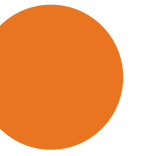




2018 HIP Waiver Renewal





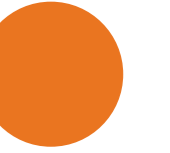
Objectives



Outline the HIP Waiver Changes

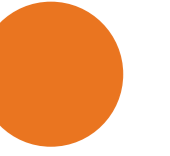
- Expanded Incentives
- Tobacco Surcharge
- Added Benefits
- Redetermination
- New Health Plan Selection Period
- Coverage of Pregnant Members
- Transitional Medicaid Assistance
- HIP Employer Link
- Gateway to Work
- Member Education

●●●● Healthy Indiana Plan Renewal



- With approval from the U.S. Centers for Medicare and Medicaid Services (CMS), the Healthy Indiana Plan will continue for an additional three years (February 1, 2018 – December 31, 2020).
- The core elements of the Healthy Indiana Plan will stay the same. However, CMS has agreed to allow several enhancements to the program to help streamline services for our members and address the state's most pressing health needs.

●●●● Expanded Incentives

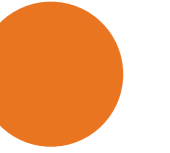


The Healthy Indiana Plan will offer additional incentives to members who meet individually achievable, relative goals as well as some process and participation measures.

The program will align member incentives with specific health challenges facing HIP members:

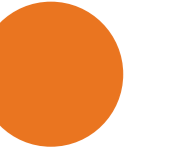
- Tobacco cessation
- Substance use disorder treatment
- Chronic disease management
- Employment-related incentives

●●●● Tobacco Use Incentives



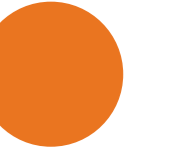
- HIP and its health plans will continue to offer programs to help members quit using tobacco.
- HIP members who use tobacco have 12 months of HIP coverage to stop tobacco use or will face a 50 percent increase in their POWER Account contribution amount for the next year.

●●●● Enhanced Substance Use Disorder Services



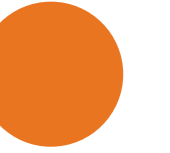
- New covered services for members, including residential treatment services and addiction recovery management.
- Expands access to providers to enable SUD and mental health services in more locations and new treatment centers throughout Indiana.

●●●● Adding Chiropractic Coverage in HIP Plus



- The state will add chiropractic benefits to the HIP Plus plan to promote participation in HIP Plus through regular contributions to the member's POWER Account.
- Benefit will now cover spinal manipulation.
- Members will be limited to one visit per day and six visits per covered person per benefit year.
- This benefit was previously only available to pregnant women and those who received State Plan services.

●●●● Redetermination Policy Update



Consistent with the original HIP program, members who lose eligibility due to failure to comply with the redetermination process will be required to wait six months to re-enroll in HIP coverage.

- Approximately 45 days prior to the end of the member's eligibility, each member will be notified of any documentation needed to determine continued eligibility.
- Members who do not return the required information before the end of his/her eligibility period will be disenrolled but will have 90 days to reenroll without a new application, if they provide the requested information.
- After a 90-day period, if the member has not complied, the member will be required to wait an additional three months before reapplying.

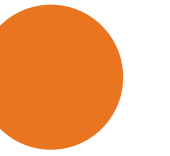
Redetermination Policy Update



Member Example 1 (Complies by Due Date)	Member Example 2 (Complies before Eligibility Period Ends)	Member Example 3 (Complies within 90 Days)	Member Example 4 (Complies after 90 Days)
Member applies for HIP and begins his/her eligibility period 1/1/2018	Member applies for HIP and begins his/her eligibility period 1/1/2018	Member applies for HIP and begins his/her eligibility period 1/1/2018	Member applies for HIP and begins his/her eligibility period 1/1/2018
Member receives notice of redetermination in October 2018	Member receives notice of redetermination in October 2018	Member receives notice of redetermination in October 2018	Member receives notice of redetermination in October 2018
There is a due date to turn in documentation by 12/14/18	There is a due date to turn in documentation by 12/14/18	There is a due date to turn in documentation 12/14/18	There is a due date to turn in documentation by 12/14/18
Member turns in documents 12/13/18	Member will not continue after eligibility period ends	Member does not turn in information before 12/31/18 and begins 90-day clock to comply	Member does not turn in information before 12/31/18 and begins 90-day clock to comply
Redetermination is complete and member's coverage continues	Member turns in documents 12/29/18	Member turns in documents on 1/25/19 – after due date but within 90 days after eligibility period end date	Member turns in documents on 4/5/19 – but not within the 90 days after eligibility period end date. Member is locked out until 7/2019
	Redetermination is complete and member's coverage will be reinstated	Member is conditionally approved by DFR and able to reenroll in HIP	Member reapplies 7/3/19. Member pays 8/3/19 and becomes a HIP Plus member 8/1/19



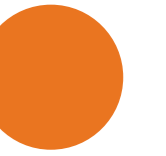
●●●● New Health Plan Selection Period for All Members



HIP members will have the opportunity at the end of each year to switch to another health plan for the following year.

- The four health plans that serve Healthy Indiana Plan members are Anthem, CareSource, MDwise and MHS.
- A member wishing to change health plans may do so by calling 877-GET-HIP-9 between November 1 and December 15.
- All changes will be effective January 1 and stay in effect for the next calendar year, even if the member has a gap in coverage during the year.

●●●● NEW Health Plan Selection Period for All Members



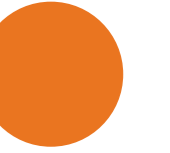
Example 1:

Member has HIP until 3/31/18 with Anthem. When they reapply and are approved for HIP on 6/1/18, they will go back to their calendar year plan with Anthem. The member will be able to change his or her health plan in the fall of 2018.

