Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Healthy Indiana Plan (HIP) provider orientation

Agenda

- Program overview
- Benefit coverage
- Eligibility
- HIP offerings
- Medically frail and various member categories
- POWER Account (PAC) and copay
- Provider reimbursement
- Hospital assessment fee
- Coordination of benefits/ third-party liability (TPL)
- Contacts
- Questions and answers

HIP plans and coverage

<table>
<tr><th>HIP Plus plan</th><th>HIP Basic plan</th></tr>
<tr><td>

- Includes:
  - Physician services
  - Inpatient and outpatient services
  - Prescription drugs
  - Routine dental, vision and chiropractic services
  - Pregnancy-related services
  - Short-term skilled nursing facility (SNF) stays
  - Non-emergent transportation
- Copays apply to nonemergent emergency department (ED) visits only
- PAC contributions

</td><td>

- Includes:
  - Physician services
  - Inpatient and outpatient services
  - Prescription drugs
  - No routine dental, vision or chiropractic
  - Pregnancy-related services
  - SNF stays
  - Non-emergent transportation
- Copays apply to outpatient and inpatient services, preferred and nonpreferred drugs, and nonemergent ED visits

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HIP plans and coverage (cont.)

HIP State Plus plan	HIP State Basic plan
• Mirrors current Medicaid-covered services, including: ○ Chiropractic care ○ Unlimited non-emergent transportation ○ Routine dental and vision ○ Short-term skilled nursing facility stays (SNF) • Copays apply to non-emergent ED visits • PAC contributions • Pregnancy care for HIP Maternity members	• Mirrors current Medicaid-covered services, including: ○ Chiropractic ○ Unlimited non-emergent transportation ○ Routine dental and vision ○ Short-term SNF stays • Copays apply to outpatient and inpatient services, preferred and nonpreferred drugs, and non-emergent ED visits • Pregnancy care for HIP Maternity members

Additional covered benefits

Pharmacy	Maternity coverage
• IngenioRx* will provide pharmacy benefit management.	• Members who begin a new benefit year while pregnant on HIP will move to HIP Maternity. • During pregnancy, members do not have copays, PAC contributions and accounts are frozen.

Additional covered benefits (cont.)

<table>
<tr><th>Dental</th><th>Vision</th></tr>
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Members in the HIP Plus plan and HIP State plans receive dental benefits.
Plus product benefits are limited.
Basic products do not include dental (except for members ages 19 to 20 and pregnant women).
DentaQuest* is the contracted administrator of HIP dental benefits.

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Members in the HIP Plus, HIP State plans, HIP Maternity and HIP Basic ages 19 to 20 receive vision benefits:

One exam per year for members under 21 years old; one exam every two years for members 21 years and older.
One pair of eyeglasses per year for members under 21 years old, one pair of eyeglasses every 5 years for members 21 years and older.

Superior Vision* is the contracted administrator of vision benefits.

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Eligibility

- Those 19 to 64 years old with income up to 138% of the federal poverty line (FPL) are eligible for HIP.
- There is no asset test.
- Eligibility is not impacted by availability of employer coverage.

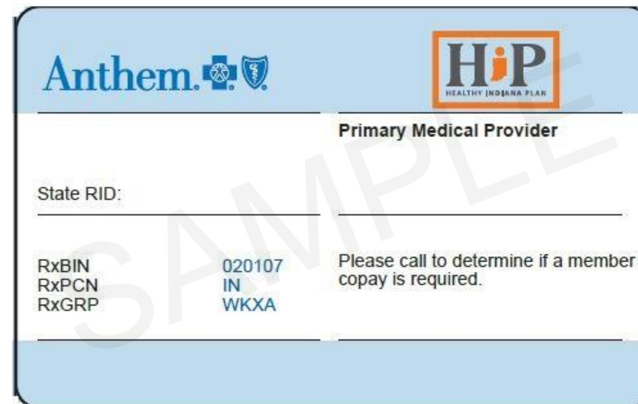
There is no waiting period for HIP and coverage lasts for one year; then, the member has to reapply.

