Healthy Indiana Plan

Objectives

After reviewing this presentation, you will understand the following aspects of HIP:

- History and fundamentals
- Program features and plan options
- Cost sharing requirements and benefits
- Application and enrollment process
- Redetermination
- Special populations

Terminology

Cost Sharing	The costs a member is responsible for paying for health services when covered by health insurance.
Deductible	A deductible is a dollar amount that is paid for initial medical costs before health insurance starts to pay. HIP has a $2,500 deductible that is funded by a combination of state and member contributions.
Copayment	A form of cost sharing. Copayments or “copays” refer to a specific dollar amount that an individual will pay for a particular service, regardless of the total cost of the service accessed. The payment may be collected at the time of service or billed later. The HIP Basic plan requires copayments of $4 for a doctors visit, $4 or $8 for prescriptions and $75 for a hospital stay.
Federal Poverty Level (FPL)	Determined annually by the federal government. The federal poverty level for 2018 is $1,012 per month for an individual and $2,092 per month for a family of four. 75% of the federal poverty level is equal to .75 x the federal poverty level for the family size.
Affordable Care Act	Federal law passed in 2010, established Federal Health Insurance Marketplace and the option for states to expand Medicaid coverage to a new group of healthy adults up to 138% FPL.
Federal Health Insurance Marketplace	Individuals with income over the federal poverty level can purchase insurance plans through the federal government’s Health Insurance Marketplace. Those with incomes up to 400% FPL may receive federal tax subsidies to help pay for coverage.
Preventive Services	Health care services recommended to identify health conditions so they can be treated before they become serious.

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Healthy Indiana Plan (HIP) Fundamentals

Covering Hoosiers since 2008

- Nation's first consumer-directed health care program for Medicaid recipients
- Began as a small demonstration program with limited enrollment
- Expanded to cover all eligible adults in 2015

Health coverage benefits modeled after an employer-sponsored health insurance plan

- Coverage provided by one of four managed care entities (MCE)
- Members may choose MCE: Anthem, Caresource, MDwise or MHS

Personal Wellness and Responsibility (POWER) account

- Each member has an account similar to a health savings account (HSA) called the POWER Account to fund initial medical expenses
- The state funds most of the $2,500 in the POWER account, but the member is responsible for a fixed monthly payment depending on his or her income
- When a member makes a POWER account payment, they become enrolled in HIP Plus, which offers better health coverage, including vision, dental and chiropractic benefits.

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HIP: Basics, Plan options

Who is eligible for HIP?

- Indiana residents*
- Age 19 to 64*
- Income under 138% of the federal poverty level (FPL)**
- Not eligible for Medicare or other Medicaid categories*

HIP Plus

Benefits: Comprehensive, including vision, dental and chiropractic coverage

Cost sharing:
Must pay affordable monthly POWER account contribution based on income
No copayment for services*

HIP Basic

Fall-back option for members with household income less than or equal to100% FPL only

Benefits: Meets minimum coverage standards, but no vision, dental or chiropractic coverage

Cost sharing:
- Members choose to not pay POWER account contribution monthly and instead must pay copayments for doctor visits, hospital stays and prescriptions

HIP State Plan

Individuals who qualify for additional benefits based on condition, disorder or disability.

Benefits: Comprehensive, with additional benefits to align with traditional Medicaid -- including dental, vision, transportation and other services

Cost sharing: HIP Plus OR HIP Basic cost sharing

Monthly Income Limits for HIP Plans

# in household	HIP Basic Income up to 100% FPL	HIP Plus Income up to ~138% FPL**
1	$1,005	$1,404
2	$1,353	$1,890
3	$1,701	$2,377
4	$2,050	$2,863

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HIP Plan Options and Benefits

HIP: Plan Options

HIP Plus

Offers best value for members.

Comprehensive benefits including vision, dental and chiropractic.

To be eligible, members pay an affordable monthly contribution based on income.

No copayment required when visiting doctors or filling prescriptions.

HIP Basic

Fallback option for lower-income individuals who choose not to make monthly contributions to their POWER account.

Covers the essential health benefits but not vision, dental or chiropractic services for adults.

