

HEALTHY INDIANA PLAN

POWER Account Contributions and Copayments Infrastructure Operational Protocol

2/26/2015

POWER Account and Copayments Infrastructure Operational Protocol describes the process to be used under the state plan for collecting POWER account contributions and copayments from beneficiaries.

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POWER account and roll-over incentives description

- a. *A description of how the POWER account and roll-over incentive will work for beneficiaries in HIP 2.0 and HIP Link with specific examples and scenarios for different household sizes.*

HIP Plus Rollover

HIP Plus members who consistently contribute to their POWER account during the plan year will be eligible to roll-over the member's unused share of the POWER account balance.

If a HIP Plus member receives all recommended preventive care services during the plan year, the member will be eligible to have their unused share, or "roll-over amount", doubled by the State as an added incentive. Depending on the balance in the account, this roll-over amount may significantly reduce or even eliminate required contributions in future plan years.

The roll-over amounts for HIP Plus members are calculated as follows:

1. First, the member's portion of the remaining POWER account balance (the Member Share) is determined by the following formula:
Amount of the member's required annual contribution for the expiring term
Plus Any balance rolled over from previous coverage terms
Divided by 2,500 (the fully funded POWER account total)
2. Second, the Base Roll-Over Amount is determined as follows:
Member Share *multiplied by* the remaining balance in the POWER account
3. Finally, the Final Roll-Over Amount is determined based on whether the member obtained recommended preventive services. The preventive services bonus is applied to the Base Roll-Over Amount as follows to determine the Final Roll-Over Amount:

If preventive services are completed during the plan year:

$$\text{Base Roll-Over Amount} \times 2 = \text{Final Roll-Over Amount}$$

If preventive services are not completed during the plan year:

$$\text{Base Roll-Over Amount} \times 1 = \text{Final Roll-Over Amount}$$

HIP Basic Rollover

HIP Basic members not contributing to their POWER accounts will still maintain the incentive to manage the account judiciously and receive recommended preventative care services. Members enrolled in the HIP Basic plan will have the opportunity to reduce their HIP Plus required contribution in future years, with a slightly different roll-over process. The discount available to HIP Basic members is directly related to the percentage of the POWER account balance remaining at the end of the plan year. For example, if a member has 40 percent of their POWER account balance remaining at the end of the plan year, they may reduce their required HIP Plus

contribution by 40 percent in the following year, provided they have received their recommended preventive services. However, this discount is limited to 50 percent in order to avoid inappropriately rewarding individuals for failing to satisfy their original POWER account contribution requirement.

The roll-over amounts for members participating in the HIP Basic plan are calculated as follows:

1. First, the Roll-Over Percentage is calculated by the following formula:
 Remaining balance in the POWER account
Divided by 2,500 (the fully funded POWER account total)
Multiplied by 100 to yield a percentage \leq 50 percent
2. The determination of the Final Discounted Contribution amount for participation in the HIP Plus plan for the subsequent year would be determined as follows:

Required flat rate contribution for the subsequent year based on FPL

Minus [Roll-over Percentage *multiplied* by the required contribution]

Table 1: HIP Rollover Scenarios

	Year 1 Contribution Amount for HIP Plus	Preventive Services	Final Roll-Over Amount	Year 2 Reduced Annual Contribution	Year 2 Monthly Cost to Participate in HIP Plus	Total Year 2 Percentage Reduction
HIP Plus Plan*						
Scenario 1	\$96.00 annual (\$8.00/ month)	NO	\$15.36	\$80.64	\$6.72 per month	16%
Scenario 2	\$96.00 annual (\$8.00/ month)	YES	\$30.72	\$65.28	\$5.44 per month	32%
HIP Basic Plan**						
Scenario 3	0	NO	0	0	\$8.00 per month	0%
Scenario 4	0	YES	0	\$80.64	\$6.72 per month	16%

* The specific calculation for the HIP Plus Plan is as follows:

Member Share: $96/2500 = .0384$;

Base Roll-Over Amount: $.0384 \times 400$ remaining balance in POWER account = \$15.36;

Base Roll-Over Amount is multiplied times a factor of 1 for no preventive services for a total of \$15.36.

Base Roll-Over Amount is multiplied times a factor of 2 for preventive services for a total of \$30.72.

