Medicaid Basics and Indiana Health Coverage Programs

Module #2
Training Resource for Indiana Navigators
Module #2 Objectives

• After reviewing this module, you will be able to:
  ▫ Assess whether someone *might be* eligible for an Indiana Health Coverage Program (IHCP), such as Medicaid, Children’s Health Insurance Program (CHIP), or Healthy Indiana Plan (HIP 2.0)
  ▫ Tell a consumer what information the consumer will need to provide as a part the IHCP application
  ▫ Explain consumer options to apply for an IHCP
  ▫ Help a consumer know what to expect after the IHCP application is filed
## Module #2 Terminology (1 of 2)

<table>
<thead>
<tr>
<th>Term</th>
<th>What It Means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indiana Health Coverage Program (IHCP)</strong></td>
<td>Any of the several programs operated under Indiana Medicaid, which have been developed to address the medical needs of low income, aged, disabled, blind, pregnant, and other populations meeting the eligibility criteria. Types of IHCPs include, but are not limited to, Hoosier Healthwise, Healthy Indiana Plan (HIP 2.0), Hoosier Care Connect, Traditional Medicaid, and the home and community-based services (HCBS) waiver.</td>
</tr>
<tr>
<td><strong>Indiana Application for Health Coverage (IAHC)</strong></td>
<td>An application for an Indiana Health Coverage Program (IHCP), which may be submitted to the Division of Family Resources (DFR) either online through the DFR Benefits Portal (<a href="http://www.dfrbenefits.in.gov">www.dfrbenefits.in.gov</a>), by phone, fax, mail, or in-person at a local DFR office.</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>A federal-state program providing free or low-cost health insurance coverage to individuals meeting state eligibility criteria, which are developed within the parameters established by the federal government.</td>
</tr>
<tr>
<td><strong>Hoosier Healthwise</strong></td>
<td>An Indiana Medicaid program for low income parents/caretakers, pregnant women, and children up to age nineteen. The program covers medical care like doctor visits, prescription medicine, mental healthcare, dental care, hospitalizations, surgeries, and family planning, at little or no cost to the member or the member’s family.</td>
</tr>
<tr>
<td><strong>Children’s Health Insurance Program (CHIP)</strong></td>
<td>A health coverage program providing health coverage to children whose income is too high to qualify for Medicaid. CHIP is administered by states with joint funding from the federal government and the states.</td>
</tr>
</tbody>
</table>
## Module #2 Terminology (2 of 2)

<table>
<thead>
<tr>
<th>Term</th>
<th>What It Means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Indiana Plan (HIP 2.0)</strong></td>
<td>Indiana’s health coverage program for non-disabled Hoosiers between the ages of 19-64 whose family incomes are less than approximately 138% of the federal poverty level (FPL) and who are not eligible for Medicare or another Medicaid category. HIP 2.0 has four “pathways to coverage”—HIP Plus, HIP Basic, HIP Link, and HIP State Plan.</td>
</tr>
<tr>
<td><strong>Pathways to Coverage</strong></td>
<td>A phrase used to describe the four different plan options under the Healthy Indiana Plan (HIP 2.0)—HIP Plus (default/best value plan), HIP Basic (fallback plan if POWER Account contributions not paid), HIP Link (employer-sponsored plan), and HIP State Plan (for the “medically frail”).</td>
</tr>
<tr>
<td><strong>POWER Account</strong></td>
<td>Account used to pay medical costs for HIP 2.0 members. Covers first $2,500 of covered services, and additional services are fully covered (except in HIP Basic where the member is responsible for any required copayments). Monthly contributions by members are approximately 2% of annual family income; the rest is contributed by the state.</td>
</tr>
<tr>
<td><strong>Managed Care Entity (MCE)</strong></td>
<td>General term used to describe health plans that are designed to control the quality and cost of healthcare delivery. In Indiana Medicaid, benefits are delivered in the Hoosier Healthwise and HIP 2.0 through MCEs for some populations.</td>
</tr>
<tr>
<td><strong>Presumptive Eligibility (PE)</strong></td>
<td>Determination by a Qualified Provider (QP) that an individual is eligible for Medicaid benefits on the basis of preliminary self-declared information. Indiana operates the following PE programs: Presumptive Eligibility (PE), PE for Pregnant Women (PEPW), Hospital PE (HPE), and PE for Inmates. The full Medicaid application must be completed within 60 days after PE determination.</td>
</tr>
</tbody>
</table>
What is Medicaid?