Eligibility (cont.)

- Eligibility verification can be done via the Availity Portal* or the Provider Healthcare Portal.
- You can:
  - Verify a member's HIP eligibility on date of service.
  - Identify the HIP plan of the member:
  - The member's HIP product type and pregnancy status drives their benefit coverage.
  - Confirm the reimbursement to be expected based on HIP eligibility (for example, Indiana Health Coverage Programs [IHCP] Medicaid fee-for-service [FFS] rates vs. Medicare rates).

Eligibility (cont.)

- HIP member ID card:



- Copays are not listed on the ID card; check the Availity Portal or call Provider Services to verify copay.
- Members will not receive new cards when they change products within the same benefit period.

Preferred medical provider

- All HIP members must have a primary medical provider (PMP) once a plan is selected.
- Availity identifies the member's PMP information, or providers can call Provider Services to obtain the member's PMP.
- Referrals are required the same as for Hoosier Healthwise:
  - When a referral has been obtained, providers should enter the NPI of the member's PMP in box 17b of the *CMS-1500* form.
- For PMPs under HIP, rosters are available on the provider website.

HIP Plus

HIP Plus:

- Is the best value and the preferred HIP plan.
- Requires monthly affordable PAC contributions.
- Covers all services currently covered under HIP Basic.

Note: Copays apply to nonemergent ED visits only.

Additional covered services include:

- Bariatric surgery.
- Temporomandibular joint syndrome (under medical benefits).
- 75 therapy visits per benefit period.
- Dental.
- Vision.
- Chiropractic.
- Transportation (as a value-added benefit) — up to 20 one-way trips/unlimited for pregnant members.

HIP Basic

- HIP Basic does not require monthly PAC contributions.
- Required copays include:
  - Outpatient services (physicians/hospital): $4 per visit
  - Outpatient services (dental): $4 per service
  - Inpatient: $75 per admission
  - Preferred drugs: $4 per prescription
  - Nonpreferred drugs: $8 per prescription
  - ED for nonemergency visit: $8
- HIP Basic includes essential health benefits and pregnancy coverage.
- HIP Basic does not include coverage for dental, vision, chiropractic, treatment of TMJ or bariatric surgery.
  - Exception includes coverage for pregnant members and members age 19 to 20.
- There is a limit of 60 combined therapy visits per benefit period.
- Transportation is covered (as a value-added benefit) — up to 20 one-way trips/unlimited for pregnant members.

HIP State plan

The HIP State plans are different from the HIP Plus and HIP Basic products.

- Members receive the same benefits as Hoosier Healthwise.
- Pregnancy-related services are covered.
- Members who are medically frail, or low-income parents or caretakers who previously would have been in Hoosier Healthwise.

HIP State plan products — cost sharing

- HIP State plus attributes:
  - Plus plan is the best value and the preferred HIP
  - Affordable monthly PAC contributions
  - Monthly contributions the same as HIP Plus
  - ER copays only
- HIP State Basic attributes:
  - Copays the same as the regular HIP Basic
  - More services require copays
  - No PAC contribution

HIP State plan benefits

- There are no therapy limits.
- Bariatric surgery and TMJ are covered.
- Dental and vision coverage is the same as Hoosier Healthwise (refer to Provider Manual).
- Non-emergent transportation coverage:
  - There is no limit on the number of trips, and coverage includes transport to health classes (Women, Infants, and Children, etc.).

Medically frail

Medically frail includes those with a serious health condition/situation, such as:

- Cancer, AIDS, aplastic anemia, diabetes with a comorbidity, coagulation defect, lipid storage disease or other primary immune deficiency.
- A disabling mental disorder.
- A chronic substance abuse disorder.
- A physical, intellectual or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living.
- Being disabled based on Social Security Administration criteria.
- Requiring an organ transplant.