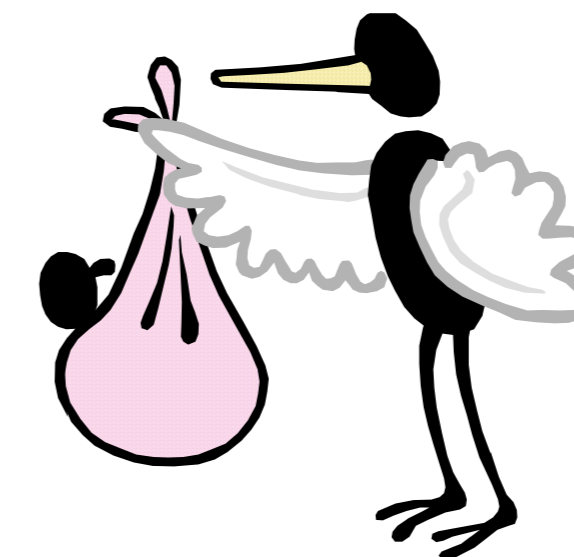
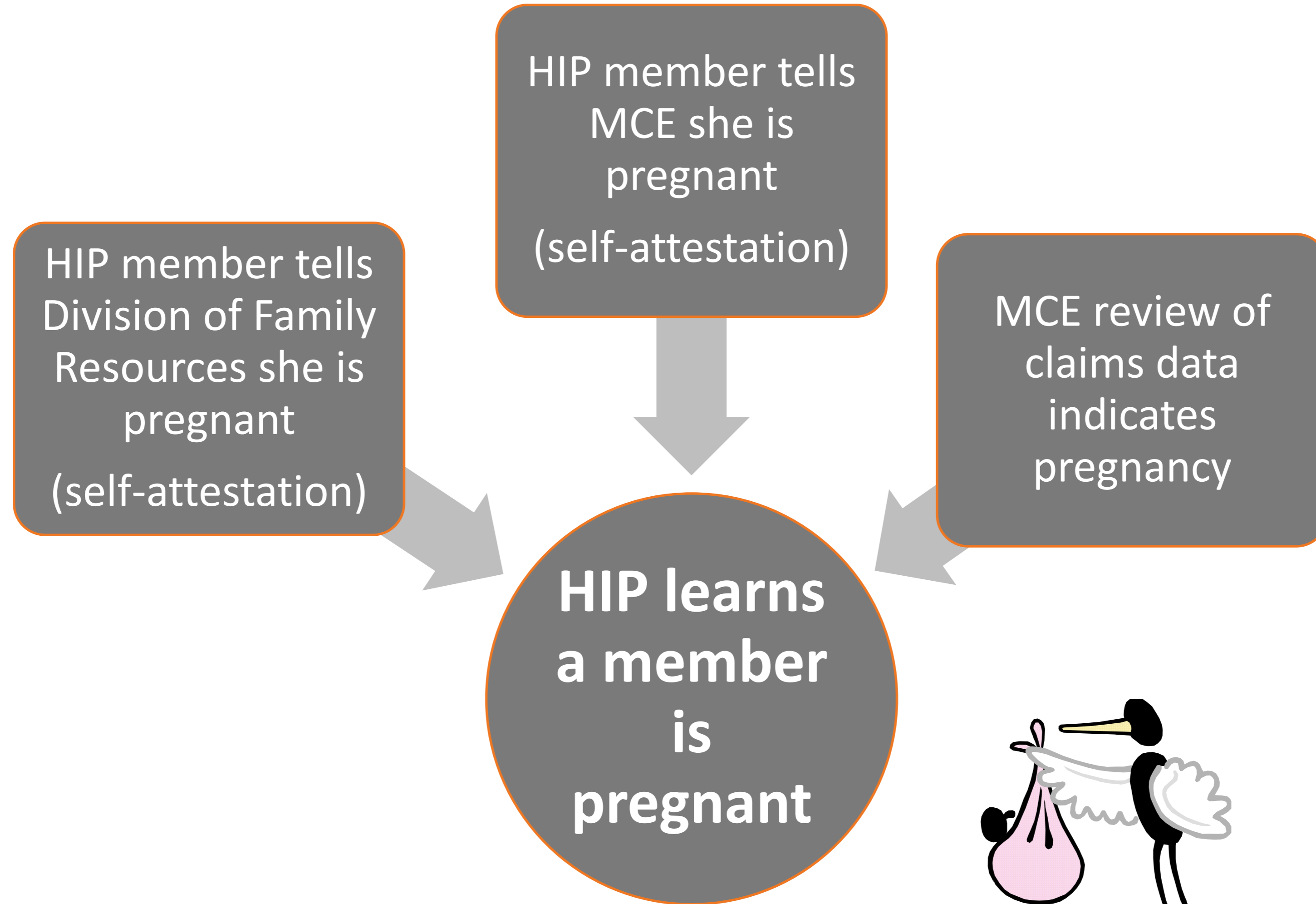
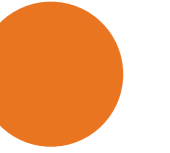
Example 2:

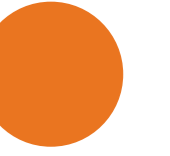
Member has HIP until 10/31/17 with Caresource. The member reapplies in March and selects MDwise. The member will be able to change his or her health plan in the fall of 2018.

●●●● HIP Maternity



- Women who are pregnant at the time of application will be enrolled in HIP Maternity if they qualify based on income. Those with incomes above 138 percent FPL will be enrolled in Hoosier Healthwise if eligible.
- Women enrolled in HIP at the time of pregnancy will stay in HIP while pregnant and move into HIP Maternity.
- Pregnant women will not have to move to different coverage due to pregnancy.
- There will be no cost sharing (POWER Account contributions or copayments) for pregnant members. Also, pregnant members receive enhanced benefits.
- All women who are presumptively eligible (PE) due to pregnancy will move to Hoosier Healthwise or HIP based on income when they are found eligible on the full IHCP application.



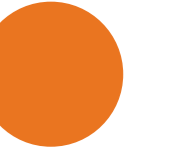


Woman becomes pregnant while enrolled in HIP

- All pregnant HIP members will move to HIP Maternity
- Additional benefits begin
- No cost sharing during pregnancy/post-partum period
- Member will remain with same health plan

Woman is pregnant at application or redetermination

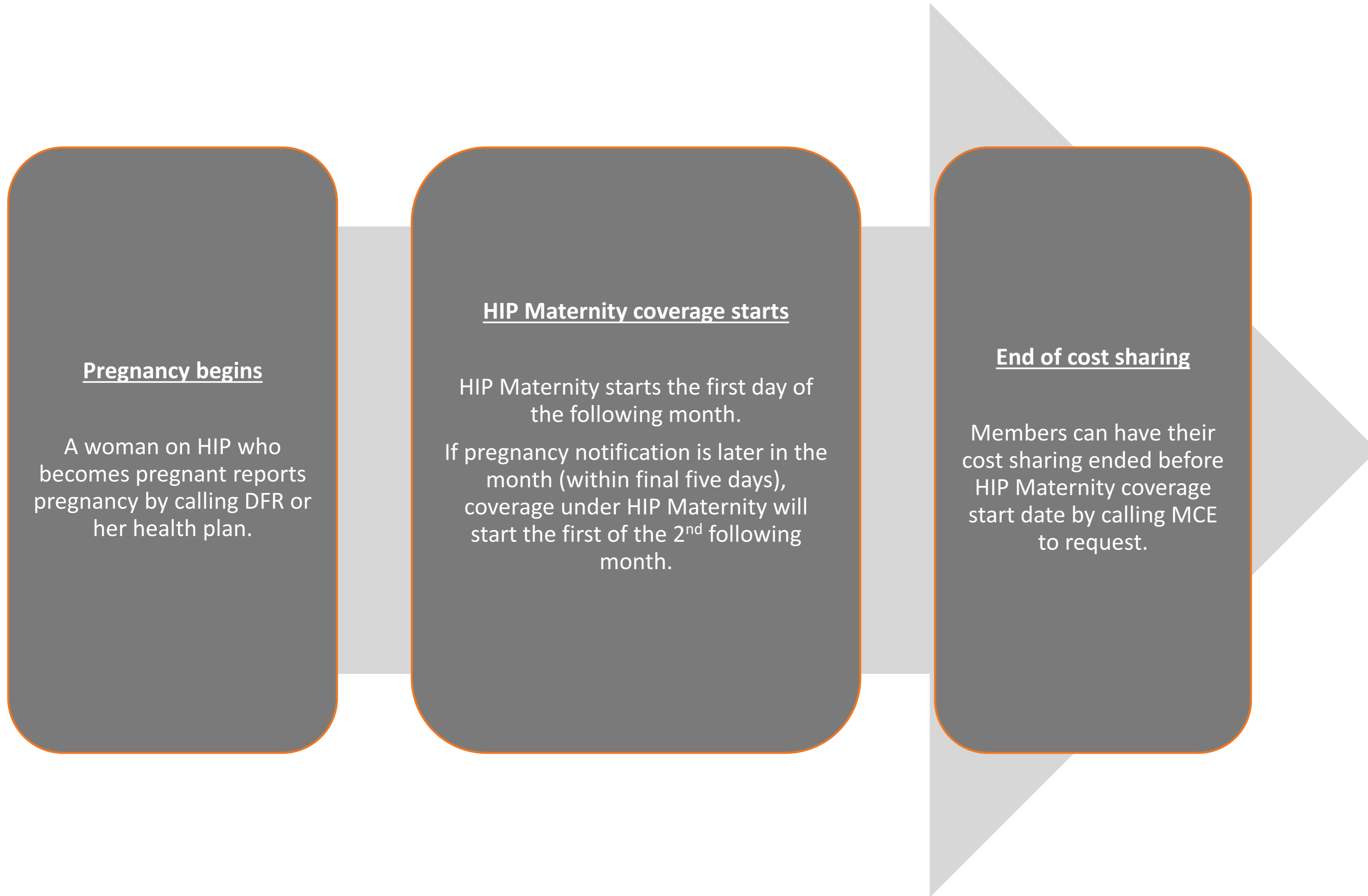
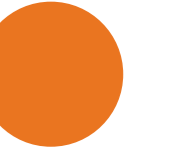
- Women eligible for HIP who are pregnant at the time of application will be enrolled in HIP Maternity (MAMA).
- This is no longer something that will change at redetermination time.
- No cost sharing during pregnancy/post-partum period
- HIP Maternity with a managed care entity will begin the month following notification. If eligible for prior month coverage – member will be fee for service.



