 3010.30.00). There are no resource requirements. Coverage is provided only to children who are ineligible for all other categories of Hoosier Healthwise. MA 10 is, therefore, last in the ICES Medical Hierarchy. Please note, however, that a child who fails MA 9, but who would be eligible for MA D or MA B, could receive MA 10, if otherwise eligible. (Refer to IHCPPM Section 2035.30.10).

Unlike the other Hoosier Healthwise categories, MA 10 has cost-sharing requirements. There are premiums that must be paid as a condition of enrollment and ongoing eligibility, and there are co-payments for some services. Retroactive coverage is not available under this category. Coverage begins with the month of application. (Refer to IHCPPM Section 2035.60.00).

1620.73.00 FOSTER CARE INDEPENDENCE

This category is identified in ICES as MA 14.

To be eligible under this category, individuals must be 18, 19, or 20 years of age and have been a ward in foster care on their 18th birthday in a state other than Indiana. Income standards are based on 210% of the Federal Poverty Level and there are no resource

requirements.²³

1620.74.00 FORMER FOSTER CHILDREN UP TO AGE 26

This category is identified in ICES as MA 15.

To be eligible under this category, an individual must have been in foster care and enrolled in Indiana Medicaid on his/her 18th birthday and must be 18 through 26 years old.²⁴

There are no income standards or resource requirements for this eligibility group.

1620.75.00 NEWBORNS

This category is identified in ICES as MA X.

MA X is based on deemed eligibility and does not have a budget or redetermination. It is a full coverage category with no cost sharing and is at the top of the Medicaid hierarchy, therefore, it should not be replaced with any other category of medical coverage.

The only exception to this is if a newborn is approved for the MA D category. If an ongoing MA X child is approved for MA D, please contact the Helpdesk/PAL to remove the MA X coverage.

A child born to a woman who was receiving (and eligible for) traditional Indiana Medicaid or any Hoosier Healthwise benefit package except Package C, at the time of the child's birth, is deemed automatically eligible for Medicaid in the Newborn category. Coverage in this category continues for 12 months from the month of birth. Refer to Sections 2225.10 and 2428.00.

1620.80.00 FAMILY PLANNING SERVICES

This category is identified in ICES as MA E.

Individuals may be eligible under this category when family planning services are requested. There is no age requirement. Income standards are based on 141% of the Federal Poverty Level and there are no resource requirements.

1621.00.00 BREAST AND CERVICAL CANCER TREATMENT SERVICES

Breast and Cervical Cancer Treatment Program (ISDH)

In Indiana, the Breast and Cervical Cancer Treatment program (BCCP) is administered by the State Department of Health. To be eligible a woman must be screened and found to be in need of treatment for breast or cervical cancer by the BCCP and have income equal to or less than 200% of the Federal Poverty Level (FPL). The Indiana Breast and Cervical Cancer Program provides access to breast and cervical cancer screenings, diagnostic testing, and treatment for underserved and underinsured women who qualify for

services.

Must be:

- Indiana resident
- Uninsured or underinsured
- Insured with unmet deductible
- 30 - 49 years of age (for office visit, clinical breast exam, and Pap smear)
- 50 - 64 years of age (for office visit, clinical breast exam, Pap smear, and mammogram)
- 65 years of age and older if not enrolled in Medicare Part B
- At or below 200% of the FPL

BCCP Option 3 (MA 12)

Alternatively, a woman can receive full Medicaid benefits and coverage for treatment under the BCCP Option 3 program, which is identified as the Medicaid category MA 12. To be eligible, an applicant must be diagnosed with breast or cervical cancer and referred to FSSA through ISDH, and also meet the following criteria:

- Indiana resident
- At least 18 years old but not over 64 years old
- Has income at or below 200% of the FPL
- Is not eligible for Medicaid under any other category and is not enrolled in Medicare
- Is uninsured or underinsured (cancer treatment not covered)

Effective date of coverage is based on dates of Application and Diagnosis.

Example 1: Application received 5/15/2020 with a diagnosis date of 4/15/2020. Effective date of coverage should be 4/1/2020.

Example 2: Application received 5/15/2020 with a diagnosis date of 12/15/2019. Effective date of coverage should be 2/1/2020 (cannot go beyond 90 days prior to application month)

For information on screening through BCCP and referrals for BCCP Option 3, see the ISDH website at:

<http://www.in.gov/isdh/24967.htm>

1622.00.00

FOOTNOTES FOR CHAPTER 1600

¹ 42 CFR 435.234

² IC 12-15-41; Social Security Act (SSA) 1902(a)(10)(ii)(XV); SSA 1902(a)(10)(ii)(XVI)

³ SSA 1902(a)(10)(E)

⁴ SSA 1905(p)(3)

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- ⁵ SSA 1902(a)(10)(E)
⁶ SSA 1905(p)(3)(A)(ii)
⁷ SSA 1902(a)(10)(E)
⁸ SSA 1905(p)(3)(A)(i)
⁹ SSA 1902(a)(10)(E)
¹⁰ SSA 1905(p)(3)
¹¹ 1902(e)(6)
¹² http://www.in.gov/fssa/hip/files/HIP_2.0_Financing_Overview.pdf
¹³ SSA 1925
¹⁴ 1902(e)(1)(A)
¹⁵ 405 IAC 10-4-1
¹⁶ 405 IAC 10-4-1
¹⁷ 405 IAC 10-4-1
¹⁸ 405 IAC 10-4-1
¹⁹ 42 CFR 435.831(1) & 42 CFR 435.603
²⁰ Section 1610.50.00
²¹ 42 CFR §435.170
²² IC 12-15-2-9; 42 CFR 435.222
²³ SSA 1902(a)(10)(A)(i)(VII)
²⁴ IC 12-17.6-3-2