- Funded by state and federal government
- Provides free or low-cost health insurance to low-income:
  - Adults
  - Children
  - Parents and caretakers
  - Pregnant women
  - Aged
  - Blind
  - Disabled
- Offer many different programs
  - Eligibility criteria varies by group
Current Indiana Health Coverage Programs (IHCPs)

- Indiana offers a variety of health coverage programs, including:
  - Hoosier Healthwise
  - Healthy Indiana Plan (HIP 2.0)
  - Children’s Health Insurance Program (CHIP)
  - Hoosier Care Connect
  - Traditional Medicaid
  - Medicaid for Employees with Disabilities (M.E.D. Works)
  - Home and Community-Based Service Waivers
  - Medicare Savings Program
  - Family Planning Eligibility Program
  - Breast and Cervical Cancer Program

- Each of these programs serves a unique population with different eligibility requirements, detailed in the following slides.
Hoosier Healthwise

- **Covered populations:**
  - Pregnant women
  - Children under 19 years old
    - **Medicaid**
      - Created for children of low-income households
    - **Children’s Health Insurance Program (CHIP)**
      - Created for children with family income too high to qualify for Medicaid
# Hoosier Healthwise Income Limits

## Monthly Income Limit* for Different Groups Covered by Hoosier Healthwise

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Children</th>
<th>Pregnant Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,475</td>
<td>n/a</td>
</tr>
<tr>
<td>2</td>
<td>$3,337</td>
<td>$2,776</td>
</tr>
<tr>
<td>3</td>
<td>$4,200</td>
<td>$3,494</td>
</tr>
<tr>
<td>4</td>
<td>$5,052</td>
<td>$4,212</td>
</tr>
<tr>
<td>5</td>
<td>$5,925</td>
<td>$4,929</td>
</tr>
</tbody>
</table>

*Income limits based on 2016 federal poverty level (FPL)– amounts updated annually
Healthy Indiana Plan (HIP 2.0)

• **Provides low-cost health insurance**
• **Qualifies as minimum essential coverage (MEC)**
• **Eligibility:**
  ▫ Indiana residents
  ▫ Ages 19 to 64
  ▫ Income under 138%* FPL
• **Program features:**
  ▫ Four possible HIP 2.0 plan options (see plan comparisons on next slide)
    • HIP Plus, HIP Basic, HIP Employer Link, HIP State Plan
  ▫ Annual deductible
    • $2,500 per year
  ▫ Co-pays for non-emergency use of emergency room
  ▫ Personal Wellness and Responsibility (POWER) Account
    • Funds $2,500 annual deductible
    • State and individual contribute funds to account
      • **Individual contributes no more than 2% of income per year**
    • Employers & nonprofits may help individual with their contributions
    • Funds still in account at end of year rollover to next year
HIP 2.0 - How to Apply

• **Visit** [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)
  ▫ May apply for HIP 2.0 either:
    • Online;
    • By Mail; or
    • By visiting local DFR office

• **Applications are processed with 45 days once all required information is received**
  ▫ After application is processed, letter is mailed stating eligibility determination
    • If approved for HIP, the health plan chosen on the application will be assigned to the new member. If no health plan was chosen, one will be selected for the member.

• **Questions?** Call 1-877-GET-HIP-9 or email [HIP2.0@fssa.in.gov](mailto:HIP2.0@fssa.in.gov)
HIP 2.0 - Plan Options

**HIP Plus**
- Initial plan selection for all members, income up to 138% FPL
- **Benefits**: Comprehensive, including vision and dental
- **Cost-sharing**: Must pay affordable monthly POWER account contribution (approx. 2% of income, ranging from $1 to $100 per month). No copayment for services. EXCEPTION: using emergency room for routine (non-emergency) medical care.

**HIP Basic**
- Fall-back option for members with household income less than or equal to 100% FPL
- **Benefits**: Meet minimum coverage standards, no vision or dental coverage
- **Cost-sharing**: May not pay one affordable monthly POWER account contribution. Must pay copayments for doctor visits, hospital stays, and prescriptions

**HIP State Plan**
- Individuals with complex medical or behavioral conditions (“medically frail”)
- **Benefits**: Comprehensive, with some additional benefits including vision, dental, and enhanced behavioral health services
- **Cost-sharing**: HIP Plus OR HIP Basic cost-sharing

**HIP Employer Link**
- Eligible members who work and have access to employer health plan.
- **Benefits**: Employer plan benefits
- **Cost-sharing**: Enhanced POWER account can be used to pay employer-plan premiums, co-payments or deductibles.
HIP 2.0 - Fast Track Payments

- “Fast Track” is a payment option in the **HIP Plus** program
  - Allows applicant to make payment during the HIP application process
    - **Amount:** $10
  - **BENEFIT:** Coverage begins the first of the month the payment is made
  - The payment goes toward first POWER account contribution

**IMPORTANT NOTE:** If Fast Track payment is not made, coverage in **HIP Plus** will begin the first of the month the first POWER account contribution is made. Members have 60 days from the date their first invoice is issued to either make a Fast Track or POWER account payment. If either payment is not made within those 60 days, then the member will default into the **HIP Basic** plan, if eligible, effective the first of the month those 60 days expire.
Hip 2.0 - *HIP Basic* Copayment Amounts

- The following copayment amounts apply to *HIP Basic* members:

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services - including office visits</td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient services - including hospital stays</td>
<td>$75</td>
</tr>
<tr>
<td>Preferred drugs</td>
<td>$4</td>
</tr>
<tr>
<td>Non-preferred drugs</td>
<td>$8</td>
</tr>
<tr>
<td>Non-emergency ER visit</td>
<td>$8 for first occurrence; $25 thereafter*</td>
</tr>
</tbody>
</table>

