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Sen. Vi Simpson



# HEALTH FINANCE COMMISSION

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## MEETING MINUTES<sup>1</sup>

**Meeting Date:** July 15, 2010  
**Meeting Time:** 9:30 A.M.  
**Meeting Place:** State House, 200 W. Washington St., House Chambers  
**Meeting City:** Indianapolis, Indiana  
**Meeting Number:** 1

**Members Present:** Rep. Charlie Brown, Chairperson; Rep. Peggy Welch; Rep. Craig Fry; Rep. Win Moses; Rep. Timothy Brown; Rep. Richard Dodge; Rep. David Frizzell; Rep. Don Lehe; Rep. Eric Turner; Sen. Patricia Miller, Vice-Chairperson; Sen. Ryan Mishler; Sen. Edward Charbonneau; Sen. Beverly Gard; Sen. Jean Leising; Sen. Sue Errington; Sen. Jean Breaux; Sen. Earline Rogers; Sen. Vi Simpson.

**Members Absent:** Rep. John Day; Rep. Charles Moseley; Rep. Scott Reske; Sen. Vaneta Becker; Sen. Carlin Yoder.

Chairperson Charlie Brown called the meeting to order at 9:33 a.m. and Commission members were introduced. Chairperson Brown offered several possible dates for the second Commission meeting and September 8th at 9:30 a.m. was chosen.

### National Conference of State Legislatures (NCSL) Presentation

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<sup>1</sup> These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

Ms. Joy Johnson Wilson, Health Policy Director for NCSL, updated the Commission on federal health care reform. See Exhibit 1 for Ms. Wilson's presentation. Ms. Wilson explained that there were two bills passed and collectively the bills are referred to as the Affordable Care Act (Act). Ms. Wilson stated that the Act does the following:

- (1) maintains an employer-based health system and imposes penalties on employers that fail to provide coverage to employees;
- (2) expands and modifies Medicaid by making individuals with incomes at or below 133% of the Federal Poverty Level (FPL) eligible for Medicaid;
- (3) establishes subsidies for premiums and cost sharing for individuals between 133% and 400% of FPL; and
- (4) requires the establishment of health care exchanges to assist individuals and small businesses in purchasing qualified coverage.

Ms. Wilson expressed the following concerns with the Act:

- (1) there is no counter-cyclical trigger within the Medicaid portions of the Act to financially protect the states from the costs of the Medicaid expansion contained in the Act;
- (2) the Act fails to adequately address long term care; and
- (3) the lack of flexibility afforded to states in the Act.

Ms. Wilson noted that the enhanced Medicaid federal match the states are currently receiving from the federal stimulus plan is set to expire at the end of the year. Ms. Wilson discussed several challenges that states will face in implementing the Act:

- (1) determining who is a "new eligible" for purposes of the Act;
- (2) upgrading eligibility systems;
- (3) ensuring that systems are interoperable with health insurance exchange systems;
- (4) employing sufficient workforce to assist in the implementation of the Act;
- (5) marketing of the Medicaid expansion for consumers who do not want to be on welfare;
- (6) ensuring public investment and support; and
- (7) improving quality of care in the Medicaid program.

#### Medicaid Expansion and other Health Provisions

Ms. Wilson informed the Commission that the Medicaid expansion group's eligibility will be based on income only, and will not allow asset disregard as currently allowed in Medicaid. Ms. Wilson warned that although this may simplify eligibility determination for the new Medicaid population, the existing procedures for interrelated programs will remain the same and may cause administrative difficulties. Ms. Wilson said that states have the option to begin the expansion of Medicaid this year but federal reimbursement for the coverage would be at the state's regular Medicaid matching rate. Ms. Wilson stated that she does not believe that the United States Department of Health and Human Services has decided how to treat Indiana's Healthy Indiana Plan (HIP), which will affect whether Indiana will be considered an expansion state for which the federal Medicaid reimbursement rates allotted to Indiana for newly eligible Indiana residents will apply. Ms. Wilson told the Commission that the Act has a temporary maintenance of effort provision that prohibits states from imposing more restrictive Medicaid eligibility standards from the date the Act was enacted (March 23, 2010) until 2014 unless the governor of a state certifies that the state is in a deficit or will be in a deficit without a restriction.

Ms. Wilson described the following Medicaid mandates in the Act (See Exhibit 1 for more information):

- (1) requires states to reimburse primary care providers under the Medicaid program at the Medicare rate beginning in 2013, and allows for federal reimbursement for the difference between the state's current rate and the Medicare rate only for 2013 and 2014;
- (2) coverage of preventative care services with no cost sharing;
- (3) reimbursement for Medicaid services provided by school-based health clinics;
- (4) quality measures for adult beneficiaries;
- (5) nonpayment for certain health facility-acquired conditions;
- (6) state use of National Correct Coding Initiative;
- (7) coverage of tobacco cessation services for pregnant women; and
- (8) background checks for long term care providers and employees.

Ms. Wilson stated that the Act includes prescription drug rebate increases starting January 1, 2010 (retroactive), but provides that the federal government keeps the amount of the increase. Ms. Wilson commented that the retroactivity of this provision is causing administrative difficulties. Ms. Wilson informed the Commission that the Act includes the following long term care provisions: (1) establishes the Community First Option beginning October 1, 2011, which will provide assistance in caring for disabled individuals and reimbursement for services other than health care; (2) provides for home and community based care services and incentives; and (3) establishes the Federal Coordinated Health Care Office within Centers for Medicaid and Medicare Services (CMS) for the purpose of coordinated care for those individuals who are eligible for both Medicaid and Medicare (dual eligibles).

Ms. Wilson informed the Commission that the Act also reduces Disproportionate Share Hospital (DSH) payments to the states beginning in 2014, although the Act doesn't specify how the reductions will occur. Ms. Wilson stated that these reductions could be problematic for the states.

Ms. Wilson stated that the Act reauthorizes the Children's Health Insurance Program (CHIP) through September 30, 2014, and requires states to maintain current income eligibility levels and prohibits more restrictive eligibility standards through September 30, 2019 (maintenance of effort). The Act also changes CHIP from a voluntary block grant program to a grant program within Medicaid. Ms. Wilson stated that compliance of a state with the CHIP maintenance of effort requirements will be a condition of future Medicaid payments to the states. Ms. Wilson stated that the Act also provides for an enhanced federal match payment for CHIP for fiscal years 2016 through fiscal year 2019 and provides certain tax credits for certain CHIP-eligible children. See Exhibit 1 for more information.

The Commission asked several questions of Ms. Wilson concerning her presentation on Medicaid changes.

#### Health Insurance Reform

Ms. Wilson stated that the Act's insurance provisions have caused some confusion within the general public because the changes are based on an insurance plan year instead of a calendar year. Ms. Wilson stated that the Act addresses the following concerning health insurance reform:

- (1) requires interim high risk pools for individuals with preexisting conditions;

- (2) requires minimum medical loss ratios;
- (3) prohibits rescissions of insurance policies except in the case of fraud;
- (4) extends coverage for young adults to age 26;
- (5) limits preexisting condition exclusions for children;
- (6) limits lifetime and annual caps; and
- (7) offers employers temporary reinsurance for early retirees, including state and local government employees. See Exhibit 1 for more information.

Ms. Wilson reminded the Commission that Indiana chose to have the federal government operate the interim high risk pool for Indiana residents effective June 21, 2010. Ms. Wilson stated that the eligibility requirements for the high risk pool include that the individual is a citizen or legally present in the United States, has been uninsured for six months, and has a preexisting medical condition. The Act requires these high risk pools to use standard premium rates, except that it allows for variances based on the individual's age. Ms. Wilson informed the Commission that the federal government allotted \$5 billion for this program, but Ms. Wilson stated that she is concerned this will not be enough money to last until 2014. Ms. Wilson stated that there is an attempt to improve coordination between the states and the Department of Health and Human Services concerning outreach in those states where the federal government is operating the pool.

Ms. Wilson stated that the Act requires health insurance plans, for plan years beginning on or after September 23, 2010, to extend coverage to adult children up to the age of 26 on the parent's health insurance plan at the option of the parent. Ms. Wilson responded that though it was publicized that insurance plans had stated that they would voluntarily allow 2010 college graduates to continue on their parents' health insurance plan during the current plan year, some employers chose not to allow the coverage until the next plan year.

Ms. Wilson informed the Commission that the Act established a \$5 billion temporary program to reimburse employers a portion of the cost of providing health care coverage to certain early retirees (ages 55-64) if the employer submits an application. Ms. Wilson stated the program ends January 1, 2014. Ms. Wilson testified that the Act prohibits the establishment of lifetime or unreasonable annual limits on health insurance plans for plan years beginning on or after September 23, 2010, and then prohibits annual limits after January 1, 2014.

Ms. Wilson briefly discussed the following provisions of the Act: (1) grandfathered health plans; (2) grants; (3) medical loss ratio provisions; (4) employer and individual responsibility; and (5) small business tax credits. See Exhibit 1 for more information.

Ms. Wilson discussed the Act's requirement that, by 2014, health benefit exchanges be established to facilitate the purchase of qualified health plans by individuals and small businesses. Ms. Wilson commented that the Secretary of the Department of Health and Human Services has a lot of work to do to establish the framework for these exchanges. Ms. Wilson mentioned that state planning grants will be available in March, 2011, to assist states in establishing the exchanges. Ms. Wilson informed the Commission that each state must, before January 1, 2013, declare whether the state plans to establish an exchange or to permit the federal government to operate an exchange for the state's residents.

When asked how the health benefit exchanges would affect state mandated benefits, Ms. Wilson replied that the exchanges do not preempt the state mandates. However, if a mandated benefit is not included in the essential benefit package established by the federal government, the state will have to pay for that service through an individual

plan to keep that service covered. Ms. Wilson stated she is not sure how that will happen and that asking individuals to pay for the covered service may be an option.

### Workforce Issues

Ms. Melissa Hansen, NCSL, discussed Medicare and Medicaid payment changes made in the Act. See Exhibit 2 for more information. Ms. Hansen informed the Commission that Indiana's Medicaid reimbursement in 2008 for providers is about 61%-69% of the federal Medicare reimbursement rates, but the Act requires Medicaid primary care payments to match Medicare rates. Ms. Hansen discussed some of the grant opportunities available to states. See Exhibit 2 for more information on grants.

### State Actions to Implement Federal Health Care Reform

Ms. Hansen stated that several states have created task forces or appointed officials to study the Act, examine the implications of the Act on the state, develop a plan for implementation of the Act, and collect data to make informed decisions. See Exhibit 3. Ms. Hansen commented that some states have started taking legislative action by amending existing bills to include federal health care reform. Ms. Hansen stated that some of the challenges with the Act include federal and state interaction, budget issues, health care workforce shortages, and incorporating and paying for new technology systems. See Exhibit 3.

### **Executive Branch Presentation on Implementation of Health Care Reform**

Ms. Lawren Mills, Office of the Governor, provided the Commission with a timeline of agency action concerning the Act. See Exhibit 4. Ms. Mills stated that the Department of Insurance (Department) and the Family and Social Services Administration (FSSA) have been working together on the implementation of the Act, and that they will be seeking stakeholder and legislator input now. Ms. Mills stated that they are starting to develop a legislative package but will need legislator input on this.

Ms. Pat Casanova, Director of the Office of Medicaid Policy and Planning, FSSA, stated that she has been working with the National Organization of State Medicaid Directors to get questions answered by the federal government. Ms. Casanova testified that there is a sense of urgency on planning for all of the changes required by the Act, but she is still waiting for direction and regulations from the federal government, especially on the new Medicaid eligibility requirements and tracking. Ms. Casanova expressed concern with the cost of the changes that will be required, including an estimate of \$30 million alone for system changes. Ms. Casanova stated that although she has not received any specifics from the federal government on benchmark packages, she believes that the HIP is a benchmark package and would assist in the implementation of health care reform. Ms. Casanova remarked on other federal requirements FSSA is currently working on implementing, including the Coding System, Hitech (health information technology) and that these requirements have stretched FSSA's resources. Ms. Casanova expressed concern with the strict maintenance of effort requirements included in the Act, especially the error rates.

When asked whether she thought Indiana would have to operate parallel systems in the future, Ms. Casanova replied that Indiana may need to operate one system with the current eligibility requirements and one system for the new eligibility requirements. In response to a question concerning how the cigarette tax revenue would be spent when HIP is terminated, Ms. Casanova testified that she believes the revenue will be completely expended by the end of the waiver. Ms. Casanova briefly discussed the current Indiana

Medicaid eligibility levels. When asked what grants had been applied for, Ms. Casanova said that she has not applied for any in the first wave of grants due to a lack of resources or ability to meet the state match requirements. Ms. Casanova stated that they are continuing to look at all of the available grants. Ms. Casanova commented that the grant application procedures are strict, and that the National Association of State Medicaid Directors has requested that the federal government loosen the grant requirements.

Ms. Robyn Crossen, Department of Insurance, stated that she has tried to keep the legislative assistants informed about the Act and about what the Department is doing, but that the Department has not received much information yet. Ms. Crossen testified that Indiana opted to let the federal government operate the interim high risk pool and that the federal government has not provided the Department with any information concerning the premiums, what is covered by the high risk pool, caps, or enrollment limitations. See Exhibit 5. Ms. Crossen stated that paper applications to participate in the high risk pool were accepted starting July 1, 2010. Ms. Crossen stated that she is aware of two grants for which Indiana has applied: (1) the Assistance for Early Retirees grant; and (2) the Rate Review grant. Ms. Crossen stated that Indiana has applied for certification as an employer for the Early Retiree grant for early retirees receiving coverage under the state employee plans. Ms. Crossen stated that last week the Department turned in the Rate Review Grant application which offers one million dollars for one year. Ms. Crossen stated that Indiana is a member of the National Association of Insurance Commissioners, and this Association was assigned the task of providing input on Act regulations.

### **Indiana Check-Up Plan/HIP**

Ms. Carol Irvin, Mathematica Policy Research Inc., informed the Commission that Mathematica contracted with FSSA to conduct an independent evaluation of HIP as required in the Medicaid demonstration waiver. Ms. Irvin provided an overview of the HIP program and reviewed key evaluation findings, including enrollment trends, member characteristics, service use, and fiscal conditions. See Exhibit 6 for Ms. Irvin's presentation. Ms. Irvin stated that seventy percent of HIP members have income that is at or below the federal poverty level and many enrollees have a chronic condition. Ms. Irvin further stated that in 2009, the costs of HIP for Indiana exceeded tax revenue collected for the year and required use of reserved funds.

Ms. Tammy Robinson, representing Anthem, provided the Commission with a handout reflecting Anthem's community outreach for HIP and a pamphlet informing individuals about HIP. See Exhibits 7 and 8. Ms. Robinson stated that Anthem operates an outreach call center and that enrollees receive a phone call to explain the program and notify the enrollee if the first payment to participate in HIP has not been received. Ms. Robinson informed the Commission that Anthem also holds new member meetings to provide information and education to new enrollees. When asked by Commission members why Anthem now limits preventative care payments to \$500 when previously Anthem paid for all of preventative care, Ms. Robinson stated that this was a cost reduction decision.

Ms. Laurie Weinzapfel, MDwise, testified that MDwise uses a variety of activities to inform HIP members of their coverage and promote general healthcare. Ms. Weinzapfel provided the Commission with the welcome packet members receive. See Exhibit 9. Ms. Weinzapfel said that MDwise provides web-based material to members but mail and telephone are primarily used in contacting HIP members. Ms. Weinzapfel informed the commission that HIP members use e-mail more than any of MDwise's other populations. When asked about the use of gift cards as an incentive for members to see providers, Ms. Weinzapfel stated that this is an incentive program used for the Hoosier Healthwise

population in order to meet Healthcare Effectiveness Data Information Set (HEDIS) requirements and is funded through MDwise.

Chairperson Brown reminded the Commission that the next meeting would be September 8, 2010 at 9:30 a.m. and adjourned the meeting at 3:58 p.m.

**Federal Health Care Reform Update  
Medicaid and CHIP Provisions  
Indiana Health Finance Commission  
Indiana General Assembly**



**Testimony Presented By:  
Joy Johnson Wilson, Health Policy Director  
National Conference of State Legislatures**

**July 15, 2010**

**The Laws**



- The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010.
- The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law on March 31, 2010 and amended some of the provisions of P.L. 111-148.
- The **package** is now referred to as..."The Affordable Care Act"

## Some Notes.....



- Because the reconciliation process was used, many technical and perfecting amendments were not in order. As a result, in part because the legislation was drafted assuming a Fall 2009 enactment.....
  - Some effective dates occur prior to enactment
  - Some drafting errors could not be addressed
  - Many effective dates will require very aggressive action to implement
  - Technical corrections could not be made because they were not in order and were subject to a point of order

## Access - Overview



- Maintains an employer-based health care system
  - Imposes a penalty on employers that fail to provide coverage or whose employees go to the health insurance exchange for coverage
- Expands and modifies the Medicaid to become the foundation for the reformed health care system
  - All individuals with incomes at or below 133% of the federal poverty level (FPL) are eligible
- Requires individuals to obtain qualified coverage
  - Imposes a tax on individuals who fail to comply
- Establishes subsidies for premiums and cost-sharing for individuals with incomes between 133% and 400% of the federal poverty level (FPL)

## Access - Overview cont.



- Establishes health care exchanges to help individuals and small businesses (initially) to purchase qualified coverage

## What Does It Mean for States



- Fundamentally changes the state role in Medicaid by changing the status of Medicaid in relation to the rest of the health care system in the United States.
  - State budget issues
    - ✦ Underfunding of the underlying program
    - ✦ Failure to address coverage for undocumented immigrants
    - ✦ Failure to include statutory countercyclical trigger
    - ✦ Implications of reduction in federal assistance in the future
    - ✦ No serious effort to address long-term care
  - State flexibility
  - The transformation of the Medicaid program largely left to state governments

## Challenges



- Show me the money
  - New Eligibles v. others
  - Systems upgrades
    - ✦ Eligibility
    - ✦ Interoperability with Health Insurance Exchanges
  - Staffing
    - ✦ State and local government
  - Workforce/Infrastructure
    - ✦ Provider reimbursement
    - ✦ Training & recruitment
    - ✦ Infrastructure improvements

## Challenges cont.



- Marketing the "New Medicaid"
  - Mainstream health care v. welfare
  - New networks/service delivery models
- Maintaining public support
- Improving quality
  
- Remember....with every challenge there is an opportunity!!!

## Medicaid Expansion



- Establishes a national minimum eligibility level at 133% of FPL (\$14, 400)
- Eligibility based on income (SSI, child welfare, SSDI, medically needy, Medicare Savings Programs beneficiaries are exempt)
- Adds new **mandatory** categories of Medicaid-eligibles
  - Single, childless adults who are not disabled
  - Parents
  - Former Foster Care Children (aged-out of foster care)

## Medicaid Expansion



- Option for states to begin expansion for certain non-elderly individuals with incomes up to 133% of FPL effective 4/1/2010. Coverage would be reimbursed at the state's regular Medicaid FMAP.
  - Connecticut and Washington, D.C. have expressed interest in this option.

## Enhanced FMAP for Newly Eligibles



- Enhanced FMAP for Newly Eligibles 2014 – 2020

Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

## Special Provision for "Expansion States"



- Between January 1, 2014 and December 31, 2015, "expansion states" will receive a 2.2 percentage point increase in their regular FMAP for people who are NOT "newly eligible".
- Expansion State - A state that as of March 23, 2010 covered parents and childless adults up to 100 percent of FPL. According the CRS, the following states qualify: AZ, DE, HI, MA, ME, MN, NY, PA, and VT. The District of Columbia also qualifies.
- The HHS Secretary will make final decision.

## Medicaid Expansion Features



- **Temporary Maintenance of Effort/Eligibility**
  - Prohibits eligibility changes that are more restrictive than those in place on date of enactment (March 23, 2010)
  - Expires in 2014 when the health care exchanges become effective
- **State Financial Hardship Exemption from Maintenance of Effort**
  - Governor **must certify that state is in deficit or will be in deficit** to qualify for the hardship exemption (12/31/2010)
- **Medicare Rates for Medicaid Primary Care Physicians for 2013 and 2014**
  - 100% federal match for the increment above current rate

## New Medicaid Mandates



- Phase-in Medicare rates for primary care providers (100% federal match for increment above current rate) **for 2013 and 2014 only**
- Coverage of preventive services, no cost-sharing
- Reimbursement of Medicaid services provided by school-based health clinics
- Quality measures for adult beneficiaries
- Non-Payment for certain Health Care Acquired Conditions (mirrors Medicare provision)
- State use of National Correct Coding Initiative (NCCI) – 10/1/2010
- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women (10/1/2010)
- Background checks for direct patient access employees of long term care facilities and providers

## Long Term Care - Background Checks



- CMS on behalf of HHS announced the availability of **\$160 million** in Affordable Care Act Grants to support all States and the U.S. Territories for a multi-year **Nationwide Program for National and State Background Checks** on direct patient access employees of long term care facilities and providers.
- Applies to the following facilities and providers: skilled nursing facilities; nursing facilities; home health agencies; hospice care providers; long-term care hospitals; personal care service providers; adult day care providers; residential care providers; assisted living facilities; intermediate facilities for the mentally retarded (ICFs/MR) and other entities that provide long-term care services, as specified by each participating state through a variety of authorities including Medicaid State Plan services and Medicaid waiver authorities.

## Long Term Care - Background Checks



- Requires each state to: (1) guarantee that it will make available non-federal funds to cover a portion of the cost to be incurred by the State to carry out the program; and (2) make available non-federal contributions as a condition of receiving the federal match.
- Provides federal grant funds to each *newly* participating state that enters into an agreement with CMS at a rate which will be three times the amount that the state guarantees, **not to exceed \$3 million dollars** in federal funds for the 2010-2013 time period.
- Provides federal grant funds to each *previously* participating state (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, & Wisconsin) at a rate that will be three times the amount that the state guarantees, **not to exceed \$1.5 million dollars** in federal funds for the 2010-2013 time period. Previously participating states that did not conduct statewide programs shall be eligible to receive federal grant funds at the same rate and level as newly participating States.

## Background Checks Grants - Timeline



- National Conference Call for States - June 17, 2010
- Letter of Intent Due - June 25, 2010
- Grant Applications Due - August 9, 2010
- Grant Awards - September 30, 2010

## Demonstrations Projects



- Demonstrations
  - Evaluate Integrated Care (bundled payments) around a Hospitalization
  - Medicaid Global Payments
  - Pediatric Accountable Care Organization (ACO)
  - Medicaid Emergency Psychiatric Care

## Prevention and Wellness



- Incentives for Coverage of Preventive Services
  - Add 1 percentage point to regular FMAP
- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women (see mandates)
- Incentive Grants for the Prevention of Chronic Diseases (1/1/2011)
  - Promoting healthy lifestyles
- Medical Home – State Option

## Prescription Drug Provisions



- Rebates
  - Increases the brand name drug rebate amount from 15.1% to 23.1%
  - Increases the generic drug rebate amount from 11% to 13%
  - Extends the rebate program to Medicaid managed care organizations (MCOs)
  - **The federal government collects the difference between the previous law rebate for brand name and generic drugs and the increased rebate established in the Act**
  - **New rebates are effective January 1, 2010!**

## Prescription Drug Provisions



- Changes the status of some formerly excludable drugs
  - Removes barbiturates and benzodiazepines from the Medicaid excluded drug list. (Effective January 1, 2014)
- Changes to Average Manufacturer's Price (AMP)
  - Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.
  - Clarifies what transactions, discounts, and other price adjustments were included in the definition of AMP.
  - Clarifies that retail survey prices do not include mail order and long term care pharmacies.

## Medicaid & Long-Term Care



- **Community First Option** (10/1/2011)
- Home & Community-Based Services
- Home & Community-Based Incentives (2011)
- Money Follows the Person Rebalancing Demonstration
- Treatment of Spousal Impoverishment in Home & Community-Based Programs (1/1/2014)
- Funding for Aging and Disability Resource Centers
- Waiver Authority for Dual-Eligible Demonstrations
- **Establishes a Federal Coordinated Health Care Office within CMS (for dual-eligibles) – 3/1/2010**

## Reduction in DSH Payments



- Directs the HHS Secretary to reduce DSH payments to states by \$14.1 billion between FY 2014-FY 2020

Fiscal Year	Reduction
2014	\$500 million
2015	\$600 million
2016	\$600 million
2017	\$1.8 billion
2018	\$5 billion
2019	\$5.6 billion
2020	\$4 billion

## Reduction in DSH Payments



- Requires the Secretary to carry out the reductions using the "DSH Health Reform Methodology" that will impose the largest reductions on states that:
  - Have the lowest percentage of uninsured individuals (determined on the basis of: (1) data from the Bureau of the Census; (2) audited hospital reports; and (3) other information likely to yield accurate data) during the most recent year for which the data is available; or
  - Do not target their DSH payments on: (a) hospitals with high volumes of Medicaid inpatients; and (b) hospitals that have high levels of uncompensated care (excluding bad debt).

## What Happens to CHIP?



- **Authorization**

- Extends the current Children's Health Insurance Program (CHIP) authorization period for two years, through **September 30, 2014**.

- **Maintenance of Effort**

- Requires states, upon enactment, to maintain current income eligibility levels for CHIP through **September 30, 2019**.
- Prohibits states from implementing implement eligibility standards, methodologies, or procedures that were more restrictive than those in place on the date of enactment (March 23, 2010), with the exception of waiting lists for enrolling children in CHIP.
- Conditions future Medicaid payments on compliance with the maintenance of effort provision.

## What Happens to CHIP?



- **Enhanced Federal Matching Payments**

- Provides that from FY 2016 to FY 2019, states will receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent.

- **Eligibility for Tax Credits in the Health Insurance Exchange**

- Provides that CHIP-eligible children, who cannot enroll in CHIP due to federal allotment caps, will be deemed ineligible for CHIP and will then be eligible for tax credits in the exchange.

## What Happens to CHIP?



- **Treatment of Enrollment Bonuses**

- Provides that the Medicaid and CHIP enrollment bonuses included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) will not apply beyond September 30, 2013.

- **CHIP Eligibility Standards**

- CHIP eligibility will be based on **existing income eligibility rules, including the use of income disregards.**

## CHIP & the Exchange



- **CHIP and the Health Insurance Exchange**

- Provides that after FY 2015 states may enroll targeted low-income children in qualified health plans that have been certified by the Secretary.
- Requires the Secretary to no later than April 1, 2015 to review in each state the benefits offered for children and the cost-sharing imposed by qualified health plans offered through a Health Insurance Exchange.
- Requires the Secretary to certify (certification of comparability of pediatric coverage) plans that offer benefits for children and impose cost-sharing that the Secretary determines are at least comparable to the benefits and cost-sharing protections provided under the state CHIP.

## CHIP - State Employee's Children



- **Exceptions to Exclusion of Children of State and Local Government Employees**
  - **Maintenance of Effort with Respect to Per Person Agency Contribution for Family Coverage** – Requires the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent state fiscal year is not less than the amount of such expenditures made by the agency for the 1997 state fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for two preceding fiscal years.
  - **Hardship Exception** – A child qualifies for a hardship exemption if the state determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved.

## Health Insurance Reforms - Now



- Temporary high-risk pools
- Minimum medical loss ratios
- Prohibition on rescissions (exception for fraud)
- Extension of dependent coverage for young adults (expires at the 26<sup>th</sup> birthday)
- Limits preexisting condition exclusions for children
- Limits lifetime and/or annual caps
- Reinsurance for early retirees (applies to state and local government plans)

## Health Insurance Reforms - **Later**



- Prohibition on preexisting condition exclusions
- Guaranteed issue/Guaranteed renewal
- Premium rating rules
- Non-discrimination in benefits
- Mental health and substance abuse services parity
- Prohibits discrimination based on health status
- Prohibits annual and lifetime caps

## Temporary High Risk Pools



- Appropriates \$5 billion (2010 - 2014) to establish programs in the 50 states and DC, effective June 21, 2010.
- Eligible individuals (citizens or legally present, uninsured for at least 6 months, has a preexisting medical condition)
- Rules-- (1) no preexisting condition exclusions; (2) limits out-of-pocket amounts to \$11,900-families and \$5,950-individuals; (3) standard premium rate; (4) rates may vary on the basis of age by a factor of 4-1.
- State MOE at 2009 levels.

