Medicaid Basics and Indiana Health Coverage Programs

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What is Medicaid?

- **Funded by state and federal government**
- **Provides free or low-cost health coverage to Hoosiers**
- **It includes many different programs where eligibility criteria varies by group**

Indiana Health Coverage Programs (IHCP)

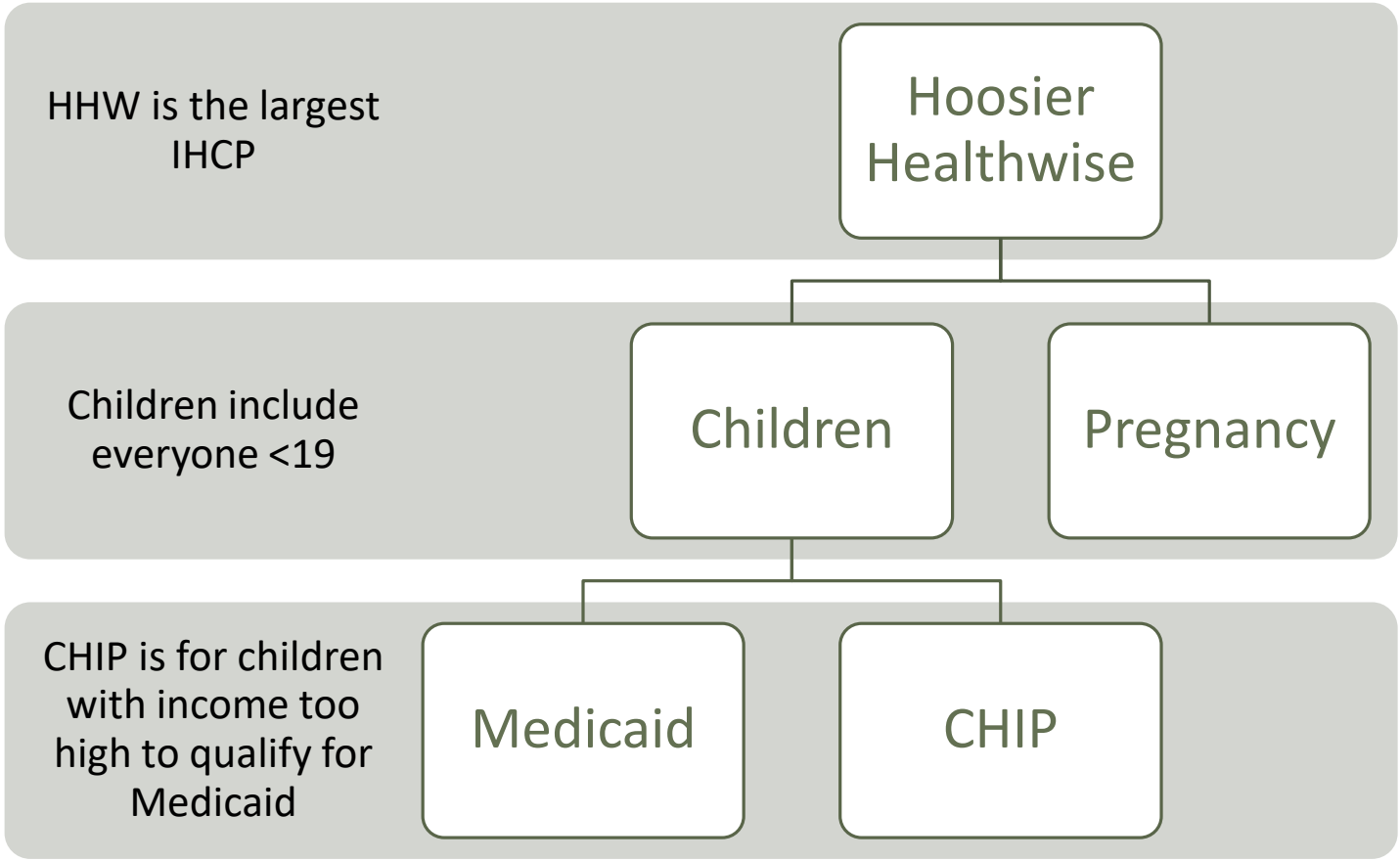
Indiana offers a variety of health coverage programs, including:

- Hoosier Healthwise
- Healthy Indiana Plan (HIP)
- Children's Health Insurance Program (CHIP)*
- Hoosier Care Connect
- Traditional Medicaid
- Medicaid for Employees with Disabilities (M.E.D. Works)
- Home and Community-Based Service Waivers
- Medicare Savings Programs
- Family Planning Eligibility Program
- Breast and Cervical Cancer Program

Each of these programs serves a unique population with different eligibility requirements, detailed in the following slides.