Additional Benefits Include:
Vision
Dental
Non-emergency transportation
Chiropractic

Pregnant women receive benefits available to pregnant women, regardless of selected HIP plan.

- Exempt from cost sharing
- Additional benefits continue for a 2-month post-partum period



Pregnancy begins

A woman on HIP who becomes pregnant reports pregnancy by calling DFR or her health plan.

HIP Maternity coverage starts

HIP Maternity starts the first day of the following month.
If pregnancy notification is later in the month (within final five days), coverage under HIP Maternity will start the first of the 2nd following month.

End of cost sharing

Members can have their cost sharing ended before HIP Maternity coverage start date by calling MCE to request.

●●●● Transitional Medicaid Assistance



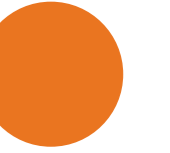
- Transitional Medicaid Assistance (TMA) will extend coverage only to HIP members who would lose coverage due to an increase in income that puts them over the 138 percent FPL threshold.
- Others with an increase in income will have other coverage options and not be at risk of losing coverage.
- TMA will be available for members for up to 12 months, as long as POWER Account contributions are paid.

●●●● HIP Employer Link



- Program ended December 31, 2017.
- Members transitioned to HIP Plus with no break in coverage and given health plan selection option through January.

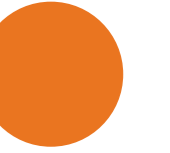
●●● Gateway to Work



To help Indiana build a healthy workforce, the Gateway to Work program will require able-bodied HIP members, with some exceptions, to work, go to school, volunteer or participate in other qualifying activities.

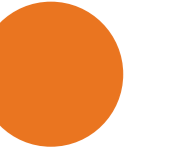
- Starting in 2019, Gateway to Work participation requirements will gradually increase from five hours per week initially up to 20 hours per week.
- Gateway to Work will help refer members to available jobs, job training programs, educational opportunities, or other community engagement opportunities. Members can receive case management services, gain access to job readiness support, and receive assistance with their job search and link to community engagement and educational opportunities.

●●●● Members Exempt from Gateway to Work

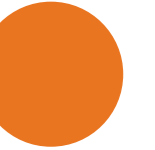


- Students
- Employed more than 20 hrs/week
- Pregnancy
- Primary caregiver of a dependent child under school age or disabled dependent
- Medically frail
- Certified temporary illness or incapacity
- Active substance use disorder treatment
- Aged over 60 years old
- Recent incarceration
- Chronically Homeless
- TANF/SNAP recipient

●●●● Gateway to Work: Qualifying Activities



- Employment
- Education
- Job skills training
- Job search activities
- Education related to employment
- Vocational education/training
- General Education (GED/HSE)
- English as a second language education
- Members of the Pokagon Band of Potawatomi participating in specific employment program
- Volunteer work
- Participation in health plan employment incentive program
- Other exemptions/activities based on individual review
- Community work experience
- Community service/public service
- Caregiving for non-dependent relative
- Accredited homeschooling



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.

●●●● 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.





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 to 100% 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

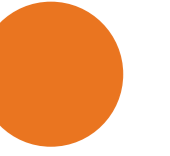
Number in household	HIP Basic Income up to 100% FPL	HIP Plus Income up to ~138% FPL
1	\$1,012	\$1,413
2	\$1,372	\$1,916
3	\$1,732	\$2,418
4	\$2,092	\$2,921



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

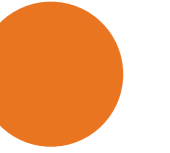
Fallback option for lower-income individuals who choose not to make monthly contributions to their POWER Account.

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.



Available for certain qualifying individuals

- Low-income (<19 percent FPL) parents and caretakers
- Low-income (<19 percent FPL) 19 and 20 year olds
- Medically frail

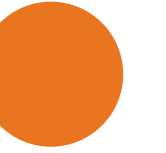
Benefits equivalent to current Medicaid benefits

- 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

HIP: Essential Health Benefits



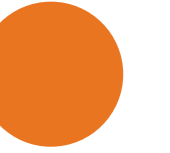
Essential Health Benefits	HIP Plus	HIP Basic	HIP State Plan
Ambulatory (Doctor Visits)	Covered – Includes coverage for Temporomandibular Joint Disorders (TMJ) 100 visit limit for home health	Covered – No TMJ coverage 100 visit limit for home health	Covered - Includes TMJ coverage & chiropractic services 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		