## Temporary High Risk Pools - Status



- 19 states - HHS Administration; 28 states and DC - State Administration (includes Maryland); 3 states - Undecided
- To Be Decided
  - Definition of "preexisting condition"
  - Premium subsidies (in or out)
  - Liability (who has it?)
  - State flexibility (how far does it go?)
  - Flow of Funds (administration v. claims)
  - Citizenship verification process
- Interim Final Rule expected to be published soon.
- Funding will be available July 1, 2010 for applications received by June 1, 2010.

## Young Adult Dependent Coverage



- Requires plans, **for plan years beginning on or after September 23, 2010** to extend coverage to adult children, up to age 26, on their parent's health insurance plan, if the parents want them to do so.
- State laws that provide additional protection are saved unless they prevent the application of the new federal law.
- Additional coverage is available for young adults who have parents that have access to cafeteria plans to offset health costs with pretax dollars.  
*(See handout for additional detail)*

## Early Retiree Reinsurance Program



- Establishes a \$5 billion temporary program to reimburse employers (including state and local governments) for the cost of providing health care coverage to early retirees (ages 55-64) and their spouses, surviving spouses, and dependents.
- For each beneficiary, the employer plan will receive up to 80% of costs, minus negotiated price concessions, for health benefits between \$15,000 and \$90,000. This reinsurance corridor will be adjusted in subsequent fiscal years by the medical component of the consumer price index.
- Effective for plan years beginning on or after October 1, 2011. Program ends January 1, 2014.
- **Interim Final Rule** published in the May 5, 2010 *Federal Register*. Effective June 1, 2010. Comments accepted until COB June 4, 2010.
- Applications are now being accepted!

## Prohibition on Rescissions



- Prohibits plans from rescinding coverage, except in cases involving fraud (intentional misrepresentation of material fact).
- Effective for plan years beginning on or after September 23, 2010.

## Preexisting Condition Exclusions & Children



- Prohibits the imposition of preexisting condition exclusions on children under age 19 (Insurers have agreed to this interpretation of the law).
- Preexisting exclusion provisions are prohibited after January 1, 2014 for **all** individuals. After that time health insurers cannot use any of the following factors to determine or deny eligibility: health status, claims experience, rate of utilization of benefits, domestic violence, disability, or genetic information.

## Limits on Lifetime/Annual Caps



- Prohibits the establishment of lifetime or *unreasonable* annual limits on the dollar value of "Essential Health Benefits" (EHBs).
  - Definition of EHBs will be determined by the HHS Secretary by administrative rule. General guidance is provided in the law.
- Effective for plan years beginning on or after September 23, 2010.
- For plan years beginning before January 1, 2014, the Secretary will define "reasonable" annual limits.
- Annual limits are prohibited after January 1, 2014.

## Treatment of Grandfathered Plans



- Effective for plan years beginning on or after September 23, 2010---
  - Prohibits lifetime limits
  - Prohibits rescissions
  - Requires dependent coverage up to age 26
  - Prohibits preexisting condition exclusions for dependents
  - Allows restricted annual limits (as determined by the HHS Secretary)

(See handout for additional detail)

## State Grants - Rate Review



- Secretary Sebelius announced the availability of \$51 million in Health Insurance Premium Review Grants on June 7, 2010. These funds are the first round of grants available to states through a new \$250 million grant program to create and strengthen insurance rate review processes.
- All states and the District of Columbia are eligible for the first round of rate review grants.
- To receive a grant, a state must submit a plan for how it will use grant funds to develop or enhance its process of reviewing and approving, disapproving, or modifying health insurance premium requests.
- States with successful applications will receive a \$1 million grant during the first round.
- The second round of grants may come with more strings attached.

## Medical Loss Ratio



- Large group plans that fail to have a medical loss ratio (MLR) of 85 percent and individual and small group plans that fail to have a MLR or 80% by January 1, 2011, will be required to provide rebates to plan participants.
- HHS is authorized to adjust these rates to avoid market destabilization.
- HHS is working closely with the National Association of Insurance Commissioners (NAIC) and other stakeholders to develop a plan.

## Employer Responsibility



- Requires employers with more than 200 employees to automatically enroll new full-time equivalent employees in coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.

## Employer Responsibility



- **Penalties for Failure to Provide Coverage**

- Requires an employer with more than 50 full-time equivalent employees that does not offer coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of \$2000 per full-time equivalent employee.
- Excludes/disregards the first 30 full-time employees.
- Requires an employer with more than 50 full-time equivalent employees that offers coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of \$3000 per full-time equivalent employee.
- Excludes/disregards the first 30 full-time employees.

- **Large Employers with Waiting Periods**

- Amends the employer shared responsibility policy such that a large employer requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of \$600 per full-time equivalent employee.

## Individual Responsibility



- Requires individuals to maintain minimum essential coverage beginning in 2014.

- **Penalties for Failure to Maintain Coverage**

- Failure to maintain coverage will result in a penalty that is the greater of a flat fee \$95 in 2014; \$325 in 2015; and \$695 in 2016 **OR** the following percent of the excess household income above the threshold amount required to file a tax return---1% of income in 2014; 2% of income in 2015; 2.5% of income in 2016 and subsequent years.
- For those under the age of 18, the applicable penalty will be one-half of the amounts listed above.
- Families will pay half the amount for children up to a cap of \$2,250 for the entire family.
- After 2016, dollar amounts will increase by the annual cost of living adjustment.

## Individual Responsibility



- **Exceptions** to the individual responsibility requirement to maintain minimum essential coverage are made for:
  - religious objectors;
  - individuals not lawfully present; and
  - incarcerated individuals.
- **Exemptions** from the penalty will be made for those who:
  - cannot afford coverage (where the lowest cost premium available exceeds 8% of income), thereby qualifying for a “hardship waiver”;
  - taxpayers with income under 100 percent of the federal poverty level;
  - members of Indian tribes; and
  - individuals who were not covered for a period of less than three months during the year.

## Small Business Tax Credit



- Small employers with fewer than 25 full-time equivalent employees and average annual wages of less than \$50,000 that purchase health insurance for employees are eligible for the tax credit.
- The maximum credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than \$25,000.
- To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost.
- Businesses that receive state health care tax credits may also qualify for the federal tax credit.
- Dental and vision care qualify for the credit as well.

## Small Business Tax Credit cont.



- 2010 - 2013
  - For 2010 through 2013, eligible employers will receive a small business credit for up to 35 percent of their contribution toward the employee's health insurance premium.
  - Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution.
- 2014 and thereafter
  - For 2014 and beyond, small employers who purchase coverage through the new Health Insurance Exchanges can receive a tax credit for two years of up to 50 percent of their contribution.
  - Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

## Health Insurance Exchanges



- **American Health Benefit Exchanges**
  - Requires states, by 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a Exchange for small businesses.
  - Requires the Secretary to:
    - ✦ Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
    - ✦ Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal.
    - ✦ Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

## Health Insurance Exchanges



- **State Planning Grants**

- Requires the Secretary to award grants, **available 3/23/2011** until 2015, to states for planning and establishment of American Health Benefit Exchanges.

- **States must declare intention to administer the exchange or to permit the federal fall-back by the end of 2012.**

## Exchange Benefit Plans



- For the individual and small group markets, requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs:

Plan	Percent of Plan Costs
Bronze	60
Silver	70
Gold	80
Platinum	90

- **Child-Only Plan**

- If an insurer offers a qualified health plan, it must offer a child-only plan at the same level of coverage.

## Exchange Benefit Plans



### • **Catastrophic Coverage Plan**

- In the individual market, a catastrophic plan may be offered to **individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they meet the requirements for a hardship exemption.**
- A catastrophic plan must cover essential health benefits and at least 3 primary care visits, and must require cost-sharing up to the HSA out-of-pocket limits.

## HSA Out-of-Pocket Limits



### • **Out-of-Pocket Spending Limits for 2010 and 2011**

- The maximum annual out-of-pocket expenses for self-coverage is \$5,950 and the maximum annual out-of-pocket amount for family coverage is twice that, \$11,900.
  - × 2011 limits were officially published in the *Internal Revenue Bulletin 2010-23* on June 7, 2010.
  - × Effective for calendar year 2011.

## Exchange Benefits



- Defines an essential health benefits package that covers essential health benefits, limits cost-sharing, and has a specified actuarial value (pays for a specified percentage of costs), as follows:
  - For the individual and small group markets, requires the Secretary to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.
  - For all plans in all markets, prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts.
  - For the small group market, prohibits deductibles that are greater than \$2,000 for individuals and \$4,000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums.

## Key Issues - Health Insurance Exchange



- State Options
  - Interstate Compacts
  - Basic Health Plan
  - Waiver (available in 2017)
- Creating a seamless Exchange/Medicaid connection
  - **Financing**
  - Technical Assistance
  - Staff Recruitment/Training
- Essential benefits/Affordability
  - Treatment of state mandated benefits
    - ✦ States must **pay (individuals or plans)** for mandated benefits not included in the essential benefit package.

## Health Insurance Exchange



- Establishes Multi-State Plans modeled after Federal Employees Health Benefits Program (FEHBP) and administered by the federal Office of Personnel Management (OPM).
  - This was adopted in lieu of the “Public Option”.
- Provides premium and cost-sharing assistance to individuals, who obtain coverage through the exchange, with incomes up to 400% of FPL.
- Cooperatives
  - Non-profit entities, operated by a board of directors, contracts established by the HHS Secretary.

## Exchange Premium Credits



- Provides affordability premium credits and cost-sharing credits to eligible individuals with incomes at 100% - 400% of the federal poverty level (FPL). Bases credits on the lowest cost “silver plan”.

Income as % of FPL	% of Income Premium Contribution
Up to 133	2
133-150	3-4
150-200	4-6.3
200-250	6.3-8.05
250-300	8.05-9.05
300-400	9.5

## Exchanges – Cost-Sharing Limits



- Establishes the health plan's share of out-of-pocket costs as follows:

Income as % of FPL	% of Plan 's Share
100-150	94
150-200	87
200-250	73
250-400	70

## Other Key Provisions



## CLASS Act



- Creates a new national insurance program, **Community Living Assistance Supports and Services (CLASS)**, to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.
- Financed through voluntary payroll deductions (**with opt-out enrollment** similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living.
- Could result in Medicaid savings.

## Maternal & Child Health



- **Maternal, Infant, and Early Childhood Home Visiting Programs**
  - Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s).
  - Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.
  - Establishes competitive grants appropriated at \$100 million in 2010, \$250 million in 2011, \$350 million in 2012, \$400 million in 2013 & 2014
  - A maintenance of effort (MOE) applies and prohibits grants from supplanting existing funding for these services.

## Medicare Provisions



- ✓ Ensuring Access to Physician Care & Other Services
- ✓ Rural Protections
- ✓ Improving Payment Accuracy
- ✓ Improving Prescription Drug Coverage
- ✓ Ensuring Medicare Sustainability
  - ✓ **Independent Payment Advisory Board\*\*\*\***
- ✓ Quality Improvements
- ✓ Protecting and Improving Guaranteed Benefits

## Other Key Provisions



- ✓ Improving Quality/Efficiency
- ✓ Public Health/Chronic Disease Prevention
- ✓ Health Care Workforce (NHSC)
- ✓ Transparency and Program Integrity
- ✓ Improving Access to Innovative Medical Therapies
- ✓ Revenue Provisions
- ✓ Indian Health Care Improvement
- ✓ Elder Justice Act
- ✓ Nutrition Labeling (Chain Restaurants)

## Other Provisions of Note



- Grants to Support School-Based Health Clinics
- Increased Community Health Center Funding
- National Health Service Corps Improvements
- Workforce Grants/Initiatives
- Public Health Initiatives
- Medicare Improvements for Rural Areas
- Medicare Rate Improvements/Medicare Rate Reductions
- Indian Health Service Reauthorization

## 2009 Poverty Guidelines



- The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
- Persons in family      Poverty guideline
  - × 1      \$10,830
  - × 2      14,570
  - × 3      18,310
  - × 4      22,050
  - × 5      25,790
  - × 6      29,530
  - × 7      33,270
  - × 8      37,010
- For families with more than 8 persons, add \$3,740 for each additional person.
- **2009 guidelines were extended through May 31, 2010**
- **(Extension pending in H.R. 4213, the American Jobs and Closing Tax Loopholes Act of 2010)**

*The Affordable Care Act: State Strategies to Strengthen the Primary Care Workforce*

NATIONAL CONFERENCE OF STATE LEGISLATURES  
*The Forum for America's Ideas*

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Overview

- Why Workforce
- National Health Care Workforce Commission
- Key Health Workforce Provisions of the Affordable Care Act
- State Policy Options and Trends
- Things to Consider

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Why Workforce?

- Administration: Strengthening the primary care workforce is the 1<sup>st</sup> step to having quality health care and critical to reforming the nation's health care system.
- 2015 estimated of shortage of 21,000 primary care physicians.
- The Administration's focus on workforce started with ARRA: \$200 million to support student loan repayments for primary care medical, dental and mental health clinicians who want to work at National Health Service Corps (NHSC) sites.

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National Health Care Workforce Commission

The Patient Protection and Affordable Care Act gave the Comptroller General of the United States responsibility for appointing 15 members to the National Health Care Workforce Commission, with appointments to be made not later than September 30th, 2010.

- Health care workforce and health professionals
- Employers
- Third-party payers
- Individuals skilled in interpretation of health care services and economic research
- Representatives of consumers
- Labor unions
- State or local workforce investment boards

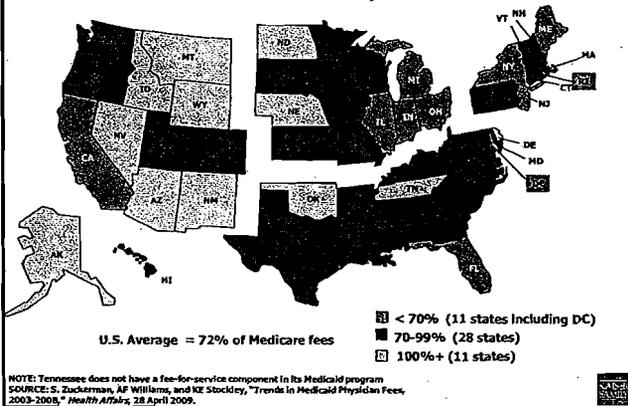
### Key Provisions: Current Workforce

- > Medicare payment changes
- > Medicaid payment changes
- > Increased access (Medicaid, employers, exchanges)
- > Reduced barriers to preventive and screening benefits
- > Administrative simplification

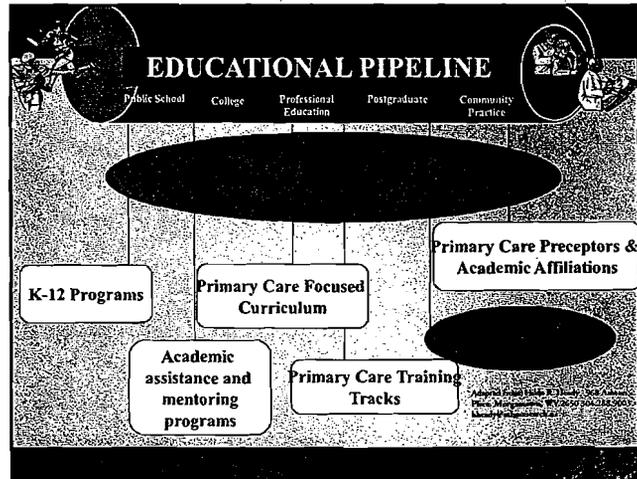
### Payment Changes

- **Medicare:** 10% bonus payment to primary care physicians (2011-16); 10% incentive pay for general surgeons performing *major surgery* in Health Shortage Areas (2011-16); 5% incentive payment for mental health services; geographic payment adjustments; Extension of the quality reporting incentive payments
- **Medicaid:** Medicaid primary care payments to match Medicare rates

### Medicaid-To-Medicare Provider Fee Ratios for All Services, 2008



### EDUCATIONAL PIPELINE



### Key Provisions: Academic Assistance and Training Programs

- Personal and Home Care Aide State Training Program (HRSA-10-288)
- Nursing Assistant and Home Health Aide Program (HRSA-10-273, \$2.5million)
- Support for community colleges, mandatory funding for Pell grants, College Access Challenge Grant, investment in minority serving institutions.

### Key Provisions: Primary Care Professional and Post Graduate Training

- Creating additional primary care residency slots (HRSA-10-277, \$168million)
- Physician assistant training (HRSA-10-278, \$32million)
- Advanced Nursing Education Expansion Program (HRSA-10-281, \$30 million)
- Expand the National Health Service Corps
  - Including ARRA expansion, NHSC is more than doubling in size

### Key Provision: Community Practice

- State Health Care Workforce Planning and Implementation Grants (HRSA-10-284 & HRSA-10-285, \$5million)
- Expanding federal tax benefits for practicing in underserved areas
- Nurse Managed Health Clinics (HRSA-10-282, \$1.5million)

### State Policy Options and Trends

- Scope of Practice (CO, NM, IA, and VI)
- Payment Structures (MN, PA, MD)
- Learning Collaboratives (UT, PA)
- "Grow your own" programs (NM)
- Other options

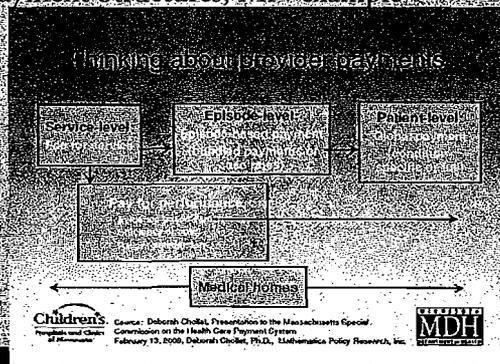
## Scope of Practice

- > Colorado: Collaborative Scopes of Care Study (2008)
- > New Mexico: Scope of Practice Review Commission (2007)
- > Minnesota: Health Occupations Review Program (2001)
- > Iowa: Reviewing Committees (1997, 2002, 2007)
- > Virginia: Board of Health Professions (2000)

## Payment Reform

- > Minnesota: Quality-based incentive payments for use by public and private purchasers
- > Pennsylvania: Chronic Care Management, Reimbursement and Cost Reduction Commission
- > Maryland: Health Services Cost Review Commission
- > Vermont: Blueprint for Health

## Payment Structures, MN example



## Learning Collaboratives

- > Pennsylvania: Chronic Care Initiative Learning Collaboratives
  - primary care practice teams receive education and support. The collaboratives meet four times per year. Meetings involve training, sharing of experiences, data review and problem solving.
- > Utah: The Assuring Better Child Health and Development (ABCD)
  - Utah conducted three learning collaboratives. The collaboratives were developed through the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ).

## K-12 Programs: Grow your own programs, New Mexico Example

- > Dream Makers (Middle School)
- > Health Careers Academy (High School)
- > Undergraduate Health Sciences Enrichment Program (College Freshman)
- > Pathways to Health Careers (eight-year combined BA/MD program)

## Other options

- > Locum Tenens Program (NM)
- > Enhancements to make communities more 'attractive to recruits' more recruit-able
  - \* Recruit-able community project (WV)
- > Utilizing returning veterans (CA, FL, LA, MI, NY)
- > Working with your medical schools (TN)

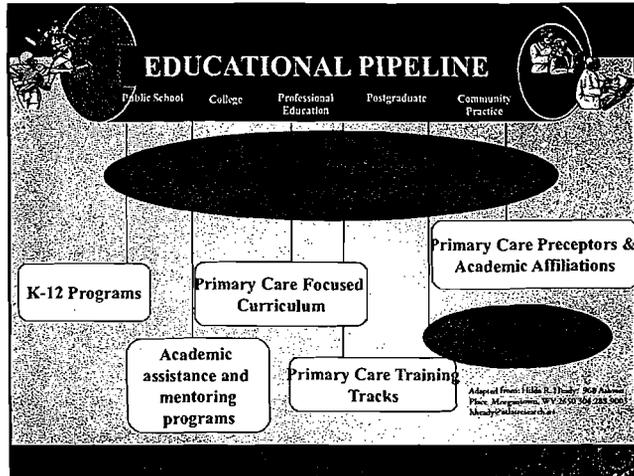
## Things to Consider

- State activities could parallel National Health Care Workforce Commission (review workforce supply and demand, and recommend steps to address future needs)
- New health care workforce development grant program
- Public Health Workforce Loan Repayment Program could leverage activity in state-based colleges and schools
- Training opportunities focused on rural needs: dental and behavioral health care providers
- Steps to strengthen primary care, including incentive payments, use of unused residency positions, grants for new programs

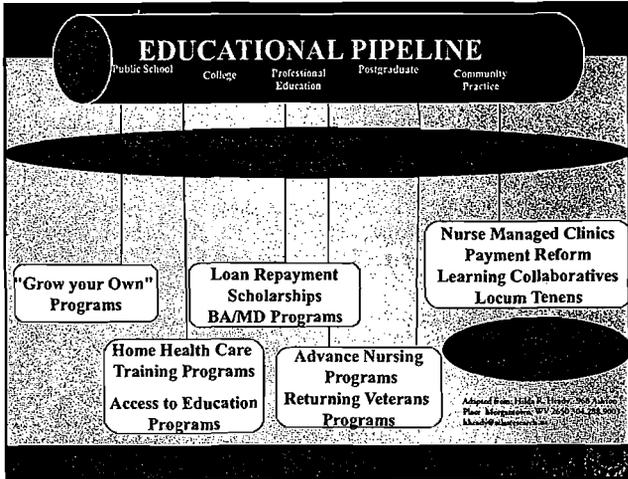
Adapted from: Keith J. Mueller, Ph.D., Director, RUPRI Center for Rural Health Policy Analysis, University of Nebraska Medical Center



## EDUCATIONAL PIPELINE

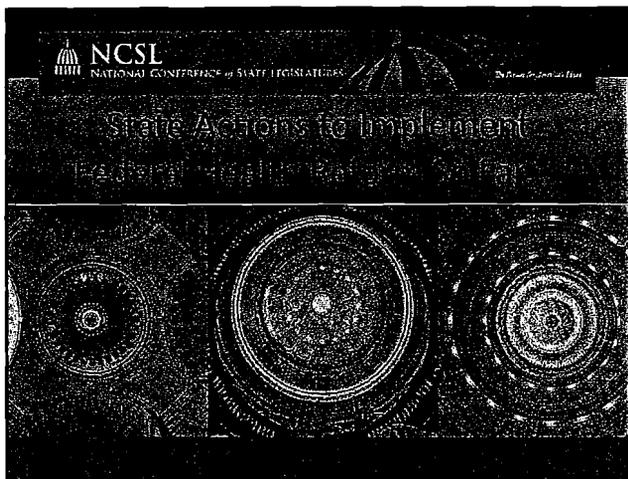


Adapted from: Linda E. Thrall, PhD, Assistant Professor, Morgan State University, Baltimore, MD



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For more information



**Addressing "how's" and "who's"**

Creating Task Forces or Appointing officials to:

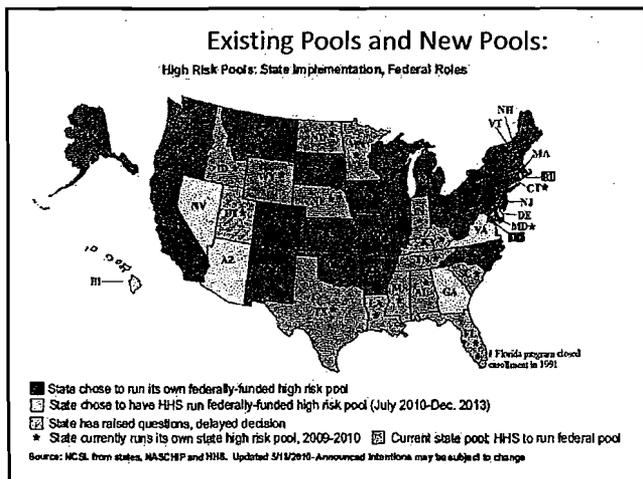
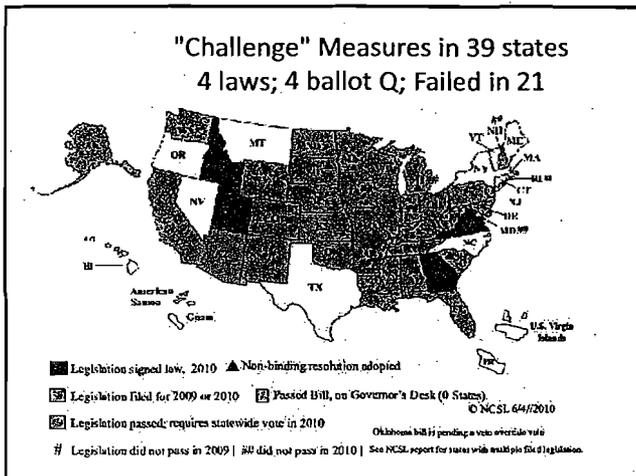
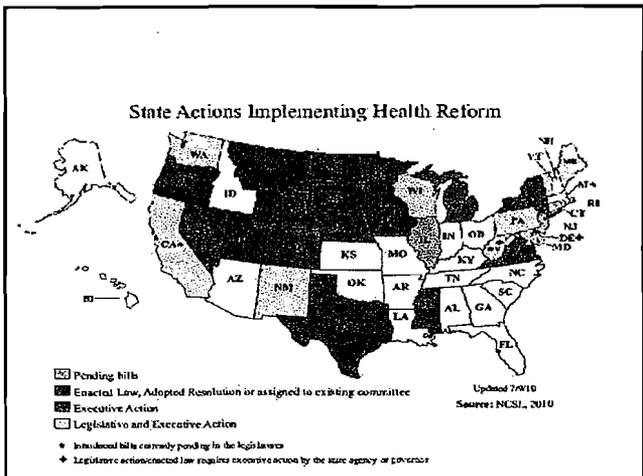
- Study details of the Patient Protection and Affordable Care Act
- Examine how federal health reform will affect existing state programs
- Develop a plan for state implementation of health reform
- Determine lead agencies for implementing components of the new law
- Collect data to make informed outcomes

**Legislative Action**

- Amending existing bills to include federal health reform
- Committee/Boards created as broad entities
- -Or- Committee/Boards are more specific to particular provisions:
  - high-risk pools, exchanges, insurance
- 2 states established task forces within the state budget bill
- Interim studies/actions still being determined as 2010 sessions end

**Executive Action**

- Most executive actions include stakeholder collaboration
- 3 states have included legislators in established committees or required action while others will determine whom to include
- Develop a plan for state implementation of the new federal law including models and recommendations



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### Some Challenges

- Working with the Executive branch
- Budget issues still remain a big concern for states
- To date, states have reported a total estimated budget gap of \$531.4 billion (FY 2008 through FY 2013)
- Many states expect at least two more years of budget gaps
- Health care workforce shortages
- Incorporating new technology systems and paying for them



### Moving Forward: First Steps

- Strategic plans for implementation
- Making recommendations
- Meeting deadlines
- Identifying funding sources
- Including appropriate stakeholders



### NCSL Web Resources

- Federal Health Reform: Overall Implementation  
[www.ncsl.org/?TabId=17639](http://www.ncsl.org/?TabId=17639)
- Tracking State Implementation Efforts  
[www.ncsl.org/?TabId=20231](http://www.ncsl.org/?TabId=20231)
- Health Reform: State Examples  
[www.ncsl.org/?TabId=17691](http://www.ncsl.org/?TabId=17691)
- State Legislation Challenging Certain Health Reforms  
[www.ncsl.org/?TabId=18906](http://www.ncsl.org/?TabId=18906)
- High-Risk Pools  
[www.ncsl.org/?TabId=14329](http://www.ncsl.org/?TabId=14329)

## INDIANA'S PARTICIPATION IN HEALTH CARE REFORM & AFFORDABLE CARE ACT (ACA) IMPLEMENTATION DISCUSSIONS

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### MARCH

15 & 16: Lawren Mills, Office of the Governor, attended the National Governor's Association (NGA) conference, *State Summit on Health Reform Implementation*.

23: Medicaid Director Casanova participated in a National Association of Medicaid Directors (NASMD) call on Health Care Reform.

24 - 28: Robyn Crosson, Department of Insurance (IDOI), attended the National Association of Insurance Commissioners (NAIC) Spring Conference where healthcare reform was a major topic of several meetings.

