Anthem Blue Cross and Blue Shield
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 and copay
- Provider reimbursement
- Hospital assessment fee
- Hospital presumptive eligibility
- Coordination of benefits/ third-party liability (TPL)
- Contacts
- Questions and answers

HIP plans and coverage

HIP Plus plan	HIP Basic plan

• Includes:
  ○ Physician services
  ○ Inpatient and outpatient services
  ○ Prescription drugs
  ○ Routine dental, vision and chiropractic services
  ○ Pregnancy-related services
• Copays apply to nonemergent emergency room (ER) visits only
• POWER account contributions
	• Includes:
	  ○ Physician services
	  ○ Inpatient and outpatient services
	  ○ Prescription drugs
	  ○ No routine dental, vision or chiropractic
	  ○ Pregnancy-related services
	• Copays apply to outpatient and inpatient services, preferred and nonpreferred drugs, and nonemergent ER visits

HIP plans and coverage (cont.)

HIP State Plus plan	HIP State Basic plan

• Mirrors current Medicaid-covered services, including:
  ○ Chiropractic care
  ○ Nonemergent transportation
  ○ Routine dental and vision
  ○ Short-term skilled nursing facility stays (SNF)
• Copays apply to nonemergent ER visits
• POWER account contributions
	• Mirrors current Medicaid-covered services, including:
	  ○ Chiropractic
	  ○ Nonemergent transportation
	  ○ Routine dental and vision
	  ○ Short-term SNF stays
	• Copays apply to outpatient and inpatient services, preferred and nonpreferred drugs, and nonemergent ER visits

Additional covered benefits

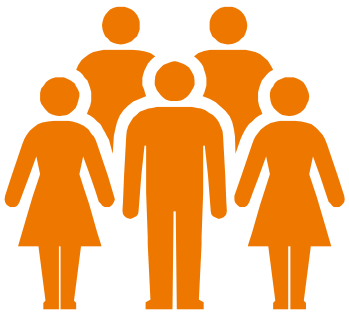
Pharmacy	Maternity coverage
• Pharmacy services will be carved-in. • Express Scripts, Inc. will provide pharmacy benefit management.	• Maternity coverage will be added. • If member is pregnant at enrollment or redetermination, they will be enrolled in HIP Maternity. • Members who begin a new benefit year while pregnant on HIP will move to HIP Maternity. • During pregnancy, members do not have copays, POWER Account contributions and POWER accounts are frozen.

Additional covered benefits (cont.)

Dental	Vision
• 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 and 20 and pregnant women). • DentaQuest is the contracted administrator of HIP dental benefits.	• Members in the HIP Plus plan and HIP State plans receive vision benefits: ○ One exam per year and one pair of glasses and lenses or contacts, if medically necessary, every two years. • The HIP Basic plan does not include vision benefits (except for members under the age of 21 and pregnant women). • VSP is the contracted administrator of vision benefits.

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 using Availity at **https://www.availity.com** or the Provider Healthcare Portal at **https://portal.indianamedicaid.com**.

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.
- Verify member's medical care evaluation (MCE) for claim submission purposes.
- 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 (PMP)

- All members enrolled in HIP must have a PMP once a plan is selected.
- Availity identifies the member's PMP information, or provider's can call the Provider Helpline to obtain the member's PMP.
- Referrals are required the same as for HHW:
  - When a referral has been obtained, providers should enter the NPI of the member's PMP in box 17b of the *CMS-1500* form (see the *Provider Operations Manual* for exceptions and complete instructions).
- For HIP PMPs, rosters are available through the provider website.

HIP Plus

- HIP Plus is the best value and the preferred HIP plan.
- HIP Plus requires monthly affordable POWER account contributions.
- Copays apply to nonemergent ER visits only.
- HIP Plus covers all services currently covered under HIP Basic.

HIP Plus (cont.)

- 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 POWER account 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
  - ER for nonemergency visit: $8

HIP Basic (cont.)