Members pay copayments for most health care services.

Can be more expensive for the member than HIP Plus.

Other benefit and cost sharing options: Individuals who qualify may receive additional benefits through the HIP State Plan Basic & HIP State Plan Plus options, or have cost sharing eliminated per federal requirements.

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HIP: State Plan

Available for certain qualifying individuals

- Low-income (<19% FPL) Parents and Caretakers
- Low-income (<19% FPL) 19 & 20 year olds
- Medically Frail

Benefits equivalent to current Medicaid benefits

- All HIP Plus benefits covered with additional benefits, including transportation to doctor appointments
- State Plan benefits replace HIP Basic or HIP Plus benefits
  - State Plan benefits are the same, regardless of HIP Basic or HIP Plus enrollment

Keep HIP Basic or HIP Plus cost sharing requirements

- HIP State Plan Plus: Monthly POWER account contribution
- HIP State Plan Basic: Copayments on most services

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HIP: Essential Health Benefits

Essential Health Benefits	HIP Plus	HIP Basic	HIP State Plan
Ambulatory (Doctor Visits)	Covered – Includes coverage for Temporomandibular Joint Disorders (TMJ) 100 visit limit for home health	Covered – No TMJ coverage 100 visit limit for home health	Covered - Includes TMJ coverage & chiropractic services. Home health limit does not apply
Emergency*	Covered	Covered	Covered
Hospitalization	Covered - Includes Bariatric Surgery	Covered - No Bariatric Surgery	Covered - Includes Bariatric Surgery
Maternity	Covered	Covered	Covered
Mental Health	Covered	Covered	Covered
Laboratory	Covered	Covered	Covered
Pharmacy	Covered	Covered - Generic Preferred	Covered
Rehab & Habilitation	Covered – 75 visits annually of physical, speech and occupational therapies 100 day limit for skilled nursing facility	Covered – 60 visits annually of physical, speech and occupational therapies 100 day limit for skilled nursing facility	Covered - Requires prior authorization but not limited to 60/75 visits annually Skilled nursing facility limit does not apply
Preventive	Covered	Covered	Covered
Pediatric	Early Periodic Screening Diagnosis and Testing (EPSDT) services covered for 19 & 20 year olds		

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HIP: Other Benefits

Other Benefits	HIP Plus	HIP Basic	HIP State Plan
Adult Vision	Covered	Not Covered	Covered
Adult Dental	Covered – Limited to 2 cleanings per year and 4 restorative procedures	Not Covered	Covered
Chiropractic	Covered – 6 visits per year. Limit of 1 per day.	Not Covered	Covered
Transportation	Not Covered	Not Covered	Covered
Substance Use Disorder	Covered	Covered	Covered
Pregnancy-Only	Additional benefits for pregnant women including transportation and chiropractic services.	Additional benefits for pregnant women including transportation, vision, dental and chiropractic services.	Pregnant women receive access to all pregnancy benefits on HIP Plus or HIP Basic plan and full State Plan benefits.

Required Documentation

Proof of Identity	• Social Security Card • Valid driver's license • Student photo ID
Proof of US citizenship	• Legal birth certificate • Certificate of Naturalization • Certificate of Citizenship • U.S. passport, if it was issued with no restrictions.
Proof of Money received by applicant, spouse, and dependent children in the home	• Income from jobs or training (paystub, paychecks) • Benefits you get now (or got in the past), such as Social Security, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), veteran's benefits, or child support • Family and tax relationship information
Proof of Immigration Status	• If you are not a US citizen, a copy of your alien registration card • Permanent resident card or • Documentation from the Bureau for Citizenship and Immigration Services

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Navigator Checklist: Member Enrollment

