Healthy Indiana Plan 2.0

HEALTHY INDIANA PLAN™
Health Coverage = Peace of Mind
HIP 2.0: Basics

Who is eligible for HIP 2.0?

- Indiana residents*
- Age 19 to 64*
- Income **under 138%** of the federal poverty level (FPL)*
- Not eligible for Medicare or other Medicaid categories*
- Also includes individuals currently enrolled in:
  - Family planning services (MA E)
  - Healthy Indiana Plan (HIP)
  - Hoosier Healthwise (HHW)
  - Parents and Caretakers (MAGF)
  - 19 and 20 year olds (MA T)

### Monthly Income Limits for HIP 2.0 Plans

<table>
<thead>
<tr>
<th># in household</th>
<th>HIP Basic Income up to 100% FPL</th>
<th>HIP Plus Income up to ~138% FPL**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$981</td>
<td>$1,369.73</td>
</tr>
<tr>
<td>2</td>
<td>$1,328</td>
<td>$1,853.85</td>
</tr>
<tr>
<td>3</td>
<td>$1,675</td>
<td>$2,337.97</td>
</tr>
<tr>
<td>4</td>
<td>$2,021</td>
<td>$2,822.09</td>
</tr>
</tbody>
</table>

*Adults not otherwise Medicaid eligible who have children must make sure their children have minimum essential coverage to be eligible for HIP

**133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.
HIP 2.0 Basics

When does service coverage begin?

• February 2015, pending federal approval
• HIP & applicable HHW members converted to HIP 2.0 without having to reapply
• New applicants submit Indiana Application for Health Coverage to be considered for HIP coverage
  • No longer using separate HIP application
  • No retroactive coverage

What types of services are covered?

• HIP Basic members
  • Minimum Essential Coverage providing Essential Health Benefits
• HIP Plus members
  • HIP Basic benefits with additional services including:
    • Vision
    • Dental
## Transition to HIP 2.0

| Who provides services to HIP 2.0 members? | • Eligible providers must enroll:*  
| |  
| | • With Indiana Medicaid as an Indiana Health Care Provider  
| | • With Managed Care Entity (MCE) to provide in-network services to HIP members  
| | • All HIP members will have a Primary Medical Provider (PMPs)  
| Who pays for services? | • HIP member  
| | • POWER account debit card** and/or copayment***  
| | • Risk-based MCEs  
| | • Anthem  
| | • MDWise  
| | • Managed Health Services (MHS)  
| How will members be placed in a MCE? | • Current members will stay with current MCE  
| | • New members select MCE  
| | • On application OR  
| | • Call enrollment broker after application OR  
| | • Auto-assigned by HP  
| How should one answer member questions? | • Refer members to their MCE  
| | • Anthem: (866)800-8780  
| | • MDWise: (800)356-1204  
| | • MHS: (877)647-4848  

*Does not include emergency service providers  
**All plans should have POWER account debit card by June 2015  
***Individuals with copayment obligation cannot use POWER account to pay copayment.
Eligibility Verification

✓ You will still be able to verify member eligibility via normal processes
✓ Verification will indicate member’s benefit plan and cost sharing responsibility

Benefit Plans
- HIP Basic
- HIP Plus
- State Plan Plus
- State Plan Basic

Copayments
- Copayments for services – check card or contact MCE for values
- No copayments

Special Flags
- Pregnancy – maternity services included
- Low-income populations – facility services paid at Medicaid rates
Cost Sharing

**HIP Basic members required to pay copayment for services**¹, ²

- **Provider verifies if member must pay copayment when checking eligibility**

**Provider should collect all copayments at time of service**³

**Payment to provider will be reduced by amount of copayment**

1. Member does not pay copayment after 5% of household income spent on out-of-pocket health care costs
2. Pregnant women and Native Americans exempt from cost sharing
3. Provider cannot deny service based on member inability to pay
HIP Basic Plan: Cost Sharing

When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic members are responsible for the following copayments for health and pharmacy services.

