



The Indiana Pregnancy Promise Program Beneficiary Consent to Enroll

Completion of this consent form is voluntary and authorizes permission to release information described Sections 1 and 2 below.

Section 1: The Indiana Pregnancy Promise Program

What is the Indiana Pregnancy Promise Program?

The Indiana Pregnancy Promise Program is a voluntary program. It is for members who are or have recently been pregnant and have an opioid-use disorder. It aims to improve the health and well-being of mothers and their infants who have been affected by OUD. Indiana Medicaid will partner with four Medicaid managed care health plans: Anthem, CareSource, MDwise and MHS. Members in this program will receive enhanced care coordination from the health plans. This will make it easier for them to get the care needed for a healthy pregnancy and for addiction recovery. The Pregnancy Promise Program is funded by the Centers for Medicare and Medicaid Services and the state of Indiana. It is a free program, and there are no costs for you or your family to take part.

How will the Indiana Promise Program benefit you?

Members in this program receive full Medicaid benefits. They also receive enhanced services from their health plan. Services begin upon enrollment and continue for 12 months after delivery. There is no Medicaid cost sharing while enrolled.

What is “case management and care coordination”?

After you enroll in the Pregnancy Promise Program, you will be connected to a case manager from your health plan. The case manager will meet with you (either by phone or in person) at times that are convenient to you. Meetings will occur at least two times a month but may be more frequent as the delivery date approaches. Your case manager can help coordinate your care. They will create a specific plan for you. This includes helping you get physical, mental and addiction treatments as needed. The case manager can also help with other non-medical needs you may have (for example, things like transportation, housing, nutrition and safety). The case manager will also help you find persons, organizations and resources to support you during and after your pregnancy.

The case managers receive specialized training to support the health of you and your baby. They will listen to you and work with you to create a care plan to meet your needs and goals. Your care plan will be discussed and updated during each case manager meeting. The care plan will only be shared with individuals you allow, such as your doctors and providers. The enhanced services provided by your case manager from the time you enroll through 12 months after delivery.



MCE Logo



Section 2: Consent to Participate in the Indiana Pregnancy Promise Program

By signing this consent form, I understand and grant permission to the following agencies, including the managed care health plan, and the Indiana Family and Social Services Administration to collect and share information with the Centers for Medicare and Medicaid Services and their partner organizations (ABT Associates, Insight Policy Research, Mathematica Inc, Myers and Stauffer LLC, NewWave and Urban Institute) related to my health information and my child's health information. I understand the data shared will be kept secure and private and the information will be used for the purpose of evaluating the Indiana Pregnancy Promise Program and federal Maternal Opioid Misuse effectiveness. In accordance with 45 CFR§164.508(c)(2)(iii), each of these agencies are required by federal privacy laws to protect personal information. As part of the evaluation of the Pregnancy Promise Program/CMS Maternal Opioid Misuse MOM Model, I understand I may be asked to take part in a one-on-one interview or a group interview about MOM. Participating in the Pregnancy Promise Program / CMS MOM program does not mean that individuals need to participate in these interviews. The team will ask for my agreement before doing the interviews. If individuals decide not to talk with the program team about MOM, they can still participate in the MOM program. I understand that all identifiable information about me and my child will be removed from any published reports and findings. Information will not be used or distributed for future research studies.

Section 3: Rights

I understand I have the right to refuse to sign this consent form with no impact to my Medicaid benefits and coverage. I understand that by refusing to sign this form and therefore declining participation in the Indiana Pregnancy Promise Program, I am still eligible to receive pregnancy-related case management services from the health plan through my Medicaid plan.

I understand that I may revoke this consent in writing at any time. If I choose to revoke this consent, I understand I can no longer participate in the Indiana Pregnancy Promise Program (CMS MOM Model). The written notice of the withdrawal of my consent must be provided to the health plan and to the Indiana Family and Social Services Administration, the organizations to which I authorized permission to release my information.

I understand that by voluntarily revoking my consent to participate in the Indiana Pregnancy Promise Program, this means my Medicaid eligibility will be subject to re-determination at 60 days postpartum, as is standard practice for Healthy Indiana Plan Maternity beneficiaries.

I understand that by signing this form, and thereby participating in the Indiana Pregnancy Promise Program, my Medicaid eligibility will be redetermined at the end of 12 months postpartum period, as is standard practice.

I understand that by signing this consent form, I authorize permission for Indiana state agencies to verify the status of my Medicaid application and verify my Medicaid eligibility.

I understand I have a right to obtain a copy of this form.

If you have any questions about the Indiana Pregnancy Promise Program or your rights as a participant, please contact:

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By signing this document, I hereby verify I have read and understand the contents. I authorize my consent to enroll in the Indiana Pregnancy Promise Program, and my signature authorizes permission for the entities above to release individualized and identified information related to my health care and my infant through twelve months postpartum the Center for Medicare and Medicaid Services for the purpose of evaluating this program. This consent will expire when I, the undersigned, complete the end of my 12-month postpartum period.

SIGNATURE

DATE

PRINTED NAME

PARTICIPANT ADDRESS

LEGALLY AUTHORIZED REPRESENTATIVE

SIGNATURE

DATE

INDIVIDUAL OBTAINING CONSENT

SIGNATURE

DATE

AGENCY/AFFILIATION

PHONE NUMBER