- ✓ **<u>Ask the member call Maximus</u> at 877-GET-HIP-9 to verify if the member has already been assigned an MCE/health plan for the calendar year.**
  - Maximus is the state's enrollment broker and assigns members to the health plans based on their choice or randomly
  - If a member previously had HIP during the year – the member is already assigned a calendar year MCE/health plan
- ✓ **<u>Call DFR</u> to see if the member has a current application on file**
  - This step will ensure that multiple applications are not filed and that the approval process is not delayed
- ✓ **If member is already assigned a calendar year MCE – please have the member select that MCE on new application**
  - If organization is making a Fast Track prepayment for member –confirm they approve and also that it is to the calendar year MCE
- ✓ **If there is no assigned calendar year MCE - ask the member if they have an MCE preference**
  - If organization is making a Fast Track prepayment for a member –confirm they approve and understand they will be locked into the selected plan until the next MCE selection period in the Fall
  - Provide the MCE comparison sheet that shows the benefits for each plan
- ✓ **Confirm that the member has all required documentation**
  - Reference the list on the previous slide for documents that fulfill the Medicaid application requirement
- ✓ **Complete the member application and submit it online**
  - Inform members that it can take up to 45 days for application approval
  - Inform members that they may receive a request for additional documentation
- ✓ **Review the Federal Notice with the member**
  - Point out the member's POWER Account contribution (PAC) in the notice

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HIP Enrollment Process

Step 1

Member completes and signs application online with a Navigator, at Home or at a local FSSA DFR office

Step 2

Member provides required documentation to prove HIP eligibility

Step 3

Member submits application and waits up to 45 days for approval. Notification letter will arrive in the mail

Step 4

Member responds to request for additional information

Step 5

Applicant determined eligible for HIP

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HIP POWER Accounts and Fast Track Payments

POWER Account

Unique feature of the Healthy Indiana Plan (HIP)

All members have a POWER Account (Plus, Basic and State Plan)

Similar to a Health Savings Account

- *All members* receive monthly POWER Account statements
- Used to pay for the first $2,500 of annual health care costs

HIP Plus and State Plan Plus:

- Members make monthly contributions to their POWER Accounts to receive better coverage including vision, dental and chiropractic benefits
- Members exempt from other cost sharing (except inappropriate use of the ER).

HIP Basic and State Plan Basic:

- Members do not make contributions to POWER Account
- Members DO have co-pays on most services

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POWER Account

HIP Plus POWER account

Pays for $2,500 deductible

Member contributes

May double rollover

Year-End Account Balance

- Unused member contribution rolls over to offset next year's required contribution
- Amount **doubled** if preventive services complete – up to 100% of contribution amount
- **Example**: Member has $100 of member contributions remaining in POWER account. This is credited to next year's required contribution amount. Credit is doubled to $200 if preventive services were completed.

HIP Basic POWER account

Pays for $2,500 deductible

Cannot be used to pay HIP Basic copays

Capped rollover option

Year-End Account Balance

- If preventative services completed, members can offset required contribution for HIP Plus by up to 50% the following year
- Members may not double their rollover as in HIP Plus
- **Example**: Member receives preventive services and has 40% of original account balance remaining at year end. May choose to move to HIP Plus the following year and receive a 40% discount on the required contribution.

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HIP: POWER Account Payments

- **Starting January 2018, POWER Account payment amounts will be one of five levels shown below**
- Members receive a monthly invoice from their selected MCE that states the amount they must pay
- Employers & not-for-profits may assist with contributions
- Spouses split the monthly PAC amount

FPL	Monthly PAC Single Individual	Monthly PAC Spouses
<22%	$1.00	$1.00
23-50%	$5.00	$2.50
51-75%	$10.00	$5.00
76-100%	$15.00	$7.50
101-138%	$20.00	$10.00

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Non-payment Penalties

- Members remain enrolled in HIP Plus as long as they make POWER Account contributions and are otherwise eligible

- Penalties for members not making the PAC contribution:

≤100% FPL

Moved to HIP Basic

Copays for all services

>100% FPL

Dis-enrolled from HIP*

Locked out for six months**

*EXCEPTION: Individuals who are medically frail.
**EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area. If an individual locked out of HIP becomes medically frail, he/she should reapply and inform the Division of Family Resources that they qualify for a "lockout exemption."

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HIP Basic Plan: Cost Sharing

HIP Basic members are responsible for the following copayments for health and pharmacy services.

Service	HIP Basic Copay Amounts Income ≤100% FPL
Outpatient Services	$4
Inpatient Stay	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	$8

Fast Track Prepayments

Fast Track is a one-time $10 payment that can be made while a member's application is being reviewed. It can help the member gain coverage faster.