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Basic Copay Amounts</th>
<th>Income ≤100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td></td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
<td>$75</td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td></td>
<td>$4</td>
</tr>
<tr>
<td>Non-preferred drugs</td>
<td></td>
<td>$8</td>
</tr>
<tr>
<td>Non-emergency ER visit</td>
<td></td>
<td>Up to $25</td>
</tr>
</tbody>
</table>

Copayments may not be more than the cost of services received.
Emergency Department (ED) Copayment Collection

✓ HIP requires non-emergent ED copayments unless:
  • Member meets cost sharing maximum for the quarter
  • Member calls MCE Nurse-line and is told to go to ED
  • The visit is a true emergency

✓ HIP features a graduated ED copayment model
  • Providers should call the MCE to determine the member’s copayment at each non-emergent ED visit

$8
1st non-emergent ED visit in the benefit period

$25
Each additional non-emergent ED visit in the benefit period
The Medically Frail

What is Medically frail?
- Required federal designation
- Individuals with certain serious physical, mental, and behavioral health conditions are required to have access to the standard Medicaid benefits
  - Called HIP State Plan benefits

What conditions make someone “medically frail”?
- Disabling mental disorders (including serious mental illness)
- Chronic substance use disorders
- Serious and complex medical conditions
- A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living
  - Activities of daily living include bathing, dressing, eating, etc.
- A disability determination from the Social Security Administration
Medically Frail: Benefits and Cost Sharing

What benefits do medically frail receive?

- HIP State Plan benefits are comprehensive and at least as generous as benefits offered in HIP Basic and HIP Plus and include:
  - Vision
  - Dental
  - Non-emergency transportation
  - Other Medicaid State Plan benefits

What out-of-pocket costs will medically frail individuals have?

- Required to pay HIP cost-sharing of their chosen program:
  - HIP Plus - Monthly POWER account contribution (PAC)
    - Available for individuals with income up to ~138% FPL
    - If fail to pay PAC, must pay copayments for services until outstanding PAC paid
  - HIP Basic - Copayments for services
    - Available for individuals with household income less than or equal to 100% FPL
Medically Frail Identification

At application: Member indicates medically frail on frail screening questions

Annually after frail verification: MCE verifies medically frail status in claims

After enrollment:
- Member notifies MCE* of medically frail status
- MCE confirms using claims, lab results, etc.

Identification of medically frail individuals

Provider Impact:
- Information request from managed care entity (MCE):
  - MCE verifying member medically frail status
- Eligibility verification provides information for:
  - Member medically frail status & access to HIP State Plan benefits

*Only MCE can review medically frail status; so member will not notify Division of Family Resources of medically frail status
Pregnancy Determination

HIP member tells MCE she is pregnant (self-attestation)

MCE review of claims data indicates pregnancy

HIP learns a member is pregnant

HIP member tells Division of Family Resources she is pregnant (self-attestation)
HIP Coverage for Pregnant Women

**Woman becomes pregnant while enrolled in HIP**
- HIP member becomes pregnant
- Additional pregnancy-only benefits begin
  - No cost sharing during pregnancy/post-partum period
  - OPTION: May request to move to HIP Maternity (MAGP)

**Woman is pregnant at application or redetermination**
- Woman eligible for HIP 2.0 and is pregnant at the time of application or at her annual redetermination timeframe will receive HIP Maternity (MAGP)
  - No cost sharing during pregnancy/post-partum period
  - May have coverage gap when reentering HIP after pregnancy if end of pregnancy not reported on time

**RECOMMEND:**
Report end of pregnancy promptly to guarantee continued HIP coverage without a gap
Pregnancy Benefits

☑ Pregnant women receive benefits only available to pregnant women, regardless of selected HIP plan
  • Exempt from cost sharing
  • Additional benefits continue for a 2 month post-partum period

Additional Benefits Include:

- Vision
- Dental
- Non-emergency transportation
- Chiropractic
### Pregnancy Benefits, cont.

<table>
<thead>
<tr>
<th>How long will maternity services be covered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Up to two months (60 days) post-partum</td>
</tr>
<tr>
<td>• Woman must report end of pregnancy</td>
</tr>
<tr>
<td>BEFORE end of 60 day post-partum period</td>
</tr>
<tr>
<td>to avoid coverage gap</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How will member costs change for pregnant women?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There is no cost sharing for pregnant women</td>
</tr>
<tr>
<td>• POWER account is frozen during pregnancy/post-partum period</td>
</tr>
<tr>
<td>• No cost sharing for HIP 2.0 or HIP Maternity (MAGP) during pregnancy/post-partum period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How will health care provider know maternity benefits status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Eligibility verification will show provider:</td>
</tr>
<tr>
<td>• Maternity benefits coverage</td>
</tr>
<tr>
<td>• No cost sharing obligation</td>
</tr>
</tbody>
</table>
Reimbursement Rates

**HIP Reimbursement Rates**

- **Medicare Rates**
  - 130% of Medicaid rate if no Medicare rate exists

**Exceptions**

- Inpatient claims for Low Income Parents, Caretakers and 19 and 20 year olds are reimbursed at the Hoosier Healthwise rate