- HIP Basic includes essential health benefits and pregnancy coverage.
- HIP Basic does not include coverage for dental, vision, treatment of TMJ or bariatric surgery.
  - Exception includes coverage for pregnant members and 19- and 20-year-old members.
- 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 HHW.
- Pregnancy-related services are covered.
- Members designated as “medically frail” include:
  - Low-income parents or caretakers who previously would have been in HHW.
  - 19- and 20-year-old noncaretakers with the lowest income level.
- Pregnant members and Native American members do not have cost-sharing responsibilities, such as POWER account contributions and copays.

HIP State plan products cost sharing

- **HIP State Plus attributes:**
  - Plus plan is the best value and the preferred HIP
  - Affordable monthly POWER account 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 POWER account contribution
  - Low-income parents/caretaker members

HIP State plan benefits

- There are no therapy limits.
- Bariatric surgery and TMJ are covered.
- Dental and vision coverage is the same as HHW:
  - HIP members receive two dental cleanings per year.
  - HIP members receive one vision exam per year and glasses every two years.
- Nonemergent transportation coverage is the same as HHW:
  - 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 one of the following 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 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 ER copays.

Pregnant members and HIP Maternity

- Pregnant HIP members move to HIP Maternity.
- At their annual HIP redetermination, HIP members due for redetermination during their pregnancy will move to HIP Maternity until they complete their two-month postpartum period.
- HIP Maternity allows the member to continue with the same experience as if eligible for HIP.
- Members will have State plan benefits.
- HIP Maternity members will receive new member ID cards.

POWER account

- HIP Plus and HIP State Plus members have a $2,500 POWER account.
- Pregnant members will have their POWER account frozen, and no services will be charged during their pregnancy.
- Preventive services are exempt from being paid from the POWER account and are paid by the health plan.
- The new Presumptive Eligibility plan does not have a POWER account.
- Dental, vision and pharmacy services must be paid from POWER accounts.

POWER account (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 and additional surcharge of 50% on their POWER Account.
- Initial payment must be made within 60 days of enrollment.
- No benefits are paid during “conditional status.” members cannot access health care until they make their first POWER account payment.

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

POWER account (cont.)

POWER account 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 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 POWER account 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 POWER account funds that they contributed.
- Members who have had their required preventive service(s) receive double credit; the total credit can’t be more than the 12-month total of their required contribution for the new benefit year.

HIP Basic
POWER account rollover

- At the end of the 12-month benefit year, a portion of unused POWER account 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 POWER account balance; the total reduction can't be more than 50% of their required annual contribution.

Copays

- HIP products require ER copays for nonemergent use of the ER.
- 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 ER.
- The ER copay is also waived if the member calls our 24/7 NurseLine first and is advised to go to the ER.

Copays (cont.)

- 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 19-20 years of age): $4 per service
  - Preferred drugs: $4 per prescription
  - Nonpreferred drugs: $8 per prescription

Copays (cont.)

- 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 POWER account 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.

Assessing HIP Basic copays (cont.)

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."

Assessing HIP Basic copays (cont.)

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.

Assessing HIP Basic copays (cont.)

Example E:

Member has three preferred prescriptions filled at pharmacy.

Total copay: $12 — member has $4 copay for each preferred prescription.

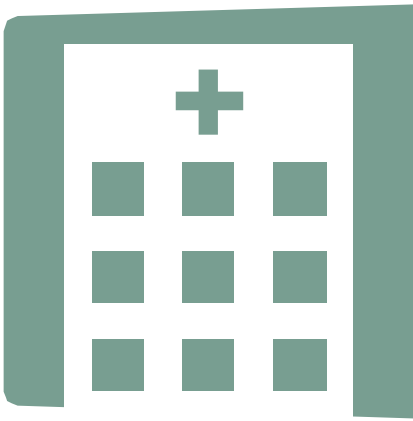
Provider reimbursement

- HIP medical claims are paid at Medicare rates.*
- When an HIP service is covered, and there is no Medicare rate, 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.