- The Fast Track payment goes toward a member's first POWER Account contribution.
- Once eligibility is determined, members who make a Fast Track payment will have coverage effective on the first day of the month in which the payment was made. (unless they were covered by presumptive eligibility, in this case the PE will continue and full coverage will start the first of the following month.)
- Depending on the member's PAC, this payment could pay for up to 10 months of coverage or they may need to pay additional funds for the first month's coverage.

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Fast Track Payments

Making Fast Track Payments:

- Payments can be made with the online application:
  - Fast Track payment can be made by credit card when completing the application

- Payments made while your application is being processed:
  - Members receive a Fast Track invoice after an MCE is selected.
  - If the payment is made, HIP Plus coverage will begin the first of the month that the payment was received (if applicant is determined eligible).

HIP APPLICATION & ENROLLMENT

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Applying for HIP

Application Methods:

1. **Indiana Application for Health Coverage**
   - Eligibility considered for all Indiana Health Coverage Programs (IHCP), including HIP

2. **Presumptive Eligibility**
   - Apply with qualified hospitals, community mental health centers (CMHCs), Federally Qualified Health Centers (FQHCs), rural health centers, psychiatric hospitals for temporary coverage
   - Applicants must complete Indiana Application for Health Coverage to maintain eligibility

3. **Federal Health Insurance Marketplace**
   - When an application is made to the federal marketplace, eligibility will be considered for Qualified Health Plans, premium tax credits, cost sharing reductions and state programs like Medicaid and HIP
   - If assessed potentially eligible for HIP, application data will be sent to Indiana's Division of Family Resources (DFR)
     - DFR will assess for IHCP eligibility, including HIP

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Application Features: Selecting a Managed Care Entity

Indiana Application for Health Coverage will offer choice of four managed care entities (MCE), also called health plans, and applicants choose:

Selecting a MCE

- Doctors and hospitals in network may vary by MCE
- Selection assistance available from MAXIMUS
  - 1-877-GET-HIP-9 (1-877-438-4479)
- If no selection made, MCE will be auto-assigned

Anthem

Caresource

MDwise

MHS

Selecting a Managed Care Entity

New members not returning within the same calendar year

Select or auto-assign managed care entity (MCE)

New member can change MCE any time before paying POWER account contribution (PAC)

Decision to change MCE does not provide additional time to make PAC

Pay POWER account contribution (PAC) to MCE

If PAC made to the wrong MCE, coverage may open for member with THAT MCE and may be locked in for the rest of the calendar year.

HIP coverage begins

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When Individuals Can Change Managed Care Entity (MCE)

Individuals may change MCE

At determination*	• **After** assessed eligible for HIP • **Before** paying POWER account contribution (PAC)
During Presumptive Eligibility period*	• **After** qualified hospital assesses presumptively eligible for HIP • **Before** paying PAC (will only change MCE for ongoing enrollment, not PE period)

For just cause	• **After** PAC paid
	• Just cause reasons include (but are not limited to):
	  • Lack access to medically necessary covered services
	  • Lack access to providers experienced in dealing with member health care needs
	  • Poor quality of care, including failure to comply with established standards of medical care

During annual plan selection period	• **New for 2018!** Members can move health plans for the following calendar year by calling 877-GET-HIP-9 from Nov 1. – Dec. 15

For more information about changing MCE, contact 1-877-GET-HIP-9 (1-877-438-4479)

*If member already had MCE during the calendar year, they will return to that MCE.