29: FSSA Secretary Anne Murphy and Medicaid Director Casanova attended a NASMD conference in Washington D.C., which included a face-to-face meeting with the Centers of Medicare and Medicaid Services (CMS).

### APRIL

5: IDOI held first meeting post NAIC to discuss ACA related resource needs, planning and implementation.

14: FSSA held a meeting with the agency's Executive Team where Seema Verma provided a summary of the legislation and implementation timeline.

15: Health and Human Services (HHS) held first of weekly calls concerning ACA, specifically High Risk Pools on this date.

16: IDOI met with Governor's policy director concerning ACA and resources.

19: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

19: IDOI met with UHC to discuss ACA.

21: IDOI Financial Division participated in NAIC Blanks Committee call concerning ACA financial reporting.

22: IDOI & FSSA participated in a call with HHS concerning High Risk Pools and ACA provisions.

26: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

27: IDOI held webinar for insurers who file premiums with IDOI and mandates electronic reporting as first step in transparency enhancement program.

27: IDOI Financial Division participated in NAIC Blanks Committee call concerning ACA financial reporting.

27: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

28: IDOI met with State Personnel to discuss resource needs resulting from ACA.

29: IDOI, FSSA and other interested parties participated in weekly HHS call.

30: IDOI served on panel for NAIFA concerning IDOI responsibilities and ACA.

30: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.

30: IDOI made High Risk Pool election.

30: IDOI responded to Chairman Crawford's High Risk Pool inquiry.

## MAY

- 3: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 4: FSSA & IDOI participated in an NGA ACA call.
- 5: FSSA participated in a Managed Care TAG Health Care Reform call.
- 5: IDOI participated in Commissioners Call concerning ACA.
- 5: IDOI presented to House Republican Legislative Assistants at their invitation concerning IDOI's functions and ACA.
- 6: FSSA & IDOI participated in weekly the HHS ACA call.
- 6: Medicaid Director Casanova participated in NASMD Executive Committee and Medical Director Executive Committee conference call.
- 7: IDOI spoke with developer for California's health exchange.
- 10: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 10: IDOI participated in a panel discussion regarding ACA impact to the Dept.
- 11: IDOI participated in NAIC Accident & Health B-Committee call concerning ACA.
- 13: FSSA & IDOI participated in the weekly HHS ACA call.
- 13: IDOI met with internal team to discuss calculation of Medical Loss Ratio (MLR) for purposes of rebating.
- 13 & 14: Seema Verma provided a summary of the ACA and implementation timeline to Medicaid and Division of Family Resources leadership teams.
- 14: IDOI met with all divisions to discuss NAIC calls and status of sub-groups and committees.
- 17: IDOI met with Aetna insurance to discuss MLR calculation and Exchanges.
- 17: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 17: FSSA sent a letter to CMS Director Cindy Mann requesting additional guidance regarding the Healthy Indiana Plan.
- 18: FSSA, IDOI & SPD participated in an HHS call regarding the Early Retiree Reinsurance Program.
- 18: IDOI participated in HHS webinar concerning Web Portal.
- 18: IDOI attended seminar regarding ACA national impact.
- 19: FSSA participated in a CMS HCR webinar.
- 19: IDOI participated in National Association of Health Underwriter presentation concerning ACA and its impact on IDOI.
- 19: IDOI participated in a call with United Healthcare concerning the calculation of MLR.
- 19: IDOI participated in joint meeting of NAIC Finance and Health Committees concerning ACA.
- 20: FSSA & IDOI participated in the weekly HHS call.
- 21: FSSA & IDOI participated in an NGA health care reform call.
- 21: IDOI attended monthly IIAC Autism meeting and discusses updates membership on ACA and IDOI impact.
- 23: Medicaid Director Casanova attended NASMD Boot Camp in Washington D.C, which included discussions regarding Health Care Reform.
- 24-25: Medicaid Director Casanova attended the 2010 NASMD Spring Conference in Washington D.C.
- 24: FSSA ACA Oversight Team met & Governor's Office executive HCR work group met.
- 24: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 25: IDOI participated in NAIC Sub-Group conference call.

- 26: FSSA representative participated in Lewin Group health care reform webinar.
- 26: IDOI met with AAPPO to discuss MLR calculations.
- 27: FSSA & IDOI participated in the weekly HHS call.
- 27: FSSA ACA Eligibility work group, led by Medicaid Director Casanova, DFR Director Boggs and Seema Verma, met for the first time.

**JUNE**

- 1: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 1: IDOI met with Physicians Health Plan to discuss dependent age 26 regulations and interpretation.
- 2: IDOI provided internal training to Company Compliance and Consumer Services personnel on the Dependent Age 26 Regulations.
- 2: IDOI participated in conference call with URAC concerning the calculation of MLR and costs that improve the quality of healthcare.
- 2: IDOI participated in conference call with NCQA concerning the calculation of MLR and costs that improve the quality of healthcare.
- 2: IDOI participated in NCSL webinar concerning ACA.
- 2: IDOI responded to HHS Web Portal request.
- 3: IDOI, FSSA, ICHIA and Governor's Office met concerning High Risk Pool and ACA.
- 3: IDOI participated in NAIC Speed to Market conference call concerning rate review disclosure form required by ACA.
- 3: IDOI participated in conference call with Utah concerning their small business health exchange.
- 3: FSSA participated in a CMS teleconference regarding Health Care Reform Implementation.
- 3: FSSA & IDOI participated in the weekly HHS call.
- 4: IDOI met with all Senate legislative assistants concerning IDOI's various functions in state government and ACA.
- 7: IDOI participated in conference call involving NAIC and HHS concerning grants available through ACA.
- 7: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 7 & 8: A representative from FSSA attended the National Medicaid Congress's Special National Health Reform Edition conference in Washington, D.C.
- 8: FSSA ACA Oversight Team met.
- 9: IDOI participated in NAIC ACA webinar concerning grants and health reform provisions.
- 9: IDOI submitted its comments on the proposed calculation of MLR and rebates.
- 10: FSSA ACA Medicaid Disability work group, led by Director Casanova & Seema Verma, met for the first time.
- 10: Seema Verma provided a summary of the ACA and implementation timeline to the Division of Aging.
- 10: FSSA & IDOI participated in the weekly HHS call.
- 10: IDOI participated in NAIC Financial Solvency conference call concerning financial impact and reporting of carriers resulting from ACA.
- 11: IDOI participated in conference call with Aetna concerning the definition of MLR.
- 11: IDOI participated in NAIC Sub-Group for Exchanges.
- 14: FSSA & IDOI met to discuss ACA implications.

- 14: FSSA & IDOI representatives participated in an HHS call regarding grandfathering and ACA implementation.
- 14: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 14: IDOI participated in conference call with HHS concerning grants.
- 15: IDOI Compliance and Financial Divisions met to discuss MLR and financial reporting under ACA.
- 15: IDOI & FSSA participated in a technical call with HHS concerning grants.
- 16: FSSA ACA long-term care work group, led by Medicaid Director Casanova, DDRS Director Julia Holloway and Seema Verma met for the first time.
- 16: FSSA representatives participated in a CMS call regarding coverage gap.
- 16: IDOI participated in webinar with Choice Administrators regarding Exchanges.
- 17: FSSA representatives participated in an HHS call regarding National Criminal Background Checks and the ACA.
- 17: FSSA and IDOI participated in the weekly HHS call.
- 18: FSSA ACA Medicaid Expansion work group, led by Medicaid Director Casanova and Seema Verma met for the first time.
- 18: IDOI participated in NAIC call concerning ACA grants.
- 21: FSSA ACA Oversight Team met.
- 21: IDOI met with a technology provider concerning premium review transparency enhancements.
- 21: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 21: IDOI ACA team met internally to discuss plan for grant application.
- 22: IDOI met with actuarial firm to discuss improved premium review processes.
- 22: IDOI met with technology vendor to discuss premium review transparency enhancements.
- 22: FSSA ACA Eligibility work group met.
- 23: Governor's Office ACA executive work group met.
- 23: IDOI met with Compliance and Consumer Services personnel to discuss Grandfathering regulations and IDOI interpretation.
- 24: FSSA ACA Medicaid Disability work group met.
- 24: FSSA and IDOI participated in the weekly HHS call.
- 24: IDOI participated in the weekly HHS call.
- 25: IDOI participated in conference calls with law firms and interested parties where such parties express concerns over state v. federal exchanges.
- 25: FSSA ACA Medicaid Program Integrity work group met for the first time.
- 28: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 28 & 29: Robyn Crosson (IDOI) & a representative from FSSA attended ACA NGA conference in Washington, D.C.
- 30: IDOI presented to House legislative assistants on IDOI role and ACA.
- 30: IDOI met with interested groups regarding Exchanges.

**JULY**

- 1: FSSA & IDOI Health Exchange work group met.
- 1: IDOI participated in Rate Review Disclosure Forms Sub-Committee of NAIC.
- 1: IDOI and FSSA participated in weekly HHS call.

- 1: Medicaid Director Casanova participated in NASMD Executive Committee and Medical Director Executive Committee conference call.
- 5: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 6: IDOI participated in Standard Definitions Sub-Committee of NAIC.
- 6: FSSA ACA Medicaid Expansion & Medicaid Disability work groups met.
- 6: FSSA participates in a CMS call regarding healthcare.gov
- 7: FSSA ACA Pharmacy work group met for the first time.
- 7: IDOI Compliance and Financial Services Divisions met to discuss MLR and financial reporting pursuant to ACA.
- 7: IDOI participated in NAIC Commissioner's call concerning ACA.
- 7: IDOI participated in NAIC Financial Committee reporting call.
- 7: IDOI submitted Rate Review Grant.
- 8: FSSA & IDOI participated in the weekly HHS call.
- 8: IDOI provided suggested consumer definitions for NAIC Definitions Sub-Group.
- 8: IDOI participated in NAIC Explanation of Coverage Sub-Group.
- 12: IDOI participated in NAIC Accident & Health Actuarial Sub-Group for ACA Rebate Calculation development.
- 13: IDOI participated in NAIC Consumer Definitions call.
- 13: IDOI participated in HHS call concerning protection of medical information.

## **NEW FEDERAL HIGH RISK POOL PROGRAM NOTICE**

**The Department of Health and Human Services (HHS) released information July 1, 2010 regarding the federal high risk insurance program. This program, named Pre-Existing Condition Insurance Plan (PCIP), is now accepting applications. Applicants approved for coverage will be effective August 1, 2010.**

**The following conditions must be met in order to enroll in PCIP:**

- **You must be a citizen, national or be lawfully present in the United States;**
- **You must be uninsured for at least the last six months;**
- **You must be unable to obtain health insurance due to an existing health condition**

**Additional information may be found at [www.PCIP.gov](http://www.PCIP.gov) or by calling 1-866-717-5826.**

**Indiana residents with a pre-existing health condition do have another option for coverage. The Indiana Comprehensive Health Insurance Association, or ICHIA, will still be available to residents as it has been since 1982. ICHIA currently provides coverage for nearly 7000 Indiana residents. ICHIA does not require an individual to be without coverage for six months. Information on this program may be found at [www.onlinehealthplan.com](http://www.onlinehealthplan.com) (enter as a guest) or by calling 1-800-552-7921.**

# Healthy Indiana Plan: The First Two Years

Carol Irvin  
July 15, 2010

Health Finance Commission  
Indianapolis, IN

**MATHEMATICA**  
Policy Research, Inc.

# Mathematica Policy Research

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- **Nationally recognized research organization**
  - In its fifth decade of conducting research on social policy, including health services research and evaluation
  
- **An employee-owned organization of more than 700 staff**
  
- **Headquartered in Princeton, NJ, with offices in**
  - Ann Arbor, MI
  - Cambridge, MA
  - Chicago, IL
  - Oakland, CA
  - Washington, DC

# Notable Research

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- **Related Evaluation Projects**
  - Medicaid managed care programs
  - Children’s Health Insurance Program (CHIP)
  - Oklahoma’s Soonercare program
  - Maine’s Dirigo Health Reform Plan
  
- **For Indiana**
  - An economic and market analysis for the Indiana State Planning Grant that assessed trends in economic conditions and insurance markets
  - Conducted in 2004

# HIP Evaluation Research Team

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- **Contracted with OMPP to conduct an independent evaluation of the Healthy Indiana Plan (HIP), as required by the terms of the demonstration**
  - **Contract began May 1, 2009**
  
- **Mathematica Policy Research**
  - **Project Director: Carol Irvin, Ph.D.**
  - **Core Research Team: Tim Lake, Ph.D., Sheila Hoag, M.A., Maggie Colby, M.P.P., and Vivian Byrd, M.P.P.**
  - **Survey Director: Holly Matulewicz, M.A.**
  
- **Cindy Collier Consulting LLC**

# Outline of Presentation

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- **Broad Overview of the HIP**
- **Review of Key Findings to Date**
  - Enrollment trends
  - Member characteristics
  - Value-based purchasing
  - Service use
  - Fiscal conditions
- **Plans for Future Research**

# The Healthy Indiana Plan

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- **Expands coverage for low-income, uninsured working-age adults**
  - Not eligible for Medicaid and no access to employer-based coverage
  - Uninsured at least six months
  - Family income must be less than 200 percent of the federal poverty level (FPL)
  
- **Members are either:**
  - Parents of children in Hoosier Healthwise (caretakers)
  - Childless adults (non-caretakers)

# The Healthy Indiana Plan (cont'd)

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- **Choice of health plans**
  - Anthem
  - MDwise
  
- **Members with selected, high-cost conditions enter the Enhanced Services Plan (ESP)**
  - Administered by the Indiana Comprehensive Health Insurance Association (ICHIA)

# The Healthy Indiana Plan (cont'd)

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- **Operates under the authority of a Medicaid 1115 demonstration waiver**
- **Federal government pays a portion of the costs (in 2009, 74 percent of costs)**
- **Subject to special terms and conditions**
  - **Must be budget neutral in terms of federal costs and enrollment of non-caretakeers is limited to 36,500**

# POWER Accounts – Key Design Feature of the HIP

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- **Personal Wellness and Responsibility (POWER) accounts**
  - Members contribute each month to their POWER account
  - A member's health care costs are first charged to the POWER account until the account is exhausted
  - Accounts are set at \$1,100
  
- **Monthly POWER account contributions**
  - Set on a sliding scale
  - No more than 5 percent of family income
  
- **State subsidizes the balance when monthly contributions do not total \$1,100**

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# Enrollment Trends

# Enrollment in the HIP Has Been Strong

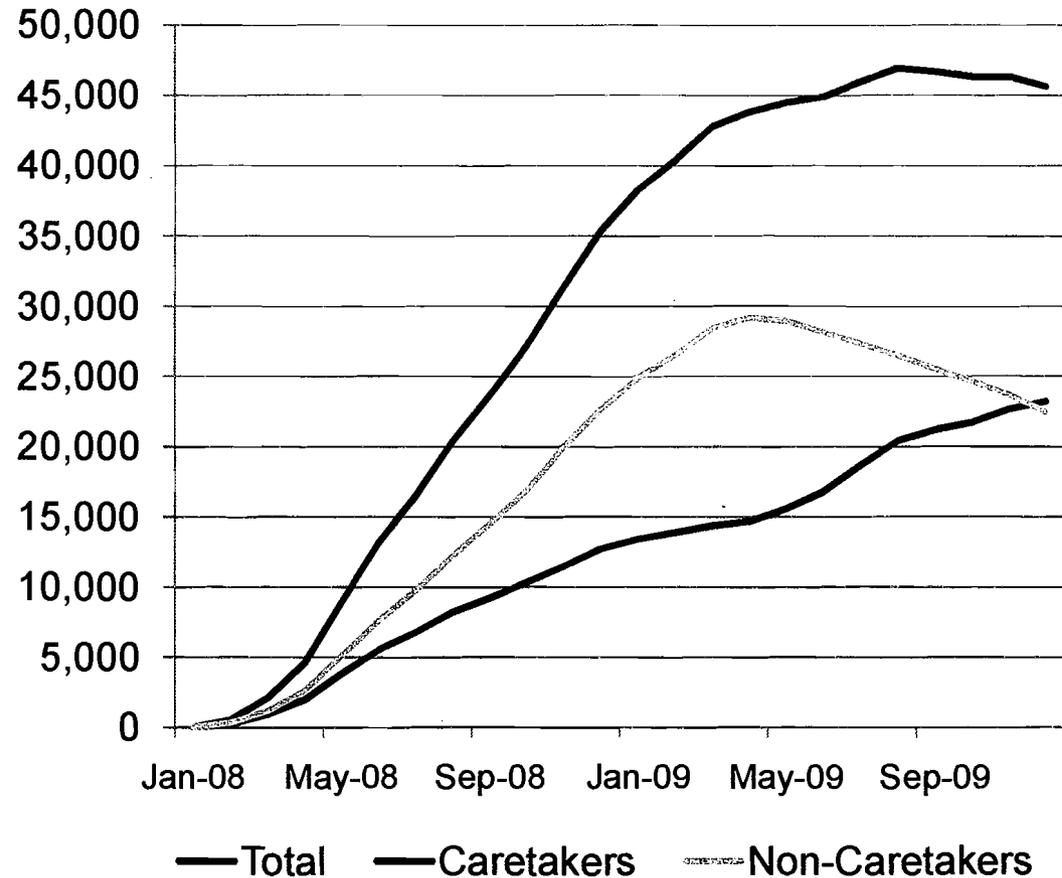
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- **During the first two years of program operations, the HIP served 61,797 Hoosiers**
- **By the end of 2009, the HIP had reached approximately 16 percent of likely eligible Hoosiers**
  - **35 percent of likely eligible caretakers**
  - **11 percent of likely eligible non-caretakers**

# Enrollment Grew Steadily Until Mid-2009

- At the close of 2009, HIP enrollment was 45,460 members
- Non-caretakers enrolled in greater numbers than caretakers until late 2009

Number Enrolled Each Month

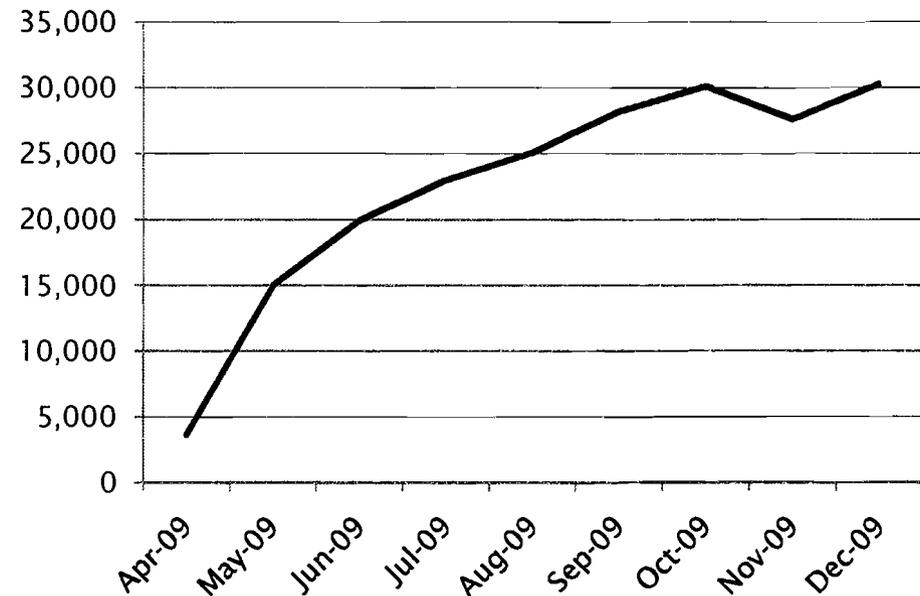


Source: Mathematica analysis of HIP eligibility records extracted on January 12, 2010.

# Enrollment of Non-Caretakers Closed in March 2009

- A waiting list was started and has shown steady growth
- 5,000 were invited to reapply in November 2009

Number of Applicants on Non-Caretaker Waiting List

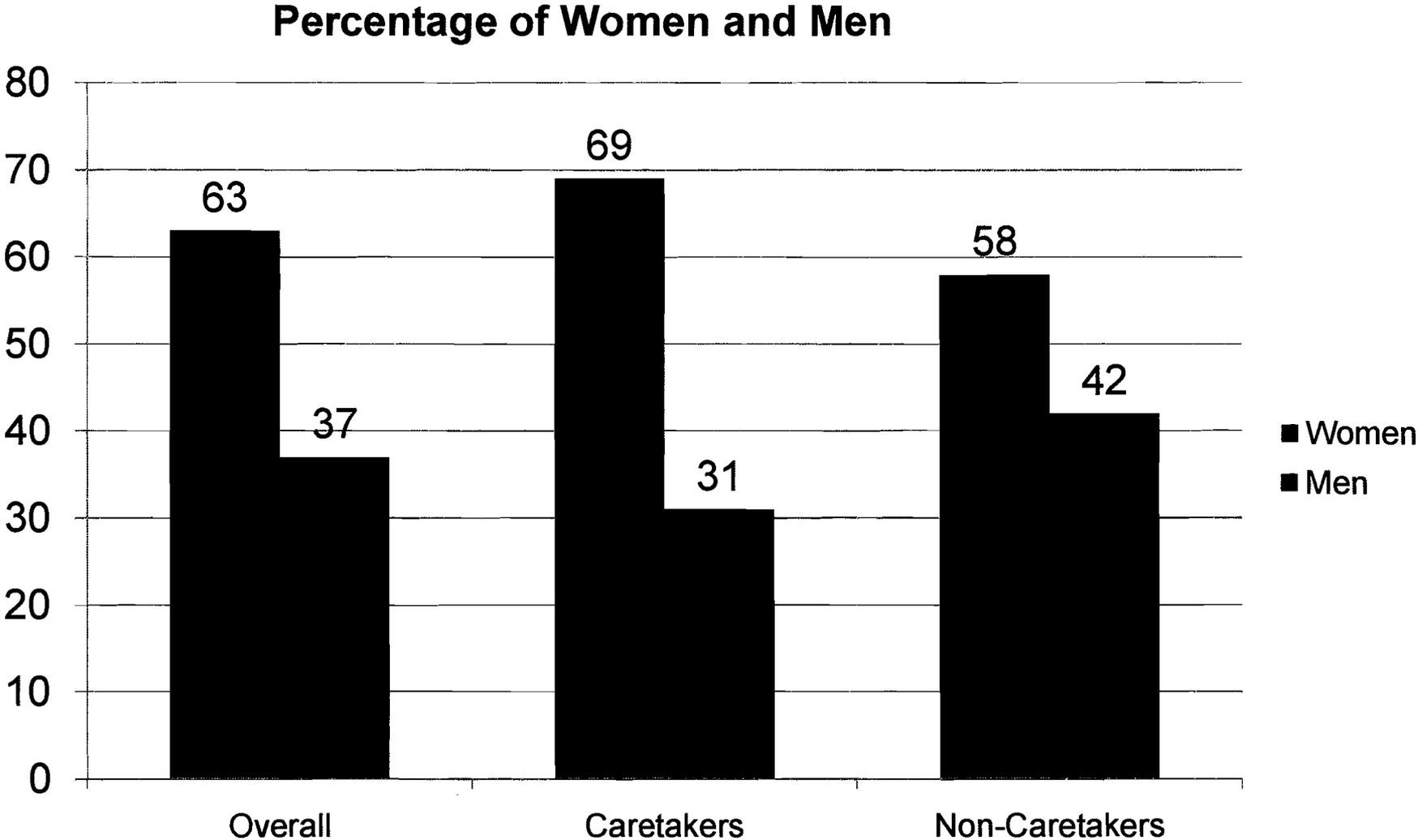


Source: Mathematica analysis of HIP Dashboards.

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# Member Characteristics

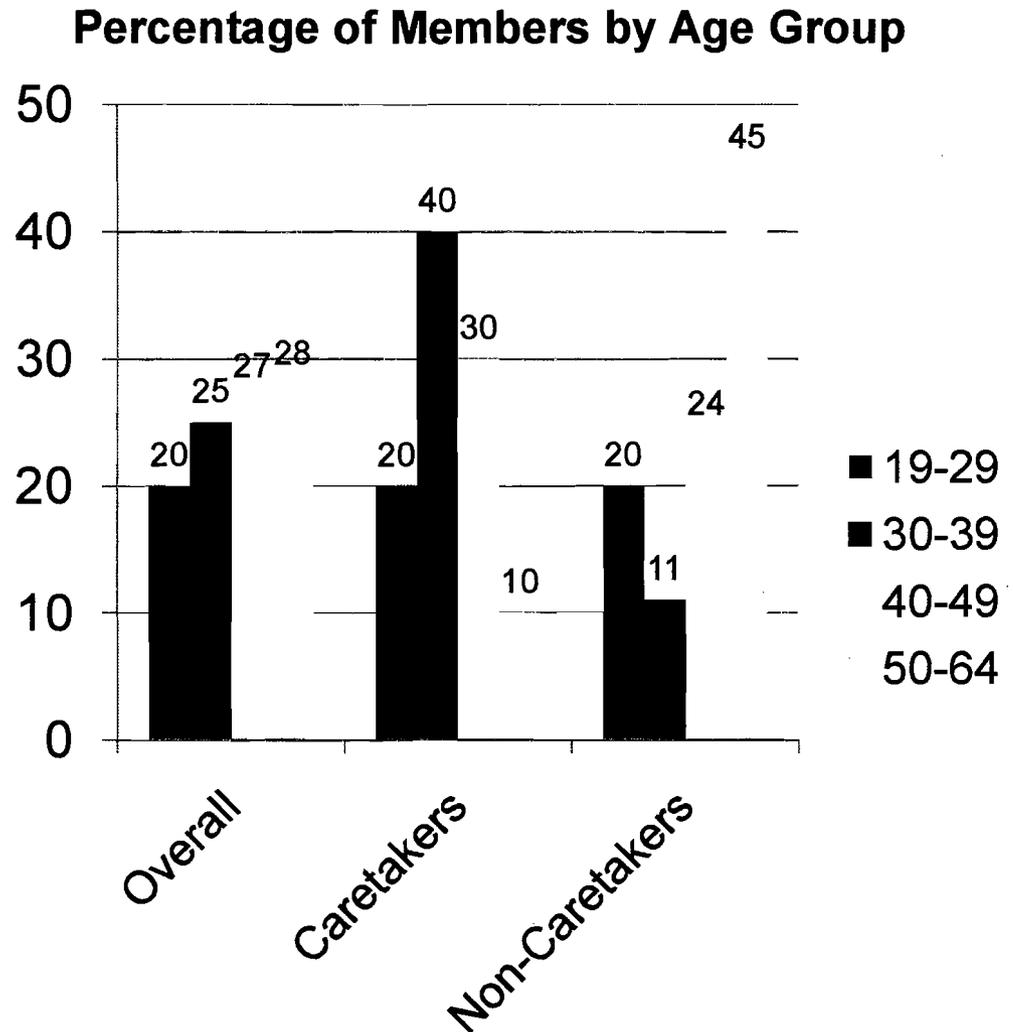
# The HIP Has Enrolled More Women Than Men



Source: Mathematica analysis of HIP eligibility records extracted on January 12, 2010.

