A wise choice for you and your family.
Agenda

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The Healthy Indiana Plan is designed by the State to offer a health insurance plan, paired with a personal health account (POWER Account), to eligible low income Hoosiers (below 138% FPL).

The program is designed to:
– Foster personal responsibility
– Promote preventive care and healthy lifestyles
– Encourage participants to be value conscious consumers of health care
– Promote price and quality transparency
Applying for HIP

- Applicants apply for HIP at the local DFR offices or by calling the State’s call center at 1-877-GET-HIP9 (1-877-438-4479).
  - Applicants select the insurer on the application.
  - Insurer selection can be made anytime before DFR makes its eligibility determination.
  - Members are auto-assigned to an insurer if no selection is made.
- Three plans administer HIP:
  - MDwise
  - Anthem
  - Managed Health Services (MHS)
- Maximus is the enrollment broker.
HIP and HHW are marketed as a whole family solution.

- If a child is eligible for HHW, you should educate their parent/guardian that they may also be eligible for HIP.
- If a parent/guardian is eligible for HIP, you should educate them that their children may also qualify for HHW.
- If a parent/guardian is eligible for HIP, you should educate them that other adults in the household (such as a spouse) may also qualify for HIP.

All eligibility determinations are made by FSSA so it is important to direct eligibility questions appropriately.
HIP Plans

• HIP Plus
  – Members pay a monthly POWER Account Contribution (PAC) of up to 2% of their income.
  – No co-pays (except non-emergency use of the ER co-pay)
  – Includes enhanced benefits such as vision and dental.
  – More extensive pharmacy options

• HIP Basic
  – Members do NOT make a PAC, but have co-payments for most services.
  – Plan maintains essential health benefits, but incorporates reduced benefit coverage (for example, fewer therapy visits).
  – Does not include vision or dental coverage.
  – More limited pharmacy options
State Plans

• **HIP State Plan—Plus**
  – Benefits are equal to those of HHW—but dental and pharmacy are carved in.
  – Transportation services are covered.
  – Members pay a monthly POWER Account Contribution (PAC) of up to 2% of their income.
  – No co-pays (except non-emergency use of the ER co-pay).

• **HIP State Plan—Basic**
  – Benefits are equal to those of HHW—but dental and pharmacy are carved in.
  – Transportation services are covered.
  – Members do NOT make a PAC, but have co-payments for services.
Eligibility

• HIP Plus is the default plan that all members will fall into (up to 138% FPL).
• Members will be conditionally eligible and are given 60 days to make a PAC.
• If a member is above 100% FPL and fails to make his/her PAC within 60 days, he/she will be termed from HIP.
• If a member is at or below 100% FPL and fails to make his/her PAC within 60 days, he/she will move to HIP Basic (or HIP State Plan—Basic).
• No benefits are available while a member is Conditional.
• Benefits for HIP Plus will begin the first of the month in which PAC is received and processed (but not before January 1, 2015).
• Non-payment of PAC for those under 100% FPL will default the member to HIP Basic, effective the first of the month in which day 60 of non-payment falls.
  – There is no way to actively enroll in HIP Basic. This is meant to be a passive enrollment following non-payment.
  – HIP coverage can begin sooner if the member makes his/her contribution.
Eligibility Example—Member Under 100% FPL

- **Member Makes Payment**
  - Jan. 8, 2015—Member is Conditionally Eligible (CE) for Plus and has 60 days to make PAC.
  - Feb. 3, 2015—Member makes initial PAC.
  - February 1, 2015—Member becomes effective with HIP Plus.

- **Member Does Not Make Payment**
  - Jan. 8, 2015—Member is CE for Plus and has 60 days to make PAC.
  - March 8, 2015—60 days pass with no PAC.
  - March 1, 2015—Member becomes effective with HIP Basic.
Medically Frail

- Members can only get this benefit package if eligible condition is verified.
- Members answer questions during the Medicaid application process to determine medical frailty.
- Medical frailty must be verified by MDwise within 60 days and includes:
  - Health Risk Screeners,
  - Claims, and
  - Physician attestation.

Low income Parents and Caretakers and 19/20 year olds.
- Currently enrolled in HHW, but will move to HIP.

Follows normal payment rules.
- Member starts as HIP State Plan—Plus and if no PAC is made, defaults to HIP State Plan—Basic.
• When a Low Income Parents or Caretaker get a new job and increase above existing income requirements, they are given the opportunity to stay on HIP through TMA.

• Low Income Parents & Caretakers are covered in the State Plan Plus or State Plan Basic. However, when they become TMA, they will transfer to either regular Plus or Basic, depending on where they were before. They will stay in State Plan only if they are Frail.

• If a TMA member fails to pay their PAC on HIP Plus, they will drop to HIP Basic regardless of their FPL%.
Eligibility Termination

- If the member does not pay their initial contribution within 60 days (and is above 100% FPL), they must reapply for HIP (no lockout).
- If a member pays their initial contribution, but misses a subsequent payment, they will be locked out of HIP for 6 months.
- Debt occurs when the POWER Account is not fully funded when the HIP eligibility terminates.
  - Insurer attempts to collect the debt.
  - Insurer reports non-payment of debt to State.
Eligibility Termination Example

• Jan. 1, 2015—Member begins HIP Plus eligibility with $25 PAC.