*Also applies to *HIP Plus* members*
HIP 2.0 - Conditions that May Qualify as Medically Frail

- The following conditions may qualify someone as “medically frail” for eligibility into the *HIP State Plan*:

<table>
<thead>
<tr>
<th>Medical</th>
<th>Mental Health</th>
<th>Activities of Daily Living</th>
</tr>
</thead>
</table>
| Cancer; Aplastic anemia; Cerebral vascular accidents; Transplant or transplant wait list for heart, lung, liver, kidney or bone marrow; HIV, AIDS; Blood clotting disorders, frequent blood transfusions; Lipid storage diseases; Primary immune deficiencies; Muscular dystrophy; Primary pulmonary hypertension; Amyotrophic lateral sclerosis; Cirrhosis; Chronic hepatitis B or C; Cystic fibrosis; Diabetes mellitus with: ketoacidosis, hypersmolar coma, renal complications, retinopathy, peripheral vascular complications, or coronary artery disease; Renal failure / end stage renal disease; CMV retinitis; Tuberculosis; Paraplegia or quadriplegia | Alcohol and substance abuse; Mental illness including major depression, schizophrenia, bipolar disorder or post-traumatic stress disorder | Need assistance in an activity of daily living:
  - 24 hour supervision and/or direct assistance to maintain safety due to confusion and/or disorientation
  - Turning or repositioning every 2 to 4 hours to prevent skin breakdown per medical plan of care
  - 24 hour monitoring of a health care plan by a license-nurse
  - Eating
  - Transferring from bed or chair
  - Dressing
  - Bathing
  - Using the toiler
  - Walking or using a wheelchair |

*Note: Having a condition on this list does not guarantee someone will be considered medically frail. Severity of their condition may also be evaluated.*
HIP 2.0 - HIP Employer Link

• **What is HIP Employer Link?**
  ▫ Premium-assistance program that helps eligible, working Hoosiers afford their employer-sponsored health insurance plans

• **Who is eligible?**
  ▫ Employees of employers registered to participate in HIP Employer Link who have household incomes at or below 138% FPL and meet HIP eligibility requirements

• **How does HIP Employer Link work?**
  ▫ Employers register health plans to participate in program
  ▫ Employees who want to participate apply through the state HIP application
  ▫ Once enrolled, employer will deduct the cost of premiums charged from employee’s pay
  ▫ State will reimburse employee for amount of deduction, minus a small contribution made by the employee
Managed Care Entities (MCEs): Hoosier Healthwise (HHW) & Healthy Indiana Plan (HIP 2.0)

- Indiana contracts with four MCEs to administer HHW and HIP 2.0

- Goal:
  - Integrate programs for a seamless healthcare experience for families

- Selecting a MCE:
  - Individuals select at application; OR
  - Individuals auto-assigned
  - NOTE: Once a HIP 2.0 member makes a POWER account payment or starts benefits in HIP 2.0, they cannot change MCEs until annual redetermination

- Selecting a doctor after MCE enrollment:
  - Individuals select a Primary Medical Provider (PMP); OR
  - Individuals assigned a PMP
Hoosier Care Connect

• **Covered population:**
  ▫ Individuals not eligible for Medicare and also:
    ▪ Aged (65+);
    ▪ Blind;
    ▪ Disabled;
    ▪ Receiving Supplemental Security Income (SSI); or
    ▪ Enrolled in M.E.D. Works

• **Goal:**
  ▫ To ensure that the individual gets the most appropriate care based upon their individualized needs

• **Process - Enrollees select either of these health plans:**
  ▫ Anthem
  ▫ MDwise
  ▫ Managed Health Services (MHS)
  ▫ CareSource

• **Health plan will then gather information from individual to ensure proper care and services are provided**
Traditional Medicaid

- **Enrollee can seek care from any Medicaid provider**

- **Covered populations:**
  - Aged, blind, and disabled
    - Dual eligible (Medicare and Medicaid recipients)
    - Nursing home care and other institutions
    - Hospice services
    - Medicaid for Employees with Disabilities (M.E.D. Works)
  - Adults
    - Recipients of waiver services
    - Medicaid eligible due to breast or cervical cancer
  - Children
    - In psychiatric facilities
    - Title IV-E Foster care and adoption assistance
    - Former foster children up to age 21
    - Former foster children up to age 26 who were enrolled in Medicaid as of their 18th birthday
  - Refugees who do not qualify for another aid category
Medicaid for Employees with Disabilities (M.E.D. Works)*

- **Covered population:**
  - Working people with disabilities

- **Eligibility criteria:**
  - Age 16-64
  - Less than or equal to 350% Federal Poverty Level (FPL)
  - Disabled
  - Below asset limit
    - Single: $2,000
    - Couple: $3,000
  - Working