# The HIP Has Enrolled Adults of All Ages

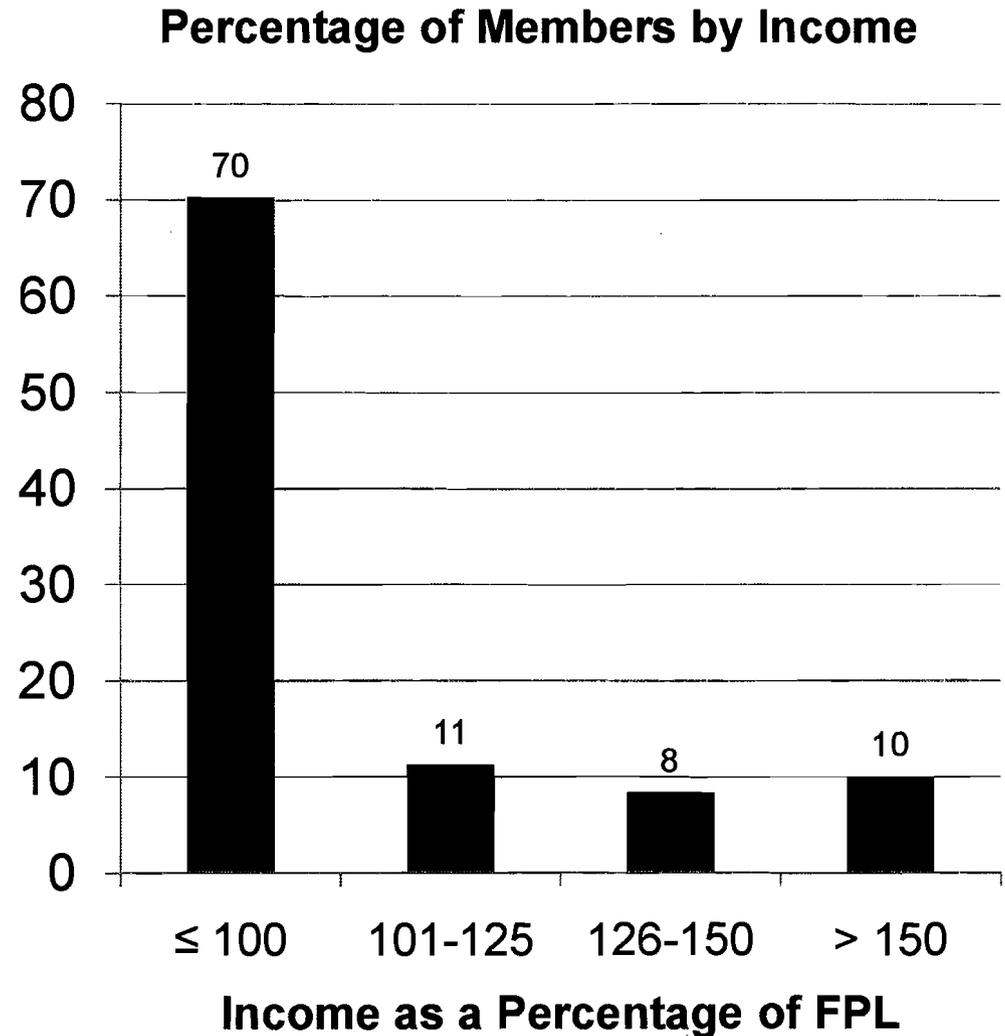
- More than one-quarter of HIP members are 50 years or older (early retirees)
- Non-caretakers are older than caretakers



Source: Mathematica analysis of HIP eligibility records extracted on January 12, 2010.

# Most HIP Members Are Poor

- **70 percent of members have income at or below the federal poverty level (FPL)**



Source: Mathematica analysis of the December 2009 HIP Dashboard.

# More Members Have Selected Anthem

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- **Of members enrolled in 2009:**
  - **66 percent were in Anthem**
  - **33 percent were in MDwise**
  - **1 percent were in the ESP**

# Chronic Disease Is Common Among HIP Members

## Percentage of Members with Chronic Conditions by Condition Category

<b>Condition Category</b>	<b>All</b>	<b>Caretakers</b>	<b>Non-Caretakers</b>
<b>Number of Members</b>	<b>61,784</b>	<b>29,246</b>	<b>32,538</b>
<b>Percentage with Selected Condition</b>			
<b>Pulmonary</b>	<b>38</b>	<b>34</b>	<b>42</b>
<b>Skeletal and Connective</b>	<b>31</b>	<b>24</b>	<b>37</b>
<b>Cardiovascular</b>	<b>28</b>	<b>18</b>	<b>37</b>
<b>Metabolic</b>	<b>28</b>	<b>21</b>	<b>34</b>

Source: Mathematica analysis of HIP encounter records.

Note: Condition categories based on the Chronic Illness and Disability Payment System (CDPS).

# Low Cost Chronic Conditions and Comorbidities Are Common

## Percentage of HIP Members by Number of Chronic Conditions

Category	Number of Members	Number of Chronic Conditions		
		None	1-2	3 or More
Low-, Medium-, and High-Cost Chronic Conditions				
All HIP Members	61,784	21	28	51
Caretakers	29,246	27	31	41
Non-Caretakers	32,538	16	24	60
Medium- and High-Cost Conditions Only				
All HIP Members	61,784	82	17	1
Caretakers	29,246	89	11	< 1
Non-Caretakers	32,538	76	22	2

Source: Mathematica analysis of HIP encounter records.

Note: Condition categories based on the Chronic Illness and Disability Payment System (CDPS).

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# Value-Based Purchasing

# The HIP Evaluation Assessed Three Elements

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- **Enrollment patterns**
- **POWER accounts**
  - Monthly contributions
  - Rollovers
- **Copayments for emergency room (ER) services**

# Members Value the HIP

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- **HIP members tend to stay enrolled in the program**
  - Only 26 percent of those ever enrolled have left the HIP
  - Of those who left:
    - 38 percent left within first 12 months
    - 55 percent left at redetermination
    - 7 percent left in the second year of eligibility
  
- **At eligibility redetermination**
  - About 85 percent submitted materials
  - Nearly 75 percent who submitted materials continued to be eligible

# Most Members Contribute to Their POWER Account

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- **During 2009, the percentage of members making a monthly contribution to their POWER accounts climbed**
  - 65 percent in January 2009
  - 74 percent in December 2009
- **Those not contributing either had no income or were already contributing at least 5 percent of family income for their children's health insurance coverage**

# 90 Percent Paid First Monthly Contribution

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- **Between January 2008 and December 2009, the HIP served 61,797 Hoosiers**
- **During the same time period, 6,581 members were disenrolled because they did not pay the first monthly contribution to their POWER account**

# Half Not Paying First Contribution Had Income Above Poverty

---

## Members Who Did Not Pay the First Monthly Contribution

FPL Level	Number	Percentage
Total	6,581	100
≤ 22% FPL	236	4
23 - 50% FPL	700	11
51 - 100% FPL	2,292	35
101 - 150% FPL	2,226	34
≥ 151% FPL	1,127	17

Source: OMPP data request number 7257, June 3, 2010.

# Many Not Paying Had Annual Contributions Between \$100 and \$500

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## Members Who Did Not Pay the First Monthly Contribution

Annual Contribution	Number	Percentage
Total	6,581	100
≤ \$100 per year (≤ \$8.33 per month)	781	12
\$101 - \$500 per year (\$8.34 - \$41.66 per month)	3,223	49
\$501 - \$1,100 per year (\$41.67 - \$91.68 per month)	2,577	39

Source: OMPP data request number 7257, June 3, 2010.

# Almost All Members Continued Their Monthly Contributions

---

- **97 percent of the 61,797 members ever enrolled in the HIP as of December 2009 continued making the monthly contributions to their POWER account**
  - **3 percent (1,835 members) were disenrolled because they did not keep up with their monthly contributions to their POWER accounts**

# Most Not Keeping Up Contributions Had Income Near Poverty Line

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## Members Disenrolled for Not Paying Monthly Contribution

FPL Level	Number	Percentage
Total	1,835	100
≤ 22% FPL	81	4
23 - 50% FPL	249	14
51 - 100% FPL	755	41
101 - 150% FPL	549	30
≥ 151% FPL	201	11

Source: OMPP data request number 7257, June 3, 2010.

# POWER Accounts Encourage Personal Responsibility

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- **Preventive services in excess of \$500 can be charged against the POWER account**
  - In 2008, no preventive services were charged to POWER accounts
  - In 2009, MDwise continued to provide all preventive services at no charge to POWER accounts and Anthem did as well until July 1
  
- **If the member obtains the required preventive services, remaining POWER account funds**
  - Roll over to the next year and are used to reduce subsequent monthly contributions

# Preventive Care Required for POWER Account Rollovers

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- **2008**

- Physical exam

- **2009**

- Physical exam
- Blood glucose screen
- Tetanus-diphtheria screen
- Cholesterol test, men age 35 and older and women age 45 and older
- Pap smear, women only
- Mammogram, women age 35 and older
- Flu shot, all members age 50 and older

# POWER Account Reconciliations Began in 2009

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- **The first group included 7,534 members who enrolled in January-June 2008**
  - 36 percent (2,732 members) in this group had POWER account funds eligible for a rollover
  - 80 percent (5,994 members) met the preventive care requirement
  
- **Of the 2,732 members who had funds to roll over**
  - 71 percent met the preventive care requirement and rolled over both the remaining member contributions and state subsidy
  - 29 percent did not meet the preventive care requirement and only rolled over remaining member contributions

# HIP Copayments

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- **Non-emergency ER visits require a copayment**
- **Copayment is determined by income and caretaker status**
- **Health plans review ER utilization and make final determination of copayment**

# Most ER Visits Are Among Caretakers with Emergencies

Number of ER Visits: October – December 2009

Copayment Category	ER Copayment Requirement	Number of ER Visits	Percentage of ER Visits
Total	—	10,667	100
Caretakers			
Emergency visits	\$0	6,376	60
Non-emergency visits			
≤ 100% FPL	\$3	1,176	11
101% - 150% FPL	\$6	262	2
151 - 200% FPL	\$25 or 20% of cost, whichever is less	118	1
Non-Caretakers			
< 200% FPL	\$25	2,735	26

Source: HIP Quarterly Reports to CMS, Quarters 3 and 4, 2009.

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# Service Utilization

# Preliminary Assessment

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- **Recent analysis**
  - **Physician office visits**
  - **Preventive services**
  
- **Ongoing analysis**
  - **Service costs**
  - **Emergency room visits**
  - **Pharmacy**

# 91 Percent Visited a Physician During the First Year

## Percentage Who Had a Physician Office Visit During the First 6 and 12 Months of Enrollment

Subgroup	First 6 Months	First 12 Months
All HIP Members	78	91
Men	69	85
19-34	63	79
35-49	71	86
50-64	70	88
Women	83	94
19-34	82	92
35-49	83	94
50-64	84	94

Source: Mathematica analysis of HIP encounter records extracted January 12, 2010.

Note: Members who enrolled January-June 2008 and stayed enrolled for at least 12 months.

# Nearly 60 Percent Obtained a Preventive Service

## Percentage Who Obtained a Preventive Service During the First 6 and 12 Months of Enrollment

Subgroup	First 6 Months	First 12 Months
All HIP Members	39	59
Men	23	40
19-34	10	22
35-49	23	39
50-64	29	49
Women	47	69
19-34	43	63
35-49	44	67
50-64	50	73

Source: Mathematica analysis of HIP encounter records extracted January 12, 2010.

Note: Members who enrolled January-June 2008, stayed enrolled for at least 12 months, and received at least one of the services required in 2009.

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# Fiscal Conditions

# The HIP Program Costs Are Shared

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- **Federal funds cover the majority of costs**
  - In 2009, approximately 74 percent of costs were covered by the federal government
  - The amount would have been approximately 64 percent if not for the enhanced funding Indiana received through the American Recovery and Reinvestment Act of 2009
  
- **Indiana pays the balance**

# The HIP Must Be Budget Neutral at the Federal Level

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- **The authority governing the demonstration requires budget neutrality**
  - **Indiana’s Hoosier Healthwise program plus the HIP cannot cost more than the Hoosier Healthwise program alone would have cost the federal government**
- **The HIP has been meeting this requirement, but projections suggest concern for the future**
  - **Costs for the Hoosier Healthwise population less than expected**
  - **Health care costs for HIP members higher than expected, which required increased payment rates for the health plans**
  - **Among other strategies, addressing the problem by carving out pharmacy costs**

# Cigarette Tax Revenue Funds the State Costs

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- **In 2009, the costs of the HIP for Indiana exceeded tax revenue collected for the year**
  - The HIP had to use reserved funds
- **Early signs indicate that tax revenue may decline in 2010, partly due to the federal excise tax increase in 2009**
  - State economic climate may reduce sales as well
- **New regulations prevent the HIP from changing eligibility criteria**
  - State costs could be an issue if the enrollment of caretakers continues to climb

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# Summary

# Summary

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- **The HIP has been well received**
  - Strong enrollment
  - Reports of high levels of satisfaction
  
- **HIP member characteristics are notable**
  - Age – many are soon to be eligible for Medicare
  - High level of chronic conditions
  - Willingness to contribute to the costs of their care
  
- **Most HIP members visit physicians and get recommended preventive care**

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# Future Work

# Assessment of Seven Goals

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- 1. Reduce the number of uninsured low-income Hoosiers**
- 2. Improve statewide access to health care services for low-income Hoosiers**
- 3. Promote value-based decision making and personal responsibility**
- 4. Promote primary prevention**
- 5. Prevent chronic disease progression with secondary prevention**
- 6. Provide appropriate and quality-based health care services**
- 7. Assure state fiscal responsibility and efficient management of the program**

# Current Work

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- **More analyses of claims records**
  - **More in-depth analyses of service utilization patterns, particularly ER services**
  - **Patterns in the cost of care to better understand the key components of HIP costs**
  
- **Survey of HIP members**
  - **Survey in the field right now**
  - **Scheduled to end in September 2010**
  - **Results available in early 2011**

HFC July 15, 2010 Exh 8



Healthy Indiana Plan<sup>SM</sup>, a health plan for adult Hoosiers sponsored by the State of Indiana



Health. Join In.



Get Healthy.

Anthem Blue Cross and Blue Shield is one of the top medical health plans for the Healthy Indiana Plan, a new health plan sponsored by the State of Indiana.

Use your HIP plan to get healthy.

\$500 coverage for Preventive Care.

At Anthem, we believe it pays to take care of your health. That's why each benefit period the first \$500 in preventive services do not count against the POWER Account. See the questions and answers section in this brochure for more details.

A. The Healthy Indiana Plan<sup>SM</sup> (HIP) is a new, affordable health care program for uninsured adult Hoosiers. The program offers full health coverage, including hospital, doctor visits, mental health services, and prescription drugs. The program is sponsored by the State of Indiana and only requires minimal monthly contributions from the participant.

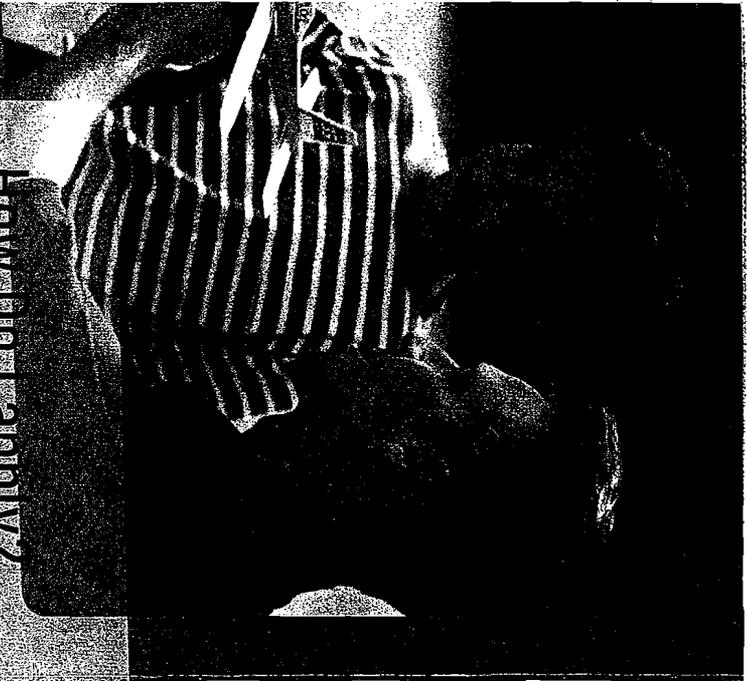
A. HIP is for uninsured Hoosier adults between the ages of 19 - 64. Parents or caretaker relatives of children in the Hoosier Healthwise program are likely candidates for HIP. Eligibility requirements for HIP include:

1. You must not have access to other health coverage through your employer.
2. You must be uninsured for the previous six months.
3. You must earn less than 200% of the federal poverty level (FPL).

A. Participants will pay between 2% and 5% of their gross family income to have the security of health care. The exact cost will depend on income and family size, based on a sliding scale.

A. All participants will have a Personal Wellness and Responsibility Account or "POWER Account." Participants use this account to pay for their first \$1,100 of initial medical expenses. Your account contains your required monthly contributions, as well as State contribution, for a combined total of \$1,100. All you need to do is present your identification card at time of service. The correct amount will automatically be deducted from your POWER Account when the claim is processed.

A. At the end of the year if all age and gender appropriate preventive services have been received, the entire account balance (including the State's portion) stays in your account. This means you will owe less for your health care in your second year. However, if you don't get your recommended preventive health services, only the unused amount you contributed stays in the account. The State's portion will go back to the state.



## How Do I apply?

You can download applications from the internet ([www.HIP.in.gov](http://www.HIP.in.gov)) or pick them up at various organizations and enrollment centers in your community. To find a location near you or to have an application mailed to you, call 1-877-GET-HIP-9 (toll-free). When you apply you will need proof of income, like a pay stub, as well as proof of identity, like a birth certificate or Social Security card.

**Anthem Blue Cross  
and Blue Shield  
also serves Hoosier  
Healthwise.**

**Hoosier Healthwise is a health insurance program for Indiana children, pregnant women, and low-income families. Health care is provided at little or no cost to Indiana families enrolled in the program.**

**Call 1-800-889-9949 to get information about the Hoosier Healthwise program.**

**HP**  
HEALTHY INDIANA PLAN<sup>SM</sup>  
Health Coverage = Peace of Mind

**Anthem.** Health. Join In.

This brochure is only a summary of benefits. It isn't part of the member handbook. The member handbook you will receive if you're approved for coverage includes all the details of the plan. In the event of a conflict between the information in this brochure and your member handbook, the terms of your member handbook will prevail. Read your member handbook carefully. Anthem has the right to amend, cancel or terminate your coverage based on provisions described in the employer handbook.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Interposition license of the Blue Cross and Blue Shield Association. \*Anthem is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

**Uninsured?  
We've got you  
covered Indiana!**



Healthy Indiana Plan<sup>SM</sup>, a health plan for adult Hoosiers sponsored by the State of Indiana

**Anthem.**   
Health. Join. In.

**HIP**  
HEALTHY INDIANA PLAN<sup>SM</sup>  
Health Coverage = Peace of Mind



**Get HIP.  
Get Healthy.**

**Anthem Blue Cross and Blue Shield  
is one of the trusted health plans  
for the Healthy Indiana Plan,  
a new health plan sponsored  
by the State of Indiana.**

**Use your HIP plan to get healthy.  
\$500 coverage for Preventive Care.**

At Anthem, we believe it pays to take care of your health. That's why each benefit period the first \$500 in preventive services do not count against the POWER Account. See the questions and answers section in this brochure for more details.

## How Do I Get HIP?

### Q. WHAT IS HIP?

A. The Healthy Indiana Plan<sup>SM</sup> (HIP) is a new, affordable health care program for uninsured adult Hoosiers. The program offers full health coverage, including hospital, doctor visits, mental health services, and prescription drugs. The program is sponsored by the State of Indiana and only requires minimal monthly contributions from the participant.

### Q. WHO IS ELIGIBLE?

- A. HIP is for uninsured Hoosier adults between the ages of 19 - 64. Parents or caretaker relatives of children in the Hoosier Healthwise program are likely candidates for HIP. Eligibility requirements for HIP include:
1. You must not have access to other health coverage through your employer.
  2. You must be uninsured for the previous six months.
  3. You must earn less than 200% of the federal poverty level (FPL).

### Q. HOW MUCH DOES IT COST TO PARTICIPATE?

A. Participants will pay between 2% and 5% of their gross family income to have the security of health care. The exact cost will depend on income and family size, based on a sliding scale.

## This Plan Uses a POWER Account

### Q. WHAT IS A POWER ACCOUNT? WHERE DOES MY MONEY GO?

A. All participants will have a Personal Wellness and Responsibility Account or "POWER Account." Participants use this account to pay for their first \$1,100 of initial medical expenses. Your account contains your required monthly contributions, as well as State contribution, for a combined total of \$1,100. All you need to do is present your identification card at time of service. The correct amount will automatically be deducted from your POWER Account when the claim is processed.

### Q. WHAT IF I DON'T USE \$1,100 OF SERVICES? WHAT HAPPENS TO THE MONEY IN MY POWER ACCOUNT?

A. At the end of the year if all age and gender appropriate preventive services have been received, the entire account balance (including the State's portion) stays in your account. This means you will owe less for your health care in your second year. However, if you don't get your recommended preventive health services, only the unused amount you contributed stays in the account. The State's portion will go back to the state.

**¿No esta  
asegurado?  
¡En Indiana  
lo cubrimos!**



**Healthy Indiana Plan<sup>SM</sup>, un plan  
de salud para Hoosiers adultos  
patrocinado por el Estado de Indiana**

**Anthem**   
Health. Join In.

**HIP**  
HEALTHY INDIANA PLAN  
Healthy Coverage. Peace of Mind.



**Obtenga HIP.  
Obtenga Salud.**

**Anthem Blue Cross and Blue Shield  
es uno de los planes de salud  
confiables para el Healthy Indiana  
Plan (HIP), un nuevo plan de salud  
patrocinado por el Estado de Indiana.**

**Use su plan HIP para quedarse  
en buena salud.**

**Cobertura de 500 dólares para  
Cuidado Preventivo.**

En Anthem, creemos que vale la pena cuidar de su salud. Por eso, durante cada período de beneficio, los primeros 500 dólares en servicios preventivos no se tienen en cuenta para la Cuenta POWER. Consulte la sección de preguntas y respuestas de este folleto para obtener más detalles.

**¿Cómo obtengo el HIP?**

**P. ¿QUÉ ES EL HIP?**

R. El Healthy Indiana Plan<sup>SM</sup> es un programa de asistencia médica nuevo y económico para los residentes de Indiana adultos no asegurados. El programa ofrece la cobertura de salud completa, incluida la hospitalización, las visitas del médico, los servicios de salud mental y los medicamentos de prescripción. El programa es patrocinado por el Estado de Indiana y sólo requiere contribuciones mensuales mínimas de parte del participante.

**P. ¿QUIÉN ES ELEGIBLE?**

R. El HIP es para residentes de Indiana adultos no asegurados entre los 19 y 64 años de edad. Los padres o los parientes que cuidan de los niños en el programa Hoosier Healthwise son candidatos probables para el HIP. Los requisitos de elegibilidad para el HIP incluyen:

1. Usted no debe tener acceso a otra cobertura de salud a través de su empleador.
2. Usted no debe haber estado asegurado durante los últimos seis meses.
3. Usted debe ganar menos del 200% del nivel de pobreza federal (FPL).

**P. ¿CUÁNTO CUESTA PARTICIPAR?**

R. Los participantes pagarán entre el 2% y el 5% de sus ingresos familiares brutos para tener la seguridad de asistencia médica. El costo exacto dependerá de los ingresos y del tamaño de la familia, con base en una escala gradual.

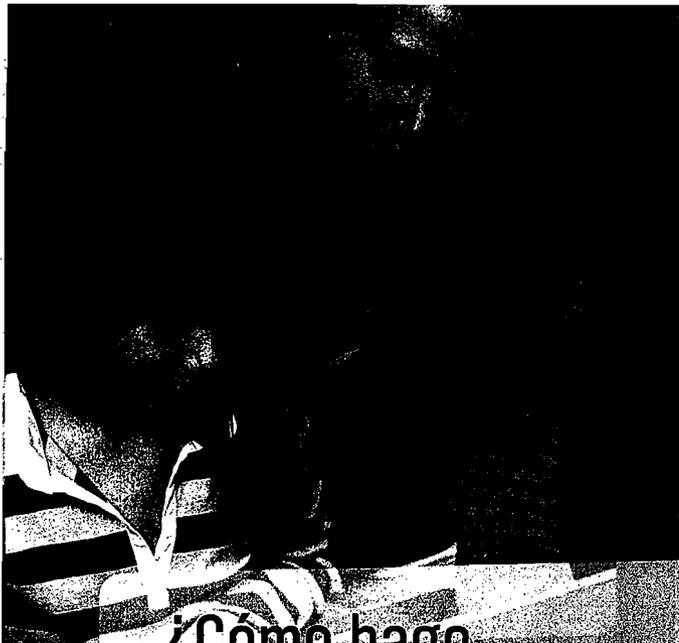
**Este Plan usa una Cuenta POWER.**

**P. ¿QUÉ ES UNA CUENTA POWER? ¿ADÓNDE VA MI DINERO?**

R. Todos los participantes tendrán una Cuenta de Responsabilidad y Salud Personal o "Cuenta POWER". Los participantes usan esta cuenta para pagar sus primeros 1,100 dólares de gastos médicos iniciales. Su cuenta contiene sus contribuciones mensuales requeridas, así como la contribución Estatal, para un total combinado de 1,100 dólares. Todo lo que usted tiene que hacer es presentar su tarjeta de identidad al momento del servicio. La cantidad correcta será descontada automáticamente de su Cuenta Power cuando se procese la reclamación.

**P. ¿QUÉ PASA SI NO UTILIZO 1,100 DÓLARES DE SERVICIOS?  
¿QUÉ LE SUCEDE AL DINERO EN MI CUENTA POWER?**

R. Al final del año, si se han recibido todos los servicios preventivos apropiados de acuerdo con la edad y el sexo, el saldo completo de la cuenta (incluida la parte del Estado) permanece en su cuenta. Esto significa que usted deberá menos para su asistencia médica en su segundo año. Sin embargo, si usted no consigue sus servicios de salud preventivos recomendados, sólo la cantidad no usada que usted aportó permanece en la cuenta. La parte del Estado volverá al estado.



## ¿Cómo hago la solicitud?

Puede descargar las solicitudes de Internet ([www.HIP.in.gov](http://www.HIP.in.gov)) o recogerlas en varias organizaciones y centros de inscripción en su comunidad. Para encontrar un sitio cerca de usted o para hacer que le envíen una solicitud por correo, llame al 1-877-GET-HIP-9 (línea gratis). Al hacer la solicitud, usted necesitará la prueba de ingresos, como un talón de pago, así como una prueba de su identidad, como la tarjeta de seguridad social o una certidão de nacimiento.

**¿DESEA MÁS INFORMACIÓN?**  
**1-877-GET-HIP-9 (línea gratis)**  
**[www.HIP.in.gov](http://www.HIP.in.gov)**

**Anthem Blue Cross and Blue Shield también presta servicios al Hoosier Healthwise.**

**El Hoosier Healthwise es un programa de seguro médico para niños, mujeres embarazadas y familias de bajos ingresos de Indiana. La asistencia médica es proporcionada con poco o ningún costo a las familias de Indiana inscritas en el programa.**

**Llame al 1-800-889-9949 para obtener información sobre el programa Hoosier Healthwise.**



Este folleto es sólo un resumen de los beneficios; no forma parte de la guía de miembros. La guía de miembros que usted recibirá si es aprobado para la cobertura incluye todos los detalles del plan. En caso de un conflicto entre la información de este folleto y la guía de miembros, los términos de la guía de miembros prevalecerán. Lea la guía de miembros con cuidado. Anthem tiene derecho a rescindir, anular o terminar su cobertura con base en las disposiciones descritas en la guía de miembros.

Anthem Blue Cross and Blue Shield es el nombre comercial de Anthem Insurance Companies, Inc., y es un concesionario independiente de la Blue Cross and Blue Shield Association. \*Anthem es una marca comercial registrada. Los nombres y símbolos de Blue Cross and Blue Shield son marcas registradas de la Blue Cross and Blue Shield Association.

