



HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind

HIP is changing ...

So here is what you need to know ...

Key Bullets for HIP 2.0

- There are multiple packages that provide essential health benefits in HIP 2.0 – HIP Plus, HIP Basic, HIP State Plan, Medically Frail and Pregnancy
- HIP Plus is the preferred plan for all HIP members
- HIP Basic members will have a copay for all services
- Verify a member's package coverage at each encounter
- Use HIP Web Interchange or mhsindiana.com for package coverage and copayment information
- Low income Caregivers on HIP will have most facility claims paid at "Medicaid Rates." If a hospital gets a Hospital Assessment Fee today (HAF), the in and outpatient services will pay at Medicaid rate in 2.0.
- There will be 3 Preferred Drug Lists (PDL) for HIP members, depending on which package they are on. PDLs can be found online at mhsindiana.com
- Call MHS if you send a member to the Emergency Room
- Pregnant members do not pay copayments

For more than six years, the **Healthy Indiana Plan (HIP)** has delivered quality care to highly satisfied members and achieved measurable results. It has been successful at encouraging the use of preventive care and decreasing the use of the emergency room for non-emergency conditions. In addition, HIP has empowered its members to act as consumers in the health care market and to take responsibility for their health care choices. HIP 2.0 builds on the successes of the original HIP design and adds additional choices that further promote HIP's consumer-directed model and provide new incentives for members to take personal responsibility for their health. Through the implementation of HIP 2.0 and the availability of HIP to more Hoosiers, Indiana will replace traditional Medicaid for all non-disabled adults ages 19-64, while ensuring that all Hoosiers have access to affordable health insurance.

Differences in HIP Benefit Packages

POPULATION	BENEFITS	COST SHARING	OTHER
Adults 19-64 income ≤100% FPL	HIP Basic or Plus	HIP Basic or Plus	All 19 & 20 year olds receive EPSDT*
Adults 19-64 income <100% and ≥ ~138% FPL	HIP Plus	HIP Plus	
Low-income Parents or Caretaker Adults	State Plan Benefits	HIP Basic or Plus	
Low-Income 19&20 Year Olds	State Plan Benefits	HIP Basic or Plus	
Medically Frail	State Plan Benefits	HIP Basic or Plus	
Pregnant Women	HIP Basic or Plus	None	Receive additional benefits only available to pregnant women. May choose to move to State Plan Benefits.
Native Americans	HIP Plus	None	Receive Plus benefits with zero cost share.
Transitional Medical Assistance	HIP Basic or Plus	HIP Basic or Plus	May receive HIP Basic if income over 100% FPL

HIP Plus is the *preferred plan* for all HIP members. HIP Plus provides the best value coverage and includes vision and dental services. HIP Plus provides health coverage for a low, predictable monthly cost. Members pay affordable monthly contributions, and the only other cost for health care in HIP Plus is a payment of \$8 or \$25 if you visit the emergency room when you don't have an emergency health condition. HIP Plus can be cheaper because you do not pay any other costs or copayments when you visit the doctor, fill a prescription or go to the hospital.

In 2015, some adult members on Medicaid will transition onto HIP 2.0. Hoosier Healthwise will become primary coverage for children and pregnant women. There are multiple categories of coverage in HIP 2.0. These include HIP Plus, HIP Basic, HIP State Plan, Medically Frail and pregnancy.

HIP Basic – Members who do not pay their monthly POWER account contribution are disenrolled from HIP Plus. Those with incomes below 100% federal poverty level will receive HIP Basic benefits. **HIP Basic** benefits provide coverage for all the required services, but are more limited and do not provide vision or dental coverage along with some other benefits. In HIP Basic, members are required to make a payment every time they receive a health care services, such as going to the doctor, filling a prescription and staying in the hospital. HIP Basic can be much more expensive than HIP Plus.

HIP State Plan – The HIP State Plan benefit option assures that if a member is otherwise eligible for Medicaid, or have a qualifying health condition, they receive enhanced benefits. Additional benefits offered under the HIP State Plan option include non-emergency transportation services, chiropractic services, and Medical Rehabilitation Option (MRO) services. With HIP Plus State Plan, members will pay an affordable monthly contribution for these benefits like they were in HIP Plus. If the member does not pay their affordable monthly contribution, they will be disenrolled from the Plus option. If their income is at or below \$973 per month for an individual, or \$1,988 per month for a family of four, after their Plus disenrollment they will still have access to the HIP Basic State Plan enhanced benefits, but will be required to pay a HIP Basic copayment ranging from \$4 to \$75 for most health services.

Medically Frail – Individuals with complex medical or behavioral health conditions, called “medically frail” are eligible to receive a benefit package called “State Plan,” which is more appropriate for their health care conditions. An individual is medically frail if he or she has been determined to have one or more of the following:

- Disabling mental disorder;
- Chronic substance abuse disorder;
- Serious and complex medical condition;
- Physical, intellectual or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living; or
- Disability determination from the Social Security Administration.

