MA D Vs HIP Opt Out FAQ
10/20/2015

Policy Clarification:

1. **If a client requests dual processing and HIP is authorized, but later MRT determines the client is disabled is retro coverage allowed?**

   Retro coverage would be allowed for MA D if the client met all other eligibility requirements. If HIP is conditional at the time MRT makes a determination, a FIAT should not be required, as conditional status does not cause an overlap in eligibility and system will automatically provide retroactive coverage, and has been tested in ICES..

   Open HIP Plus coverage will not be removed to replace with MA D coverage if found eligible. Workers should make dual processing clients aware of this when initially approving HIP. If HIP is only open one or two months prior to MA D eligibility then a FIAT can be used to put in MA D for the months prior to the HIP coverage date to provide client with benefits in the retro period.

2. **Why is it that a person who states they are disabled but refuses to apply for Social Security cannot receive HIP?**

   Based upon the rules which have been reviewed since the webinar was developed and presented it has been determined that, applying for Social Security is not a requirement under HIP. HIP will stay open or can be selected and processed. Only MA D will be denied for reason code 597 if applicant fails to apply for a benefit in which they may be entitled.

3. **Original feedback (below) after reviewing the material on 8/13/15 is still on the table. There are 2 issues in our previous response below. We'd like direction/clarification on the "option to" question as well as whether or not it is still appropriate to deny the D/B and close the HIP if they fail to apply for SSA as instructed.**

   If MA D is denied/closed for any reason, HIP can be processed.

4. **We need to know what happens when someone applies with NOT disabled but there is a DE on AEIDP.**

   OR:

There was a MA D decision on them within the last 48 months and were due a progress report but went off for not doing that. They state they are no longer disabled and just want HIP.

They must be reviewed for MA D if we have a decision within 48 months. This is not to say that you can't advise the member of their options to dual process in case they are found to not qualify for MA D determination as they expect. Make sure to go over the differences of HIP and MA D as stated in the webinar and listed below. If client refuses to cooperate in completed the progress report, deny the MA D and process the HIP, if not already being dual processed.

HIP

-requires monthly contribution in Plus or relatively high copayments in Basic for most services

-will be in managed care but not in Hoosier Care Connect

-certain individuals (low income parents/caretakers, low income 19/20 year olds, TMA, medically frail, some American Indians/Alaska Natives) will receive State Plan benefits which are the equivalent to benefits under Hoosier Care Connect

-certain low-income individuals may submit claims incurred in the three months before approval

-increased or new earnings may make you ineligible for HIP if above 138% FPL

-can receive benefits under HIP while a determination is being made for Medicaid for the Disabled/Blind

-if a disability determination has not yet been made, an individual can opt for HIP and does not have to go through the disability/blind determination process

MA D/MA B

-requires no monthly contribution and relatively low copayments for some services, such as prescription

-receive appropriate care coordination and case management services under Hoosier Care Connect which focuses on aged, blind, and disabled populations

-all individuals receive the same State Plan benefits

-increased or new earnings may allow individuals to transition to MEDWORKS and remain in Hoosier Care Connect

-all individuals receive three months of retroactive Medicaid coverage (provided eligibility passes for those months)