HEC July 15, 2010 Exh. 7

July, 2010



**Anthem**  
**Healthy Incentives**

JULY, 2010



# Intensive Community Based Outreach

- Outbound Call Center
  - 4 Representatives plus 1 Supervisor
- Get HIP Outreach Team
  - 1 Coordinator
  - 4 Outreach Specialists and Adding 1 in Ft Wayne
    - North
    - Southwest
    - Southeast
    - Central
- Anthem Community Resource Centers
  - Three Anthem CRCs: Northwest, Central and Southwest
  - 4 Member Outreach Specialists
  - 1 Community Health Programs Consultant
  - 1 Health Promotions Specialist
  - 4 Provider Network Education Representatives (RNs)
  - 2 Clinical Quality Compliance (HEDIS) Administrators (RNs)

# Conditional Members

Members Are Not Fully Enrolled Until Their Initial Contribution is Processed

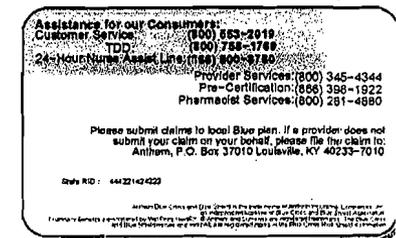
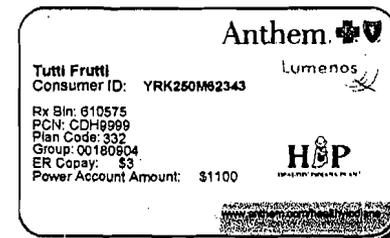
- Initial Contribution Must Be Received Within 60 Days
  - Outbound Calls at 45 Days
- Anthem Sends Notice Member Has Paid
  - Checks held 10 days first
- Anthem Receives File From the State (HP) to Fully Enroll Member
  - Anthem Automated Processes Receive the File and Update Enrollment System
- Effective Date is Given to Anthem on the File
- Effective Date Always First of the Month and Never Retro

# Fully Enrolled Members

File Received from HP

Records at Enrollment Broker, State and MCO must be in Sync

- Anthem Receives File From the State (HP) to Fully Enroll Member
  - Anthem Automated Processes Receive the File and Update Enrollment System
  - Triggers Set Up of POWER Account and Generation of ID Card and Letter
  - File Generated for Outbound Welcome Calls and Welcome Packets
  - Welcome Packet Includes Materials for Employer Contribution
- Invoices are Automatically Generated and Mailed Monthly for Required POWER Account Contribution - Due 1<sup>st</sup> of Month
  - Notice Sent for Termination if 65 Days Delinquent

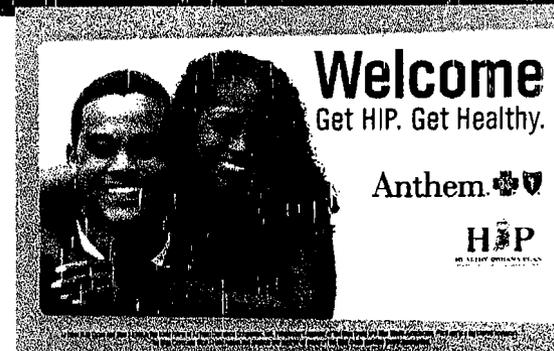


# Member and Community Outreach

## Outbound Call Center

Approximately 65% Success Rate Reaching Members by Telephone

- Initial Contribution Follow-up at 30 days
- Welcome Calls - Explain Basics and Identify Possible ESP
- Assist Pregnant Members to Transfer to Hoosier Healthwise
- Contribution Delinquency at 45 Days
- Annual and Lifetime Maximum Risk
- Recertification Reminder and Preventive Services Reminder
- Notice of Transfer to Enhanced Services Plan
- Mail New Member Welcome Packets (English and Spanish)
- Enter Health Assessment Information Received by Phone or Mail
- Send Birthday Cards with Preventative Care Reminder



# Member and Community Outreach

## Get HIP Outreach Team

- 30 New Member Meetings Each Month

Locations include:

- Anthem's Community Resource Centers
  - County Health Departments and Clinics
  - Work One
  - Community Based Organizations
  - Hospitals and Other Provider Offices
  - Faith Based Organizations
  - Pharmacies
- Health Fairs and Community Events – Promote and Facilitate HIP Enrollment
  - Partnerships with Community Organizations and Safety Net Providers



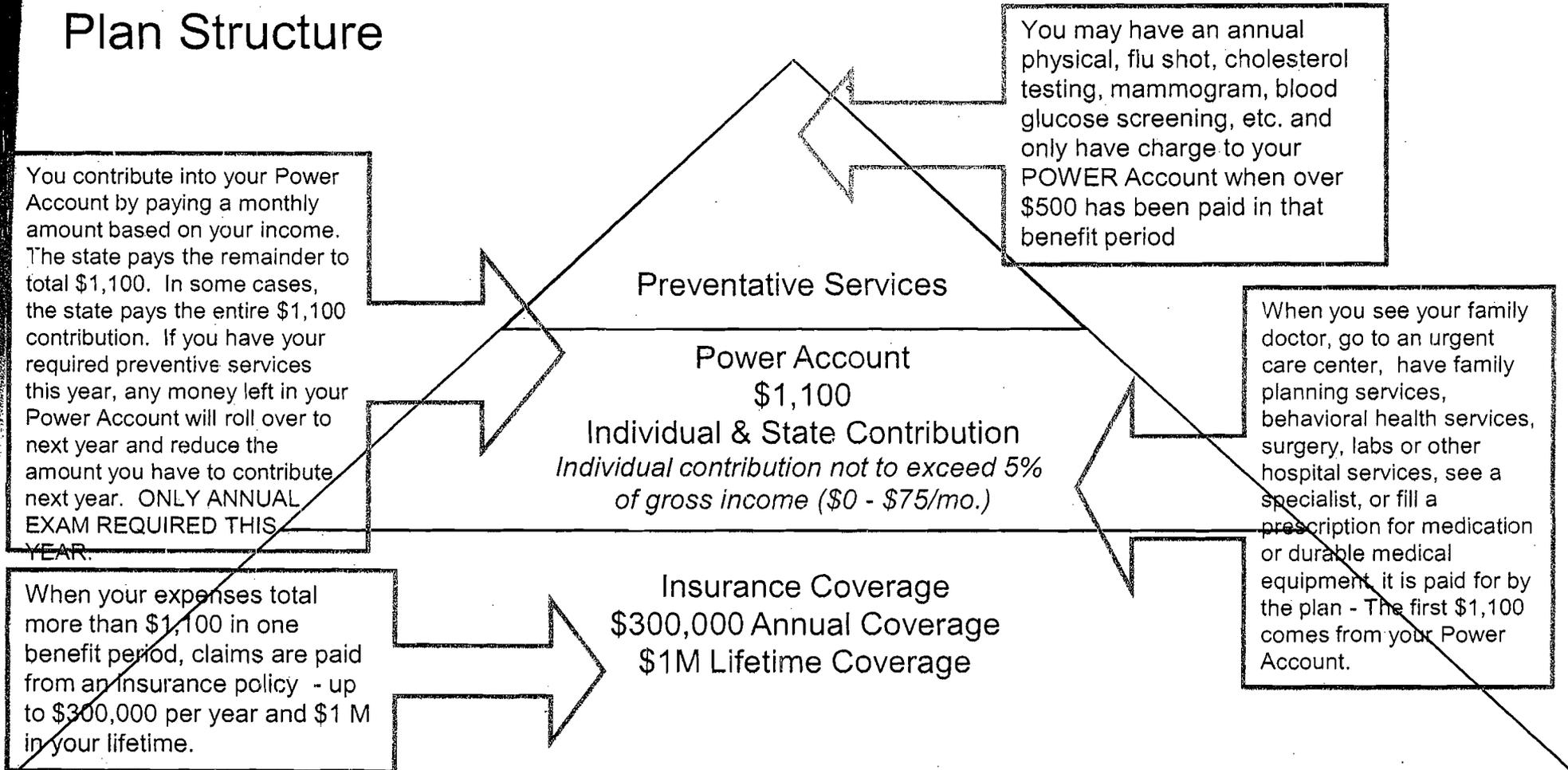
# Other Member Outreach

- Emergency Room Over Utilization
- Right Choices Program
- Transfer to Enhanced Services Plan (ESP)
- Missed Appointments or Other Provider Office Referrals
- Preventive Service Reminders
- Language Translation Assistance



# Example from Member Education Meeting

## Plan Structure



# Example from Member Education Meeting

## Example

Ms. Reed is 48 years old. She is not married and has no children.

Ms. Reed had a complete physical, including a mammogram, cholesterol screen, and blood glucose screen. She also had a flu shot this year. She went to in-network doctors, hospital, lab and radiologist and didn't have to pay anything.

Ms. Reed contributes \$66 per month to her Power Account and the state put in \$308. Since she has had her required preventive service this year, any money left in her Power Account at the end of the year will roll over to next year and reduce the amount she has to contribute to it next year.

Up to \$500  
Free  
Preventive Services

Power Account  
\$1,100  
Individual & State Contribution  
*Individual contribution not to exceed  
5% of gross income (\$0 - \$75/mo.)*

Ms. Reed had an eye infection and went to the urgent care center. They gave her a prescription for medicine to put in her eye. Ms. Reed paid nothing because she went to an in-network urgent care center. The claims were paid (\$60 for urgent care center and \$30 for medicine) and she now has \$1,010 left in her Power Account.

Ms. Reed hasn't used all of her Power Account yet. If something happens and she uses all \$1,100, her claims will be paid from this insurance policy up to \$300,000/ yr. The state pays the entire cost of the insurance for Ms. Reed.

Insurance Coverage  
\$300,000 Annual Coverage  
\$1M Lifetime Coverage

# Example from Member Education Meeting

## How to access what you need to know

- Call Member Services at 1 800-553-2019
- New Member Welcome Packet
- Anthem HIP website [www.anthem.com/healthyindiana](http://www.anthem.com/healthyindiana)
  - Obtain certificate/handbook online \*
  - Access the provider directory online AND On Cell Phone
  - Access prescription formulary list online
  - Where to obtain internet access
    - Anthem Community Resource Centers
    - Library
    - Neighborhood Resource Centers
    - Schools and Churches

\*You can also call the Member Helpline or return the eCert form by mail and a Handbook will be sent to you



# Healthy Indiana Plan Public Web Site

Anthem 

Overview

Customer Service

1-800-553-2019

Get to know

The Healthy Indiana Plan (HIP) is a new, affordable health insurance program for uninsured adult Hoosiers. The program offers comprehensive health benefits, including physician services, mental health services, and prescription drug coverage. If you have any questions please contact Member Customer Service at 1-800-553-2019 or TDD: 1-800-758-1769. Si no habla inglés, podemos traducir esta información a su idioma sin cargo adicional. Llame al número telefónico que figura en el reverso de su tarjeta de identificación (ID card).

Welcome Healthy Indiana Plan Members

Plan Overview

Plan Overview

General Information about Power Accounts

My Provider

Search for Providers

Search for Pharmacy Providers

360 Health

Prescription Drug Family

Health and Wellness Programs

Preventive Care

Other Useful Information

Member Handbook

HIP State of Indiana Site

HIPAA Notice of Privacy Practices

Annual Quality Improvement Report

Member Rights and Responsibilities

Benefit Guide

HIP  
HEALTHY INDIANA PLAN

To access the Anthem Healthy Indiana Plan public site, enter:

[www.anthem.com/healthyindiana](http://www.anthem.com/healthyindiana)

The site features the plan overview, provider search, member handbook and more.

Anthem 

HIP  
HEALTHY INDIANA PLAN



Anthem Blue Cross and Blue Shield  
Healthy Indiana Plan<sup>SM</sup>

WFL.COM

Anthem 

# MyAnthem™ Overview tab

**MyAnthem™**

Welcome Roger Harris [My Profile](#) [Contact Us](#) [Logout](#)

**Overview** | [Provider Finder](#) | [360° Health](#) | [MyAccount](#) | [MyClaims](#) | [MyBenefits](#)

Consumer ID: 205M00045

**Message Center**  
 You have 2 new messages

**Things You Can Do**

- Find A Provider
- Download Forms
- Manage My Profile
- Request ID Card
- HIA Plus Activity

**Health Tools and Resources**

- Anthem Care Comparison
- Hospital Comparison
- Medical Cost Estimators
- MyHealth Coach
- 24/7 Nurseline
- MyHealth Assessment
- Cheat Sheet
- Healthy Lifestyles

**My Account**

Annual HIA Plus Allocation: **\$125.00**  
 Current HIA Plus Balance: **\$125.00**

**360° Health**

- MyHealth Assessment
- MyHealth Coach

**Message Center**  
 View important messages about your health care

Message ID	Date	Category	Status
12345	3/21/2010	PHARMACY	Open
67890	3/27/2010	PHARMACY	Open

Number of Characters limited to: 1000  
 Response Preference:  
 Contact me by phone  
 Please respond via the Message Center

The Overview tab is designed to give quick access to the most commonly used tools and resources "at a glance"

- Secure Message Center
- Find a Provider
- Request ID Card
- Manage Profile
- Manage Prescriptions
- POWER Account Activity
- Quick links to 360° Health
- Contact Us

# MyAnthem™ Pharmacy tab

**MyAnthem™**

Welcome Donna [My Profile](#) [Contact Us](#) [Logout](#)

[Overview](#) [Provider Finder](#) **MyPharmacy** [360° Health](#) [My Account](#) [My Claims](#) [My Benefits](#)

**MyAnthem™ My Pharmacy**

**Member Information**

Name:

**Account Summary**

Total spent in the last 30 days	50.00
Total spent in the last 365 days	50.00

**Available for Refill**

No prescriptions Available

[Refill Prescription](#)

**Prescription Shipments**

No Shipped Orders Available

[View Order Status](#)

Manage your prescriptions through the My Pharmacy tab and take advantage of a host of other prescription related information and services

- Refill Prescription
- View Order Status
- View Pharmacy Benefits
- Search Drug List
- Look Up Drug Prices
- Check Drug Interactions

**MyAnthem™ Anthem.**

Welcome [My Profile](#) [Contact Us](#) [Help](#) [Logout](#)

[Overview](#) [MyPharmacy](#) [360° Health](#) [My Account](#) [My Claims](#) [My Benefits](#)

**Refill Prescriptions**

view prescriptions for:

Select	Rx Number	Drug Name	Expires Remaining	Next Refill Date	Patient Name	Rx Status
<input type="checkbox"/>	4272309	PREVACID-CAP 15MG DR	3	2007-09-10	SAW	Renew Now

[Place Refill](#) [Remove from List](#)



# MyAnthem™ 360° Health tab

MyAnthem™
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Welcome
MyAnthem | MyAnthem | MyAnthem

Overview
Provider Finder
MyPharmacy
**360° Health**
MyAccounts
MyClaims
MyBenefits

**RESOURCES**

- [Hospital Comparison on FHIR®](#)
- [Health Assessment](#)
- [Condition Spotter](#)
- [Preventive Care Guides](#)
- [Health Topics A-Z](#)
- [Health Outcomes](#)
- [Symptom Checker](#)
- [Labs](#)
- [Health Trackers](#)

## 360° Health

**Healthy Lifestyles**

Learn what steps to take to live healthier. Get tips and support to succeed including on-line nutrition, fitness and health assessment plans, up 7 smoking plans, nutrition and more to maintain a healthy weight, and more.

[Get the latest news and cutting edge health information](#)

**Update MyHealth Record**

RCV: Allow your health plan to send your claims to WebMD to populate MyHealth Record. This information is secure and only available to you.

I agree to allow my health plan to send claims to WebMD to populate MyHealth Record. [Click here](#)

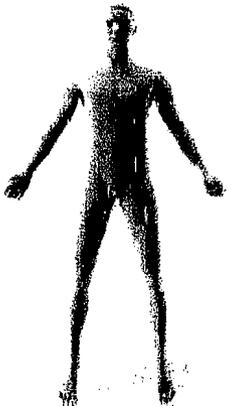
**Body Healthy**

- MyHealth Coach**  
Personalized information and resources to help you make a better health decision.
- MyHealth Assessment**  
An easy-to-complete tool to help you better understand your health.

**Access Health Info & Tools**

**Health Coach™**  
Program for your doctor, you, and shared conditions, treatments and hospital.

**WebMD**



- Skin
- Head/Neck
- Eyes/Ears
- Nose/Mouth
- Chest
- Back
- Arm/Hand
- Abdomen
- Male Groin
- Buttocks
- Leg/Foot

[Other Symptoms](#)

Front View  Back View

**CLAIMS STATUS**

[Change Claim Preferences](#)

**NEED HELP?**

[Contact Us](#)

[Frequently Asked Questions](#)

Our Privacy has definitions for the terms used on our site.

**360° Health -**  
Your gateway into leading a better, healthier life and becoming a more informed healthcare consumer

- Compare Hospitals
- Health Risk Assessment
- 3D Symptom Checker
- Personal Health Record
- Animated surgery guides
- Talk to a Health Coach

**Anthem.** Operated by: [Knee Arthroscopy Removal of Loose Tissue and Torn Cartilage](#) [Medical Term: Knee Arthroscopy](#)

• [Animation of Surgery](#)

[Explanation of Each Surgical Complication](#)

[List of Complications \(PDF\)](#)

[All Complications with Illustrations to Print](#)



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# MyAnthem™ My Account tab

Manage your POWER Account with easy-to-use tools and information

MyAnthem™
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Welcome Roger Harris [My Profile](#) [Contact Us](#) [Logout](#)

Overview [Provider Finder](#) [360° Health](#) **MyAccount** [My Claims](#) [My Benefits](#)

**Things You Can Do**

- [HIA Plus Activity](#)
- [Claims](#)
- [Account Analysis](#)

**Health Tools and Resources**

- [Download Forms](#)
- [Deductibles/Benefits Used](#)

**Need Help?**

- [Contact Us](#)
- [Glossary](#)

## My Account

### HIA Plus Summary

Annual HIA Plus Allocation:  
Current HIA Plus Balance:

---

### Bridge Details

Annual Bridge Amount:

**Traditional Health Coverage**

Begins after spending this amount on services:  
Begins after spending this amount on services:  
Amount spent to date on In-Network  
Amount spent to date on Out-of-Network

### Recent Claims Activity

You can view the five most recent final claims. The subscriber can view claim activity for adult dependents on the policy (including dependents age 18 and over).

Description	Amount
OSU Surgery LLC	\$1,200.00
University Family Physicians Inc	\$800.00
OSU Pathology Services LLC	\$500.00

Anthem 
View HIA Monthly Status  
For the current year: September 01, 2007 to September 30, 2007

Account Number: 123456789012  
Health Program #: 9876543210  
Plan: POWER  
Last Payment: 12/31/2006

### 1. Previous Account Information: Group Coverage (HIA) 2007

Description	Amount	Category
Medical (Preventive)	\$1,200.00	104
Medical (Non-Preventive)	\$800.00	104
Prescription Drugs	\$500.00	104

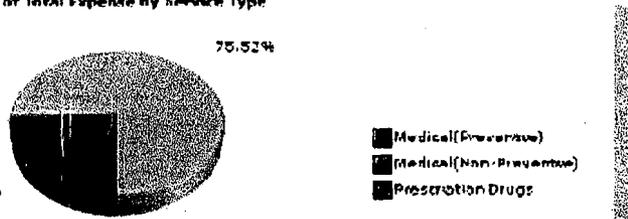
### 2. Summary of Health Coverage Activity (September 2007)

Address to Health Coverage System	Amount	Category
OSU Surgery LLC	\$1,200.00	104
University Family Physicians Inc	\$800.00	104
OSU Pathology Services LLC	\$500.00	104

### 3. View Health Care Expenses Grouped by Date

Date	Description	Amount
09/01/07	OSU Surgery LLC	\$1,200.00
09/15/07	University Family Physicians Inc	\$800.00
09/30/07	OSU Pathology Services LLC	\$500.00

- Account Summary Balance
- YTD amounts spent on services
- Most Recent Claim Activity
- Account Analysis Tool
- User-friendly Health Statement



# MyAnthem™ My Claims tab

Stay on top of your Medical & Pharmacy claims from one integrated user experience

**MyAnthem™** Anthem. Lumenos

Welcome Roger Harris | My Profile | Contact Us | Logout

Overview | Provider Finder | My Health | My Account | **My Claims** | My Benefits

**My Claims / Medical Claims**

### Medical Claims

Select Member and Service Date(s)

Consumer Name: Roger Harris

Start Date: 04/10/2006

End Date: 04/10/2008

Search

We have found 3 medical claims between 04/10/2006 and 04/10/2008 for

Claim Number	Service Date(s)	Provider Name	Total Billed	Amount Paid
K05612031300	11/20/2006 - 11/20/2006	Ronald P PeReber	\$5,900.00	\$1,760.00
PL0611280200	11/15/2006 - 11/15/2006	Robert Smith	\$75.00	\$0.00
06299E2A6F00	10/10/2006 - 10/10/2006	DSU Pathology Services LLC	\$344.00	\$0.00

**Your Claim Recap**

**How Much was the Expense?**

The total charge was	1	5,900.00
Amount allowed by your health plan	1	4,140.00

**How Much was Paid Under Your Program?**

Amount paid from your Health Account	1	140.00
Amount paid by Traditional Health Coverage	1	1,760.00
Total paid under your Program	2	1,860.00

**What is Your Out-of-Pocket Responsibility?**

Coinsurance and other cost-sharing responsibility	1	0.00
Co-payment responsibility	1	140.00
<b>Your total responsibility for this claim</b>	<b>2</b>	<b>140.00</b>

**Your Health Account**

Outstanding account balance	1	22.00
-----------------------------	---	-------

**Your Traditional Health Coverage**

Program and spending limit (maximum allowed)	1	2,000.00
Amount spent so far	2	130.00

**Your Annual Out-of-Pocket Maximum**

Maximum for Member/Primary	1	2,000.00
Amount Researched/Spent to Maximum so far	1	22.00

- Processed/Pending Claim Status
- View Processed Date & Amount Paid
- Claim Details Member Responsibility
- Download Claims Recap
- Printer-friendly pages
- View Benefits/Deductibles Used



# MyAnthem™ My Benefits tab

**MyAnthem™**

Welcome Roger Harris [My Profile](#) [Claims](#) [Log out](#)

[My Profile](#) [Claims](#) [Log out](#) **MyBenefits**

**Things You Can Do**

- > [View Benefits Details](#)
- > [View Plan Certificates of Coverage](#)
- > [Request ID Card](#)

**Health Tools and Resources**

- > [Forms Library](#)
- > [Appeals Process](#)

**Need Help?**

- > [Contact Us](#)

Our glossary has definitions for the terms used on our site.

**My Benefits**

Please select the member whose benefits you want to view. The current product effective date is displayed below. It represents the effective date of the product(s) you are enrolled in. It does not represent your original effective date of eligibility with your group or plan.

**Consumer Name** Roger Harris

**Consumer Information**

Consumer Name	Roger Harris	Group Number	42042010
Consumer ID	205M00045	Employer Group	Missouri Individual For CDHP E-Biz
Relationship	Subscriber		

**My Lumenos Plan**

Name	Lumenos HIA Plus
Effective Date	01/01/2005
Coverage End Date	

[Consumer Benefits Details](#)

[Benefits Certificates Used](#)

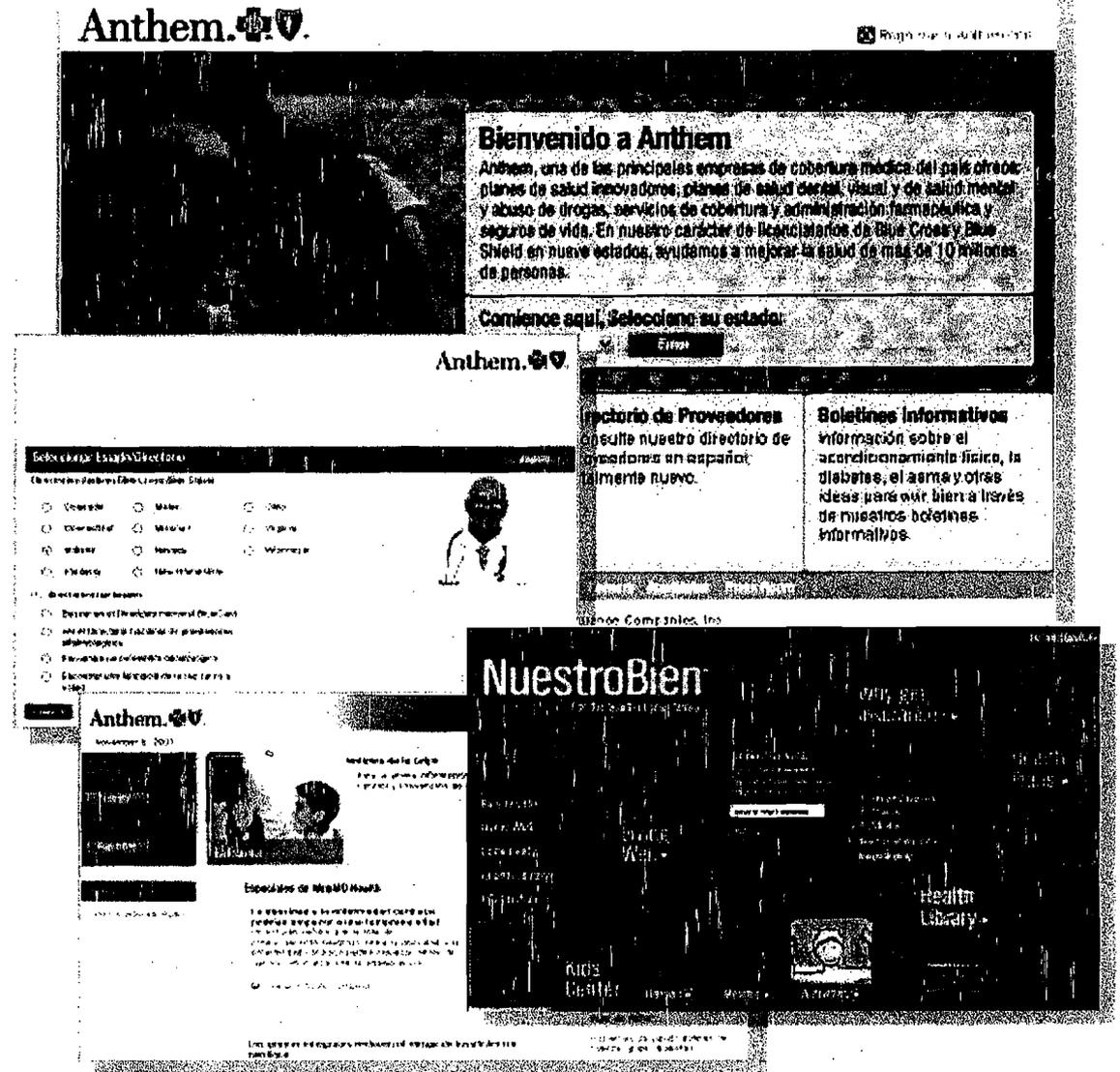
[Certificate Booklet](#)

24 x 7 access to your Plan Summary, Benefit Details, Certificate Booklet, Benefits Used, & Eligibility information

# Spanish Language Support

Leading multi-lingual web capabilities:

- Spanish language provider directories
- Health and wellness information
- WebMD
- Product information
- Health Risk Assessment
- Cost and quality tools
- Newsletters
- Health alerts and product recalls
- Mini health quizzes
- Condition centers
- Tools and calculators



# POWER Account

- POWER Account
  - Contributions are based on income-not everyone has a required monthly amount.
  - Must make the required monthly contribution on-time - you will be removed from the plan if more than 60 days late.
  - Members of the Anthem HIP contact center will make a courtesy reminder call if you are 45 days past due.
  - Pay by phone (1-800-553-2019), mail, credit card, bank draft, or cash (at National City Bank located downtown Indianapolis at 101 W. Washington Street)

# POWER Account

## KEEP the POWER

- Get Your Preventative Care
  - Rollover Option-
    - if you receive your age/gender appropriate preventative care by the end of your benefit period the entire account balance (including the State's portion) rolls over.
    - If you don't receive the recommended preventative care, only the unused amount you contributed rolls over.
- Check Monthly POWER Account balance statements by mail and on-line.