*CHIP is not Medicaid, but it is still an IHCP

Hoosier Healthwise



Healthy Indiana Plan

- **Provides low-cost health insurance**
- **Qualifies as minimum essential coverage (MEC)**
- **Eligibility:**
  - Indiana residents
  - Ages 19 to 64
  - Income under 138%* FPL
  - Parents must obtain coverage for dependents
- **Program features:**
  - Three possible HIP plan options (see plan comparisons on next slide)
    - HIP Plus, HIP Basic, HIP State Plan
  - Co-pays for non-emergency use of emergency room
  - Personal Wellness and Responsibility (POWER) Account
    - Funds $2,500 annual deductible
    - State and individual contribute funds to account
    - Employers & nonprofits may help individual with their contributions
    - Funds still in account at end of year rollover to next year

*138% + 5% income disregard

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HIP – Plan Options

HIP Plus

- Initial plan selection for all members, income up to 138% FPL
- **Benefits:** Comprehensive, including vision and dental
- **Cost-sharing:** Must pay affordable monthly POWER account contribution (approx. 2% of income, ranging from $1 to $100 per month). No copayment for services. EXCEPTION: using emergency room for routine (non-emergency) medical care.

HIP Basic

- Fall-back option for members with household income less than or equal to 100% FPL
- **Benefits:** Meet minimum coverage standards, **no vision or dental coverage**
- **Cost-sharing:** Must pay copayments for doctor visits, hospital stays, and prescriptions

HIP State Plan

- Individuals with complex medical or behavioral conditions ("medically frail") or low-income parents/caretakers
- **Benefits:** Comprehensive, with some additional benefits including vision, dental, and enhanced behavioral health services
- **Cost-sharing:** HIP Plus **OR** HIP Basic cost-sharing

HIP Plus POWER Account Payments

- **POWER Account payment amounts will be one of five levels shown below**
- Members receive a monthly invoice from their selected MCE that states the amount they must pay
- Employers & not-for-profits may assist with contributions
- Spouses split the monthly PAC amount

FPL	Monthly PAC Single Individual	Monthly PAC Spouses
<22%	$1.00	$1.00
23-50%	$5.00	$2.50
51-75%	$10.00	$5.00
76-100%	$15.00	$7.50
101-138%	$20.00	$10.00

HIP – Fast Track Payments

- **"Fast Track" is a payment option in the *HIP Plus* program**
  - Allows applicant to make payment during the HIP application process
    - Amount: $10
  - BENEFIT: Coverage begins the first of the month the payment is made
  - The payment goes toward first POWER account contribution

IMPORTANT NOTE: **If Fast Track payment is not made, coverage in *HIP Plus* will begin the first of the month the first POWER account contribution is made. Members have 60 days from the date their first invoice is issued to either make a Fast Track or POWER account payment. If either payment is not made within those 60 days, then the member will default into the *HIP Basic* plan, if eligible, effective the first of the month those 60 days expire.**

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HIP – *HIP Basic* Copayments

- **The following copayment amounts apply to ***HIP Basic*** members:**

Service	Copayment Amounts
Outpatient services - including office visits	$4
Inpatient services - including hospital stays	$75
Preferred drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	$8

Conditions that May Qualify as Medically Frail

- **The following conditions may qualify someone as "medically frail" for eligibility into the *HIP State Plan*:**

Medical	Mental Health	Activities of Daily Living
Cancer; Aplastic anemia; Cerebral vascular accidents; Transplant or transplant wait list for heart, lung, liver, kidney or bone marrow; HIV, AIDS; Blood clotting disorders, frequent blood transfusions; Lipid storage diseases; Primary immune deficiencies; Muscular dystrophy; Primary pulmonary hypertension; Amyotrophic lateral sclerosis; Cirrhosis; Chronic hepatitis B or C; Cystic fibrosis; Diabetes mellitus with: ketoacidosis, hypersmolar coma, renal complications, retinopathy, peripheral vascular complications, or coronary artery disease; Renal failure / end stage renal disease; CMV retinitis; Tuberculosis; Paraplegia or quadriplegia	Alcohol and substance abuse; Mental illness including major depression, schizophrenia, bipolar disorder or post-traumatic stress disorder	Need assistance in an activity of daily living: • 24 hour supervision and/or direct assistance to maintain safety due to confusion and/or disorientation • Turning or repositioning every 2 to 4 hours to prevent skin breakdown per medical plan of care • 24 hour monitoring of a health care plan by a license-nurse • Eating • Transferring from bed or chair • Dressing • Bathing • Using the toilet • Walking or using a wheelchair