The MCE has to confirm the member's status as medically frail.

Treatment of Unique Populations Under HIP 2.0

- **Medically Frail:** Individuals with a disability determination, certain conditions impacting their physical or mental health or their ability to perform activities of daily living such as dressing or bathing will receive enhanced benefits
 - HIP Basic or Plus cost sharing will apply but access to vision, dental and non-emergency transportation benefits is ensured regardless of cost sharing option
- **Pregnant Women:** Pregnant women will have no cost sharing in either Plus or Basic once their pregnancy is reported and will receive additional benefits available only to pregnant women.
- **Native Americans:** By federal rule, Native Americans are exempt from cost sharing. Will receive Plus benefits with zero cost sharing.
- **Transitional Medical Assistance (TMA):** Individuals who no longer qualify as low-income parents or caretakers due to an increase in pay are eligible for a minimum of six months even if income is over 138% FPL.

Member Copays

When HIP members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic.

In HIP Basic, members are required to make copayments for doctor visits, hospital stays, and prescription drugs. These payments will range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay.

Copayments may not be more than the cost of services received.

SERVICE	HIP BASIC CO-PAY AMOUNTS
Outpatient Services – Including Doctor’s Office Visits	\$4
Inpatient Services – Including Hospital Stays	\$75
Preferred Drugs	\$4
Non-Preferred Drugs	\$8
Non-Emergency ER visit	Up to \$25

You can find a member’s copay amount on the MHS secure provider portal.

Please note – copay information will NOT be on the POWER Account member ID cards.

Emergency Room Copays

HIP members may be responsible for an emergency room copay. The copay is \$8 for the first non-emergent visit and \$25 for subsequent non-emergent visits. Members cannot pay their emergency room copay with their POWER Account card. **Co-pays for non-emergency use of an ER will be collected by all eligible HIP members EXCEPT for those exempt from cost-sharing (pregnancy, medically frail or Native American Indian). If you send a member to the ER, please notify MHS at 1-877-647-4848. If it is after normal business hours, you can verify if an ER referral was made for the member by calling our 24 hr nurse advise line at 1-877-647-4848.**

- \$8 for the first non-emergency visit in a benefit period
- \$25 for all subsequent non-emergency visits during a benefit period
- Primary care provider notifies MHS that their office sent member to the ER

Helpful Tips for Copays

- HIP Basic and HIP State Plan Basic have copays for services
- Some members (pregnant and Native American) will have copays waived
- All packages can potentially have Emergency Room Copays with the exception of pregnant women and Native American members.
- Emergency Room Copays are \$8 for the first non-emergency room visit, and \$25 for additional non-emergency room visits.
- Use HIP Web Interchange or mhsindiana.com for package coverage and copayment information. You will also be able to see if the member has been to the ER previously within the past 6 months.

Pharmacy

Pharmacy benefits for MHS HIP members will now be administered through US Scripts. The level of the drug benefit will depend on the package the member is enrolled with. The Preferred Drug list (PDL) can be found on our website at mhsindiana.com.

PREFERRED DRUG LIST (PDL)

HIP Plus - www.usscript.com/Media/Default/docs/FORMULARY-MHS_PLUS_PDL.pdf

The MHS HIP Plus PDL provides an expanded selection of drugs for the treatment of most illnesses. This list includes many generic drugs along with a larger list of brand-name drugs. Some generic drugs may also have a higher copayment. More brand-name drugs are available on the MHS HIP Plus PDL without the need for a prior authorization.

HIP Basic - www.usscript.com/Media/Default/docs/FORMULARY-MHS_BASIC_PDL.pdf

The MHS HIP Basic PDL provides a broad selection of drugs for the treatment of most illnesses. This list includes mostly generic drugs along with a limited number of brand-name drugs. If members purchase a preferred generic drug they will have a lower copayment than if they purchase a brand-name drug. Some generic drugs may also have a higher copayment. Some drugs will only be covered with a prior authorization.

HIP State Basic - www.usscript.com/Media/Default/docs/FORMULARY-MHS_STATE_PDL.pdf

The MHS HIP State Basic Preferred Drug List (PDL) provides a broad selection of drugs for the treatment of most illnesses. This list includes mostly generic drugs along with a limited number of brand-name drugs. If the member has the State Basic PDL, they will not have to pay a copayment for drugs. Some drugs with only be covered with a prior authorization.

Contact the Pharmacy Benefit Manager (PBM) US Script for approval for drugs that require a PA. PA Forms can be found on our website at mhsindiana.com. Providers will need to submit their PA request via fax & then we will confirm approval (or denial) via fax. A Pharm D is a Doctor of Pharmacy. Basically means only a clinical person will deny your request.