Medically frail guidelines

- Milliman Underwriting Guidelines (MUG) are used to quantify the seriousness of a member's condition.
- MUG utilizes a point system based on diagnosis, key medical indicators and medications.
- The rating is intended to project the level-of-care the member is likely to require for the next 12 months.
- Members are validated as medically frail when their MUG total meets the combined physical and behavioral criteria:
  - 150 points for physical condition
  - 75 points for behavioral or substance abuse condition

Member categories

- **Pregnant women**: Pregnant women will not have cost sharing (PAC contributions and copays) in either HIP Plus or HIP Basic once their pregnancy is reported, and they will receive additional benefits available only to pregnant women.
- **Native Americans**: By federal law, Native Americans are exempt from cost sharing; they can receive HIP benefits without required contributions or copays.

Pregnant members and HIP Maternity

- Pregnant HIP members move to HIP Maternity.
- Pregnant HIP members will remain in the HIP Maternity Plan until they complete their 60 day postpartum period.
- HIP Maternity members have State plan benefits and will continue with those benefits throughout their pregnancy and postpartum period.
- HIP Maternity members will receive new member ID cards.

PAC

- HIP Plus and HIP State Plus members have a $2,500 PAC.
- PACs are frozen and no services will charged to their PAC during their pregnancy.
- Preventive services are exempt from being paid from the PAC and are paid by the health plan.
- Dental, vision and pharmacy services can also be paid from PACs.

PAC (cont.)

- HIP Plus and HIP State Plus members are required to pay monthly contributions in one of five PAC tiers based on income (except during pregnancy).
- Members who use tobacco products will be assessed an additional surcharge of 50% on their PAC.
- Initial payment must be made within 60 days of enrollment.
- No benefits are paid during conditional status.

Note: HIP Basic plan members also have PACs but are not required to make contributions.

PAC (cont.)

PAC tiers:

Tiers	Monthly PAC — single person	Monthly PAC — spouses	PAC with tobacco surcharge	Spouse PAC when one has tobacco surcharge	Spouse PAC when both have tobacco surcharge
Tier 1	$1	$1	$1.50	$1 and $1.50	$1.50
Tier 2	$5	$2.50	$7.50	$2.50 and $3.75	$3.75
Tier 3	$10	$5	$15	$5 and $7.50	$7.50
Tier 4	$15	$7.50	$22.50	$7.50 and $11.25	$11.25
Tier 5	$20	$10	$30	$10 and $15	$15

POWER account (cont.)

- Members whose income is greater than 100% of the FPL and become more than 60 days delinquent will be termed from the HIP plan and must wait six months to reapply.
- Members whose income is equal to or less than 100% of the FPL are moved to HIP Basic benefits if they become more than 60 days delinquent.

HIP Plus — POWER account rollover

- At the end of the 12-month benefit period, a portion of unused PAC funds may be rolled over to the next benefit year; this determination is done 120 days into the next benefit period.
- HIP Plus members receive rollover credit for the unused balance of their PAC funds that they contributed.
- Members who have had their required preventive service(s) receive double credit.
  - **Note**: The total credit can’t be more than the 12-month total of their required contribution for the new benefit year.

HIP Basic — PAC rollover

- At the end of the 12-month benefit year, a portion of unused PAC funds may be rolled over to the next year; this determination is done 120 days into the next benefit year.
- HIP Basic members receive rollover credit only if they have had their required preventive service(s).
- Members can use the credit to reduce the amount they need to contribute if they move to HIP Plus for the next benefit year.
- The amount of credit is the percentage of the remaining PAC balance; the total reduction can’t be more than 50% of their required annual contribution.

