

# IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS    BT201776    NOVEMBER 30, 2017

## IHCP announces upcoming changes to the HIP program

The Indiana Health Coverage Programs (IHCP) has applied for renewal of the Healthy Indiana Plan (HIP) program waiver through the Centers for Medicare & Medicaid Services (CMS). The waiver renewal application includes a number of program changes designed to ease administrative processes and increase healthy behaviors. The IHCP will roll out some of the changes to the HIP program in January 2018, while others will be implemented in February 2018 to coincide with the waiver renewal period.



### Benefit period and MCE selection based on calendar year

Effective January 1, 2018, HIP will shift to a calendar-based benefit year (January-December). Member health plan selections will also be aligned with the calendar year. After a managed care entity (MCE) is selected, the member will stay with that health plan for the remainder of the calendar year, even if the member leaves the program and returns at a later date in that year.

- Member benefit periods, including a new \$2,500 Personal Wellness and Responsibility (POWER) Account as well as any benefit limitations, will reset with each new calendar year.
- Members will have the opportunity to change MCEs each fall between November 1 and December 15. Postcards will be sent to members throughout the month of October to inform them of the new health plan selection period. If a member does not wish to change MCEs, he or she will not need to take any action and will automatically stay with his or her current health plan for the new year. Health plan selection for the 2018 calendar year is currently under way. A member wishing to change MCEs may do so by calling MAXIMUS (1-877-GET-HIP-9) by December 15, 2017. All health plan changes will be effective January 1, 2018, and stay in effect for the *calendar year*.
- When invoicing members for January POWER Account payments, MCE notices will advise members who change health plans they may receive two invoices – one from their old plan and one for their new plan. Members will be instructed to make January POWER Account payments **ONLY** to their new health plan. Any member who incorrectly pays the old MCE for a January contribution will be refunded by that MCE. The member will not be reassigned to the old health plan as a result of the payment error.

Members will no longer change their health plan when they go through eligibility redetermination. Redetermination will still occur for each member every 12 months. Eligibility redetermination offers members a chance to upgrade from *HIP Basic* by buying into *HIP Plus* coverage with POWER Account contributions.

### HIP POWER Account contribution amounts to be based on FPL tiers

Effective January 1, 2018, HIP POWER Account contribution (PAC) amounts will be tiered, based on federal poverty level (FPL) percentage ranges rather than on the current 2% of monthly income calculation. The tiered contribution structure is roughly equivalent to 2% of monthly income but allows more stability for members in that small changes in monthly income will no longer require frequent changes in contribution amounts. Members will be billed at the new tiered levels beginning with the January 2018 payment. The PAC will change only when a member's income change moves them to a different FPL percentage range. The reporting requirements for income changes and the process associated with how and when PAC recalculations are applied are unaffected by the change to a tiered structure. Table 1 defines the required PAC amounts associated with each tier of FPL percentages.



### Tobacco use surcharge on PACs

In an effort to curb the high tobacco use rates among HIP members and reduce the associated adverse health outcomes, HIP will implement a tobacco use surcharge on PAC amounts for all tobacco users effective January 1, 2019. The tobacco use surcharge will be equal to a 50% increase in a member's required PAC. PAC amounts for enrolled spouses who are tobacco users will also be assessed a tobacco surcharge.

The definition of "tobacco user" is a person who has used tobacco on average four or more times per week in the past six months. The definition of tobacco includes: chewing tobacco, cigarettes, cigars, pipes, hookah, and snuff. Tracking of member tobacco use and sharing information with members about the upcoming surcharge will begin effective January 1, 2018. All members who use tobacco will also be made aware of the cessation programs and aids that are available to them as part of their HIP benefits.

The smoking surcharge is considered in the 5% maximum out-of-pocket cost-share limit calculation. Members with a tobacco use surcharge who reach the 5% maximum cost-share limit in any given quarter will have their PAC reduced to \$1 plus the 50% surcharge, resulting in a \$1.50 PAC for the remainder of the calendar quarter. See Table 1 for the surcharge amounts associated with each PAC tier.

*Table 1 – Monthly PAC amounts based on FPL percentages and tobacco surcharges*

FPL %	Individual PAC Amount (effective 1/1/18)	Individual PAC with Tobacco Surcharge (effective 1/1/19)
≤22%	\$1.00	\$1.50
23-50%	\$5.00	\$7.50
51-75%	\$10.00	\$15.00
76-100%	\$15.00	\$22.50
101-138%	\$20.00	\$30.00

**IHCP to add chiropractic benefits to *HIP Plus***

Effective January 1, 2018, the IHCP will add coverage of chiropractic services to the *HIP Plus* benefit plan. This addition will further enhance the value of *HIP Plus* coverage – which already includes vision and dental services – and will serve as an incentive for members to make POWER Account contributions. The *HIP Plus* chiropractic benefit covers services provided by a licensed chiropractor when rendered within the chiropractic scope of practice. Coverage does not require prior authorization or a referral from the member's primary medical provider (PMP). Spinal manipulation visits are limited to six per covered person, per benefit year. Only one service per member per day is allowed. This change does not impact the coverage of chiropractic services currently included under the *HIP State Plan – Basic* or *HIP State Plan – Plus* benefit plans; nor does it expand coverage of chiropractic services to the *HIP Basic* benefit plan.

**End Fast Track payments for members during their PE period**

Effective January 1, 2018, members who are presumptively eligible for HIP will no longer be offered the opportunity to make a Fast Track payment to an MCE based upon their Presumptive Eligibility (PE) enrollment. If a PE member completes a full IHCP application and otherwise meets Fast Track criteria, he or she will be eligible to make the \$10 Fast Track prepayment to their MCE at the time of application. If a member with an open PE segment submits a full IHCP application and makes a Fast Track prepayment, he or she will begin *HIP Plus* coverage beginning the first of the month following the prepayment.