• Jan-June 2015—Member has claims in excess of $2500 POWER Account.

• July 2015—Member stops paying PAC.

• Member accrues debt equal to the remaining POWER Account Contribution for June to December 2015.
  – Member still owes $150.
  – July thru Dec. = 6 months x $25/month PAC = $150.
Moving Between Basic and Plus

- HIP members cannot move between HIP Basic and HIP Plus except:
  - At initial authorization,
  - At time of redetermination, and
  - At time of rollover.

- State Plan eligibility is not determined by member choice.
  - Members can self-report medical frailty or income changes that may impact their eligibility for State Plan.
• Members cannot change insurers once HIP coverage begins unless they receive verifiable, irresolvable quality of care problems with the insurer.

• Poor Quality of Care, defined:
  – Failure of the insurer to provide covered services,
  – Failure of the insurer to comply with established standards of medical care administration,
  – Significant language or cultural barriers,
  – Corrective action levied against the insurer by the Indiana Family Social Services Administration (FSSA), or
  – Other circumstances determined by the FSSA or its designee to constitute poor quality of care.

• Members may request to change plans for cause at any time after exhausting their insurer’s internal grievance and appeals process.

• Members may change plans at the end of their 12-month benefit period, before the next coverage period begins.
• POWER Account = Personal Wellness Responsibility Account
• Used to pay the first $2500 of eligible medical expenses to participating providers.
• Preventive Services are not deducted from the POWER Account.
• Comprised of a member contribution plus a state contribution.
  – The member’s employer can still contribute up to 50% of the member’s annual POWER Account Contributions.
  – Not-For-Profit Organizations can contribute up to 75% of the member’s annual POWER Account Contributions.
  – There is a plan called HIP Link that is in development that is focused on encouraging more employer contribution. More information to come.
• POWER Account Contribution is set at up to 2% of a member’s household income.
• Basic members also have a POWER Account, but it is fully funded by the state.
• Each adult in a household has their own POWER Account.
• MDwise is partnered with Vision for premium/contribution management and member questions.
• Vision, our billing department, will receive member calls concerning billing or collection.
  – Calls to MDwise customer service can be warm transferred to 1-877-744-2317.
  – Members can call billing directly, the billing department phone number (above) is located on invoices and statements under the heading “Billing Questions?”
• Coverage begins on the first of the month during which the monthly contribution clears the bank.
• POWER Account Contributions for married couples are split.
A member’s POWER Account Contribution will be verified every 12 months at redetermination.

- The State will update the member’s contribution, as necessary, based on any changes in the member’s income recognized during redetermination.

Members must report all changes to the State that may affect eligibility and POWER Account contributions including:

- Changes in income or
- Changes in family size such as:
  - Death,
  - Divorce,
  - Birth, or
  - Family member moving out of the household.
Q: When can I request a recalculation of my POWER Account Contribution?

- A: Your POWER Account Contribution will be verified every 12 months at redetermination, but if you experience a change that may affect your POWER Account Contribution, I can help you report that change to FSSA. Examples of changes that may affect your POWER Account Contribution include:
  - Changes in income
  - Changes in family size, such as:
    - Death
    - Divorce
    - Birth
    - Family member moving out of the household

- You should continue making your current POWER Account Contribution until you are notified of any change to your contribution. Making your payment ensured that you will be able to keep your HIP Plus benefits. HIP Plus can be cheaper because you do NOT have to make payments when you visit the doctor, fill a prescription or go to the hospital. Other than your monthly contribution, the only other cost you may have for health care in HIP Plus is a payment of $8 to $25 if you visit the Emergency Room when you don’t have an emergency health condition.
MDwise and its providers encourage members to receive the appropriate age and gender preventive services, including but not limited to:

- Annual physical
- Colonoscopy
- Flu shot
- Pap smear
- Cholesterol testing
- Mammogram
- Chlamydia screening
- Blood glucose screening
- Tetanus-diphtheria booster
- Lead testing (19-20 year olds)
- Hearing screening

A preventive care guide can be found in the member handbook.

Preventive services are subject to change per FSSA direction.
• Emergency services require a co-pay for both Plus and Basic members, if the ER is used for a non-emergency.
  – Providers collect the co-pay.
    • $8 for the first ER visit.
    • $25 for each subsequent visit.
  – The co-pay is refunded if the member is admitted to the hospital.
  – Co-payment will be waived if a member gets approval from the MDwise NURSEon-call hotline.
    • Note: A pilot program will be rolled out at a later date where a small random sampling of members will pay $8 co-pay regardless of the number of ER visits. More information will be passed along when the program rolls out.
Prior Authorization

• Certain services require prior authorization (PA) by MDwise to be covered.
  – It is the providers responsibility to determine if the service requires PA and either call or fax the request to the appropriate delivery system.
  – A list of services requiring prior authorization can be found on the MDwise website (For Providers/Forms/Prior Authorization).