HIP: Other Benefits

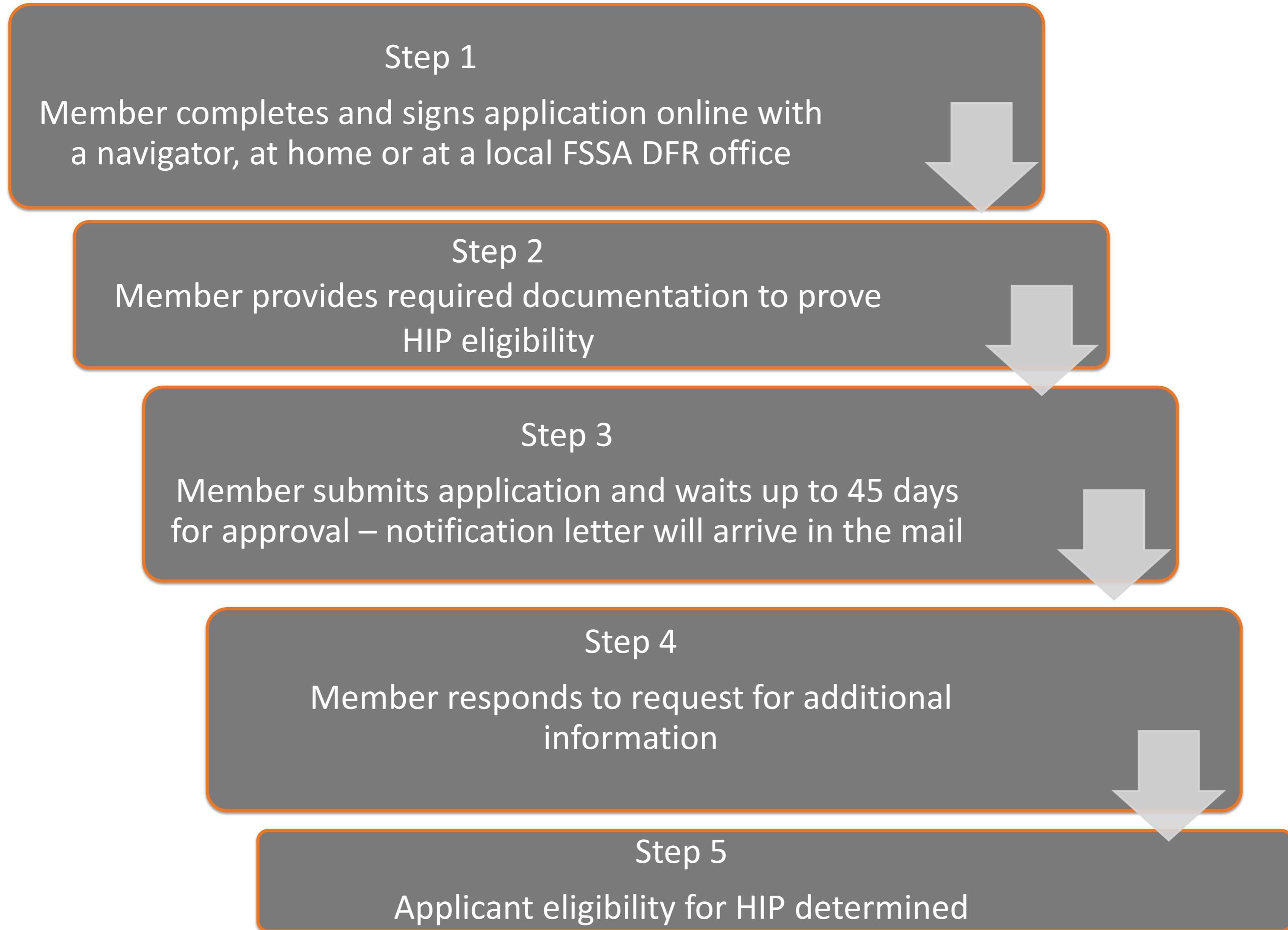
Other Benefits	HIP Plus	HIP Basic	HIP State Plan
Adult Vision	Covered	Not Covered	Covered
Adult Dental	Covered – Limited to two cleanings per year and four restorative procedures.	Not Covered	Covered
Chiropractic	Covered – six visits per year. Limit of one per day.	Not Covered	Covered
Transportation	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.

●●● Navigator Checklist: Member Enrollment



- ✓ **Call Maximus to verify if member has already been assigned an MCE for the calendar year**
 - If member previously had HIP during the year – they are already assigned a calendar year MCE
- ✓ **Call DFR 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 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 member that it can take up to 45 days for application approval
 - Inform member 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

●●●● HIP Enrollment Process





Required Documentation

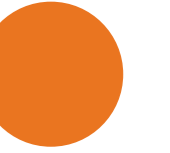
Proof of identity	<ul style="list-style-type: none">• Social security card• Valid driver's license• Student photo ID
Proof of U.S. citizenship	<ul style="list-style-type: none">• Legal birth certificate• Certificate of Naturalization• Certificate of Citizenship• U.S. passport, if it was issued with no restrictions.
Proof of money received by applicant, spouse, and dependent children in the home	<ul style="list-style-type: none">• Income from jobs or training (pay stub, paycheck)• 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	<ul style="list-style-type: none">• If you are not a U.S. citizen, a copy of your alien registration card• Permanent resident card• Documentation from the Bureau for Citizenship and Immigration Services



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:

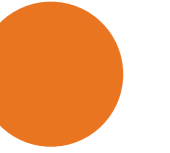
- All members receive monthly POWER Account statements
- Used to pay for the first \$2,500 of annual health care costs

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 copays on most services



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 percent 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.

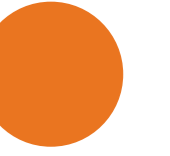
HIP Basic POWER Account

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 percent the following year
- Members may not double their rollover as in HIP Plus
- **Example:** Member receives preventive services and has 40 percent of original account balance remaining at year-end. May choose to move to HIP Plus the following year and receive a 40 percent discount on the required contribution.

HIP: POWER Account Payments



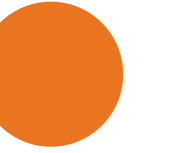
- Starting January 2018, POWER Account payment amounts will be one of five levels shown below
- Members receive a monthly invoice from their selected MCE that states the amount they must pay
- Employers & not-for-profits may assist with contributions
- Spouses split the monthly PAC amount

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

*EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area.



●●●● Non-payment Penalties



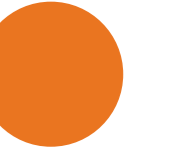
- Members remain enrolled in HIP Plus as long as they make POWER Account contributions and are otherwise eligible
- Penalties for members not making the PAC contribution:



*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."

●●●● 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

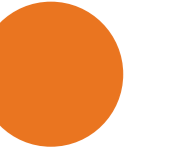
●●●● Fast Track Prepayments



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 which 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.

●●●● 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 and Enrollment



●●●● 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

Application Features: Selecting a Managed Care Entity

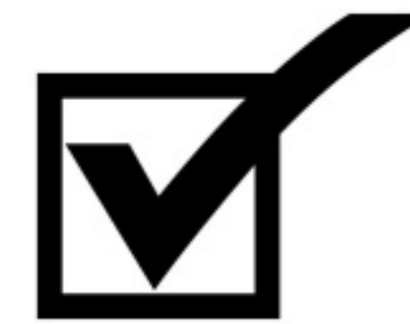
Indiana Application for Health Coverage will offer choice of four managed care entities (MCE), also called health plans, and applicants choose:

Selecting an 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

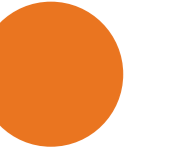


MDwise



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)

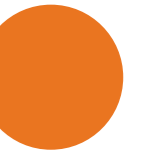
Decision to change MCE does not provide additional time to make PAC