***Note: Having a condition on this list does not guarantee someone will be considered medically frail. Severity of their condition may also be evaluated.**

Managed Care Entities (MCEs): HHW & HIP

- **Indiana contracts with four MCEs to administer HHW and HIP**
- **Goal:**
  - Integrate programs for a seamless healthcare experience for families
- **Selecting an MCE:**
  - Individuals select at application; OR
  - Individuals auto-assigned
    - NOTE: Once a HIP member makes a POWER account payment or starts benefits in HIP, they cannot change MCEs until the HIP Plan Selection Period
- **Selecting a doctor after MCE enrollment:**
  - Individuals select a Primary Medical Provider (PMP); OR
  - Individuals assigned a PMP

Anthem

CareSource

Managed Health Services (MHS)

MDwise

MCE Selection Period for HIP Members

HIP members will have the opportunity at the end of each year to switch to another health plan for the following year.

- A member wishing to change health plans may do so by calling **Maximus**, the HIP Enrollment Broker, between **November 1st and December 15th**.
- All changes will be effective **January 1st** and stay in effect for the next calendar year, even if the member has a gap in coverage during the year.

Traditional Medicaid

Members can seek care from any Medicaid provider

Covered populations include, but are not limited to:

- Aged, blind, and disabled
  - Dual eligible (Medicare and Medicaid recipients)
  - Nursing home care and other institutions
  - Hospice services
  - Medicaid for Employees with Disabilities (M.E.D. Works)
- Adults
  - Recipients of waiver services
  - Medicaid eligible due to breast or cervical cancer
- Children
  - In psychiatric facilities
  - Title IV-E Foster care and adoption assistance
  - Former foster children up to age 21
  - Former foster children up to age 26 who were enrolled in Medicaid as of their 18th birthday
- Refugees who do not qualify for another aid category

Medicaid for Employees with Disabilities (M.E.D. Works)*

- **Covered population:**
  - Working people with disabilities
- **Eligibility criteria:**
  - Age 16-64
  - Less than or equal to 350% Federal Poverty Level (FPL)
  - Disabled
  - Below asset limit
    - Single: $2,000
    - Couple: $3,000
  - Working
- **Benefits:**
  - Full Medicaid benefits
  - May have employer insurance**

*Must apply through Indiana Application for Health Coverage
**Medicaid is the secondary payer

Home & Community-Based Service (HCBS) Waivers

- Covered population:
  - Would otherwise require institutionalized care
- Goal:
  - Keep individual in home and community setting
  - Avoid need to go to institution (*i.e.*, nursing home)
- Eligibility:
  - Income less than or equal to 300% of the maximum Supplemental Security Income (SSI) federal benefit rate
    - If income exceeds this threshold a member may establish a Miller Trust
    - If under age 18: Does not include parental income or resources
  - Meets "Level of Care"
    - Example: Complex medical condition, intellectual disability

Medicare Savings Programs

- **Covered population:**
  - Low-income Medicare beneficiaries
- **Goal:**
  - Help pay for out-of-pocket Medicare costs
- **Eligibility:**
  - Must be eligible for Medicare Part A
  - Four potential categories depending on income and worker status

Medicare Savings Programs

Program	Benefits
QMB (Qualified Medicare Beneficiary)	• Medicare Part A & B Premiums, Co-pays, Deductibles, and Coinsurance
SLMB (Specified Low-Income Medicare Beneficiary)	• Part B Premiums
QI (Qualified Individual)	• Part B Premiums

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Family Planning Services

- **Goal:**
  - Pregnancy prevention/delay
  - Provide family planning services and supplies
- **Eligibility:**
  - Do not qualify for any other Medicaid category*
  - Income at or below 141% Federal Poverty Level (FPL)
  - Citizenship/immigration eligibility requirements
  - Not pregnant
  - Have not had hysterectomy (removal of uterus)
  - Have not had sterilization procedure
- **<u>NOT</u> Considered Minimum Essential Coverage (MEC)**