- **Benefits:**
  - Full Medicaid benefits
  - May have employer insurance**

<table>
<thead>
<tr>
<th>Single</th>
<th>Monthly Income</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,485 - $1,733</td>
<td>$48</td>
</tr>
<tr>
<td></td>
<td>$1,734 - $1,980</td>
<td>$69</td>
</tr>
<tr>
<td></td>
<td>$1,981 - $2,475</td>
<td>$107</td>
</tr>
<tr>
<td></td>
<td>$2,476 - $2,970</td>
<td>$134</td>
</tr>
<tr>
<td></td>
<td>$2,971 - $3,465</td>
<td>$161</td>
</tr>
<tr>
<td></td>
<td>$3,466 and over</td>
<td>$187</td>
</tr>
<tr>
<td>Married</td>
<td>$2,003 - $2,336</td>
<td>$65</td>
</tr>
<tr>
<td></td>
<td>$2,337 - $2,670</td>
<td>$93</td>
</tr>
<tr>
<td></td>
<td>$2,671 - $3,338</td>
<td>$145</td>
</tr>
<tr>
<td></td>
<td>$3,339 - $4,005</td>
<td>$182</td>
</tr>
<tr>
<td></td>
<td>$4,006 - $4,671</td>
<td>$218</td>
</tr>
<tr>
<td></td>
<td>$4,674 and over</td>
<td>$254</td>
</tr>
</tbody>
</table>

Based on 2016 FPL - amounts adjusted annually

*Must apply through Indiana Application for Health Coverage

**Medicaid is the secondary payer
Home & Community-Based Service (HCBS) Waivers

- **Covered population:**
  - Would otherwise require institutionalized care

- **Goal:**
  - Keep individual in home and community setting
  - Avoid need to go to institution (i.e., nursing home)

- **Eligibility:**
  - Income less than or equal to 300% of the maximum Supplemental Security Income (SSI) federal benefit rate
    - $2,199/month (2016 limit)
    - If income exceeds this threshold a member may establish a Miller Trust
    - If under age 18: Does not include parental income or resources
  - Meets “Level of Care”
    - Example: Complex medical condition, intellectual disability
Medicare Savings Program

• **Covered population:**
  ▫ Low-income Medicare beneficiaries

• **Goal:**
  ▫ Help pay for out-of-pocket Medicare costs

• **Eligibility:**
  ▫ Must be eligible for Medicare Part A
  ▫ Four potential categories depending on income and worker status
Medicare Savings Program, cont.*

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Threshold**</th>
<th>Resource Limit</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QMB (Qualified Medicare Beneficiary)</strong></td>
<td>Single: $1,505/month&lt;br&gt;Married: $2,023/month</td>
<td>• Single: $7,280&lt;br&gt;• Couple: $10,930</td>
<td>• Medicare Part A &amp; B Premiums, Co-pays, Deductibles, and Coinsurance</td>
</tr>
<tr>
<td><strong>SLMB (Specified Low-Income Medicare Beneficiary)</strong></td>
<td>Single: $1,703/month&lt;br&gt;Married: $2,290/month</td>
<td>• Single: $7,280&lt;br&gt;• Couple: $10,930</td>
<td>• Part B Premiums</td>
</tr>
<tr>
<td><strong>QI (Qualified Individual)</strong></td>
<td>Single: $1,852/month&lt;br&gt;Married: $2,490/month</td>
<td>• Single: $7,280&lt;br&gt;• Couple: $10,930</td>
<td>• Part B Premiums</td>
</tr>
</tbody>
</table>

*Must apply through Indiana Application for Health Coverage (IAHC)

**As of 2016
Family Planning Services for Women and Men

• **Goal:**
  ▫ Pregnancy prevention/delay
  ▫ Provide family planning services and supplies

• **Eligibility:**
  ▫ Do not qualify for any other Medicaid category*
  ▫ Income at or below 141%** Federal Poverty Level (FPL)
  ▫ Citizenship/immigration eligibility requirements
  ▫ Not pregnant
  ▫ Have not had hysterectomy (removal of uterus)
  ▫ Have not had sterilization procedure

• **NOT** Considered Minimum Essential Coverage (MEC)

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*Women losing other Medicaid coverage after the birth of a child are automatically assessed for eligibility

**$1,395 per month for family size of 1; $1,882 per month for a family size of 2 (2016 FPL standard)
Breast and Cervical Cancer Program

• **Goal:**
  - Provide Medicaid coverage to women with breast or cervical cancer

• **Eligibility:**
  - Diagnosed through Indiana State Department of Health Breast & Cervical Cancer Screening Program
  - OR
  - Age 19-64
  - Not otherwise eligible for Medicaid
  - Income less than 200% FPL*
  - Need treatment for breast or cervical cancer
  - No health insurance that covers their treatment

*$1,980 per month for family size of 1; $2,670 for a family size of 2 (2016 FPL standard)
# Summary of Medicaid Programs: Hoosier Healthwise (HHW)