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

●●●● 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 to Dec. 15

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

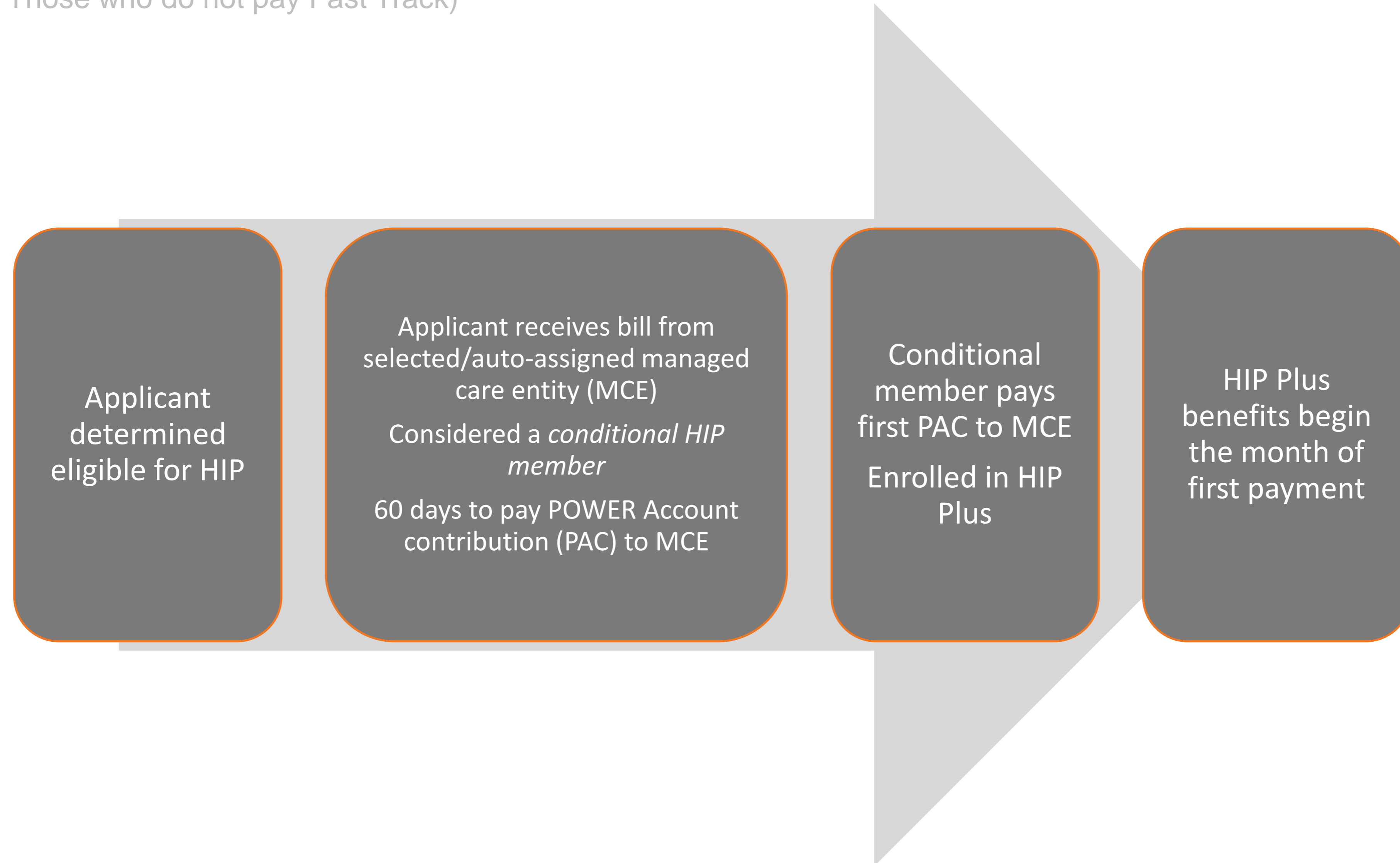
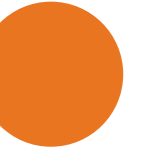
*If member already had MCE during the calendar year, they will return to that MCE.





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
- 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



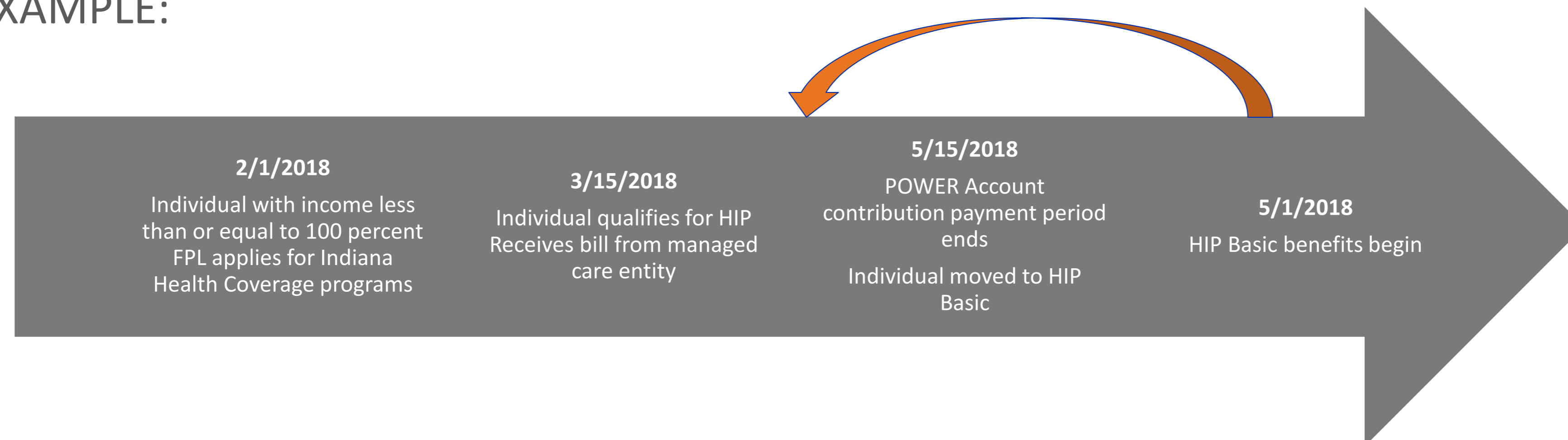
HIP Basic available for individuals:

- With income less than or equal to 100 percent 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 first of the month in which the 60-day invoice payment period ends

EXAMPLE:



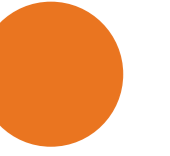
●●●● Moving to HIP Plus



Members may move from HIP Basic to HIP Plus

- During annual redetermination
- During POWER Account rollover period

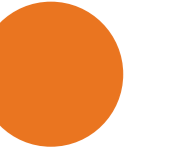
●●●● Enrollment for Individuals with Income Greater than 100 Percent FPL



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



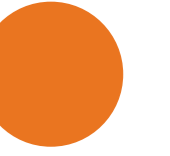
Reasons individuals would dis-enroll from HIP:

1. No longer eligible for HIP

- Failed to complete redetermination
- Gained employer-sponsored coverage
- Income increased to over 138 percent FPL
- Became eligible for Medicare
- Became eligible for other Medicaid category
 - E.g. Disability, Aged, etc.
- Moved out of state

2. HIP Plus members with incomes greater than 100 percent 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 percent of remaining member contribution
- For non-payment of POWER Account contribution: Amount will be reduced by 25 percent

●●●● Lockout Periods



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

1. They were a HIP Plus member receiving benefits AND
2. Have income greater than 100 percent FPL and less than ~138 percent 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.”