Copays

- HIP products require ED copays for nonemergent use of the ED.
- The copay is $8.
- The copay is waived if a prudent lay person judges the visit as emergent or the member is admitted from the ED.
- The ED copay is also waived if the member calls our 24/7 NurseLine first and is advised to go to the ED.
- HIP Basic requires additional copays:
  - Inpatient: $75 per admission
  - Outpatient services (physicians/hospital): $4 per visit
  - Outpatient services (dental for members who are pregnant or 19 to 20 years of age): $4 per service
  - Preferred drugs: $4 per prescription
  - Nonpreferred drugs: $8 per prescription
- Copays are due at the time of service.
- No copays are required for preventive care, family planning, maternity services and any service when the member is pregnant (through 60 days postpartum).
- HIP members can’t use their PAC to pay any copay.

Assessing HIP Basic copays

- **Example A:**
  - Member has an office visit and is then sent to the hospital for CT scan and to the lab for multiple tests.
  - Total copay: $12 — member has $4 copay for office visit, $4 copay for hospital CT scan and a single $4 copay for lab services
- **Example B:**
  - Member has an office visit, and an X-ray and three lab tests are done in the physician's office.
  - Total copay: $4 — office visit and services by a single provider at a single location are treated as a single visit
- **Example C:**
  - Member has a dental visit with screening X-rays, teeth cleaning and three fillings.
  - Total copay: $4 — screening X-rays and cleanings are preventive and do not have copays; single $4 copay for the three fillings

Assessing HIP Basic copays (cont.)

- **Example D:**
  - Member has dental visit for three fillings and a crown fitting.
  - Total copay: $8 — dental services require $4 for each type of service rendered
- **Example E:**
  - Member has three preferred prescriptions filled at pharmacy.
  - Total copay: $12 — member has $4 copay for each preferred prescription

Provider reimbursement

- HIP medical claims are paid at Medicare rates.*
- When a HIP service is covered, and there is no Medicare rate, Anthem Blue Cross and Blue Shield (Anthem) will pay 130% of the Medicaid rate (see the *Medicaid Fee Schedule* on the IHCP website).

* Hospital claims (inpatient and outpatient) for members in the low-income parent/caretaker plans are paid at Medicaid rates, and hospitals also receive hospital assessment fee (HAF) payments.

Hospital Assessment Fee

- The Indiana Family and Social Services Administration (FSSA) implemented an HAF in accordance with *Public Law 229-2011*, *Section 281*, as enacted by the 2011 session of the Indiana General Assembly.
- HAF permits inpatient and outpatient aggregate claims payment at the upper Medicare payment limits without exceeding them.
- Per *IHCP Bulletin BT201608*, dated January 26, 2016, HAF adjustments will be applied to reimbursements for HIP member services.
- IHCP modified HAF payment distributions to include increased reimbursement to eligible hospitals for services provided to all HIP members, including presumptive eligibility HIP members.
- HIP managed care entities (MCEs) will apply HAF adjustment factors accordingly when adjudicating claims.
- Non-HAF eligible hospitals will continue to be reimbursed applying current rates and methodologies.

Coordination of benefits/TPL

- Members enrolled in HIP may have other insurance at the time of service that Anthem and the state are not aware of; coordination of benefits must take place, and there will continue to be coordination of TPL for accidents.
- Anthem will recoup claims paid if a member had other insurance, and providers have six months from the date of the recoupment notification to submit claims.
- Providers may not pursue reimbursement from the member for any reason.

HIP contacts

- HIP Provider Services: **1-844-533-1995**
- Member Services: **1-866-408-6131 (TTY 711)**
- 24/7 NurseLine: **1-866-408-6131 (TTY 711)**
- Medical and pharmacy precertification: **1-844-533-1995**
- Superior Vision: **1-877-235-5317**
- DentaQuest: **1-888-291-3762**
- Transportation: **1-844-772-6632**
- Submit claims to:
  Anthem Blue Cross and Blue Shield
  Mailstop: IN999
  P.O. Box 61010
  Indianapolis, IN 46206-6144

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

* IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross and Blue Shield. DentaQuest is an independent company providing dental benefit management services on behalf of Anthem Blue Cross and Blue Shield. Superior Vision is an independent company providing vision benefit management services on behalf of Anthem Blue Cross and Blue Shield. Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

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Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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