<table>
<thead>
<tr>
<th>Description</th>
<th>Income Limit</th>
<th>Age Requirement</th>
<th>Other Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td>Up to 250% FPL</td>
<td>0-18 year old</td>
<td>N/A</td>
</tr>
<tr>
<td>Household Size</td>
<td>Monthly Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$152</td>
<td>19-20 years old</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$247</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>$310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$373</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$435</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnant Women</strong></td>
<td>Up to 208% FPL</td>
<td>N/A</td>
<td>Pregnant</td>
</tr>
<tr>
<td><strong>Transitional Medical Assistance (TMA)</strong></td>
<td>No limit for first six months. May be eligible for additional six months provided income stays below 185% FPL.</td>
<td>N/A</td>
<td>Parent or caretaker of dependent child under age 18</td>
</tr>
</tbody>
</table>
# Traditional Medicaid Program Summary (cont. to next slide)

<table>
<thead>
<tr>
<th>Category</th>
<th>Income Limit</th>
<th>Age Requirement</th>
<th>Other Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>Up to 100% FPL¹</td>
<td>Aged: 65 years old or older</td>
<td>Blind or Disabled: Has received a disability determination from the Social Security Administration (SSA) related to determination of blindness or disability – or – has received MRT determination and applied for SSA benefits within 45 days of Medicaid application</td>
</tr>
<tr>
<td>Blind</td>
<td>Single: $990/month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td>Married: $1,335/month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home &amp; Community-</td>
<td>Up to 300% Supplemental Security</td>
<td>N/A</td>
<td>Meets “Level of Care” needs (must require long-term care services)</td>
</tr>
<tr>
<td>Based Services Waivers &amp; Institutional Care</td>
<td>Income (SSI) benefit¹²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast &amp; Cervical</td>
<td>Up to 200% FPL</td>
<td>18-64 years old</td>
<td>Diagnosed with breast and/or cervical cancer</td>
</tr>
<tr>
<td>Cancer Program</td>
<td>Single: $1,980/month</td>
<td></td>
<td>Cannot qualify for any other Medicaid category</td>
</tr>
<tr>
<td></td>
<td>Married: $2,670/month</td>
<td></td>
<td>No health insurance that covers cancer treatment</td>
</tr>
<tr>
<td>M.E.D. Works³</td>
<td>Up to 350% FPL</td>
<td>16-64 years old</td>
<td>Meets definition of disability as described above</td>
</tr>
<tr>
<td></td>
<td>Single: $3,465/month</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Resource limits also apply – 2) $2,199/month, as of 2016. If income exceeds 300% of the SSI benefit, can establish a Miller trust to retain eligibility – 3) Medicaid for the Working Disabled
# Traditional Medicaid Program Summary, cont.

<table>
<thead>
<tr>
<th>Description</th>
<th>Income Limit</th>
<th>Age Requirement</th>
<th>Other Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children – Psychiatric Facility</strong></td>
<td></td>
<td></td>
<td>Inpatient at a Medicaid certified psychiatric facility</td>
</tr>
<tr>
<td>Household Size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$152</td>
<td>19-21* years old</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$247</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
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<td>$373</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$435</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children – Adoption Assistance</strong></td>
<td>N/A</td>
<td>Under age 19</td>
<td>Receiving adoption assistance</td>
</tr>
<tr>
<td><strong>Children – Foster Children</strong></td>
<td>N/A</td>
<td>Under age 19, some eligible through 20</td>
<td>Current foster child</td>
</tr>
<tr>
<td><strong>Former Foster Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual: $2,079/month</td>
<td>Up to 210% FPL</td>
<td>18-21 years old</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td>18-25 years old</td>
<td>Enrolled in Medicaid as of 18th birthday**</td>
</tr>
</tbody>
</table>

*If approved for Medicaid before 21st birthday, can remain on Medicaid until age 22 if still in psychiatric facility

**New eligibility group created by the Affordable Care Act
# Summary of Medicaid Programs: Other Available Coverage

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Description</th>
<th>Income Limit</th>
<th>Age Requirement</th>
<th>Other Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Indiana Plan (HIP 2.0)</td>
<td>Adults</td>
<td>138% FPL</td>
<td>19-64 years old</td>
<td>Not disabled or eligible for Medicaid or Medicare</td>
</tr>
<tr>
<td>Hoosier Care Connect</td>
<td>Aged, Blind, Disabled</td>
<td>N/A</td>
<td>65 and older</td>
<td>Aged, blind or disabled, and not eligible for Medicare</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Family Planning</td>
<td>Up to 141% FPL</td>
<td>N/A</td>
<td>Cannot qualify for any other Medicaid category</td>
</tr>
<tr>
<td>Medicare Savings Program</td>
<td>QMB&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$1,505/month&lt;sup&gt;1,5&lt;/sup&gt;</td>
<td>N/A</td>
<td>Qualifies for Medicare Part A &amp; B</td>
</tr>
<tr>
<td></td>
<td>SLMB&lt;sup&gt;3&lt;/sup&gt;</td>
<td>$1,703/month&lt;sup&gt;1,5&lt;/sup&gt;</td>
<td>N/A</td>
<td>Qualifies for Medicare Part B</td>
</tr>
<tr>
<td></td>
<td>QI&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$1,852/month&lt;sup&gt;1,5&lt;/sup&gt;</td>
<td>N/A</td>
<td>Qualifies for Medicare Part B</td>
</tr>
</tbody>
</table>