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 lockout

●●●● 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:
 - Six-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:

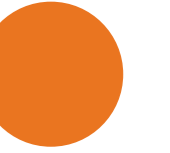
To avoid lockout, ***all*** HIP members should complete and submit redetermination paperwork on time



HIP – Special Populations

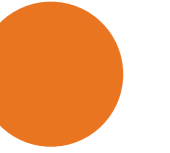


HIP: Treatment of Special Populations



<p>Medically Frail</p>	<p>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.</p> <ul style="list-style-type: none"> • 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
<p>Pregnant Women</p>	<p>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.</p>
<p>Native Americans</p>	<p>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.</p>
<p>Transitional Medical Assistance (TMA)</p>	<p>Individuals who no longer qualify as low-income parents or caretakers due to an increase in pay over 138 percent FPL are eligible for HIP Plus benefits for a minimum of six months.</p>
<p>Low-Income Parents/Caretakers</p>	<p>Individuals eligible for HIP State Plan Plus or HIP State Plan Basic benefits.</p>

●●● 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 HIP 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

●●● The Medically Frail: Benefits and Cost Sharing

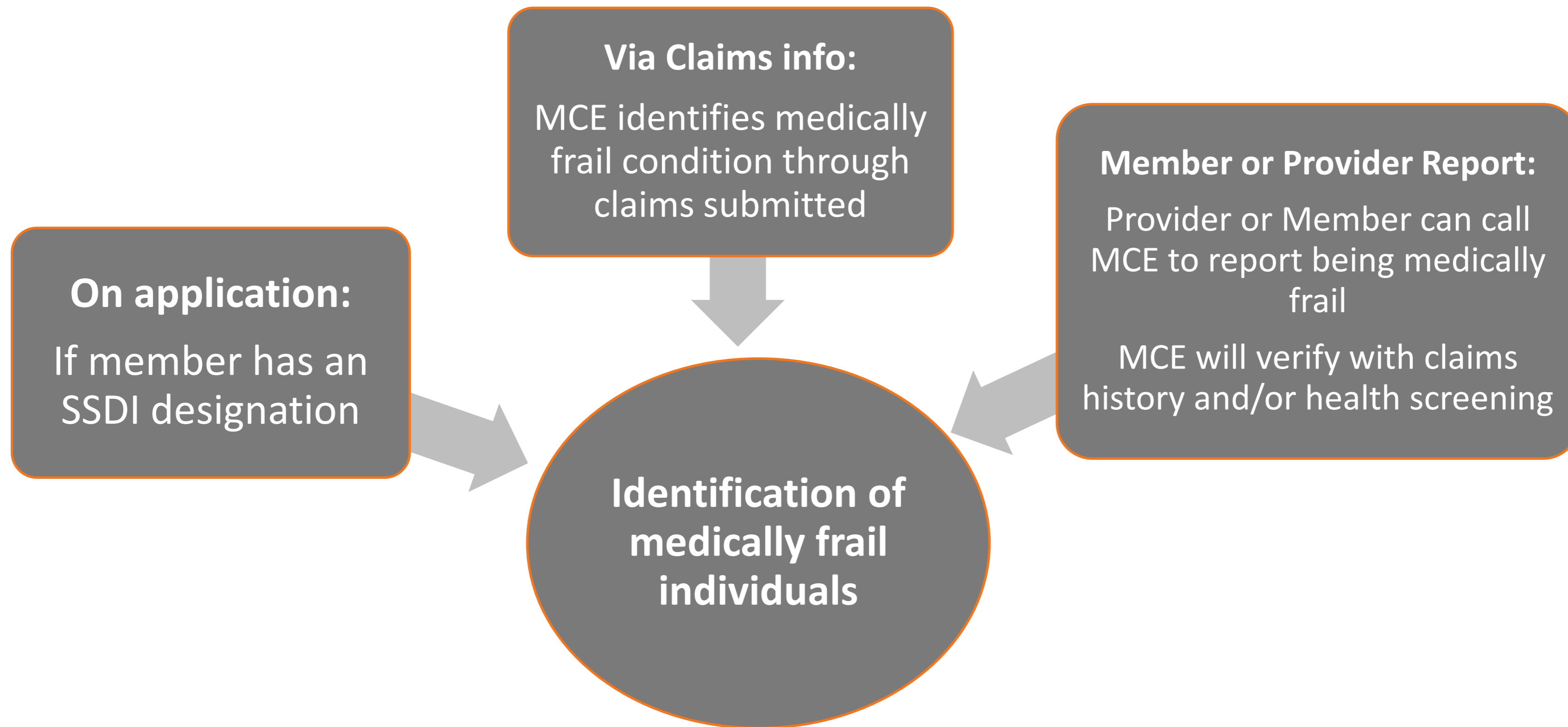
What benefits do the medically frail receive?

- 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 percent 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 percent FPL

●●●● The Medically Frail Identification

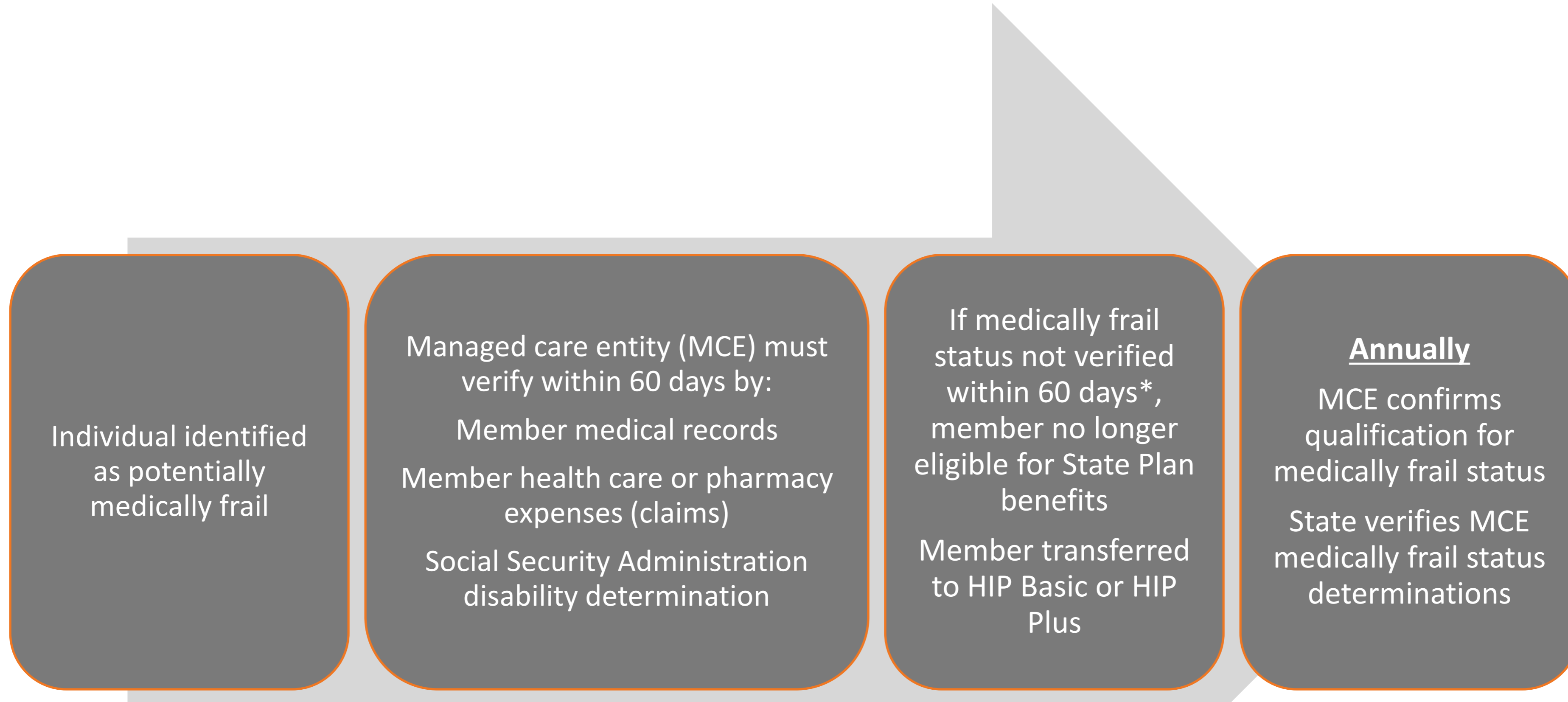
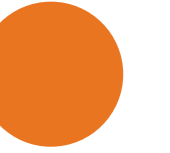


MCE will review medically frail status annually. If MCE cannot confirm on-going medically frail status, it will remove the designation

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

●●●● The Medically Frail Verification



●●●● Transitional Medical Assistance



What is Transitional Medical Assistance (TMA)?