# Health Needs Survey

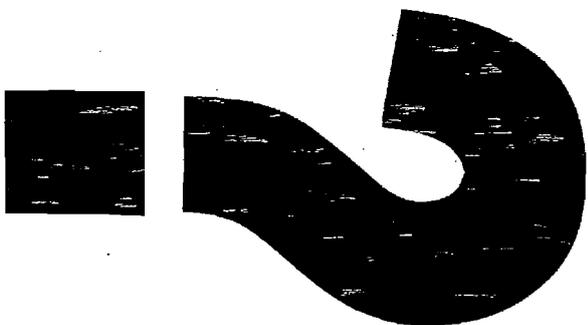
- Eliminated Anthem's HNA - Changing to State Format
- New Process Being Implemented in August
- Post Card in Welcome Packet
- Incentive: \$25 or \$15 Gift Card
  - Higher Amount for On-Line
- Encourage to do On-Line
  - Can Also do by Phone or Mail
- Analysis by Medical Management
  - Disease Management Programs
  - Care Management
  - Other Health Improvement Programs
  - Member Outreach

# Member Satisfaction

## DSS Research Conducts CAHPS

- Consumer Assessment of Health Care Providers and Systems
- DSS is a National Research Company Specializing in Healthcare Market Research
- NCQA Requires CAHPS for Accreditation and HEDIS – Anthem Healthy Indiana Plan is Accredited by NCQA
- DSS Successfully Surveyed 771 Anthem HIP Members in 2010
- Anthem Healthy Indiana Plan 2010 Health Plan Overall Rating
  - 78.8%
  - Significantly Higher Than DSS 2010 Average of 70.9
  - Estimated Accreditation Score = 13.000 Points out of 13.000 Possible

# Questions



# MDwise Health Plans



  
**MDwise**



# Hoosier Healthwise

p: 1-800-356-1204 • 1-317-630-2831  
f: 1-877-822-7190 • 1-317-829-5530



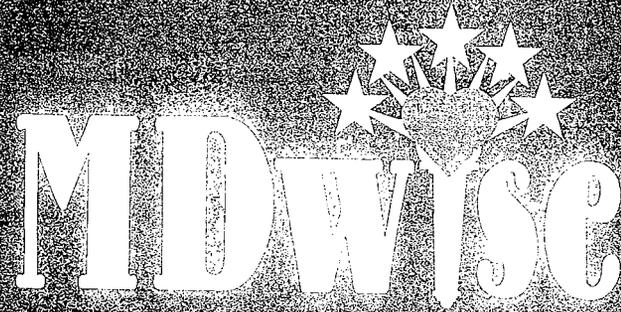
*Indiana Care Select*

p: 1-866-440-2449 • 1-317-829-8189  
f: 1-877-822-7188 • 1-317-822-7519



# Hoosier Healthwise

p: 1-800-356-1204 • 1-317-630-2831  
f: 1-877-822-7190 • 1-317-829-5530

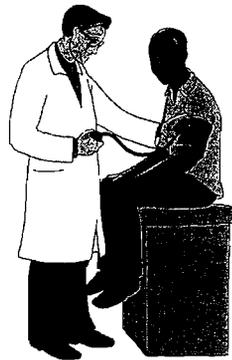


# MDwise

MDwise is a not-for-profit managed care organization founded in 1994 by the Health and Hospital Corporation of Marion County and Clarian Health Partners. Until 2007, MDwise focused exclusively on Hoosier Healthwise eligible members in Indiana. Today MDwise offers three Indiana Health Care Programs: Hoosier Healthwise, Indiana Care Select and the Healthy Indiana Plan (HIP).



## Healthy Indiana Plan



Member Education and  
Orientation Activities  
July 15, 2010

### MDwise's Approach to Member Engagement

- MDwise conducts a variety of activities to engage the member in their Healthy Indiana Program coverage, as well as promote the general healthcare of the member
- Activities start during "conditional enrollment" (before first member contribution is made) and continue throughout "full enrollment" (each month, as member continues to make contributions and maintain coverage)
- Member engagement as a key hallmark of HIP - helping educate the member to take charge of their own healthcare



## Conditional Member Welcome/Invoicing

- **Receive Welcome Letter and First Invoice**
  - Welcome letter explains:
    - Payment options including employer contributions and making payment for multiple family members
    - Preventive care guidelines
    - Non-payment consequences
  - Invoice
    - Monthly contribution amount due
    - Reminds member of due date
    - Notifies member that coverage will not begin until payment has been made
    - Where to mail payments
    - Where to call with questions
- **MDwise Customer Service makes outbound phone call to new members**
  - Welcome to MDwise
  - Health Risk Assessment
  - Inquire about invoice receipt and encourage payment
  - Answer questions about HIP and MDwise



## Fully Eligible Member Education/Programming

- **ID Cards**
  - Card issued by MDwise
  - Mailed to member when fully eligible notification is received from the State
  - Cards include: ER copay amount, PMP Information, Customer Service contact information, Pharmacy Contact information, Member ID #
  - MDwise website address
  - Where to call with questions
- **Member Handbook**
  - Mailed to member within 2 weeks of fully eligible notification from the State
  - Handbook includes: Pertinent information to navigate their Healthcare including; POWER Account, Payment options, Preventive care, Benefits, Self referral services, Specialty care, ER use, BH services, Rights and Responsibilities, Grievance filing procedures, Privacy policies, Wellness programs, Co-pay amounts



## Fully Eligible Member Invoices & Past Due Reminders

- **Monthly Invoices Include:**
  - Contribution amount due
  - Reminds member of due date
  - Where to mail payments
  - Where to call with questions
  - Any past due amounts
  - Adjustments to amounts due (contribution changes etc.)
- **Monthly Past Due Reminder Notices Include:**
  - Past due amounts
  - Reminds member of due date
  - Notifies member that coverage will be lost if payment is not received
  - Where to call with questions



## Fully Eligible Member Monthly Statement

- **Member Monthly Statement**
  - Mailed to member on paper plus available on the MDwise web portal
- **POWER Account Summary**
  - Promotes member financial responsibility by providing:
    - Medical/Pharmacy claims transactions
    - Member contributions paid to date
    - State contributions paid to date
    - Employer contributions paid to date
- **Preventive Service Information**
  - Reminds members of the roll over benefit when required preventive services are received
  - List of claims that apply to the preventive service target
  - Tells member if they have met the preventive service target for the year



**MDwise H&P**

MDwise Health's Indiana Plan  
P.O. Box 46236  
Indianapolis, IN 46244-0236  
www.mdwise.org

John Doe  
123 Main Street  
Wabash, IN 45995-1125

**Member Monthly Statement**

<b>Member Name:</b> John Doe	<b>Year to Date Contributions:</b>
<b>Member RID:</b> 1234567890	Member: \$325.50
<b>Plan Year:</b> 09/01/2009 - 08/31/2010	Employer: \$0.00

**POWER Account Transactions 4/1/2010 - 4/30/2010**

Date	Description	Amount	Balance
4/06/2010	Medical Claims Payment	\$93.19	
4/29/2010	Member Contributions		\$14.42

**Claims Transactions 4/1/2010 - 4/30/2010**

Provider	Date	ICD-9	ICD-10	Rate	Rate	Rate	Rate
101152020	4/19/2010	95214	OFFICE/OUTPATIENT VISIT, EST	\$115.00	\$93.19	0	\$93.19

**Preventive Service Target**  
Reaching your preventive service target ensures that your POWER Account balance is rolled over to the next year rather than being spent. You can see your yearly preventive service target by looking at your member handbook, going to the MDwise website at [www.mdwise.org](http://www.mdwise.org) or by calling our Customer Service department at 1-877-822-7196 or 1-877-822-7196.

No activity this period.  
You HAVE NOT reached the preventive service target for this year.

**H&P**  
HEALTHY INDIANA PLAN  
Health Care Plans • Plans of Health

**MDwise**

**HIP Customer Service**

**MDwise Healthy Indiana Plan**  
Phone: 1-877-822-7196 or in Indianapolis 317-822-7196  
Fax (317) 822-7192 or 1-877-822-7192  
Website: [www.MDwise.org](http://www.MDwise.org)

**HIP phone options**

Members:	Option 1
Behavioral Health:	Option 2
NURSEon-call:	Option 3
Spanish-Speaking Members:	Option 4
Provider Services:	Option 5

**H&P**  
HEALTHY INDIANA PLAN  
Health Care Plans • Plans of Health

**MDwise**

## MDwise Wellness Programs

These are designed to engage members in managing their own healthcare issues.



### **NURSE**on-call

Speak with a nurse 24 hours a day



### **IN**control

Learn to manage your asthma, diabetes or other chronic illness



### **WELLNESS**chats

Take charge of your health



### **WEIGHT**wise

Reach and maintain a healthy weight



### **HELP**link

Work with a member advocate who knows about health, school and community services



### **SMOKE**-free

Get help kicking the tobacco habit



## Newsletters

- **Member Newsletter (Steps to Prevention)**
  - Published quarterly
  - Articles include: redetermination reminders, preventive care guidelines, appropriate use of emergency room, information on common health conditions found within the HIP population such as COPD, Diabetes, etc., Good nutrition habits, smoking cessation, and much more



# MDwise Website

Includes a variety of member education materials, such as:

- Handbook
- Newsletters
- Cost of Services information
- Provider Quality Information
- My WellnessZone - interactive library of health information, with written and video educational materials, as well as tools member can use



The screenshot displays the MDwise website interface. At the top, there are navigation tabs for Home, Members, My Plan, My Health, My Account, and About Us. The main content area is divided into several sections:

- Members:** A sidebar menu with links to Register HealthInfo, Handbook & Overview, Find a Provider, Special Programs, Behavioral Health, My Wellness Zone, Healthy Resources, Member Resources, Contact Us, Healthy Indiana Plan, and Indiana Care Select.
- Member Wellness Tools:** A central section with three main tool descriptions:
  - Online Health History Management:** Allows members to view and manage their health records.
  - Diseases & Conditions:** An interactive encyclopedia for over 835 conditions.
  - Health News:** A section for staying current with the latest health and medical developments.
- Additional Tools:** Links to Cardiac Catheterization, Colonoscopy, and Hip Replacement.
- Everyday Health:** A featured section with a video player and the text "Prevent Illness. Stay Healthy. Live Well."

At the bottom of the page, there is a footer with the text: "All Accessibility | Terms of Use | Privacy Policy | Contact Us" and the MDwise logo.



## Case Management/Disease Management

- Members are identified for Case Management and/or Disease Management by review of claims, referrals from providers, member referral, emergency room encounters, appeals, health needs assessments
- Stratify members based on their individual severity of illness. (Higher level of stratification means member receives more intensive and more frequent interventions)
- Interventions for Case Management and/or Disease Management include but are not limited to:
  - Contact with a Registered Nurse
  - Disease-specific educational materials at a 5th grade reading level
  - Review of preventive care guidelines and promotion of self-management skills
  - Periodic contact and updates with the treating providers
  - Home health evaluations as needed
  - Specialty referrals as needed



## Case Management Disease Management (cont'd)

- MDwise provides access to a web based portal via My Health Zone that covers a variety of health related topics regarding diabetes, asthma, COPD, CHF, tobacco cessation, nutrition and exercise
- Observations:
  - MDwise has found that the majority of HIP members have not previously gotten preventive care or disease-specific care (i.e. diabetics who have not had their necessary blood testing)
  - For many members, their disease is far advanced when they become an eligible MDwise HIP member due to the lack of care as noted above
  - Majority of HIP members use tobacco which may account for the high percentage of HIP members with pulmonary related problems (i.e. COPD)



## HELPlink

### Member Advocate Program

- Social workers
- Link members with providers and social service agencies in the community
- Bridge communication between members, healthcare providers and community programs
- Raise the level of member awareness and understanding of MDwise health plan and covered services
- Ensure prescribed wraparound services are being provided to members

### Areas of education/intervention include but are not limited to:

- Missed medical appointments
- Issues or conflicts between doctor and MDwise patient
- Emergency room education/awareness.
- Assistance with eligibility issues
- Family issues (assessing a member's needs for mental health services, housing, financial, finding other services such as support groups and other community resources, etc.)
- Health plan (assisting a member in understanding benefits and how to access services)
- Crisis intervention



## Emergency Services Education Program

### HIP Member visits to ER identified via:

- Indiana Health Information Exchange (IHIE) notification
- Emergency room claim disputes
- NURSEon-call triage notifications
- Provider or Delivery System notifications
- Calls to Customer Service
- Utilization data



## Emergency Education Cont'd

MDwise Medical Management reviews data and refers the member to the following options as indicated or appropriate:

- Case management
- Disease management
- Right Choices Program (restricting members to one pharmacy, one hospital and one primary care physician)
- IVR call to member (inquire about calling PMP before ED visit and educate about when to utilize Emergency Department)
- Member Advocate Referral- (address psychosocial issues, educate about ER, remind about availability of PMP and NURSEon-call, encourage follow-up care)



## Preventive Care Reminders

- Targeted mailings (postcard)
  - Reminds members of what preventive services are needed for their age and gender
  - Reminders to members that unlimited preventive services are covered by MDwise and not deducted from the POWER Account
- Targeted IVR reminder calls (Women's annual exams in the Fall of 2009)
  - Asked women if they had their annual pap (all), mammogram (40+) and Chlamydia (19-25 year olds) screenings
  - Educated as to importance of obtaining these services
  - If they responded that they had not obtained the service, were asked why they had not obtained
- Letter and phone call at redetermination
  - Reminds members that they have time to get preventive care in 2009 to the end of their coverage year to get rollover benefits



# Preventive Care Postcard



**Everyone needs check-ups**

Did you know that as a member of the Healthy Indiana Plan (HIP) you need to get certain preventive services in order to not owe your HICR account balance at the end of the year for backfill costs.

**MDwise**

Call your doctor today to schedule an appointment

**The Facts:**  
Regular health exams and tests can help find problems before they start. They also can help find problems early when your chance for treatment and cure are better by getting the right health services, counseling, and treatments you are taking steps that help your chance for living a longer healthier life.

**HIP**  
HEALTHY INDIANA PLAN

**MDwise**



# Preventive Care Postcard



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**HIP**  
HEALTHY INDIANA PLAN

**MDwise**



## Member Satisfaction Survey

- Began HIP Member CAHPS survey in 2009
- Feedback is used to identify opportunities to improve our services to members
- 2009:
  - Rating of Health Plan - On a scale of 0-10, 90.3% of MDwise Healthy Indiana Plan members rated their plan an 8, 9, or 10. (This score is significantly above the Quality Compass Summary Rate and ranks at the 99th percentile.)
  - Customer Service - This composite is another Key Driver of Rating of Health Plan. MDwise's 2009 Customer Service composite Summary Rate is 86.1%. (This score ranks at the 84<sup>th</sup> percentile for Quality Compass.)



## Community Outreach

- MDwise presence throughout the state
- Develop relationship with community partners
  - Enrollment Centers
  - Community agencies and coalitions
- Promotes and educates about the HIP program and how to apply
- Participates in health fairs and community events to interact and educate face-to-face with members and potential members





MDwise (HIP)  
P.O. Box 44236  
Indianapolis, IN 46244-0236  
Phone: 317-822-7196/1-877-822-7196  
Fax: 317-822-7192/1-877-822-7192  
[www.MDwise.org](http://www.MDwise.org)

Issue Date

Mailing Name

Mailing Address 1

Mailing Address 2

Mailing Address 3      Mailing Zip

Dear MDwise HIP Member:

Welcome to the MDwise Healthy Indiana Plan! Attached is your MDwise Member ID Card. Please take a moment to look at the information on your card to be sure it is correct. If you find any errors or have any questions, please call Customer Service at 1-877-822-7196 or in Indianapolis at 317-822-7196. If everything is correct, please remove the card carefully and fold it in the middle. Keep the card in your purse or wallet. Show it to your doctor each time you visit or to the pharmacy when you have a prescription filled.

If you chose a doctor yourself, thank you! If you did not select a doctor, we assigned you to a doctor that is close to you. If you would like to change this doctor, please call MDwise Customer Service as soon as possible at 1-877-822-7196 or 317-822-7196 in the Indianapolis area. Your MDwise member handbook will be sent to you soon. Please take time to read it. It has a lot of information about your benefits and services.

It is important to remember to get your preventive care! Your doctor will arrange any preventive services that you need to get. You must get your preventive care before the end of your 12-month coverage term. You must do this to qualify for rollover of any remaining funds you have in your POWER Account. This may mean that your contribution will be less next year.

If you have not completed a health needs survey with a MDwise representative, please call us at 1-877-822-7196 or in Indianapolis at 317-822-7196.

Wishing you good health,

MDwise Customer Service

Si necesita una copia de esta informacion en espanol, Llame a nuestro Servicio al Cliente al 1-877-822-7196.  
HIPM0129 (04/10)

(To remove cards, please peel to expose the adhesive back and carefully fold at the middle)



**Member Name:**

Subscriber Name



**Member RID#**

Other ID #

PMP Name: Provider Name

PMP Phone: Provider Phone

Delivery System: Provider Group Name

ER Copay: Message 2

POWER Account Amt: Message 1

Rx Bin 610467

Rx PCN INCAIDPROD

Claim Payer ID:MDWIS

[www.MDwise.org](http://www.MDwise.org)

This card does not prove eligibility nor guarantee coverage.

**EMERGENCIES:** Call 911 or go to the nearest Emergency Room

If you become pregnant, please call Customer Service as pregnancy services are NOT covered under the Healthy Indiana Plan. You may apply for another plan to cover pregnancy care.

**Pharmacy:**

Pharmacy Prior Authorization Helpline: 1-866-879-0106

Pharmacy Services POS Help Desk: 1-800-577-1278 or 317-655-3240

Member Services Helpline: 1-800-457-4584 or 317-713-9627

**MDwise Customer Service for Members and Providers:**

1-877-822-7196, Local 317- 822-7196, TTY/TDD: 1-811-743-3333

**Claims Address:** MDwise, P.O. Box 33049, Indianapolis, IN 46203



MDwise Healthy Indiana Plan  
 P.O. Box 44236  
 Indianapolis, IN 46244-0236  
[www.mdwise.org](http://www.mdwise.org)

John Doe  
 123 Maple Street  
 Wabash, IN 46992-1125

### Member Monthly Statement

<b>Member Name:</b>	<b>John Doe</b>	<b>Year to Date Contributions</b>
<b>Member RID:</b>	<b>123456789199</b>	<b>Member: \$105.86</b>
<b>Plan Year:</b>	<b>09/01/2009 – 08/31/2010</b>	<b>State: \$927.00</b>
		<b>Employer: \$0.00</b>

#### POWER Account Transactions: 4/1/2010 – 4/30/2010

DATE	TRANSACTION DESCRIPTION	WITHDRAWAL	DEPOSIT
4/26/2010	Medical Claims Payment	\$93.19	
4/28/2010	Member Contribution		\$14.42

#### Claims Transactions 4/1/2010 – 4/30/2010

CLAIM #	START DATE PROCEDURE EXPLANATION	END DATE	BILLED	ALLOWED	POWER	PAID
Provider: 1011350280	Jones, M.D., John L. 4/19/2010 99214	4/19/2010	\$115.00	\$93.19	0	\$93.19
			OFFICE /OUTPATIENT VISIT, EST			

#### Preventive Service Target

Reaching your preventive service target ensures that your POWER Account balance is rolled over to the next year rather than beginning at zero. You can see your yearly preventive service targets by looking in your member handbooks, going to the MDwise website at [www.mdwise.org](http://www.mdwise.org) or by calling our Customer Service department at 317-822-7196 or 1-877-822-7196

No activity this period.

You **HAVE NOT** reached the preventive service target for this year.



Date

Member Name

Address

City, State Zip

Dear Member Name:

You will have been with the MDwise Healthy Indiana Plan for 12 months as of Month 1<sup>st</sup>, 2010. Very soon you will have to renew your Healthy Indiana Plan membership. We want to let you know how reenrollment works.

**90-days** before your coverage ends, you will get a letter from the Division of Family Resources with information on how to enroll for next year. Please read this information VERY carefully! If you have questions about it, feel free to call us at 1-877-822-7196 or in Indianapolis, 317-822-7196.

**60-days** before your coverage ends, you will get another letter from the Division of Family Resources with a reenrollment form. You must fill out this form completely and mail back to:

FSSA Document Center

P.O. Box 1630

Marion, IN 46952

You can also fax the completed form to: 1-800-403-0864.

It is very important that you fill out the reenrollment form right away and send it in! The Division of Family Resources must get this completed form **45-days BEFORE** your coverage term ends or you will be disenrolled from HIP. You will not be able to re-enroll for 12-months if you miss the deadline.

If you need help to fill out this form, please call us and we would be happy to help you! Also, if you do not get this form **60 days before** your enrollment year ends, call 1-877-438-4479 to request a new one be sent to you.

Don't forget that you need to get a check-up each year. Your doctor will arrange any preventive services that you need to get. You must get all of your preventive care screenings before the end of your coverage term. You must do this to qualify for rollover of any remaining funds you have in your POWER Account. This may mean that your contribution will be less next year. Please see your MDwise Member Handbook page 7 for more information. You can also go to our website at [www.MDwise.org](http://www.MDwise.org) and look at "Healthy Resources".

If you have not completed a new health needs assessment with MDwise, please call us at 1-877-822-7196. We hope that you have been happy with the services through MDwise. However, if you want to change your plan, call 1-877-438-4479.

Wishing you good health,  
MDwise Customer Service

HIPM0125 (02/10)

MDwise Healthy Indiana Plan (HIP) P.O. Box 44236 Indianapolis, IN 46244-0236  
p: 317.822.7196/1.877.822.7196 f: 317.822.7192/1.877.822.7192 [www.MDwise.org](http://www.MDwise.org)

...to the hospital that  
our doctor uses. Call your doctor first!

Examples of when you should use your doctor's hospital:

- When you have planned surgery
- When your doctor wants to admit you for other reasons

However, if you have a true emergency, you do not have to call your doctor. Just go to the nearest hospital for immediate care. The chart inside has examples of true emergencies.

#### Out-of-area care

If you are far away from home, you can still get health care. Before getting care, you must call your doctor. You can also call MDwise for help at 1-877-822-7196 or in the Indianapolis area (317) 822-7196. If you have a true emergency, do not call first. Go straight to the nearest hospital.

#### After-hours care

Even after-hours, you can call the doctor's regular office number. If you hear a message, listen for instructions on what to do.

#### Emergency Room Copay

Healthy Indiana Plan members must pay a copay when you go to the Emergency room. Your copay can be from \$3 to \$25. Your copay is listed on your MDwise card.

Your MDwise doctor is:

---

Your doctor's phone number is:

---

Your doctor's hospital is:

---

...to the hospital that  
atiende su médico. ¡llame antes a su médico!

Ejemplos de cuándo debe usted ir al hospital de su médico:

- Cuando va a someterse a una operación quirúrgica programada
- Cuando su médico quiere que ingrese al hospital por otros motivos

Sin embargo, usted no tiene que llamar a su médico si tiene una verdadera emergencia. Sólo vaya al hospital más cercano para que lo atiendan de inmediato. La tabla interior tiene ejemplos de verdaderas emergencias.

#### Atención fuera de área

Usted puede recibir atención médica aunque se encuentre lejos de casa. Antes de atenderse, usted debe llamar a su médico. También puede llamar a MDwise para que le ayuden al 1-877-822-7196 o (317) 822-7196 en el área de Indianápolis. Si tiene una verdadera emergencia, no llame antes. Vaya directamente al hospital más cercano.

#### Atención fuera de hora de consulta

Usted puede llamar al teléfono del médico que lo atiende regularmente aún fuera del horario de consulta. Si escucha un mensaje, ponga atención a las instrucciones sobre lo que debe hacer.

#### Copago de la sala de emergencias

Los miembros del Healthy Indiana Plan deben abonar un copago cuando acuden a una sala de emergencias. Su copago puede ir de \$3 a \$25. Su copago figura en la credencial de MDwise.

Su médico MDwise es:

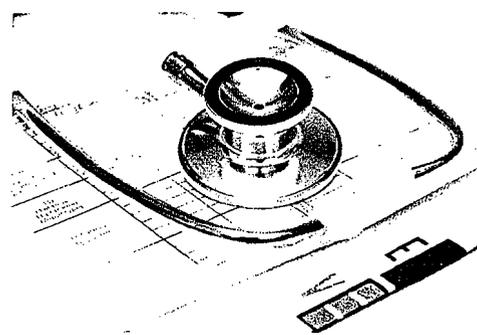
---

El teléfono de su médico es:

---

El hospital de su médico es:

---



## Emergency Care

No one likes to spend hours in an emergency room. You can help by getting preventive care from your doctor. This way, you can get health care before the problem gets too bad.

You should not use the ER for anything but true emergencies! If you are not sure if it is an emergency, call your doctor for advice. Your doctor has someone who can help 24 hours a day. If you hear a recorded message when you call, listen carefully for instructions.

## Atención de Emergencia

A nadie le gusta pasar horas en una sala de urgencias. Usted puede evitarlo si recibe atención preventiva de su médico. Así, usted puede recibir atención médica antes que el problema se agrave.

¡No vaya a la sala de urgencias a menos que sea una verdadera emergencia! Si usted no está seguro de que se trata de una emergencia, llame a su médico para consultarle. Su médico tiene a alguien que puede ayudarlo las 24 horas del día. Si usted escucha un mensaje grabado, ponga atención a las instrucciones.

Use the  
Emergency  
Room  
Wisely

Utilice una Sala  
de Emergencia  
Prudentemente



  
**MDwise**

Phone/Teléfono: (317) 822-7196

Toll Free/Línea Gratuita: 1-877-822-7196

Website: [www.MDwise.org](http://www.MDwise.org)

  
**HIP**

HEALTHY INDIANA PLAN™  
Health Coverage = Peace of Mind



### Call your doctor first

Always call your doctor when you need medical care. Your doctor has someone who can help you 24 hours a day.

As a MDwise member, you get the best care when you go to your assigned doctor. This way, your doctor can organize all your health care services. This helps you to be as healthy as possible.

If you have a new doctor, you should make an appointment even if you are not sick. This is a good way to get to know your new doctor so he or she can take better care of you – before an emergency happens!

If you do not know who your doctor is, call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area at (317) 822-7196.



are nurses who can answer your health questions 24/7. Call 1-877-822-7196 or (317) 822-7196 and choose option #3.

You can also call the MDwise NURSEon-call. There

Give your family the gift of health. Call for a check-up today.  
Deleja su familia el regalo de la salud. Llame hoy para una revisión médica.

### Llame primero a su médico

Llame a su médico siempre que necesite atención médica. Su médico tiene a alguien que puede atenderlo las 24 horas del día.

Como miembro de MDwise, usted obtiene la mejor atención cuando va con su médico asignado. Así, su médico puede organizar todos sus servicios de atención médica. Esto le ayudará a estar lo más sano posible.

Si usted tiene un nuevo médico, usted debe hacer una cita aún si no está enfermo. Esta es una buena manera de conocer a su nuevo médico para que él o ella puedan cuidar mejor de usted, antes de que sea una emergencia!

Si usted no sabe quién es su médico, llame al Servicio al Cliente de MDwise al 1-877-822-7196 o al (317) 822-7196 si se encuentre en el área de Indianápolis.



NURSEon-call. Hay enfermeras que pueden responder sus preguntas de salud las 24 horas del día 7 días a la semana. Llame al 1-877-822-7196 o al (317) 822-7196 y elija la opción #3.

Usted también puede llamar a MDwise

### your doctor uses. Call your doctor first!

Examples of when you should use your doctor's hospital:

- When you have planned surgery
- When your doctor wants to admit you for other reasons

However, if you have a true emergency, you do not have to call your doctor. Just go to the nearest hospital for immediate care. The chart inside has examples of true emergencies.

#### Out-of-area care

If you are far away from home, you can still get health care. Before getting care, you must call your doctor. You can also call MDwise for help at 1-877-822-7196 or in the Indianapolis area (317) 822-7196. If you have a true emergency, do not call first. Go straight to the nearest hospital.

#### After-hours care

Even after-hours, you can call the doctor's regular office number. If you hear a message, listen for instructions on what to do.

#### Emergency Room Copay

Healthy Indiana Plan members must pay a copay when you go to the Emergency room. Your copay can be from \$3 to \$25. Your copay is listed on your MDwise card.

Your MDwise doctor is:

\_\_\_\_\_

Your doctor's phone number is:

\_\_\_\_\_

Your doctor's hospital is:

\_\_\_\_\_



# Everyone needs check-ups

Did you know that as a member of the Healthy Indiana Plan (HIP) you need to get certain preventive services in order to roll over your POWER account balance at the end of the year? See back for details.



MDwise

Call your doctor today to schedule an appointment.

For more information, visit [www.MDwise.org](http://www.MDwise.org) or call 1-866-MDwise1.

The chart below lists the preventive care you need for your age group. You **MUST** get these services each year in order for your HSA/FSA Account Balance to roll over at the end of the year.

Male ages 19-35	Annual Physical Exam Blood Glucose Screen* Tetanus-Diphtheria Screen
Male ages 35-50	Annual Physical Exam Cholesterol Testing* Blood Glucose Screen* Tetanus-Diphtheria Screen
Male ages 50-64	Annual Physical Exam Cholesterol Testing Blood Glucose Screen* Tetanus-Diphtheria Screen Flu Shot*

\*Annual or as required for your disease/history specific condition

Si quisiera esta tarjeta en español, por favor visite [www.MDwise.org/espanolpostcard](http://www.MDwise.org/espanolpostcard) o llame al 1-877-822-7196

M0101 (09/09)

### The Facts:

Regular health exams and tests can help find problems before they start. They also can help find problems early, when your chances for treatment and cure are better. By getting the right health services, screenings, and treatments, you are taking steps that help your chances for living a longer, healthier life.