1) Resource limits also apply  
2) Qualified Medicare Beneficiary  
3) Specified Low-Income Medicare Beneficiary  
4) Qualified Individual  
5) Income thresholds effective 6/1/14
General Eligibility Factors and Verification Requirements

Eligibility factors that apply for any type of Indiana Health Coverage Program (IHCP)
General IHCP Eligibility Factors and Requirements

- Age
- Income
- Indiana Resident
- Citizenship/Immigration Status
- Provide Social Security Number (SSN)
- Provide information on other insurance coverage
- File for other benefits
IHCP Requirement: Citizenship, Immigration Status

• **Eligibility:**
  - U.S. citizens*
  - U.S. non-citizen nationals
  - Immigrants with qualified immigration status
    - Lawful permanent residents eligible for full Medicaid after 5 years

• **Exemptions (do not need to verify citizenship):**
  - Medicare enrollees
  - Foster care children
  - Receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
  - Newborns with a mother enrolled in Medicaid

**IMPORTANT NOTE:** Indiana Navigators should always confirm whether or not a consumer is a U.S. citizen in order to answer the U.S.-citizen question correctly on the Indiana Application for Health Coverage and provide any supporting documentation (if applicable).
IHCP Requirement: Provide a Social Security Number

- Individuals **must** supply a Social Security number (SSN), **unless:**
  - Not eligible to receive a SSN
  - Do not have a SSN and may only be issued one for a valid non-work reason
  - Refuse to obtain SSN due to well-established religious objections
  - Only eligible for emergency services due to immigration status
  - A newborn baby with mother on Medicaid
  - Receiving Refugee Cash Assistance (RCA), eligible for Medicaid
  - Have already applied for a SSN
IHCP Requirement: File for other benefits

- **Individuals must apply for other benefits if they may be eligible, including:**
  - Pensions from local, state, or federal government
  - Retirement benefits
  - Disability
  - Social Security benefits
  - Veterans' benefits
  - Unemployment compensation benefits
  - Military benefits
  - Railroad retirement benefits
  - Worker's compensation benefits
  - Health and accident insurance payments
IHCP Requirement: Report and use other insurance

• Applicants may:
  ▫ Have other insurance
    • Exceptions: Children’s Health Insurance Program (CHIP)

• Applicants must:
  ▫ Provide information about other insurance
    • On application
    • After a change in insurance status

• Why it is important to report other insurance:
  ▫ Applicants must use other insurance first
  ▫ Medicaid pays costs that are left after other insurance has paid – it is the “payer of last resort”
Under the Affordable Care Act (ACA) of 2013, there have been required changes to income and household calculations for certain groups. Medicaid must also provide healthcare coverage to certain groups not previously covered.
Modified Adjusted Gross Income (MAGI)

• **What is MAGI?**
  - Standardized income counting across all states
  - Used in both Medicaid and Federally-facilitated Marketplace (FFM) program to determine eligibility for tax credits
  - Medicaid has changed the way it counts:
    • Number of people in a household
    • Income
    • Assets

<table>
<thead>
<tr>
<th>Immediate MAGI impact</th>
<th>Delayed MAGI impact</th>
<th>No MAGI impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New applicants</td>
<td>• Those approved for Medicaid before December 31, 2013</td>
<td>• Those exempt from MAGI calculation</td>
</tr>
<tr>
<td>• Adults</td>
<td>• Were subject to new income counting when:</td>
<td>• Examples: Aged, Blind, Disabled</td>
</tr>
<tr>
<td>• Parents and caretaker relatives</td>
<td>• Redetermined Medicaid eligible OR</td>
<td></td>
</tr>
<tr>
<td>• Children</td>
<td>• A change was reported</td>
<td></td>
</tr>
<tr>
<td>• Pregnant women</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Basic MAGI: Household Size & Income Changes

<table>
<thead>
<tr>
<th>Applicant Description</th>
<th>Household Composition (as applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax filer</strong></td>
<td>• Tax filer</td>
</tr>
<tr>
<td></td>
<td>• All tax dependents</td>
</tr>
<tr>
<td></td>
<td>• May include:</td>
</tr>
<tr>
<td></td>
<td>• Step -parents, -children, and -siblings</td>
</tr>
<tr>
<td></td>
<td>• Adult child tax dependent</td>
</tr>
<tr>
<td><strong>Non-Filer &amp; Certain Tax Dependents</strong></td>
<td>• Applicant</td>
</tr>
<tr>
<td></td>
<td>• Spouse</td>
</tr>
<tr>
<td></td>
<td>• Children</td>
</tr>
<tr>
<td></td>
<td>• If applicant is child:</td>
</tr>
<tr>
<td></td>
<td>• Siblings</td>
</tr>
<tr>
<td></td>
<td>• Parents</td>
</tr>
</tbody>
</table>