- Low-income parents and caretaker gains income over 138 percent FPL
- No upper income limit first six months – up to 185 percent FPL for months 6-12

How long are individuals eligible for TMA?

- 6-12 months

●●●● Transitional Medical Assistance

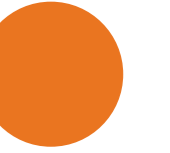


Individuals newly eligible for TMA will receive HIP Plus or HIP Basic benefits

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

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

●●●● Transitional Medical Assistance



By federal rule, Native Americans are exempt from cost sharing

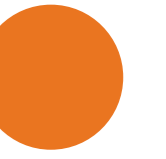
- Receive HIP Plus
- Do not have POWER Account contributions or emergency room copayments
- May opt out of HIP Plus and into fee-for-service coverage as of April 1, 2015

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

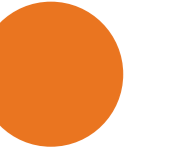
- Medically frail
- Low-income parent/caretaker



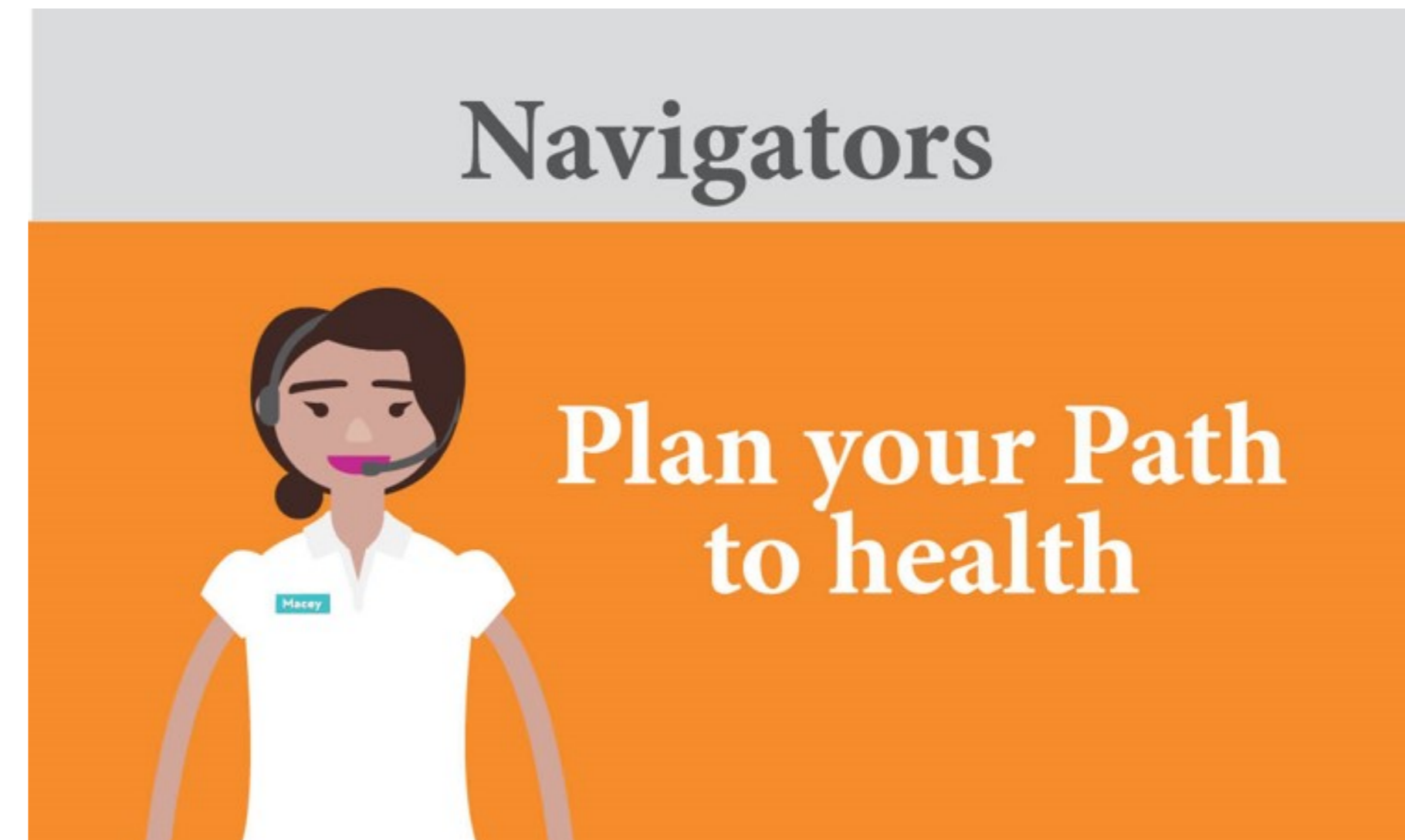
2018 HIP Member Education ●●●●



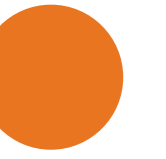
●●●● Strategies and Tactics



Message shift from awareness to education



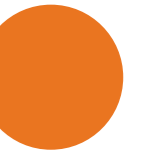
●●● Strategies and Tactics



Current and Potential HIP Members



Member Education Campaign Service Lines



POWER Accounts



**Wellness for
the People**

Redetermination



**Renew your
Membership**

HIP Maternity Plan



**Prenatal Peace
of Mind**

Tobacco Cessation



**Plan for
Health**

Gateway to Work

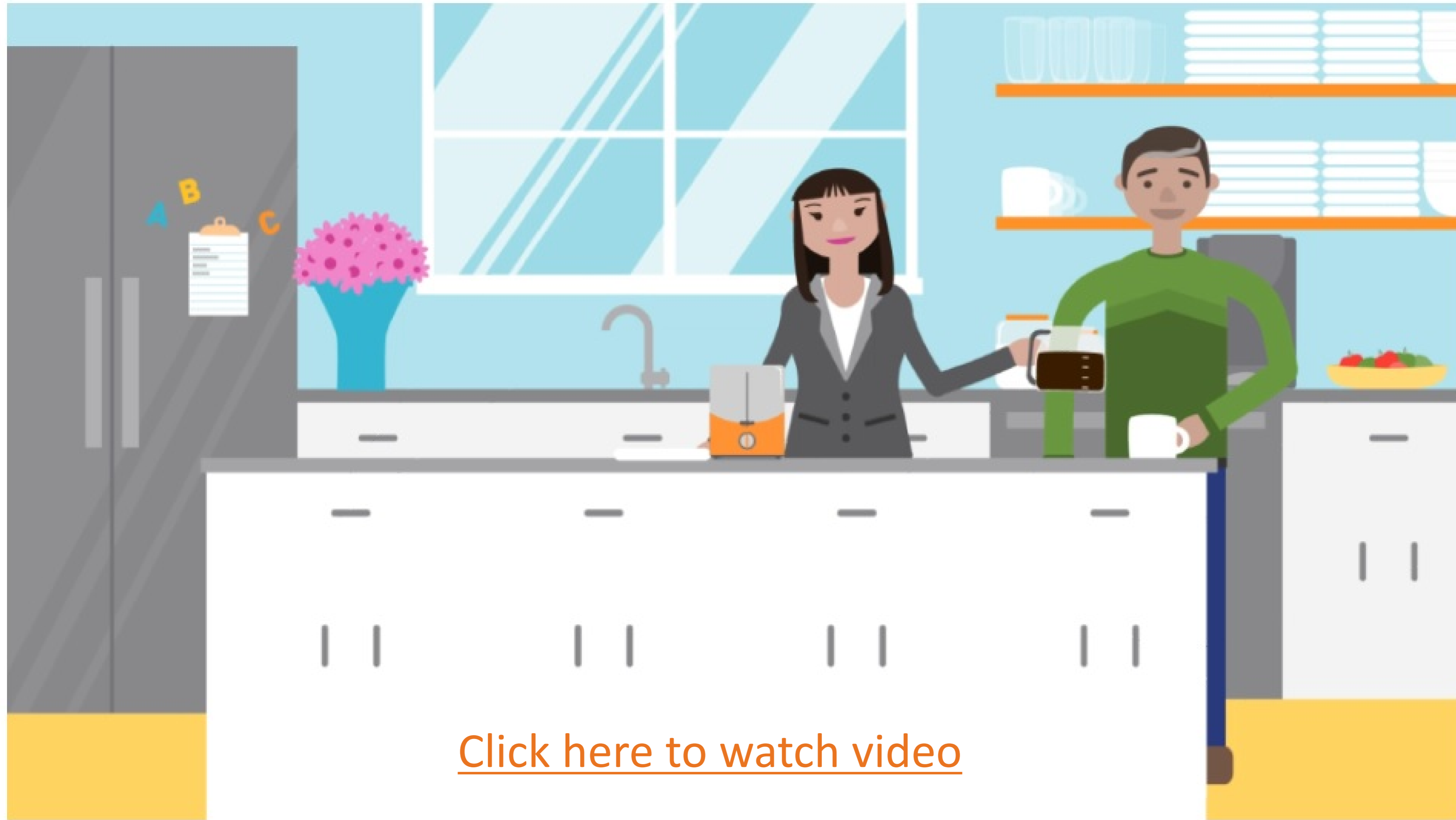
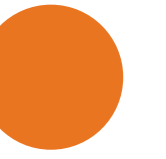


**Access to the
Workforce**

HIP TIPS

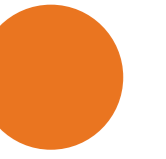


●●●● Member Education - Redetermination



[Click here to watch video](#)

●●●● Member Education – Tobacco Cessation



[Click here to watch video](#)

●●●● Member Education – Email Blasts and Newsletter

- Tactic: Distribute an educational email series to members
- Tactic: Distribute an e-newsletter with HIP updates and general health information
 - A quarterly health newsletter would be targeted specifically to members to focus on the HIP program and wraparound services offered by MCEs.
 - The newsletter will be distributed via email and sign-ups would be generated through the HIP website.

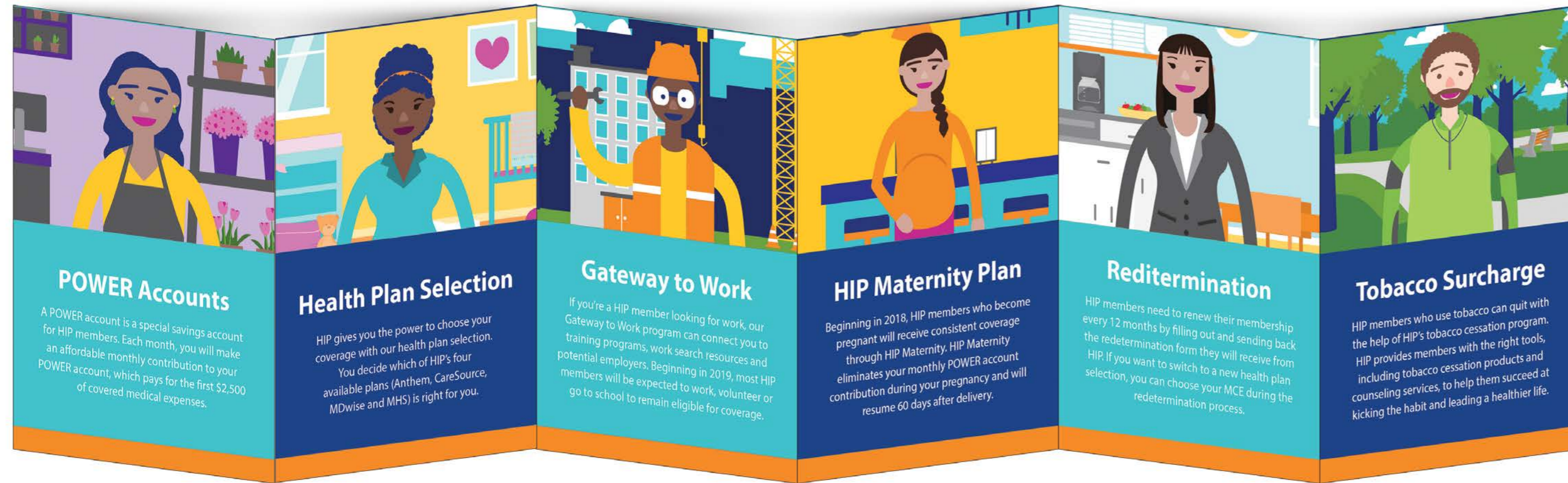