** The specific calculation for the HIP Basic plan is as follows:

Roll-Over Percentage: $400/2500 \times 100 = 16\%$

Flat rate contribution for Year 2 would be \$96.00 annually/ \$8.00 per month based on 45% FPL
 The Final Discounted Contribution amount would be $\$96 - (16\% \times 96) = \80.64

Table 2: HIP Rollover Scenarios

	Year 1 Contribution Amount for HIP Plus	Preventive Services	Final Roll-Over Amount	Year 2 Reduced Annual Contribution	Year 2 Monthly Cost to Participate in HIP Plus	Total Year 2 Percentage Reduction
HIP Plus Plan						
Scenario 1	\$180.00 annual (\$15.00/ month)	NO	\$144.00	\$36.00	\$3.00 per month	80%
Scenario 2	\$180.00 annual (\$15.00/ month)	YES	\$288.00	\$0	\$0 per month	100%
HIP Basic Plan						
Scenario 3	0	NO	0	0	\$15.00 per month	0%
Scenario 4	0	YES	0	\$90.00	\$7.50 per month	50%*

* The discount for HIP Basic plan members receiving preventive care services is capped at 50%.

Since each individual enrolled in HIP has a separate POWER account family size does not impact the POWER account rollover.

HIP Link rollover will be addressed in the HIP Link protocol.

POWER account and copayment data collection

- b. A description of how the state will collect data from the plans regarding the amount of POWER account contributions and copayments due.*

The member’s income as requested and verified through the Indiana Application for Health Coverage determines an individuals POWER account contribution and if they are eligible for HIP Basic if they do not make their POWER account contribution. MCEs receive the amount of POWER account contributions due from the State. The data regarding the amount of POWER account contributions comes from the State in all instances and is never calculated or changed by the MCE.

POWER account contributions are indexed to 2 percent of household income. For example, a HIP plus member whose annual countable income is \$9,800 will have a required annual contribution of \$196. This will then be divided by 12 to determine a predictable monthly PAC of \$16.33. The maximum monthly POWER account contribution is \$100 and the minimum contribution for all HIP Plus members of \$1.

Individuals who elect to not make their POWER account contribution and have income over 100 percent FPL are disenrolled from HIP. Those with income under 100 percent FPL will default to HIP Basic. Individuals in HIP Basic have a copayment applied to all services which is collected at the point of service. Copayment amounts are as follows:

- No copayment is required for preventive care, maternity services or family planning services
- Four dollar (\$4.00) copayment for outpatient services
- Seventy-five (\$75.00) copayment for inpatient services
- Four dollar (\$4.00) copayment for preferred drugs
- Eight dollar (\$8.00) copayment for non-preferred drugs

Members may not pay copayments out of POWER accounts. MCEs do not calculate POWER account contribution amounts, and the state sends any updated POWER account contribution requirements or copayment requirements to the MCEs. Regular reporting is required regarding member POWER accounts. The details and frequency of the regular reports provided by MCEs is detailed in the POWER account excerpt of the HIP Reporting Manual included in Enclosure 1.

Process to identify exempt individuals

- c. The process by which the state will identify individuals who are exempt or meet qualifying event criteria with respect to the POWER account contributions and copayment requirements. Before any beneficiary with income above 100 percent of the FPL can be terminated from the HIP 2.0 program for failure to pay POWER account contributions, the state shall have this procedure in place.*

Each exempt population has different processes by which the State will identify those members who meet exemption requirements.

1. Pregnant Women

HIP members who become pregnant while enrolled in the program will have all cost sharing suspended regardless of whether they make POWER account contributions or copayments. The Managed Care Entity (MCE) is contractually obligated with the State to notify the State's fiscal agent, HP, within one business day of knowledge of the member's pregnancy. The pregnancy confirmation can occur through either the Notification of Pregnancy (NOP) or another mechanism. Once the pregnancy is known about through either pathway, the MCE will suspend the member's POWER account from being debited for services used. Cost sharing will also be suspended including member POWER account payments and copayments. Pregnant women have the choice to remain enrolled in HIP or transfer to Pregnancy Medicaid.

2. Native Americans

A second exempt population from any cost sharing is Native Americans. The State will identify Native Americans pursuant to identification documents listed in 42 CFR 136.12. The individual will need to present appropriate identifying information to their local office. Once verification of Native American status is complete, the individual will have all cost sharing suspended and receive HIP Plus services if they elect not to opt out to Fee-For-Service (FFS). If the Native American member is either a low income parent caretaker, 19 and 20 year old low income dependent, TMA recipient, or Medically Frail they will be eligible to receive HIP State Plan benefits without cost sharing as well. Native Americans that opt out to FFS will have no cost sharing applied.

3. Medically Frail

The medically frail may not be disenrolled for non-payment of POWER account contributions. Individuals who are medically frail are identified as frail on their account. No members identified as frail will be disenrolled for non-payment.