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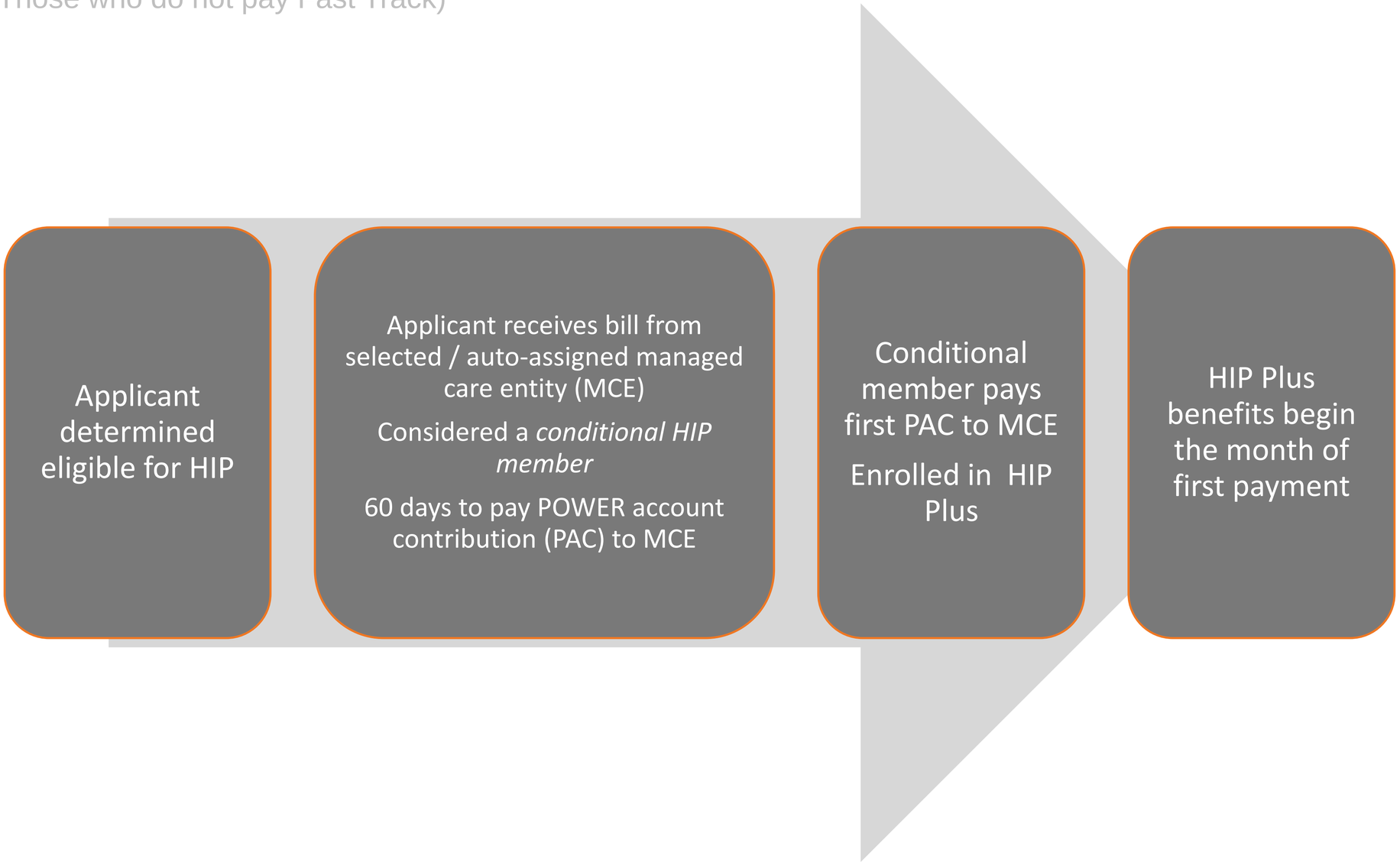
HIP Plus Enrollment

(For Those who do not pay Fast Track)



Retroactive Coverage

HIP does not provide coverage for:

- The months before the initial POWER account contribution is (PAC) paid *or*
- The months prior to when an individual defaults into HIP Basic

HIP Maternity for women entering the program while pregnant does allow retroactive coverage for up to 90 days prior to the date of application.