• A provider who is not contracted with MDwise must always obtain a referral authorization to see the member (except emergency services).

• All HIP delivery system specialist networks are closed.
• Dental Services are carved into HIP.
  – Dental services for MDwise are administered by DentaQuest.
  – Dental is not available for Basic members (unless Pregnant or 19/20 year olds).

• DentaQuest will provide first touch resolution for dental issues. Callers will be routed directly to DentaQuest by choosing the appropriate option through the IVR.
  – Providers can be warm transferred to 1-855-453-5286
  – Members can be warm transferred to 1-844-231-8310

• Vision Benefits are administered through DST (like H HW).
  – Vision is not available for Basic members (unless Pregnant or 19/20 year olds).
Pharmacy

- Pharmacy services are carved in to HIP.
  - The MDwise Pharmacy Benefit Manager (PBM) for HIP is MedImpact.
- MedImpact will provide first touch resolution for pharmacy issues. Callers will be routed directly to MedImpact by choosing the appropriate option through the IVR.
  - Callers can be warm transferred to MedImpact at 1-844-336-2677.
- Basic members have a pharmacy co-pay.
  - $4.00 for Preferred Drugs
  - $8.00 for Non-Preferred Drugs
Transportation

- Transportation is a covered service for State Plan and Pregnant Members.
- Members receive 20 one-way rides per year.
  - Members can receive transportation for covered services such as doctor appointments.
  - Transportation to the pharmacy is not covered.
- Additional trips, trips over 50 miles, or out-of-state trips may need prior authorization.
- Members can be connected to the Transportation Department directly by following the prompts in the IVR.
  - Customer Service may transfer a Transportation call to 1-888-513-0710 (do not give the direct number to a member).
Members Unable to Pay

• All HIP members will have some cost-sharing in the form of either:
  – POWER Account Contributions for Plus members, or
  – Co-payments due at the time of service delivery for Basic members.

• Services can’t be denied if a Basic member is unable to pay, but the member is still responsible for the amount and can be billed by the provider.
HIP is intended to promote personal responsibility and engage participants in making health care decisions based on cost and quality.

- This is done primarily in the form of cost sharing, either through PAC or co-payments.

There are some situations that warrant the cost-sharing to be eliminated.

- Member exceeds 5% out of pocket limit
- Native Americans
- Pregnant Women
HIP and Pregnancy

• If already a HIP member when she becomes pregnant:
  – She can choose to remain in her current HIP benefit package (Basic, Plus, State Plan-Basic, State Plan-Plus), she will now begin receiving additional benefits only available to pregnant women.
  – She can choose to change to HIP Maternity which offers the same benefits.
  – Benefits are equal to HHW (including transportation).
  – All cost sharing is turned off (no PAC or co-payments while pregnant).
  – POWER Account is frozen.

• If redetermination happens during pregnancy or a new applicant is pregnant:
  – Member will be placed into HIP Maternity benefit plan.
  – Benefits are equal to HHW (including transportation).
  – At 60 days post-partum, she will be moved to HIP Plus and cost sharing will resume or begin.
Member presents at hospital and initially goes into a HIP Basic benefit plan.

- Basic benefits with co-pays, but the member does not have a POWER account.

MDwise will outreach to members to assist the member in completing the formal application by mailers and phone calls.

Once the application is submitted and approved their HPE status is termed and they become conditionally eligible with HIP and follow the same guidelines as new members.

- This will lead to an initial coverage gap.
June 1, 2015—Presumptive Eligibility member shows up at hospital and is signed up for HPE.

June 15, 2015—MDwise assists the member is completing the application.

June 17, 2015—Member application is approved.
  - HPE coverage terms.
  - Becomes Conditionally Eligible HIP Plus member.

July 3, 2015—Member makes PAC.

July 1, 2015—Member becomes eligible with HIP Plus.
POWER Account Rollover

- Unused portion of the POWER Account will rollover to the next 12-month benefit period.
  - FSSA may also add recommended preventive care services related to a member’s pre-existing conditions.

- Rollover amounts will offset the contribution amounts for the next benefit period.
  - Rollover calculations occur no later than 120 calendar days following the end of the member’s benefit period.

- If the member does not receive the appropriate preventive services, only the member’s unused portion of the POWER Account will rollover. The state’s portion will not.
• HIP Plus/HIP State Plan Plus members who receive all appropriate preventive services are eligible to have their roll-over amount doubled by the state.
  – If the rollover amount exceeds the member’s contribution amount, the member’s contribution will be reduced to $0. Members will not receive a rollover credit in excess of their contribution amount.

• HIP Basic/HIP State Plan Basic members are not eligible for a rollover since they do not contribute to their POWER Account.
  – Basic members are still incentivized to manage their POWER Account effectively and are eligible for a HIP Plus discount directly related to the percentage of their POWER Account balance remaining.
  – The discount cannot exceed 50% of the member’s HIP Plus contribution.
  – The member must still receive all appropriate preventive services in order to qualify. If the preventive services are not received, the HIP Plus discount is NOT available.