Source: Centers for Disease Control and Prevention



**HEALTHY INDIANA PLAN**<sup>SM</sup>  
Health Coverage = Peace of Mind

MDwise Healthy Indiana Plan  
PO Box 44236  
Indianapolis, IN 46244-0236

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INDIANAPOLIS  
PERMIT NO. 90

# steps to PREVENTION

# MDwise

Si quiere que le mandemos esta información en español, favor de llamar a nuestro departamento de Servicio al Cliente de MDwise al 1-877-822-7196 o en Indianápolis al 317-822-7196. También puede encontrar esta información en español en nuestra página web en [www.MDwise.org](http://www.MDwise.org). Gracias.

SUMMER 2010

## You Can Quit Smoking

Anyone who's tried it knows—quitting smoking isn't easy.

But now extra help is as close as your phone. And it's help that can double your chance of success. Just call a smoking quitline.

When you call a quitline, you can talk to someone who is an expert in how to stop smoking. That person can help you make a plan to quit. These experts can

also send you information in the mail. If you start smoking again, they can help you figure out why, and they can make it easier for you to get back on track.

Call the Indiana Tobacco Quitline at 1-800-784-8669. The MDwise SMOKEfree program also has resources that may help you. Call 1-877-822-7196 for more information or visit [www.MDwise.org](http://www.MDwise.org).

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and Diabetes ...2

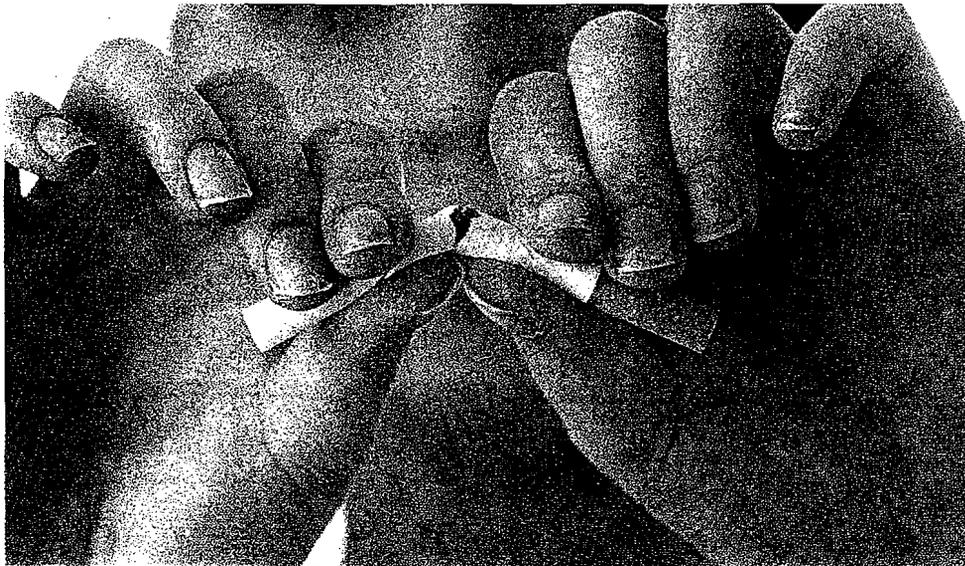
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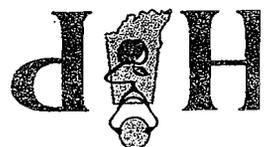
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Questions? Call us at  
1-877-822-7196, or in  
the Indianapolis area  
317-822-7196. You may  
also visit our Web site at  
[www.MDwise.org](http://www.MDwise.org).



ALTHY INDIANA PLAN<sup>SM</sup>  
Coverage = Peace of Mind



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# Weight Gain and Diabetes

Extra pounds can do more than make your clothes feel tight. They also increase your risk of diabetes.

Most people with Type 2 diabetes, the most common form of diabetes, are overweight. And it doesn't matter what your age is. Both overweight kids and adults are at risk for diabetes.

But losing even a little weight, often only 10 pounds or so, can help you avoid diabetes.

These tips can help:

- Get moving. Try to exercise at least 30 minutes every day. If you don't have much time, get up early and go for a brisk walk.
- Eat smart. Help yourself to plenty of fruits, veggies and whole-grain foods. Go easy on sweets, fatty foods and sugary sodas.
- Don't skip meals. If you do, you'll overeat later on.
- Grocery shop on a full stomach. This will help you to avoid unhealthy foods that you may be tempted to buy if you shop while hungry.

Sources: American Diabetic Association; National Institutes of Health



## Member Redetermination

Healthy Indiana Plan members must re-enroll every 12 months. 90 days before your coverage ends, you will get a letter from the Division of Family Resources with information on how to enroll for next year.

60 days before your coverage ends, you will get another letter from the Division of Family Resources with a re-enrollment form.

It is very important you that you fill out the re-enrollment form right away and send it in! The Division of Family Resources must get this completed form 45 days before your coverage ends or you will be disenrolled from HIP. If that happens, you will not be able to re-enroll for 12 months.

Please mail the form to:  
FSSA Document Center  
PO. Box 1630  
Marion, IN 46952

You can also fax the completed form to 1-800-403-0864.

If you have any questions, call MDwise Customer Service at 1-877-822-7196 or 317-822-7196 in the Indianapolis area.



STEPS TO PREVENTION is published for members of MDwise by MDwise, Inc. P.O. Box 44236, Indianapolis, IN 46244-0236, telephone 1-877-822-7196. Web site: [www.MDwise.org](http://www.MDwise.org).

Information in STEPS TO PREVENTION comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care provider.

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Questions? Comments? Complaints? If you need help with anything about MDwise or your doctor, we can always help. Please call MDwise Customer Service at 1-877-822-7196, or in the Indianapolis area 317-822-7196.

# Emergency or Urgent Condition?

## Emergency

An emergency can cause loss of life or severe disability if not treated right away. Examples of emergencies include:

- Poisoning
- Severe head injury
- Excessive bleeding
- Convulsions
- Serious burns
- Loss of consciousness
- Sudden severe chest pains
- Trouble breathing



In an emergency, go to the nearest emergency room.

## Urgent Condition

Urgent conditions aren't life-threatening. Examples of urgent situations include:

- Earache
- Sore throat
- Fever
- Minor cut that may need stitches

In urgent situations, going to the emergency room usually isn't the best choice. Urgent conditions can usually be treated at home until you can see your doctor. Call your doctor to find out what you should do. The doctor can give you advice on how to reduce discomfort and arrange an appointment. You can reach your doctor on call 24 hours a day. Even after normal business hours you can call your doctor's office. Either a recording or an answering service will tell you how to reach the doctor on call.

MDwise also has a NURSEon-call service available to you 24 hours a day, seven days a week. Call 1-877-822-7196 or 317-822-7196 in the Indianapolis area. Select Option 3. Nurses can answer your health questions.



**NURSEon-call**

Speak with a nurse 24 hours a day

Source: *Well Advised, Second Edition, Text copyright © 2003 Park Nicollet Institute*

## What is My Wellness ZONE?

MDwise has a new interactive tool at [www.MDwise.org](http://www.MDwise.org) to help you stay healthy. With My Wellness ZONE, you can find a range of health news and information.

The Diet and Nutrition Zone has helpful tips for healthier food choices. It also gives health advice for children, teens, and older adults.

In addition to healthy eating tips, My Wellness ZONE has information on Exercise and Fitness, Family Health, Allergies, and many more topics. It is a great resource to learn new ways to be healthy.

Visit the MDwise Web site today to learn more!  
[www.MDwise.org](http://www.MDwise.org)

## What is High Blood Pressure?

High blood pressure is a serious condition that can lead to heart disease, heart failure, stroke, kidney failure, and other health problems.

Blood pressure is the force of blood pushing against the walls of the arteries as the heart pumps out blood. If this rises and stays high over time, it can harm the body in many ways.

### Overview

About 1 in 3 adults in the United States has high blood pressure. High blood pressure usually has no signs. You can have it for years and not know. During this time it can harm the heart, blood vessels, kidneys, and other parts of your body.

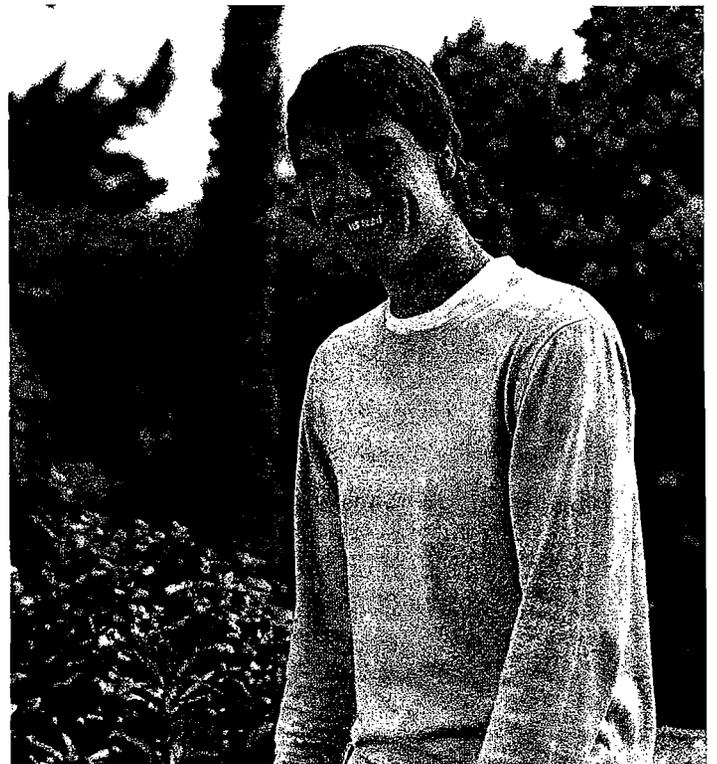
This is why knowing your blood pressure is important, even when you are feeling fine. If your blood pressure is normal, your doctor can help you keep it that way. If your blood pressure is too high, you need treatment to prevent harm to your body.

### Outlook

Blood pressure tends to rise with age. A healthy lifestyle helps some people delay or prevent this rise in blood pressure.

People who have high blood pressure can take steps to control it and lower their chances for related health problems. This includes following a healthy lifestyle, having ongoing medical care and following your doctor's treatment plan.

Source: National Heart Lung and Blood Institute



**MDwise**

# Healthy Indiana Plan Member Handbook



HEALTHY INDIANA PLAN  
Health Coverage = Peace of Mind



## Welcome to MDwise!

Dear MDwise Member:

Welcome to the Healthy Indiana Plan! Your Healthy Indiana Plan is MDwise. You will get health care benefits from this plan.

### Five Basic Rules

Now that you're a member, you should always follow these basic rules:

1. Carry your MDwise with you at all times. Show your card every time you get health care.
2. Contact your Primary Medical Provider for all medical care.
3. Only use the emergency room for true emergencies.
4. You must get preventive health care and check-ups each year that you have coverage.
5. You must pay your monthly contribution to stay in this health plan.

This handbook explains your benefits. Please call us with any questions.

Please read this handbook carefully.

Some pages have "TIP" boxes. These boxes have good advice to get the most out of your new benefits.

Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196. There are representatives that can help you. If you should get an automated message after-hours, please leave your name and number and someone will return your call no later than the next business day. You can also visit [www.MDwise.org](http://www.MDwise.org) for news and information.

Thanks!

Wishing You Good Health,

MDwise Customer Service Department

## You Must Call Now to Activate Your Extra Benefits!

When you call, your customer service representative will:

- Welcome you to the MDwise plan and answer your questions.
- Tell you about your benefits.
- Tell you about special incentive programs and health programs.
- Ask you a few questions to find out about your health needs.
- Provide information about extra services besides health care, especially if you have special needs.
- Make sure that we have the correct address and phone number for you.

It will only take a few minutes, but it will help us to serve you better—and you'll learn about your plan **BENEFITS!**  
**PLEASE CALL TODAY!**

MDwise Customer Service Department: 1-877-822-7196  
in the Indianapolis area 317-822-7196.

Si quiere que le mandemos esta información en español, favor de llamar a nuestro departamento de Servicio al Cliente de MDwise al 1-877-822-7196 o en Indianápolis 317-822-7196. Gracias.

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PLEASE CALL THE MDWISE CUSTOMER SERVICE DEPARTMENT WITH ANY QUESTIONS ABOUT THIS HANDBOOK OR YOUR NEW BENEFITS 1-877-822-7196 or in the Indianapolis area 317-822-7196.

You can also visit the MDwise Web site: [www.MDwise.org](http://www.MDwise.org)

**Welcome to MDwise!**

## HOW TO USE YOUR POWER ACCOUNT

As a member of the Healthy Indiana Plan, there are special rules to follow. Once you are eligible for the Healthy Indiana Plan, you will get a letter that will let you know what your monthly contribution is. You must pay this each month. If you do not pay this, you will be **disenrolled** from the program. We will send you a statement each month to remind you. If you are disenrolled due to non-payment, you cannot re-enroll for 12 months and there will be a 25% penalty on your POWER Account.

If a HIP member is disenrolled due to their death, MDwise will refund the POWER Account to the member's estate without penalty. This is done within 60 days of receiving notice of the member's death.

There are a number of ways you can make your monthly POWER Account contribution:

1. **Check or Money Order.** Make your check or money order payable to MDwise and mail your payment to:

MDwise  
P.O. Box 713194  
Cincinnati, Ohio 45271-3194

You can also pay by check or money order **in person** at:

MDwise/ACS  
4550 Victory Lane  
Indianapolis, IN 46203

**Important note:** All checks and money orders are held for 10 days to allow them time to clear. Please keep this in mind when mailing your contribution.

If you do not have enough money in your bank account to cover the payment that you make, you will have an additional fee to pay. You will have to pay an \$8.50 fee if your check bounces. This is in addition to making your monthly payment again.

2. **Cash.** Please do not mail cash. Cash, check or money order payments can be made **in person** at Key Bank locations, statewide. Please call Customer Service to find participating Key Bank branches, as all branches will NOT be participating.

When paying by cash, you must have your initial payment letter or monthly invoice for payment to be accepted.

3. **Employer Contribution.** Ask at work if your employer is willing to pay part of your contribution. If so, your employer has to fill out the Employer Contribution Form. You can call Customer Service to give us the name and phone number of your employer. We will then contact your employer for you. Only a part of your contribution can be made by your employer. You will get a bill each month for the rest.
4. **Payroll Deduction.** Ask at work if your employer is willing to take your contribution from your check. If so, your employer has to fill out a Payroll Deduction Form. You can call Customer Service to give us the name and phone number of your employer. We will then contact your employer to get this set up.

For you to keep your Healthy Indiana Plan coverage, you must pay your POWER Account contributions by the due date on the bill you get each month. If your employer agrees to pay a part of your contribution, and then does not make that payment, we will let you know. You will then have 60 days to pay it yourself.

The Healthy Indiana Plan will add the rest of the funds that you will need to get health care services. This money will go into a POWER Account. POWER Account stands for Personal Wellness Responsibility Account. You will have \$1,100 in your POWER Account. You will get a MDwise card in the mail. Use this MDwise card whenever you go to the doctor, the pharmacy or anytime that you get health care services. Except for your preventive care, other medical services will be paid for by your POWER Account. When the cost of your medical services is more than \$1,100, MDwise will cover the costs.

This plan does have some limits. They are:

- \$300,000 per year
- \$1 Million dollars in a lifetime

## HOW TO USE YOUR POWER ACCOUNT *continued*

It is important to remember that preventive care is covered. The Healthy Indiana Plan will cover all preventive care. Please see **Pages 7 and 8** for more information about the preventive care that you need to get. If you get the preventive services you need by the end of the year, and you have money left over in your POWER Account, that money will be rolled over to your POWER Account for next year! If you **DO NOT** get the preventive care that you need, any state contribution money left over at the end of the year will not roll over to the next year.

If you have any questions about your new POWER Account and to find out how much is in your account, please call MDwise Customer Service at 1-877-822-7196, or in the Indianapolis area 317-822-7196.

### How to Know What Medical Service Cost Your POWER Account

It is important to know what your medical services cost. That way you will know how much is going to be taken out of your POWER Account each time you get medical care. Please visit the MDwise Web site at **www.MDwise.org** for a list of medical services and their costs. You can also call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area, 317-822-7196, and we can mail you a list of services and their costs.

### MDwise Healthy Indiana Plan Benefit Summary

Annual Maximum	\$300,000
Lifetime Maximum	\$1,000,000
POWER Account	\$1,100
Emergency Care	\$3-\$25 member copay; Copay is not required if ER visit is a true emergency or if you are admitted
Preventive Care: Annual check-ups, annual screening recommended by your P.M.D. and according to preventive care guidelines for your age and gender	MDwise pays 100%
Family Planning	Paid from POWER Account; Then MDwise pays 100%
Prescription Drugs	Paid from POWER Account; Then State pays 100%
Inpatient Hospital Care Outpatient Hospital Care Physician Office Visits Outpatient Diagnostic X-rays and Lab Tests Inpatient and Outpatient Mental/Behavioral Health Medical Supplies, DME and Prosthetics Outpatient Therapy Services Ambulance (Emergency Transportation Only)	Paid from POWER Account; Then MDwise pays 100%
Organ and Tissue Transplant Services	Paid from POWER Account; Then MDwise pays 100%
Pregnancy Services, Dental, Vision	Not Covered
Out of Network Services (Except for Emergency Care and Family Planning)	Not covered

## MEMBER REDETERMINATION

Healthy Indiana Plan members must re-enroll every 12 months. This is also called redetermination. The process will determine if you are still eligible. It will also determine what monthly amount that you need to pay for the next year.

90 days before your coverage ends, you will get a letter from the Division of Family Resources with information on how to enroll for next year. Please read this information VERY carefully! If you have questions about it, feel free to call us at 1-877-822-7196 or in Indianapolis, 317-822-7196.

60 days before your coverage ends, you will get another letter from the Division of Family Resources with a re-enrollment form. You must fill out this form completely and mail back to:

FSSA Document Center  
P.O. Box 1630  
Marion, IN 46952

You can also fax the completed form to: 1-800-403-0864.

It is very important that you fill out the re-enrollment form right away and send it in! The Division of Family Resources must get this completed form 45 days BEFORE your coverage term ends or you will be disenrolled from HIP. You will not be able to re-enroll for 12 months.

If you need help to fill out this form, please call us and we would be happy to help you! Also, if you do not get this form by 60 days prior to your re-enroll date, call 1-877-438-4479 to request a new one be sent to you.

## GETTING MEDICAL SERVICES

You chose or were assigned to MDwise. Your MDwise doctor is called your Primary Medical Provider (PMP). PMPs can be one of four types of doctors:

- Family practice doctor
- General medicine doctor
- Internal medicine doctor
- Gynecologist doctor—for women only

Some PMPs work with trained health care assistants. The types of assistants that may help your PMP are:

- Nurse Practitioners
- Physician Assistants
- Medical Residents

These assistants can do many health care services that your doctor does. They can take medical histories, complete physicals, order lab tests, and give you health education.

If you would like to learn more about these assistants, or would like to see one of these assistants at your doctor's office, please call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

### Your MDwise Doctor Will Handle All of Your Health Care.

This includes:

- Giving check-ups and immunizations (shots)
- Giving routine care
- Writing prescriptions
- Referring you to specialists or other providers
- Admitting you to the hospital

*You should call your doctor whenever you need care.*

### Visit Your Doctor First

As a MDwise member, you must get most health care through your assigned doctor.

This way, your doctor can organize all your health care services. This helps you be as healthy as possible.

Always call your doctor when you need medical care.

Your doctor has someone who can help you 24 hours a day.

**If you get sick after hours, call your doctor's regular office number. If you hear a message, listen for instructions on what to do.**

Sometimes, your doctor may want you to get care from other providers. When this happens, your doctor will give you a written okay. This will let you go to another doctor or to a hospital or lab. **This written okay is called a referral.** Your doctor will give you a referral to visit another MDwise doctor. If we do not have the doctor you need in MDwise, then we will find you a doctor outside of MDwise that can help you.

#### **TIP:**

New MDwise members should call to make an appointment with their doctor right away. Make an appointment with your new doctor in the first 3 months or 90 days. You should make an appointment even if you are not sick. You can ask to have a physical exam and talk to your doctor about any other preventive care that you need to get. This is also a good way to get to know your new doctor so he or she can take better care of you—before an emergency happens!



## HOSPITALS

You may need to go to the hospital at some time. Your doctor will set this up for you. You should not go to the hospital without your doctor's okay. This is very important. Otherwise, MDwise may not cover your hospital care.

### Choosing a Hospital

Your doctor only treats patients at a certain hospital. You should only use the hospital that your doctor uses. Ask your doctor first!

Examples of when you should use your doctor's hospital:

- When you have planned surgery
- When your doctor wants to admit you for other reasons

However, if you have a true emergency, you do not have to call your doctor. Just go to the nearest hospital for immediate care.

Remember that you must pay a copay when you use the emergency room.

### Special Situations

#### *What Do I Do If There Is An Emergency?*

You should call your doctor whenever you have questions or need care. This is the best way to help your doctor take care of you. However, if it is an emergency, do not wait to call your doctor first!

Call 911 or go straight to the nearest hospital emergency room.

You can read more about emergency care on **Page 13**.

#### *What Do I Do When I Am Far From Home?*

If you are far away from home, you should still call your doctor if you need care. He or she can help you get routine or urgent health care.

If you cannot afford the long distance call to your doctor, we can help. You can call MDwise free of charge. We will help you reach your doctor.

#### **TIP:**

Your doctor should be available 24 hours a day! You should always be able to reach your doctor or your doctor's after-hours number. It is okay to call, even late at night, if you have an emergency or urgent health care needs.



#### **TIP:**

Ask your doctor which hospital to use before you need it. Always use that hospital, unless it is a true emergency. Then, just go to the closest hospital right away.



### Interpretation Services

MDwise doctors can talk to you in Spanish or other languages. This is a free service. It is available to you 24 hours a day, 7 days a week by phone and at doctor visits. You or your doctor can call MDwise Customer Service and these services will be arranged for you.

### Get Check-ups Regularly

It is important to get check-ups from your doctor every year. This is true even if you feel healthy. There are many reasons to get preventive care check-ups. The information you will learn will help you take charge of your health!

Check-ups will help you:

- Get immunizations (shots) that can help keep you from getting sick.
- Catch early warning signs before a disease or illness gets worse.
- Check “vital statistics” so your doctor can compare them when you do get sick.
- Get advice on eating better, quitting smoking, or other healthy living tips.

#### **TIP:**

Regular check-ups help you and your doctor get to know each other. This will help your doctor understand your needs when you are sick! Regular visits will help you feel that you can trust your doctor about your health.



### Preventive Care for Adults

Adults need several kinds of preventive care, like:

- Routine exams and tests, as your doctor recommends. This may include mammograms or prostate exams.
- Annual pelvic exams, Pap tests and breast exams for adult females.
- Flu shots.

## PREVENTIVE CARE GUIDE

### Preventive Care

The following chart lets you know what care or screenings you may need for someone your age and gender. For example, if you are a 25 year old female, please find that row for the preventive care that you may need. Your doctor will know what preventive services you need. For those members that started HIP in 2008 and are in their second year of coverage and for new members in 2009, the following chart shows you the preventive services that you need to get in order to roll-over your POWER Account balance at the end of the year.

IF YOU ARE:	YOU NEED:
Male age 19-34	Annual Physical Exam Blood Glucose Screen* Tetanus-Diphtheria Screen
Female age 19-34	Annual Physical Exam Pap Smear Blood Glucose Screen* Tetanus-Diphtheria Screen
Male age 35-49	Annual Physical Exam Cholesterol Testing Blood Glucose Screen* Tetanus-Diphtheria Screen
Female age 35-49	Annual Physical Exam Pap Smear Cholesterol Testing* (if you are over 45) Mammogram Blood Glucose Screen* Tetanus-Diphtheria Screen
Male age 50-64	Annual Physical Exam Cholesterol Testing Blood Glucose Screen* Tetanus-Diphtheria Screen Flu Shot
Female age 50-64	Annual Physical Exam Pap Smear Cholesterol Testing* Mammogram Blood Glucose Screen* Tetanus-Diphtheria Screen Flu Shot*

*\*Annual or as required by your disease/history specific condition*

Please remember that all preventive care that you get is covered by MDwise. This will not be taken out of your POWER Account. If you get preventive services every year, and you have money left over in your POWER Account, that money will be rolled over to your POWER Account for next year! If you **DO NOT** get the preventive care that you need, any state contribution money left over at the end of the year will not roll-over to the next year.

## MAKING DOCTOR APPOINTMENTS

### Call for an Appointment

You should always call before visiting the doctor's office. When you call, the doctor's staff will schedule a time for you to see the doctor as soon as possible.

### Before You Call

When you need health care, you should call your doctor right away. When you call, you can also ask to talk to a nurse if you have medical questions.

Before you call, be sure that you:

- Have your MDwise Card handy
- Are ready to explain what is wrong
- Have a phone number where the doctor can call you later (this can be a family member or friend's number, if needed)
- Have a pen and paper ready to write down any instructions

### Schedule Your Appointment

This list shows the longest you should have to wait to get an appointment:

- Within 2 months for a first appointment.
- Within 1 day, for urgent care (like a fever).
- Within 3 days, for non-urgent care (like ongoing knee pain).
- Within 3 months for an annual physical exam.

It is very important to keep your doctor's appointments. This helps your doctor take better care of you!

### Getting Ready for Your Doctor's Appointment

Before you see the doctor, be sure to write down your questions. Never be afraid to ask questions. The doctor wants you to understand all your treatment decisions.

#### **TIP:**

Please call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196 if you have problems with waiting times or making an appointment.

#### **TIP:**

Always call at least 24 hours before your appointment if you have to cancel it. The doctor's office will set up a new appointment for you. Calling will also let the doctor's office know they can give your appointment time to someone else.



If this is your first appointment with a doctor, plan to arrive early. The doctor's office may have paperwork for you to fill out before you see the doctor.

### In the Waiting Room

You will have the shortest wait in the waiting room if you make an appointment first. Your wait time should be under one hour. Sometimes it may take longer if your doctor has unplanned emergencies.

## COVERED MEDICAL SERVICES

MDwise wants to help you stay healthy. That is why we cover preventive care as well as sick care. **If there are changes to your benefits, we will let you know by mail.** If you have any questions about your benefits, please talk to your doctor or call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

### Preventive Care

Getting regular preventive care is the key to better health. You get preventive care when you go to the doctor for check-ups and other well care. MDwise covers preventive care because it keeps you healthy and checks for problems before they become serious. Examples include:

- Check-ups and shots.
- Physical exams.
- Mammograms and Pap smears.

### Necessary Care

Care must be “medically necessary.” This means it is:

- Needed to diagnose or treat you.
- Proper based on current medical standards.
- Not more than what is needed.

### Prior Authorization

Some services need approval from MDwise before you get them. This is called prior authorization. If your doctor does not get prior authorization when it is needed, MDwise will not pay for the services.

Prior authorization decisions are based only on the appropriateness of care and services. These decisions are also based on whether or not you have coverage. Doctors and staff that make prior authorization decisions do not get incentives or rewards for making these decisions. They do not get payment for deciding to deny a service or for making decisions that may make it harder to get care and services.

### Services Your Doctor Must Approve and Refer You To

Members can get the full list of services on this page. Your doctor must approve all these services.

To get the following services, you must call or go to your doctor first. The doctor will refer you for any treatments you need:

#### **Doctor Care:**

Physical exams  
Primary care  
Preventive care  
Specialty care

#### **Hospital Care:**

Inpatient services  
Outpatient services  
Diagnostic services  
Lab tests and X-rays

#### **Medical Supplies:**

Prescriptions  
Durable medical equipment  
Hearing aids for 19 and 20 year olds

#### **Other:**

Immunizations (shots), health care screenings and diagnosis

Home health care therapy, including:

- Physical therapy
- Respiratory therapy
- Speech therapy
- Occupational therapy

Renal dialysis

Smoking cessation

Disease Management

Lead screening for 19 and 20 year olds

Hospice services

Skilled Nursing facility (60-day maximum)

**If you have questions about your benefit package please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196.**

## SERVICES FROM OTHER DOCTORS

Sometimes, you may need to see a provider other than your regular doctor.