*Women losing other Medicaid coverage after the birth of a child are automatically assessed for eligibility

Breast and Cervical Cancer Program (BCCP)

- Goal:
  - Provide Medicaid coverage to women with breast or cervical cancer
- Eligibility:
  - Diagnosed through Indiana State Department of Health Breast & Cervical Cancer Screening Program

-OR-

  - Age 19-64
  - Not otherwise eligible for Medicaid
  - Income less than 200% FPL
  - Need treatment for breast or cervical cancer
  - No health insurance that covers their treatment

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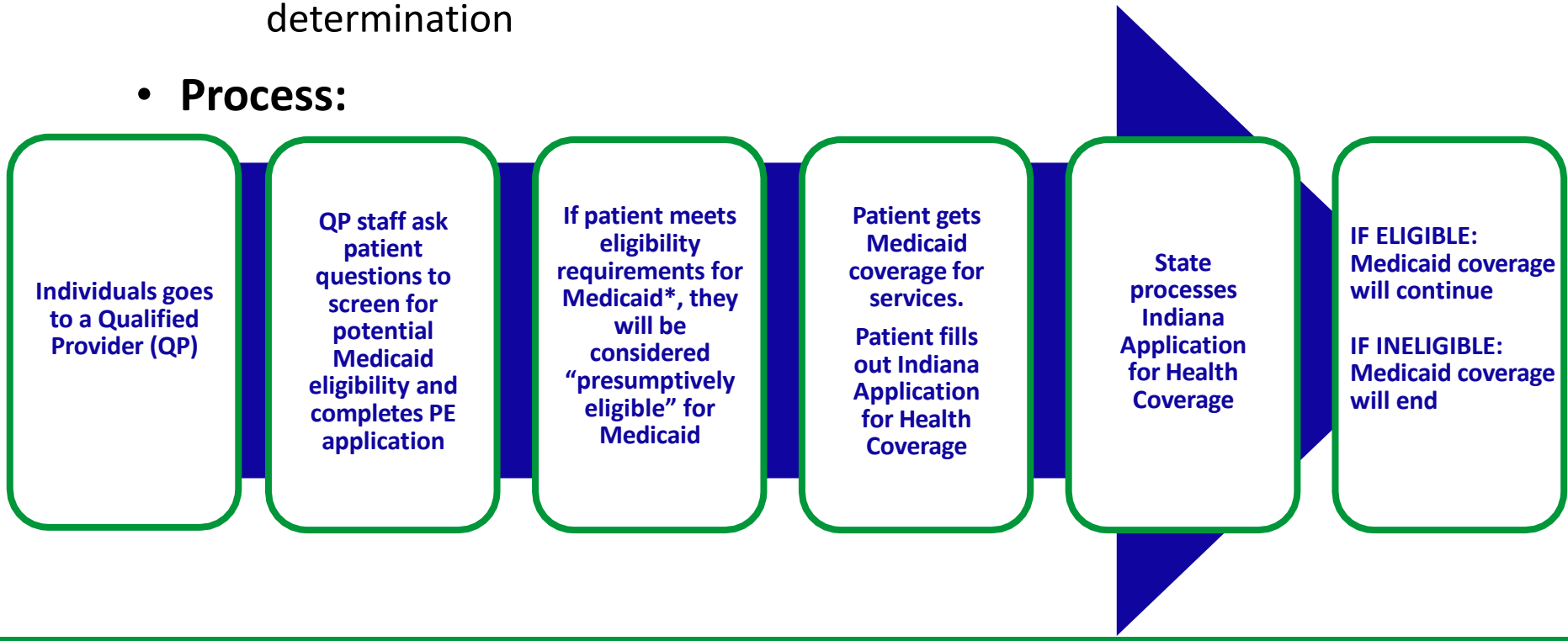
Presumptive Eligibility

- **Overview:**
  - Presumptive eligibility (PE) allows qualified individuals to have services paid for by Medicaid pending the outcome of a full Medicaid determination
- **Process:**



* If PE determination says that applicant is not eligible for Medicaid, applicant cannot appeal decision, but can complete the Indiana Application for Health Coverage to see if he/she is Medicaid-eligible based on complete information.