**Phase out of prior claims payment**

The IHCP will end the one-year transitional “prior claims payment program” December 31, 2017. This program provides the ability for some HIP members to have claims paid for services rendered prior to their eligibility in the HIP program.

**HIP maternity coverage for pregnant women**

Effective February 1, 2018, the HIP program will encompass coverage for pregnant women; HIP-eligible pregnant women will no longer be transitioned to Hoosier Healthwise for coverage.

- Pregnant applicants at or below 138% of the FPL and eligible for the HIP program will be enrolled in HIP. The IHCP Eligibility Verification System (EVS) will indicate ***HIP Maternity*** as the member's coverage and will identify the enrolling MCE.
- Pregnant applicants above 138% of the FPL and eligible for IHCP services will be enrolled in Hoosier Healthwise. The IHCP EVS will indicate ***Package A Standard Plan*** as the member's coverage and will identify the enrolling MCE.
- Pregnant applicants, whether enrolled in HIP or Hoosier Healthwise, may also be determined eligible for retroactive coverage for up to three months prior to their application date. If eligible for retroactive coverage, the IHCP EVS will indicate ***Package A Standard Plan*** as the member's coverage during the retroactive time period, with no enrolling MCE indicated. Retroactive coverage is paid through the fee-for-service (FFS) delivery system.



- Whether enrolled in HIP or Hoosier Healthwise, pregnant women will receive the same benefits and will not be subject to cost-sharing.
- HIP members who become pregnant will be covered under the new *HIP Maternity* benefit plan beginning the first of the month following notification of pregnancy and continue under that benefit plan until her postpartum coverage period is over. Members will not change health plans during pregnancy or at eligibility redetermination, as long as they continue to meet eligibility requirements.

### **Presumptive eligibility and pregnancy**

Effective February 1, 2018, the PE process will be modified so that all PE applicants, including pregnant women, go through the same process regardless of their entry point. There will no longer be a unique Presumptive Eligibility for Pregnant Women (PEPW) process. Providers certified as PEPW qualified providers (QPs) will be automatically considered QPs under the general PE process.

All pregnant women who go through the PE process and are determined presumptively eligible will be covered under the ***Presumptive Eligibility for Pregnant Women*** benefit plan. This benefit plan will continue to be limited to pregnancy-related services and will not include coverage of labor and delivery services. Covered services will be delivered under the FFS delivery system and no managed care assignment will be made during the PE period.

The QP will assist the member in completing the *Indiana Application for Health Coverage* for ongoing coverage. After a determination is made on the full application, the member will be assigned to the appropriate program based on income and other eligibility criteria. If the member is determined eligible for HIP, she will select an MCE and begin HIP coverage beginning the first of the month following eligibility determination. The member may also be eligible for up to three months of retroactive coverage prior to the date of her application. If eligible, the member's retroactive coverage will be paid through the FFS delivery system. The IHCP EVS will indicate ***Package A Standard Plan*** as the member's coverage during the retroactive time period without an assigned MCE. This retroactive coverage will override the existing PE coverage and includes benefits beyond the pregnancy-related services covered under the PE benefit plan.

### **IHCP establishes individual open enrollment limits**

Effective February 1, 2018, the IHCP will implement a member-specific limit on the open enrollment period for members reenrolling after losing HIP coverage due to failure to comply with eligibility redetermination requirements. Members who lose coverage under these circumstances will be required to wait 6 months for an open enrollment period allowing them to reapply for IHCP coverage. The open enrollment limitation will be applied as follows:

- HIP members are required to complete the annual eligibility redetermination process within the required time frames. Approximately 45 days prior to the expiration of their 12-month eligibility period, each member is notified of the upcoming redetermination and may be asked to submit documentation necessary for the State to determine continued eligibility. If required documentation is not provided by the due date, the member will be disenrolled from HIP effective on the last day of his or her redetermination month.





- Members who submit their redetermination documentation BEFORE the end of their redetermination month will not be disenrolled from HIP. **Under this scenario there would be no gap in coverage.**
- Members have a 90-day grace period in which to submit redetermination documents without having to REAPPLY for IHCP coverage. Redetermination documentation submitted within the 90-day grace period will be accepted as a basis for redetermining the member's HIP eligibility. If eligible, the member will be reenrolled in HIP following the normal enrollment processes and timelines. **Under this scenario, the member may have a gap in coverage.**
- Members who do not submit their redetermination documentation within the 90-day grace period will be required to wait an additional 3 months, or a total of 6 months from the date of disenrollment, for an open enrollment period allowing them to reapply for IHCP coverage.



The open enrollment policy does not apply to members who are medically frail, pregnant, low-income parents and caretakers, or low-income 19- and 20-year-old dependents. Individuals who experience a change in circumstances, which prevented completion of their redetermination process (as detailed in *Indiana Administrative Code 405 IAC 10-10-13*) may also be exempted from the open enrollment limitation. Exempt members may reapply at any time after disenrollment.

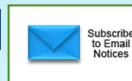
### **IHCP to revise copayment charges for nonemergent ER use**

Effective February 1, 2018, HIP members will be charged an \$8 copayment for each nonemergent use of emergency room (ER) services. The graduated copayment amounts for numerous infractions will no longer apply. The current rule of no copayments for nurse hotline calls and lay person review inquiries remains in effect.

#### **QUESTIONS?**

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

#### **SIGN UP FOR IHCP EMAIL NOTIFICATIONS**



To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

#### **COPIES OF THIS PUBLICATION**

If you need additional copies of this publication, please [download them](#) from indianamedicaid.com.

#### **TO PRINT**

A [printer-friendly version](#) of this publication, in black and white and without graphics, is available for your convenience.