### Seeing a Specialist

A specialist is a doctor who treats one part of the body, like the heart, skin, or bones. Your regular doctor will write you a referral if you need to see a specialist. That specialist will be in the MDwise network.

If MDwise does not have the doctor that you need in our network, or that is not within 60 miles of your home, we may authorize out-of-network doctors to take care of you. These providers must be Indiana Health Coverage Program or Medicaid providers.

### You Must Get a Referral from Your Doctor Before Going to a Specialist.

MDwise will not cover specialist care unless you have a referral from your doctor. Your doctor will tell you how to get specialist care.

### Self-Referral Services

The following services are “self-referral” services:

- Emergency services
- Family planning

MDwise covers these services. Your doctor can help you get these services, but you do not have to go through your doctor to get them. You can go to any provider, who is an Indiana Health Coverage Program or Medicaid provider, to get these services. Self-referral providers must get an okay from MDwise before giving you some services.

*Remember, your doctor can best take care of you if you talk to the doctor before getting any kind of health care.*

### Services Not Covered

The following services are not covered under the Healthy Indiana Plan:

- Services that are not medically necessary
- Maternity and related services (*see page 12*)
- Dental Services
- Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly
- Vision services
- Elective abortions and abortifacients
- Non-emergency transportation services (i.e., transportation services that are unrelated to an emergency medical condition)
- Chiropractic manipulations such as back and spinal adjustments
- Drugs excluded from HIP
- Long term or custodial care
- Experimental and investigative services
- Day care and foster care
- Personal comfort or convenience items
- Cosmetic services, procedures, equipment or supplies, and complications directly relating to cosmetic services, treatment or surgery, with the exception of reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or a previous medically necessary procedures
- Hearing aids (unless you are 19 or 20) and associated services
- Safety glasses, athletic glasses and sunglasses
- LASIK and any surgical eye procedures to correct refractive errors

- Vitamins, supplements and over-the-counter medications, with the exception of insulin
- Wellness benefits other than tobacco cessation
- Diagnostic testing or treatment in relation to infertility
- In vitro fertilization
- Gamete or zygote intrafallopian transfers
- Artificial insemination
- Reversal of voluntary sterilization
- Transsexual surgery
- Treatment of sexual dysfunction
- Body piercing
- Over-the-counter contraceptives
- Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reiki therapy, massage therapy and herbal, vitamin or dietary products or therapies
- Treatment of hyperhidrosis
- Court ordered testing or care, unless medically necessary
- Travel related expenses including mileage, lodging and meal costs
- Missed or canceled appointments for which there is a charge
- Services and supplies provided by, prescribed by, or ordered by immediate family members, such as spouses, caretaker relatives, siblings, in-laws or self
- Services and supplies for which an enrollee would have no legal obligation to pay in the absence of coverage under the plan
- The evaluation or treatment of learning disabilities
- Routine foot care, with the exception of diabetes foot care
- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia
- Any injury, condition, disease or ailment arising out of the course of employment if benefits are available under any Worker's Compensation Act or other similar law
- Examinations for the purpose of research screening

## PREGNANCY CARE

The Healthy Indiana Plan does not cover pregnancy care. If you become pregnant while you are on the plan, please call MDwise Customer Service right away. All pregnancy services are covered under the Hoosier Healthwise Package B plan for pregnant women. You may be eligible for this plan. We can help you to sign up.

You must complete a "Report of Change" form and fax or mail to:

FSSA Document Center  
P.O. Box 1630  
Marion, IN 46952  
Fax: 1-800-403-0864

You must also send proof of your pregnancy.

You will then be disenrolled from the Healthy Indiana Plan. At the end of your pregnancy, you can re-enroll in the Healthy Indiana Plan.

You can choose to stay in the Healthy Indiana Plan, but if you do this, your pregnancy services will not be covered.

Regular check-ups are important for a healthy baby so don't forget to call right away, so that you can get the care that you need! You can call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

No one likes to spend hours in an emergency room. You can help by getting preventive care. This way, you can get health care before the problem gets too bad. See **Page 8** for a list of preventive care services that are right for you.

MDwise will cover emergency care 24 hours a day. If you have a true emergency, go to the closest hospital right away. MDwise will cover your emergency care even if:

- You are far away from home.
- You cannot get to your doctor's regular hospital.

Post-stabilization services in the emergency room are also covered. The emergency room doctor will stabilize the condition that you went to the ER for. If the doctor decides that you need more testing or services, he/she can contact MDwise to get approval for more tests or services. This happens only after you are stable and are no longer in immediate danger.

### Emergency Room Copay

Healthy Indiana Plan members must pay a copay when you go to the Emergency room. The copay is based on your level of coverage. Your copay can be from \$3 to \$25. Your copay is listed on your MDwise card. You **cannot** use your POWER account to pay for this copay.

If you are admitted to the hospital after your emergency room visit, you do not have to pay this copay.

### Three Kinds of Care

There are different kinds of health care: preventive care, urgent care, and emergency care. This chart shows you what to do when you need each kind of care. If you have questions, always ask your doctor for advice.

KIND OF CARE	WHAT TO DO
<p><b>Preventive Care</b> - This is when you get regular care to keep you healthy. Examples are:</p> <ul style="list-style-type: none"> <li>• Checkups</li> <li>• Annual exams</li> <li>• Immunizations (shots)</li> <li>• Prescriptions and refills</li> </ul>	<p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>• You should always call your regular doctor to make an appointment for preventive care.</li> </ul>
<p><b>Urgent Care/Sick Visit</b> - This is used when you need immediate care, but you are not in danger of lasting harm or loss of life. Examples are:</p> <ul style="list-style-type: none"> <li>• Earache</li> <li>• Sore throat</li> <li>• Fever</li> <li>• Minor cut that may need stitches</li> </ul>	<p><b>Urgent Care/Sick Visit</b></p> <ul style="list-style-type: none"> <li>• Call your doctor. The doctor will make you an appointment or give you other instructions.</li> <li>• You should go to the same place you go to for urgent care.</li> <li>• If you are unsure at night, you should always talk to someone who can help you and help.</li> </ul>
<p><b>Emergency Care</b> - This is used when you have a serious medical condition and are in danger of lasting harm or loss of life. If you do not go to the Emergency Room immediately. Examples are:</p> <ul style="list-style-type: none"> <li>• Poisoning</li> <li>• Severe head injury</li> <li>• Excessive bleeding</li> <li>• Convulsions</li> <li>• Serious burns</li> <li>• Loss of consciousness</li> <li>• Sudden severe chest pain</li> <li>• Trouble breathing</li> </ul>	<p><b>Emergency Care</b></p> <ul style="list-style-type: none"> <li>• Go to the nearest hospital or call 911. You do not have to call your doctor first in an emergency.</li> <li>• When you get to the hospital, or as soon as you are able:             <ul style="list-style-type: none"> <li>• Show them your MDwise card.</li> <li>• Tell them you are a MDwise member.</li> <li>• Ask them to call your doctor within 24 hours.</li> </ul> </li> </ul>

### Out-of-Area Care

If you are far away from home, you can still get health care. Before getting care, you must call your doctor. You can also call MDwise for help at 1-877-822-7196 or in the Indianapolis area 317-822-7196. If you have a true emergency, do not call first. Go straight to the nearest hospital.

### After Hours Care

Even after-hours, you can call the doctor's regular office number. If you hear a message, listen for instructions on what to do. Most MDwise doctors will have someone "on call" that will call you back to answer your questions.

Your MDwise Card lists numbers you can call when you need help.

### When to Go to the Emergency Room

- You should not use the ER for anything but true emergencies!
- If you are not sure if it is an emergency, call your doctor for advice.
- Your doctor has someone who can help 24 hours a day. If you hear a recorded message when you call, listen carefully for instructions.

#### **TIP:**

Always keep your MDwise Card in your wallet or purse. That way, if you need help, you will have our phone numbers close at hand.

Many people think mental or emotional problems are rare. In fact, they are common. A mental illness or emotional problem can affect thoughts and behavior. It can make it hard to cope with normal life routines.

### Covered Services

If you think you may have a mental or emotional problem, it is important to remember there is help. MDwise covers behavioral health services for our members. These services include:

- Mental health
- Behavior problems
- Alcohol and drug abuse

MDwise members can choose a behavioral/mental health provider and set up appointments without a referral from a doctor. However, you should always talk to your doctor. He or she can help you find the right behavioral health provider.

You must choose a behavioral health provider within the MDwise network. There is a list of behavioral/mental health providers that you can choose from. To find a behavioral/mental health provider you can call MDwise Customer Service or go to [www.MDwise.org](http://www.MDwise.org).



If you have any questions about behavioral and mental health services, call MDwise at 1-877-822-7196, or call 317-822-7196 if you are in the Indianapolis area. When you call you will be asked to pick a number from a list of options. Listen carefully and pick **option #2** for “behavioral or mental health services”. If you have a behavioral or mental health emergency, there is an option that you can pick and someone will help you right away.

We can answer your questions!

Medicines for MDwise members are covered. You can go to any pharmacy that accepts Indiana Medicaid. If you have pharmacy questions or problems, please call 1-800-457-4584 and choose option #2.

#### How the Prescription Benefit Works

When you need medicine, your doctor will write a prescription. You can take that prescription to the pharmacy.

There are no copays for your prescription medicine. Your medicines are paid for through your POWER Account.

Over the counter medicines or vitamins are not covered under HIP unless they are on the preferred drug list (PDL). See below for more information about the PDL.

#### Prescription Medicine

The Healthy Indiana Plan covers necessary medicines. Your doctor must prescribe these medicines. It must be a medicine approved by the Food and Drug Administration (FDA).

The Healthy Indiana Plan gives your health care provider a tool called a preferred drug list. This helps him or her prescribe drugs for you. A preferred drug list is a list of some of the brand and generic medicines covered by the Healthy Indiana Plan. MDwise Healthy Indiana Plan members can call 1-800-457-4584 and choose option #2 to ask about medicines that are covered. If you have Internet access, you can go to [www.indianamedicaid.com](http://www.indianamedicaid.com) or to [www.indianapbm.com](http://www.indianapbm.com). This drug list will also show you any of the over-the-counter medicine and vitamins that are covered.

There is also the Indiana Medicaid Pharmacy Services Member Handbook. It is available online at [www.indianamedicaid.com](http://www.indianamedicaid.com) under Pharmacy Services or you may call 1-800-457-4584, option #2, to have a copy mailed to you.

If you need help, you can call MDwise Customer Service for help at 1-877-822-7196 (toll-free) or 822-7196 in the Indianapolis area. You can also visit [www.MDwise.org](http://www.MDwise.org) to find a list of pharmacies. Please click on “find a provider” and choose the IHCP pharmacy directory.

Healthy Indiana Plan members can get ambulance transportation for true emergencies. You should only call an ambulance when it is a true emergency. If you think your problem could cause lasting harm or loss of life, call 911.

**TIP:**

Since non-emergency transportation is not covered under the Healthy Indiana Plan, here are some other ideas for getting a ride to your doctor appointment:

- Ask a family member or friend to take you.
- Find a bus route or other public transportation to take you.

Remember, you must pay for these types of transportation. MDwise does not cover them.



MDwise has several ways to help us talk with special needs members. Instructions are shown below.

#### Hearing and Speech Impaired Members

1. Call the Relay Indiana Service at 1-800-743-3333. You can also dial "711". This number can be used anywhere in Indiana.
2. Ask them to connect you to MDwise: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

#### Language Assistance

1. MDwise has customer services representatives that can talk to members in other languages. Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196.
2. The customer service representatives can also get an interpreter on the line if needed. The customer service representative and the interpreter will both help answer your questions.

#### Member Advocates

MDwise also has staff that can help you with difficult issues that you may have such as help in talking to your doctor, keeping appointments or finding other services, like a parent support group or help with food, housing or utility problems. These Member Advocates can help if you need suggestions or information about other services available in your community. We call this program HELPlink.

#### Advance Directives

Advance Directives are documents you can complete to protect your rights for medical care. It can help your family and doctor understand your wishes about your health care. You can:

- Decide, right now, what medical treatments you want or don't want.
- Give someone the power to act for you in a lot of situations, including your health care.
- Appoint someone to say yes or no to your medical treatments when you are no longer able.
- Inform your doctor, in advance, if you would or would not like to use life support systems, if ever necessary.
- Inform your doctor if you would like to be an organ donor.

These are the types of Advance Directives in Indiana:

1. Talking directly to your doctor and family
2. Organ and Tissue donation
3. Health Care Representative
4. Living Will Declaration or Life-Prolonging Procedures Declaration
5. Psychiatric advance directives
6. Do not Resuscitate Declaration and order (out of hospital)
7. Power of Attorney

Advance Directives will not take away your right to make your own decisions. Advance Directives will work only when you are unable to speak for yourself.

MDwise cannot refuse care or discriminate against members based on whether they choose to have, or not to have, an advance directive. MDwise is required to follow State and Federal laws. Your MDwise doctor should document whether or not you have executed an advance directive in your medical record.

If you have concerns that a MDwise organization or provider is not meeting Advance Directive requirements, please call MDwise Customer Service.

MDwise has a number of extra programs for you and your family. They will help you get healthy and stay healthy. Special MDwise programs include:



### **NURSE**on-call

Speak with a nurse 24 hours a day

Sometimes you have questions about your health. Just call our 24-hour phone line and speak with a nurse, not a recorded message. Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Select option 3.



### **IN**control

Learn to manage your asthma, diabetes or other chronic illness



### **WELLNESS**chats

Fun, educational community events where you can learn about good health



### **HEL**Plink

Work with a member advocate who knows about health, school and community services



### **SMOKE**-free

Get help kicking the tobacco habit



### **WEIGHT**wise

Reach and maintain a healthy weight

If you have questions about any MDwise programs, call us at: 1-877-822-7196 or in the Indianapolis area 317-822-7196, or visit the MDwise Web site [www.MDwise.org](http://www.MDwise.org).

We want to answer all your questions about your new MDwise plan. If you have any complaints, we are here to help fix the problem. We want you to get the best health care and service possible.

There is a MDwise representative that can help you 8:00 a.m. to 6:00 p.m. (EST), Monday through Friday. After hours, you can leave a message and someone will call you back right away the next business day.

If you need your member handbook and other MDwise information in other ways let us know. Examples are if you need the information in larger print, Braille or on an audiocassette.

Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have good or bad comments! You can also visit the MDwise Web site at [www.MDwise.org](http://www.MDwise.org). Click on the Healthy Indiana Plan.

The next few pages have tips on how to handle changes or questions you might have about MDwise or your doctor. Keep this booklet handy in case you need help with one of these situations.

**TIP:**

MDwise members have certain RIGHTS and RESPONSIBILITIES!

A list of these is on **Page 25** of this handbook.

We want to provide high quality service to you. So, here is our promise to you:

- If you have a problem, we will be here to listen.
- We will do our best to fix the problem for you.

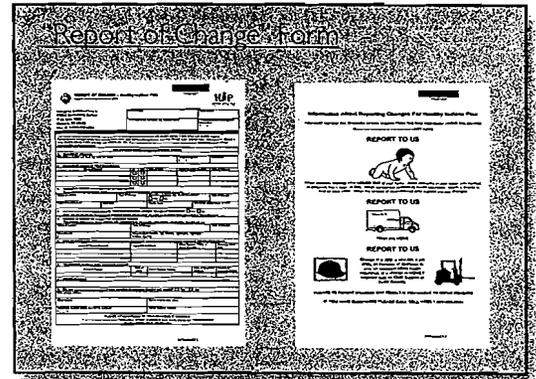
### New Address or Phone Number

If you move or change your phone number, you **MUST** call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196. You will need to fill out a "Report of Change" form. We can help you fill out this form.

### Other Insurance Plans

If you have other health insurance, you must let us know. You are not eligible for the Healthy Indiana Plan if you have other health insurance. You must also tell us, and the Healthy Indiana Plan (1-877-438-4479), if:

- You have changes in your insurance
- You get hurt in a car wreck
- You get hurt at work
- You get hurt and someone else may have to pay



### Changing Your Doctor

If you are not happy with your health care or your doctor, please call MDwise. We will work with you to fix any problems you have.

You are able to change your doctor once each year. You can only change for the following reasons:

- You have moved.
- Your doctor has moved or no longer belongs to MDwise.
- Your doctor does not return your calls.
- You have trouble getting the care you want or your doctor says you need.
- Your doctor was assigned by MDwise before you had the chance to choose a doctor for yourself.
- Other reasons—call for more information.

To change your doctor or to ask for a list of doctors in your area, please call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196 or visit [www.MDwise.org](http://www.MDwise.org) to get a list of MDwise doctors.

Remember, it is better for your health to stay with one doctor, rather than to change doctors often.

### Changing Your Plan

We hope that you are happy with the services that you receive from MDwise. If you are not happy please call MDwise Customer Service and we will try to help.

You can change your plan:

- At the end of the year when you re-certify for the Healthy Indiana Plan
- If you become eligible for the ESP plan
- If there are quality of care problems that we cannot fix for you

### Changing Your Contribution Amount

If you have a change in family size or income, call 1-877-438-4479 (1-877-GET-HIP-9). Let them know about the change. You can also call MDwise Customer Service and we will help you complete a change form.

### What To Do if You Pay More Than 5% of Your Annual Income

Are you on the HIP program as a caretaker adult? This means that you are on HIP and you have children that live with you that are on Hoosier Healthwise or Care Select. If you are and you have paid for healthcare services over 5% of your income, let us know.

This money must have been paid for:

- Monthly contributions
- ER copays

If what you have paid for these things is more than 5% of your income in a 12-month coverage period, you may not have to pay future contributions to HIP or ER copays.

If you think this is true for you:

- You must collect and send in copies of all of your receipts
- We must confirm your income

Requests and documentation can be sent to:

MDwise Customer Service  
P.O. Box 44236  
Indianapolis, IN 46244-0236

We will review all of your documents. We will confirm whether you have paid over 5% of your income during a month coverage period. We will then let you know the outcome of our review. Call MDwise Customer Service for more information at 1-877-822-7196 or in Indianapolis 317-822-7196.

#### What To Do if You Get a Bill for Health Care

MDwise only pays your provider for the covered services you get. A provider cannot require you, your relatives, or others to pay additional charges for these covered services.

Health care providers generally cannot bill Healthy Indiana Plan members unless it is for a non-covered service.

If you do get a bill for health care services, take care of it right away by following the steps below. Otherwise, it may be sent to a collection agency.

- Contact your health care provider to make sure they know you are on the MDwise Plan.
- Contact MDwise and tell them you received a bill.

Providers know the limits placed on their services. The provider must tell you if MDwise does not cover a service before the service is provided. A provider may charge you for services that are not covered by MDwise if:

- The provider told you before providing the services that the services are not covered.
- You agreed to pay for the service in writing.

Remember to take your MDwise Card with you to all health care appointments and show it to the office staff.

#### Help MDwise Stop Fraud and Abuse

- Do not give your MDwise Card number to anyone. It is OK to give it to: your doctor, clinic, hospital, pharmacy, or MDwise Customer Service.
- Do not let anyone borrow or use your MDwise Card
- Do not ask your doctor or any health care provider for medical care that you do not need
- Work with your primary doctor to get all of the care that you need
- Do not share your Healthy Indiana Plan or other medical information with anyone except your doctor, clinic, hospital, or other health provider

Call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have questions or concerns about fraud and abuse.

## YOUR OPINIONS

#### Member Surveys and Outreach

Your opinions matter to us! We do a member survey to make sure you are happy. This helps us improve our service and also helps us give better health care for you. This survey is done once each year.

MDwise members may occasionally receive phone calls from MDwise. One type of call might be to ask questions about your health needs. Your answers help MDwise know which programs might be right for you. Another type of call might be to ask about your satisfaction with your doctor. A MDwise caller will tell you right away who they are and why they are calling. Your answers to our questions help us serve you better.

MDwise also does automated calls. These calls may include reminders about monthly contributions or they might be a reminder to get needed preventive care.

If you have any questions at any time about these calls or the survey, please call: MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

## MDWISE COMMITMENT TO QUALITY CARE

MDwise is always looking for new ways to improve your health and to serve you better. The Quality Program wants MDwise members to get high quality health care services. Health services that are safe and meet your needs are important to us.

We monitor your care and services throughout the year. Our Quality program looks at:

- Services given by doctors/providers
- Members being able to get the services they need
- Members getting the right number of services
- Results of our member satisfaction surveys

What we find from these reviews helps us to work closely with providers. Results also help us know what information to send to our members.



## HOW TO GET HELP WITH A PROBLEM

### Getting Help with a Problem

The quality of service you get from MDwise is important to us. If you have a concern, call the MDwise Customer Service Department at: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

A MDwise customer service representative will file a grievance. The customer service representative will try to solve your concerns right away. If we cannot solve the issue by the next business day, we will follow up with a letter.

### Filing an Appeal

If you do not agree with a decision you get, you have the right to ask for further review of the problem. This is called an "appeal." You can file an appeal about any health care decisions. Someone, like your doctor, can do this on your behalf if you want them to.

You must file an appeal within 30 days of the date that the decision was made. When you file an appeal, you may be able to continue getting a service that has been denied. This can only happen if you are getting those services already. You must send your appeal in before the denial takes effect. If MDwise decides that the services will not be authorized, you will have to pay for those services. Ask us about continued services if this is important to you.

### How to File an Appeal:

#### Step 1. Submit Your Appeal

You must write a letter. You can call the MDwise Customer Service Department for help writing your letter. When you write a letter, you should include the following:

- Your name, address, telephone number, and MDwise card number.
- Date and description of the service that was denied
- Additional information that can help in our review
- You must sign the letter

Keep a copy of these papers for yourself.

Then, send us the original at:

MDwise Customer  
Service Department  
Attn: Appeals  
PO Box 44236  
Indianapolis, IN 46244-0236

Step 2. Wait for a Written Answer from MDwise  
MDwise will review your appeal.

You will get a letter telling how we handled your problem. We will reply within 25 business days. If we need more time to review the problem we will write to you and let you know.

#### Step 3. MDwise Second Level Appeal Process

If you still do not agree with our answer, you can ask for an appeal by calling MDwise. You must also write us a letter to appeal. You have 30 business days to file an appeal. The MDwise Appeals Panel will review your problem. You can speak to the panel if you want. You can also have someone else speak for you. You will get a reply within 35 business days.

#### Step 4. Review by Independent Review Organization

If you are still not happy, you can sometimes ask for a review by an Independent Review Organization (IRO). The IRO will make a decision within 15 business days and MDwise will then notify you of the results.

#### Step 5. Appeal to FSSA

To appeal the IRO decision, you must contact the State. The Indiana FSSA Office of Hearings and Appeals handles this. You can write to them at: Office of Hearings and Appeals, 402 West Washington, Room W392, Indianapolis, IN 46204. The FSSA decision is the final administrative ruling. If you are still not happy, you can file a lawsuit. A court will then review your case.

Other Notes: In an emergency, appeals will be handled quickly. This is called an "expedited" appeal. If your case can be expedited, we will review your case and notify you of a decision within 72 hours. Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196 to see if this can be done.

## YOUR RIGHTS AND RESPONSIBILITIES

MDwise provides access to medical care for all its members. We do not discriminate based on your religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age.

Medical care is based on scientific principles. We provide care through a partnership that includes your doctor, MDwise, other health care staff, and you – our member.

### **MDwise is committed to partnering with you and your doctor. We will:**

- Treat you and your family with dignity and respect.
- Maintain your personal privacy. Keep your medical records confidential as required by law.
- Give you a clear explanation of your medical condition. You have a right to be part of all your treatment decisions. If you understand the options, you can better decide if you want a certain treatment. Options will be discussed with you no matter what they cost or whether they are covered as a benefit.
- Provide you with information about MDwise, its services, and doctors.

### **In addition, YOU have the right to:**

- Change your doctor once each year by calling the MDwise Customer Service Department.
- Timely access to covered services.
- Appeal any decisions we make about your health care. You can also complain about personal treatment you get.
- Get copies of your medical records or limit access to these records, according to state and federal law.
- Amend your medical records that we keep.
- Get information about your doctor.
- Request information about the MDwise organization and operations.
- Refuse care from any doctor.
- Ask for a second opinion.
- Make complaints about MDwise, its services, doctors, and policies.
- Get timely answers to your complaints or appeals.
- Take part in member satisfaction surveys.
- Prepare an advance directive.
- Get help from the Indiana Family and Social Services Administration (FSSA) about covered services, benefits, or complaints.
- Get complete benefit information. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered services.
- Request information about our physician incentive plan.
- Be told about changes to your benefits and doctors.
- Be told how to choose a different health plan.
- Health care that makes you comfortable based on your culture.
- Be free from any form of restraint or seclusion used

as a means of coercion, discipline, convenience or retaliation, in accordance with Federal regulations. This means that your doctor cannot restrain or seclude you because it is the easiest thing to do. The doctor cannot make you do something that you do not want to do. The doctor cannot try to get back at you for something that you may have done.

- When you exercise these rights, you will not be treated differently.
- Provide input on MDwise member rights and responsibilities.
- Participate in all treatment decisions that affect your care.
- If MDwise closes or becomes insolvent, you are not responsible for our debts. Also, you would not be responsible for services that were given to you because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally in the case of insolvency, you do not have to pay any more for covered services than what you would pay if MDwise provided you the services directly.

### **YOU are responsible for:**

- Contacting your doctor for all your medical care.
- Treating the doctor and their staff with dignity and respect.
- Understanding your health problems to the best of your ability and working with your doctor to develop treatment goals that you can both agree on.
- Telling your doctor everything you know about your condition and any recent changes in your health.
- Telling your doctor if you do not understand your care plan or what is expected of you.
- Following the plans and instructions for care that you have agreed upon with your doctor.
- Keeping scheduled appointments.
- Notifying your doctor 24 hours in advance if you need to cancel an appointment.
- Telling us about other health insurance that you have.

### **IMPORTANT TIP:**

If you do not follow your doctor's advice, this may keep you from getting well. It is your job to talk with your doctor if you have any questions about your medical care. Don't ever be afraid to ask your doctor questions! It is your right!

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dear MDwise Member,

This notice tells about your privacy rights. You have rights about the medical information we keep about you. MDwise cares about your privacy. We protect your privacy rights. Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have questions about this notice. You can ask to see a copy of the medical information we keep about you. When you call, ask for the Privacy Officer.

Wishing you good health,

MDwise

#### Summary of Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities and, when required or authorized by law, for public health and interest activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

We will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures we may make of your medical information, and to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

#### Organizations Covered by this Notice

This notice applies to the privacy practices of MDwise, Inc.

#### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2008, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send you a new notice within sixty (60) days of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

## Uses and Disclosures of Medical Information

We will use and disclose medical information about you for treatment, payment, and health care operations.

For example:

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to determine eligibility, process claims, or make payment for covered services you receive under your benefit plan. Also, we may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include, for example, health care quality assessment and improvement activities and general administrative activities.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement. We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as a medical emergency or during disaster relief efforts.

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services and Appointment Reminders: We may contact you to remind you of appointments. We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services, that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and interest activities, judicial and administrative proceedings, law enforcement, research, and other public benefit functions:

- For public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- To avert a serious and imminent threat to health or safety;
- For health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- For research;
- In response to court and administrative orders and other lawful process;
- To law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- To coroners, medical examiners, funeral directors, and organ procurement organizations;
- To the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- As authorized by state worker's compensation laws.

#### Individual Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to obtain access to your medical information. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances after January 1, 2008, in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before January 1, 2008. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this notice for information about our fees.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. You may

obtain a form from that contact to make your request. Any agreement we may make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of that health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Right to Obtain a Paper Copy: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information at the end of this notice to obtain this notice in written form.

#### Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: MDwise  
Attention: Privacy Officer  
Telephone: 1-877-822-7196 or in the Indianapolis area 317-822-7196  
E-mail: [legal@mdwise.org](mailto:legal@mdwise.org)  
Address: P.O. Box 44236, Indianapolis, IN 46244-0236

MDwise (HIP)  
P.O. Box 44236  
Indianapolis, IN 46244-0236