### Major income counting changes:

**COUNT:**
1. Taxable income
2. Income of children required to file a tax return

**DO NOT COUNT:**
1. Assets
   - *e.g.*, bank account balance, stocks, retirement account
2. Non-taxable income
3. Income disregards (except tax deductions)

---

*Tax Dependent defined as:
- Other than a spouse, biological, adopted or step child of the tax filer
- Child claimed as tax dependent by non-custodial parent
- Child living with both parents who do not file joint return*
## Rules for Populations Not Using Modified Adjusted Gross Income (MAGI)

| Who will not use MAGI? | • Aged  
|                       | • Blind  
|                       | • Disabled  
|                       | • Need long-term care or home and community-based services  
|                       | • Eligibility does not require income determination from Medicaid agency (i.e., Coverage under the Breast & Cervical Cancer Treatment Program)  
|                       | • Applicants for Medicare cost-sharing (i.e., Medicare Savings Program)  
|                       | • Former foster children under age 26  
|                       | • Newborn babies with mothers on Medicaid (deemed newborns) |

| What income counts for “non-MAGI”? | • Pre-ACA income counting and household composition rules remain in place  
|                                   | • Pre-ACA asset limits continue to apply  
|                                   |   • Certain assets excluded such as:  
|                                   |     • Individual’s home  
|                                   |     • Household goods  
|                                   |     • Personal items |
Eligibility Exception: Calculating Income for Nursing Facility Medicaid

• If institutionalized person has a spouse that does not reside in an institution ("community spouse")
  ▫ Special income & resource provisions apply
  ▫ Community spouse may maintain:
    • All of his/her personal income
    • Half of income from assets owned by both spouses
  ▫ If this totals less than $1,967/month*, community spouse may keep some of the institutionalized spouse’s income

*Effective 2016
ACA-Created Eligibility Groups

• The Affordable Care Act (ACA) created new Medicaid groups the states must cover, including:
  ▫ Former foster children
    • Under age 26
    • In foster care in Indiana and receiving Indiana Medicaid as of 18th birthday
    • Not subject to income limits until age 26
  ▫ Children ages 6-18
    • Up to 133% Federal Poverty Level (FPL)
    • Indiana already covers this group
New ACA-Created Medicaid Categories

- With the implementation of the Modified Adjusted Gross Income (MAGI) methodology:
  - Some eligibility categories ("aid categories") changed
    - Some categories were combined and given new names
    - Category name changes have not impacted benefits
Indiana Application for Health Coverage and Applying for Disability Medicaid
Changes to Indiana Application for Health Coverage

• Starting October 2013

• Applications for health coverage and other state benefits include:
  ▫ Indiana Application for Health Coverage (IAHC),
  ▫ Indiana Application for Supplemental Nutrition Assistance Program (SNAP) & Temporary Aid to Needy Families (TANF) and

• Applications accepted:
  ▫ Online (Recommended),
  ▫ Phone,
  ▫ Fax,
  ▫ Mail, or
  ▫ In person at local Division of Family Resources (DFR) offices
Disability Medicaid Application Process: effective June 1, 2014

Applications to Social Security Administration (SSA)

Exceptions:
Direct application to Indiana Medicaid without SSA determination if:
• Applicant is a child
• Applicant has a recognized religious objection to applying for federal benefits (e.g., Amish)
• Applicant moves to the M.E.D. Works medically improved category
• Applicant cites other “good cause” for not applying to SSA

Supplemental Security Income (SSI) Eligible
• State auto-enrolls in Medicaid

Social Security Disability Income (SSDI) Eligible
• Apply to Indiana Medicaid for verification of other eligibility factors
• Will not undergo medical review team (MRT) process

SSA Denial (determined non-disabled)
• Generally Medicaid ineligible
  • State will not initiate MRT process for applicant except in two cases (to be discussed)
New Medicaid Applications on the Basis of Disability

State requires Social Security Administration (SSA) application for disability determination

SSA application status checked through shared data file

If no SSA application filed within 45 days of Medicaid application date:
  • Medicaid application denied

State initiates Medical Review Team (MRT) process

If SSA determination received during MRT process:
  • State stops MRT
  • State defers to SSA decision

MRT determination applies pending SSA decision

If the two conflict:
  • SSA overrides MRT

Process effective June 1, 2014
Exceptions to SSA Denial

Applicant with an SSA denial may undergo MRT process in the following circumstances:

• Change or worsening of old condition since SSA denial

OR

• A new condition

AND

1. More than 12 months have passed since denial
   • State will require applicant to re-apply/appeal to SSA

OR

2. Fewer than 12 months have passed since denial and SSA has refused to consider new evidence
Verifying Eligibility Information

**PREVIOUS:**
Applicant provides some paper verification documents at time of application

**CURRENT:**
1. Verify eligibility information using state & federal electronic data sources
2. Ask applicant for paper documentation ONLY if no electronic data or inconsistent with application

**NOTE:** Applicants **must** submit requested verification documents by the posted due date.
Presumptive Eligibility

**Overview:**
- Presumptive eligibility (PE) allows qualified individuals to have services paid for by Medicaid pending the outcome of a full Medicaid determination.