HIP Basic Enrollment

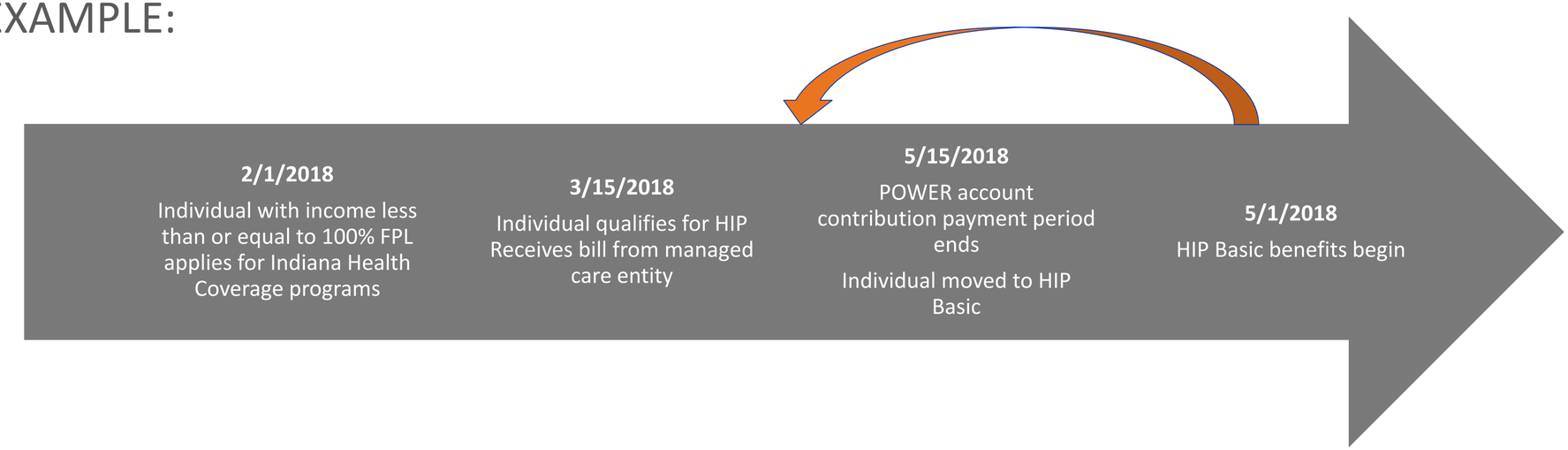
HIP Basic available for individuals:

- With income less than or equal to 100% FPL **AND**
- Who do not make the HIP Plus required contribution within 60 days
  - Members may not call and ask to be enrolled in HIP Basic prior to the end of the 60 day payment period

HIP Basic coverage:

- Effective the 1st of the month in which the 60 day invoice payment period ends

EXAMPLE:



Moving to HIP Plus

Members may move from HIP Basic to HIP Plus

- During annual redetermination
- During POWER account rollover period

Enrollment for Individuals with Income Greater than 100% FPL

Access to HIP Plus

- Members who make POWER Account contributions (PACs) to enroll and remain enrolled
- No benefits received until the first of the month in which the initial payment is made

Dis-enrolling from HIP

Reasons individuals would dis-enroll from HIP

1. No longer eligible for HIP
   - Failed to complete redetermination
   - Gained employer-sponsored coverage
   - Income increased to over 138% FPL
   - Became eligible for Medicare
   - Became eligible for other Medicaid category
     - E.g. Disability, Aged, etc.
   - Moved out of state

1. HIP Plus members with incomes greater than 100% FPL who do not pay monthly POWER Account contribution

Dis-enrolling from HIP (cont.)

POWER Account contributions after dis-enrolling

- Members leaving the program early may receive a refund for any unused contribution
  - Reporting a change that makes them ineligible for HIP (e.g. move to a different state): 100% of remaining member contribution
  - For non-payment of POWER Account contribution: Amount will be reduced by 25%

Lockout Periods

HIP Members are subject to a 6 month lockout period* if:

1. They were HIP Plus members receiving benefits **AND**

2. Have income greater than 100% FPL and less than ~138% FPL **AND**

3. Failed to make POWER account contribution
   - Members have 60 days after the due date to pay POWER account contribution before being locked out of the program
   - If locked out, application data forwarded to the federal Health Insurance Marketplace

4. **OR** they fail to submit their redetermination paperwork on time

Medicaid eligibility during lockout periods

1. Individuals who submit a new application during their HIP lockout period will have their eligibility considered for Medicaid categories, but will not be eligible for HIP

*EXCEPTION: Individuals who are medically frail.
**EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area. If an individual locked out of HIP becomes medically frail, he/she should reapply and inform the Division of Family Resources that they qualify for a "lockout exemption."