PE Programs

PE for Pregnant Women

- Provides temporary coverage of prenatal care services (Package P only)
- Pregnant women can apply with doctors or clinics enrolled as a qualified provider (QP)

Hospital PE

Hospital QPs may determine PE for:

- Pregnant women
- Children under 19
- Adults 19-64
- Low-income parents & caretakers
- Family Planning Eligibility Program
- Former foster children up to age 26

- Certain health clinics and county health departments can also do PE

PE for Inmates

- **Hospital QPs may determine PE for Inmates**
- Inmate must be in a correctional facility under MOU with FSSA, not under house arrest, not pregnant or in labor/delivery, admitted to inpatient hospitalization, and under age 65

Hoosier Care Connect

- **Covered population:**
  - Individuals that are eligible for the Traditional Medicaid categories who require Managed Care due to their condition. Individuals must not also qualify for Medicare.

  Goal:
  - To ensure that the individual gets the most appropriate care based upon their individualized needs
- **Process - Enrollees select either of these health plans:**
  - Anthem
  - Managed Health Services (MHS)
  - UnitedHealthcare

  The health plan will then gather information from individual to ensure proper care and services are provided

General IHCP Eligibility Factors and Requirements

Eligibility factors that apply for any type of Indiana Health Coverage Program (IHCP)

General IHCP Eligibility Factors and Requirements

- **Age**
- **Income**
- **Indiana Resident**
- **Citizenship/Immigration Status**
- **Provide Social Security Number (SSN)**
- **Provide information on other insurance coverage**
- **File for other benefits**

Citizenship, Immigration Status

- **Eligibility:**
  - U.S. citizens
  - U.S. non-citizen nationals
  - Immigrants with qualified immigration status
    - Lawful permanent residents (LPR) eligible for full Medicaid after 5 years
    - Unqualified Immigrants can only get Emergency Services Only
      - Unqualified LPRs who are Pregnant may receive Package B for Pregnancy Coverage
- **Exemptions (do not need to verify citizenship):**
  - Medicare enrollees
  - Foster care children
  - Receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
  - Newborns with a mother enrolled in Medicaid

Social Security Number

- **Individuals must supply a Social Security number (SSN), unless:**
  - Not eligible to receive a SSN
  - Do not have a SSN and may only be issued one for a valid non-work reason
  - Refuse to obtain SSN due to well-established religious objections
  - Only eligible for emergency services due to immigration status
  - A newborn baby with mother on Medicaid
  - Receiving Refugee Cash Assistance (RCA), eligible for Medicaid
  - Have already applied for a SSN

File for other benefits

- **Individuals must apply for other benefits if they may be eligible, including:**
  - Pensions from local, state, or federal government
  - Retirement benefits
  - Disability
  - Social Security benefits
  - Veterans' benefits
  - Unemployment compensation benefits
  - Military benefits
  - Railroad retirement benefits
  - Worker's compensation benefits
  - Health and accident insurance payments

Report and use other insurance

- **Applicants may:**
  - Have other insurance
    - Exceptions: Children's Health Insurance Program (CHIP)
    - Cannot have Medicare and HIP or HCC
- **Applicants must:**
  - Provide information about other insurance
    - On application
    - After a change in insurance status
- **Why it is important to report other insurance:**
  - Applicants must use other insurance first
  - Medicaid pays costs that are left after other insurance has paid – it is the "payer of last resort"

Affordable Care Act-Mandated Changes

The Patient Protection and Affordable Care Act (ACA) of 2010 made changes to income and household calculations for certain groups. Coverage was also expanded to previously uncovered populations.

Modified Adjusted Gross Income (MAGI)

- **What is MAGI?**
  - Standardized income counting across all states
  - Used in both Medicaid and Federally-facilitated Marketplace (FFM) program to determine eligibility for tax credits
  - HHW and HIP use different eligibly criteria for:
    - Number of people in a household
    - Income
    - Assets

Household Size & Income

Applicant Description	Household Composition (as applicable)

Tax filer	• Tax filer
	• All tax dependents
	  • May include:
	  • Step -parents, -children, and -siblings
	  • Adult child tax dependent

Non-Filer & Certain Tax Dependents*	• Applicant
	• Spouse
	• Children
	• If applicant is child:
	  • Siblings
	  • Parents

COUNTS:

1. Taxable income
2. Income of children required to file a tax return

DOES NOT COUNT:

1. Assets
   - *e.g.*, bank account balance, stocks, retirement account
2. Non-taxable income
3. Income disregards (except tax deductions)