**Process:**
1. QP staff ask patient questions to screen for potential Medicaid eligibility and completes PE application.
2. Patient meets eligibility requirements for Medicaid.
3. Patient considered “presumptively eligible” for Medicaid.
4. Patient gets Medicaid coverage for services.
5. Patient fills out Indiana Application for Health Coverage.
7. 1. IF ELIGIBLE: Medicaid coverage will continue.
8. 2. IF NOT ELIGIBLE: Medicaid coverage will end.

* If PE determination says that applicant is not eligible for Medicaid, applicant cannot appeal decision, but can complete the Indiana Application for Health Coverage to see if he/she is Medicaid-eligible based on complete information.

** Provider will still be reimbursed for services provided during PE period.
## Presumptive Eligibility (PE) Programs

### PE for Pregnant Women

- **Delivery System:** Managed Care
- Provides temporary coverage of prenatal care services (Package P only)
- Pregnant women can apply with doctors or clinics enrolled as a qualified provider (QP)

### Hospital PE

- **Delivery System:** Fee-for-Service, except for adults (Managed Care)
- **Effective January 1, 2014, Hospital QPs may determine PE for:**
  - Pregnant women
  - Children under 19
  - Adults 19-64
  - Low-income parents & caretakers
  - Family Planning Eligibility Program
  - Former foster children up to age 26
- **NOTE:** There is also PE required under the HIP waiver for certain health clinics and county health departments

### PE for Inmates

- **Delivery System:** Fee-for-Service
- **Effective July 1, 2015, Hospital QPs may determine PE for Inmates**
- Inmate must be in a correction facility under MOU with FSSA, not under house arrest, not pregnant or in labor/delivery, admitted to inpatient hospitalization, and under age 65
Regardless of whether an applicant is eligible for an Indiana Health Coverage Program (IHCP), the applicant can expect a notice to explain the decision. If the applicant disagrees with the decision, the applicant may file an appeal.
Eligibility Notices

• **Notice from:**
  - Division of Family Resources (DFR)

• **When Medicaid applicant or beneficiary will get notice:**
  - After application reviewed:
    - Approved
    - Denied
  - After changes in coverage:
    - Terminate coverage
    - Suspend coverage
    - Change in benefit package or aid category
Eligibility Appeals

• What is an appeal?
  ▫ Applicant or beneficiary:
    • Disagrees with Medicaid agency decision
    • *Requests that agency re-evaluate decision in front of an Administrative Law Judge (ALJ)

• What can be appealed?
  ▫ Termination of benefits, or
  ▫ Suspension of benefits, or
  ▫ Reduction of benefits
  ▫ Delay in determining eligibility

*The notice obtained from DFR will list the process for eligibility appeal.
After Being Determined Eligible for an Indiana Health Coverage Program

Each year, the state will conduct eligibility redeterminations to determine if Indiana Health Coverage Program (IHCP) enrollees may stay enrolled in their respective programs.
Eligibility Redeterminations

- **Purpose:**
  - To be sure that individuals with Indiana Health Coverage Program (IHCP) are still eligible

- **How often:**
  - Every 12 months

- **Process:**
  - State checks if there is enough electronic data to renew eligibility
    - If yes: State will renew IHCP
    - If no: State will contact enrollee for more information

**IMPORTANT NOTE:** HIP 2.0 members may only change plans/Managed Care Entities (MCEs) during redetermination. They must select a new MCE no more than 45 days prior to the end of their benefit period.
Helpful Contacts

- Indiana Application for Health Coverage and listing of local DFR offices: [www.dfrbenefits.in.gov](http://www.dfrbenefits.in.gov)
- Indiana Medicaid/CHIP: 1-800-403-0864
  - Office of Hearings and Appeals: 1-866-259-3573
- HIP 2.0: 1-877-GET-HIP-9; [HIP2.0@fssa.in.gov](mailto:HIP2.0@fssa.in.gov)
- Medicare: 1-800-633-4227 (1-800-MEDICARE)
- MAXIMUS (state enrollment broker): 1-866-963-7383
- Managed Care Entities (MCEs):
  - Anthem: 1-866-408-7188
  - CareSource Indiana: 1-877-806-9284
  - Managed Health Services (MHS): 1-800-743-3333
  - MDwise: 1-800-356-1204
Module #2 Review

• Having reviewed this module, you should now be able to:
  ▫ Assess whether someone is potentially eligible for an Indiana Health Coverage Program (IHCP)
  ▫ Tell a consumer what information the consumer will need to provide as a part of the IHCP application
  ▫ Explain consumer options to apply for health coverage through the state
  ▫ Help a consumer know what to expect after the IHCP application is filed