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HIP - Redetermination

Annual Eligibility Redetermination

HIP eligibility is granted for one year, after which members are required to have their eligibility reassessed

The state will try to determine eligibility based on available information. If necessary, HIP members receive a letter to inform them what information they need to provide the state.

1. Redetermination letter sent 45 days before the end of the 12 month eligibility period
2. If member receives letter, must comply with directions in the letter and may need to return additional information
    - **Return information on time and determined eligible**: Continue coverage without a coverage gap
    - **Return mailer late**: Late redetermination processing with possible coverage gap or possible lock out.

Late Redeterminations

Members have 90 days after coverage end date to return redetermination paperwork and have it processed

1. If paperwork is turned in late and member is eligible for HIP but not other Medicaid categories:
   - May have a health coverage gap
2. If paperwork not turned in within 90 days:
   - 6 month HIP lockout period, starting from coverage end date
   - To regain HIP coverage, member must reapply for HIP benefits after lockout period ends
   - Member application considered for other Medicaid category eligibility, as well

RECOMMENDATION:
To avoid lockout, ***all*** HIP members should complete and submit redetermination paperwork on time

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HIP – Special Populations

HIP: Treatment of Special Populations

Medically Frail	Enhanced benefits are available to individuals whose health status qualifies them as medically frail, such as a disability, chronic substance abuse disorder or other serious and complex medical condition. • Members will receive enhanced HIP State Plan benefits • HIP Basic or HIP Plus cost sharing will apply but access to vision, dental, and non-emergency transportation benefits is ensured regardless of cost sharing option • Will not be locked out due to non payment of POWER account contribution
Pregnant Women	Pregnant women will move to HIP Maternity and will have no cost sharing once their pregnancy is reported and will receive additional benefits available only to pregnant women
Native Americans	By federal rule, Native Americans are exempt from cost sharing. Can receive HIP benefits without required contributions or emergency room copayments. May opt out of HIP in favor of fee-for-service benefits.
Transitional Medical Assistance (TMA)	Individuals who no longer qualify as low-income parents or caretakers due to an increase in pay over 138% FPL are eligible for HIP Plus benefits for a minimum of six months.
Low-income Parents, Caretakers	Individuals eligible for HIP State Plan Plus or HIP State Plan Basic benefits

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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
  - Individuals receive State Plan benefit package

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 but not eligible for Aged, Blind or Disabled Medicaid due to income or resources.

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The Medically Frail: Benefits and Cost Sharing

What benefits do medically frail receive?

- HIP State Plan benefits are comparable to traditional Medicaid and include more comprehensive than HIP Plus or HIP Basic, including:
  - 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