HIP TIP:

POWER accounts can only be used for covered services provided by your physician or a hospital or other health care service provider, or for covered prescriptions or medical supplies.



Member Education – Brochure/Poster



With the Healthy Indiana Plan, you can expect more from your coverage.



POWER Accounts



A POWER account is a special savings account for HIP members. Each month, you will make an affordable monthly contribution to your POWER account, which pays for the first \$2,500 of covered medical expenses.

Health Plan Selection



HIP gives you the power to choose your coverage with our health plan selection. You decide which of HIP's four available plans (Anthem, CareSource, MDwise and MHS) is right for you.

Gateway to Work



Our Gateway to Work program can connect HIP members looking for work to training programs, work search resources and potential employers. Beginning in 2019, most HIP members will be expected to work, volunteer or go to school to remain eligible for coverage.

HIP Maternity Plan



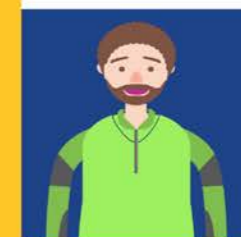
Beginning in 2018, HIP members who become pregnant will receive consistent coverage through HIP Maternity. HIP Maternity eliminates your monthly POWER account contribution during your pregnancy and will resume 60 days after delivery.

Redetermination



HIP members need to renew their membership every 12 months by filling out and sending back the redetermination form they will receive from HIP. If you want to switch to a new health plan selection, you can choose your MCE during the redetermination process.

Tobacco Surcharge



HIP members who use tobacco can quit with the help of HIP's tobacco cessation program. HIP provides members with the right tools, including tobacco cessation products and counseling services, to help them succeed at kicking the habit and leading a healthier life.



HIP TIP:
If you are just thinking about joining HIP and want to make sure you choose a health plan that includes your doctor, call 1-877-GET-HIP-9 to discuss your options.



HIP TIP:
POWER accounts can only be used for covered services provided by your physician or a hospital or other health care service provider, or for covered prescriptions or medical supplies.



Member Education – Social/Facebook/Twitter