MHS encourages the use of electronic prescriptions or e-prescribing. E-prescribing is an important element in improving patient safety and quality of patient care. USScript contracted pharmacies can accept electronic prescriptions.

Hospital Presumptive Eligibility (HPE)

Hospital Presumptive Eligibility (HPE) is a program created by the Affordable Care Act in which hospital participation is optional. Any hospital qualified by the state to take HPE applications is able to make temporary Medicaid determinations based on questions asked by the hospital worker to the applicant. This includes contracted staff of the hospital assisting in HPE application, regardless of whether the individual is seeking medical care at the time of the application. The implementation of HIP 2.0 also creates an HPE – Adult category for applicants. HPE coverage is short-term **coverage limited up to 60 days**. Once an individual is enrolled and receiving HPE services, MHS will encourage member to complete the Indiana Application for Health Coverage.

- The Individual will have until the end of the following month after receiving HPE to submit an application
- HPE is to only serve as a band aid for the individual before enrolling in HIP 2.0
- If individual does not apply in this time frame, eligibility will end
- Individuals may only have one HPE coverage period per 12 months

HPE Process

Once an individual is determined HPE eligible and under 65 years of age, the adult is given opportunity to pick an MCE or will be auto-assigned to an MCE if no selection made. (HP will base auto-assignment using a rotational method between the three health plans).

- The HPE adult will be placed into Hospital Presumptive Eligibility for Adults (MAHA)
- Effective date of coverage begins once the determination is made upon completion of the HPE application
 - HPE can begin any day of the month
 - HPE does not require a POWER Account contribution
 - **Coverage limited to a maximum of 60 days**. Now HPE members will be assigned an MCE during and the provider should bill the MCE for those services during that 60 day period. HPE eligible individual will need to complete full application to be eligible past 60 days.
 - **HPE Adults will be assigned a RID that begins with 600**

Pregnancy in HIP 2.0

When a HIP member becomes pregnant, she needs to alert MHS or the DFR of her pregnancy as soon as possible. She can do this by completing a Notification of Pregnancy (NOP) form on our website at mhsindiana.com which will qualify her for up to \$85 additional dollars on her CentAccount Healthy Rewards card. Don't forget, as a provider you can also earn \$60 for completing the NOP form also available on our provider website.

Once the member confirms her pregnancy, she will receive benefits only available to pregnant members. As a pregnant HIP member, she will have zero cost sharing responsibility throughout her pregnancy. This means no monthly POWER account contribution and no copays for doctor visits or pharmacy services. She will also receive additional benefits. These benefits include transportation to and from doctor visits, chiropractic services, and Medicaid Rehabilitation Option (MRO services). These benefits include transportation to and from doctor visits, chiropractic services, and Medicaid Rehabilitation Option (MRO services). Pregnant members will either present a POWER account ID card, or a HIP Maternity ID card or a Hoosier Healthwise ID card. Her rid will remain the same and regardless of the id card she presents, and she will not be subject to copays at the time of service. Pregnancy claims may pay at Medicaid or HIP rates, depending on the members eligibility at the time of service. Remember to use HIP Web Interchange or mhsindiana.com for package coverage and copayment information.

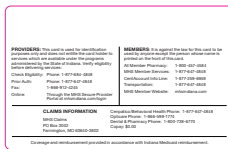
Member ID Cards

All MHS members will have one of the following ID cards that will contain their RID. Remember to use HIP Web Interchange or mhsindiana.com for package coverage and copayment information at each encounter. Pregnant HIP members are not subject to copayments or other cost sharing responsibilities.



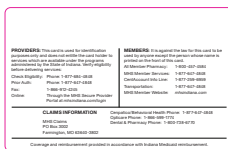
POWERAccount ID Card

All HIP members will receive a POWERAccount ID card. They are instructed to present this card at the time of service for all medical and pharmacy encounters. Members CAN NOT use their POWERAccount card to pay for copayments at time of service.



HIP Maternity ID Card

All new pregnant Medicaid members who are below 138% of the federal poverty level will be placed into HIP Maternity and will receive a HIP Maternity ID card. Or, when a HIP member is pregnant at the time of redetermination, she will move to HIP Maternity and will receive a new HIP Maternity ID card.



Hoosier Healthwise ID Card

All pregnant MHS members above 138% of the federal poverty level will receive a Hoosier Healthwise ID card.

Reimbursement for Facility Based Claims

Payment to facilities for both inpatient and outpatient services in general will follow reimbursement as outlined in the HIP Reimbursement Manual published by FSSA. It is important to note that reimbursement levels may vary based on the members benefit package when services are provided in a facility that is designated as a Hospital Assessment Fee (HAF) facility. For low income parent/caretakers, services provided in HAF facilities will be reimbursed under Hoosier Healthwise levels. All other services provided in HAF facilities and those provided at non-HAF facilities will be reimbursed according to the HIP Reimbursement Manual.