*Tax Dependent defined as:
- Other than a spouse, biological, adopted or step child of the tax filer
- Child claimed as tax dependent by non-custodial parent
- Child living with both parents who do not file joint return

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MAGI vs. Non-MAGI Populations

Who will use MAGI?	• Hoosier Healthwise • Healthy Indiana Plan
Who will not use MAGI?	• Traditional Medicaid Categories • Hoosier Care Connect

What income counts for "non-MAGI?"	• Pre-ACA income counting and household composition rules remain in place
	• Pre-ACA asset limits continue to apply
	  • Certain assets excluded such as:
	  • Individual's home
	  • Household goods
	  • Personal items

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Indiana Application for Health Coverage

Indiana Application for Health Coverage

- **Applications for health coverage and other state benefits include:**
  - Indiana Application for Health Coverage (IAHC),
  - Indiana Application for Supplemental Nutrition Assistance Program (SNAP) & Temporary Aid to Needy Families (TANF)
- **Applications accepted:**
  - Online (Recommended),
  - Phone,
  - Fax,
  - Mail, or
  - In person at local Division of Family Resources (DFR) offices

Disability Medicaid Application Process

Applications to Social Security Administration (SSA)

Exceptions:
Direct application to Indiana Medicaid without SSA determination if:

- Applicant is a child
- Applicant has a recognized religious objection to applying for federal benefits (*e.g.*, Amish)
- Applicant moves to the M.E.D. Works medically improved category
- Applicant cites other "good cause" for not applying to SSA

Supplemental Security Income (SSI) Eligible

- State auto-enrolls in Medicaid

Social Security Disability Income (SSDI) Eligible

- Apply to Indiana Medicaid for verification of other eligibility factors
- Will not undergo medical review team (MRT) process

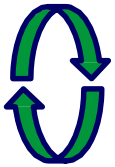
SSA Denial (determined non-disabled)

- Generally Medicaid ineligible
  - State will not initiate MRT process for applicant except in two cases (to be discussed)

Disability Medicaid Applications

State requires Social Security Administration (SSA) application for disability determination

- SSA application status checked through shared data file
- If no SSA application filed within 45 days of Medicaid application date:
  - Medicaid application denied



State initiates Medical Review Team (MRT) process

- If SSA determination received during MRT process:
  - State stops MRT
  - State defers to SSA decision

MRT determination applies pending SSA decision

- If the two conflict:
  - SSA overrides MRT

Verifying Eligibility Information

PREVIOUS:

Applicant provides some paper verification documents at time of application

CURRENT:

1. Verify eligibility information using state & federal electronic data sources
2. Ask applicant for paper documentation ONLY if no electronic data or inconsistent with application

NOTE: **Applicants must submit requested verification documents by the posted due date**

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Eligibility Notices, Appeals & Redetermination

Regardless of whether an applicant is eligible for an Indiana Health Coverage Program (IHCP), the applicant can expect a notice to explain the decision. If the applicant disagrees with the decision, the applicant may file an appeal.

Each year, the state will conduct eligibility redeterminations to determine if Indiana Health Coverage Program (IHCP) enrollees may stay enrolled in their respective programs.

Eligibility Notices

- **Mailed Notice from:**
  - Division of Family Resources (DFR)
- **IHCP Applicant or beneficiary will get notices:**
  - After application reviewed:
    - Approved
    - Denied
  - After changes in coverage:
    - Terminate coverage
    - Suspend coverage
    - Change in benefit package or aid category

Appeals

- **What is an appeal?**
  - If the Applicant or beneficiary:
    - Disagrees with Medicaid agency decision
    - Requests that agency re-evaluate decision in front of an Administrative Law Judge (ALJ)*
  - Appeals must be made in writing, typically through the mail.
- **What can be appealed?**
  - Termination of benefits, or
  - Suspension of benefits, or
  - Reduction of benefits
  - Delay in determining eligibility

*The notice obtained from DFR will list the process for eligibility appeal.

Eligibility Redeterminations

- **Purpose:**
  - To be sure that individuals with Indiana Health Coverage Program (IHCP) are still eligible
- **How often:**
  - Every 12 months
- **Process:**
  - State checks if there is enough electronic data to renew eligibility
    - If yes: State will renew IHCP
    - If no: State will contact enrollee for more Information

IMPORTANT NOTE: **HIP members may only change their MCE during the Plan Selection Period designated by FSSA.**