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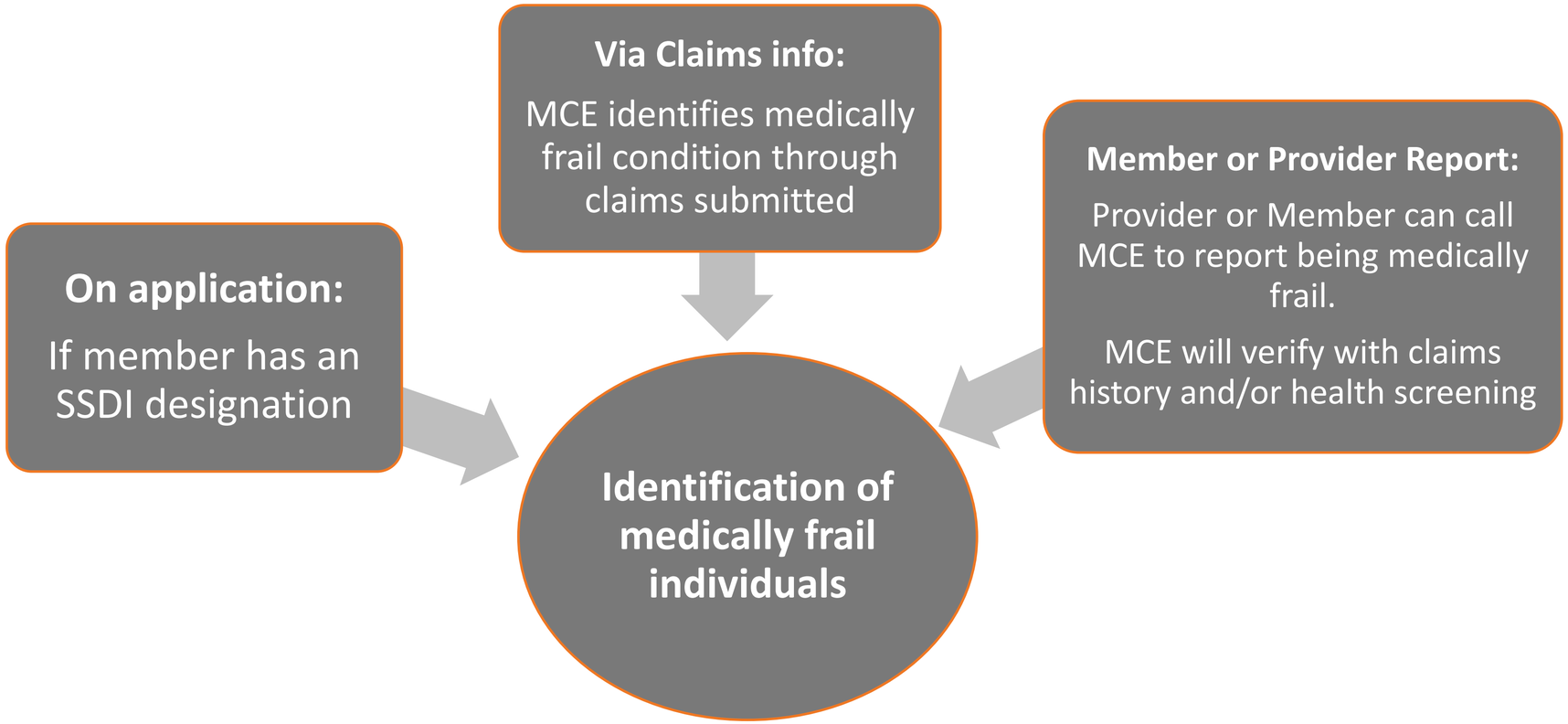
The Medically Frail Identification



MCE will review medically frail status annually. If MCE cannot confirm on-going medically frail status, it will remove the designation

If member reports medically frail to managed care entity (MCE) and findings show individual does not meet definition of medically frail, individual will receive notification of finding and appeal rights

If member disagrees with medically frail appeal decision, may appeal to the State

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The Medically Frail Verification

Individual identified as potentially medically frail

Managed care entity (MCE) must verify within 60 days* by:

Member medical records

Member health care or pharmacy expenses (claims)

Social Security Administration disability determination

If medically frail status not verified within 60 days*, member no longer eligible for State Plan benefits

Member transferred to HIP Basic or HIP Plus

Annually

MCE confirms qualification for medically frail status

State verifies MCE medically frail status determinations

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Transitional Medical Assistance

What is Transitional Medical Assistance (TMA)?

- Low-income Parents and Caretaker gains income over 138% FPL.
- No upper income limit first 6 months. Up to 185% FPL for months 6-12.

How long are individuals eligible for TMA?

- 6-12 months

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Transitional Medical Assistance

Individuals newly eligible for TMA will receive HIP Plus or HIP Basic benefits

Regardless of income, individuals receiving Transitional Medical Assistance (TMA) may not be dis-enrolled from the program for at least 6 months

- May receive TMA up to 12 months if individual income is above 138% but below 185% FPL

Transitional Medical Assistance

By federal rule, Native Americans are exempt from cost sharing

- Receive HIP Plus
- Do not have POWER account contributions or emergency room copayments
- May opt out of HIP Plus and into fee-for-service coverage as of April 1, 2015

May be eligible for HIP State Plan benefit option if also:

- Medically frail,
- Low-income Parent/Caretaker,

Native American status subject to verification with DFR.