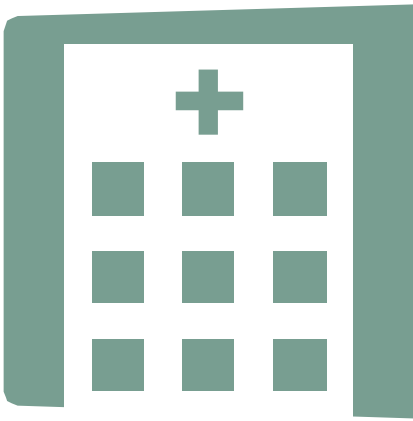
Hospital assessment fee

- 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.



Hospital assessment fee (cont.)

- In-state acute care hospitals licensed under IC 16-21-2 and freestanding psychiatric hospitals licensed under IC 12-25 are subject to HAF.
- Outpatient laboratory services (codes listed on the Medicare clinical laboratory fee schedule) are not subject to the HAF increase.



Hospital assessment fee (cont.)

- 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.

Hospital presumptive eligibility

What benefits do presumptively eligible individuals receive?

- Presumptively eligible individuals receive Presumptive Eligibility Basic, which is equivalent to HIP Basic and has no vision or dental services.
- Presumptively eligible individuals are placed into MCE.
- Presumptively eligible individuals must apply for full coverage within 60 days.

Hospital presumptive eligibility (cont.)

What costs will hospital presumptive eligibility adult members need to pay?

- Copays are the same as HIP Basic.
- Copay is due at time of service.
- Note, these individuals do not have a POWER account.

Hospital presumptive eligibility (cont.)

When does coverage begin?

- The coverage period for hospital presumptive eligibility begins on the date the qualified provider makes determination the individual is presumptively eligible.
- The effective date is not the date individual first receives care.

Hospital presumptive eligibility (cont.)

Hospital staff asks individual questions to complete hospital presumptive eligibility application.

If found eligible for hospital presumptive eligibility, individual determined "presumptively eligible" for up to 60 days. Individual receives a recipient identification number (RID) to use on Indiana Application for Health Coverage.

- If over 65 years of age and a parent/caretaker of a child under the age of 18, individual will be placed in MAHP (presumptive eligibility for parent/caretakers).
- If hospital presumptive eligibility adult, individual placed in MAHA (hospital presumptive eligibility for adults) and approval notice printed for applicant to use as proof of eligibility. Individual selects MCE or is auto-assigned. They must submit Indiana Application for Health Coverage to maintain benefits. No POWER account contribution required.

If not found eligible for hospital presumptive eligibility, health plan Web application will deny eligibility and denial letter will be printed for applicant.

- Individual may reapply at any time.
- No appeal rights.

Hospital presumptive eligibility (cont.)

Why is hospital presumptive eligibility important?

- Hospital presumptive eligibility allows individuals to obtain health care while the *Indiana Application for Health Coverage* is being processed.
- Hospital presumptive eligibility allows providers to be reimbursed for services provided immediately after hospital presumptive eligibility approval.
- During the presumptive eligibility period, the individual will be able to receive treatment from other IHCP providers after they leave the hospital.

Hospital presumptive eligibility (cont.)

To qualify for adult hospital presumptive eligibility, applicant must:

- Be a U.S. citizen, a permanent resident in the U.S. for at least five years or a qualified alien.
- Be an Indiana resident.
- Not be incarcerated.
- Not be covered under presumptive eligibility for pregnant women.
- Not a hospital presumptive eligibility recipient in the previous 12 months.
- Not enrolled in the IHCP.
- Be under 138% of the FPL.

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)**
- Submit claims to:
  Anthem Blue Cross and Blue Shield
  Mailstop: IN999
  P.O. Box 61010
  Indianapolis, IN 46206-6144

HIP contacts (cont.)

- Medical and pharmacy precertification: **1-844-533-1995**
- VSP (vision): **1-866-866-5641**
- DentaQuest (dental): **1-888-291-3762**
- Transportation: **1-800-508-7230**

Thank you

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