Members may be identified medically frail through:

- Completing the health condition questionnaire on the Indiana Application for Health Coverage. The application has a set of questions embedded in the application and if an individual selects yes on one of the questions they will be considered potentially medically frail. MCEs must confirm this frail status through follow up with the member, providers, and claims.
- MCEs will continually analyze claims to identify members who are frail but did not indicate a frail condition on the application.
- Members may self-report that they have become frail to their MCE at any point. Self-reports are subject to MCE verification.

Members locked out due to non-payment who become frail may reapply for health coverage and indicate their health status on the health condition questionnaire. If the member indicates frail status and this status is confirmed by their selected MCE they may not be subject to the lockout provisions and may reenter HIP prior to the expiration of the non-payment lockout period.

4. 5 percent of Income Limit

Members who are enrolled in the HIP program will have a 5 percent maximum contribution that is put in to place by federal regulations at 42 CFR 447.78. The 5 percent maximum contribution tracking applies to POWER account contributions, premiums, co-payments and co-insurance of the family's income on a monthly or quarterly basis as

determined by the state. The state has determined to have the 5 percent maximum contribution apply on a quarterly basis. To ensure a family's total cost-sharing does not exceed 5 percent of the family's income on a quarterly basis, the MCE shall accept family income data from the State's fiscal agent and track the POWER Account contributions, premiums, co-payments, payments on member debt collected and/or other cost-sharing information available to the MCE against the total family income data provided by the State. When a family's total cost-sharing expenditures come close to exceeding 5 percent of the family's income in the quarterly period, the MCE shall be required to notify the State. This notification will trigger cost sharing for the member to be waived for the remainder of the quarter.

5. Members in a lockout period

Members who are subject to non-payment lockout may reenter the program if they qualify for an exemption. Exemptions include:

- i. Obtained and subsequently lost private insurance coverage;
- ii. Had a loss of income after disqualification due to increased income;
- iii. Took up residence in another state and later returned;
- iv. Is a victim of domestic violence;
- v. Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment; or
- vi. Is medically frail.

Members who file an application and are in a lockout period will be sent a verification request for a lockout exemption and will need to complete the form and provide documentation to validate the exemption. Members who verify a lockout exemption will be able to reenter HIP prior to the expiration of their lockout period.

Copay Operational Plan

- d. *The state's operational plan to ensure that the beneficiaries with the option of paying nominal co-pays will only be charged a nominal copay by a Medicaid healthcare provider when covered benefits are provided.*

All members are eligible for HIP Plus which has no copayments except for non-emergency use of the Emergency Department and requires a monthly contribution of approximately 2 percent of income. Members who do not make their monthly contribution within 60 days and who have income less than 100 percent of the federal poverty level will be eligible for HIP Basic. HIP Basic charges nominal copayment amounts in lieu of the required monthly contribution.

Managed care entities administering HIP are subject to the following requirements surrounding HIP Basic copayments per the Scope of Work.

Members enrolled in HIP Basic or HIP State Plan Basic are not required to make monthly contributions to their POWER Account, but are required to pay the following copayments at the time services are rendered:

- *No copayment is required for preventative care, maternity services or family planning services.*
- *Four dollar (\$4.00) copayment for outpatient services.*
- *Seventy-five (\$75.00) copayment for inpatient services.*
- *Four dollar (\$4.00) copayment for preferred drugs.*
- *Eight dollar (\$8.00) copayment for non-preferred drugs.*

The MCE shall also establish education, policies and procedures for its contracted providers to collect copayments for HIP Basic members at the time of service.

Providers may access the electronic verification system (EVS) to verify if a member has a copayment, providers may also call the member's MCE to verify the member's copayment amount or use the MCE's online verification system. The EVS supports HIP member eligibility verification requests from providers through the following functions:

- Automated Voice Response (AVR)
- Web interChange
- HIPAA-compliant EDI 270/271 Eligibility Benefit Transaction

When an inquiry is made, the EVS response includes a member's MCE assignment, their phone number, and their assigned primary medical provider, if reported by the MCE, for HIP members. EVS also returns a member's benefit package and copay values, when applicable for the member's enrollment status.

For HIP members a provider may see the following enrollment plans, followed by the corresponding aid category:

- HIP BASIC; aid category MARB
- HIP PLUS; aid category MARP
- HIP State Plan BASIC; aid category MASB
- HIP State Plan PLUS; aid category MASP

The following HIP indicators relevant to copayments may also apply for the member and date of service being verified:

- Pregnant: The pregnancy indicator will display, when applicable, for pregnant HIP BASIC, HIP Plus, HIP State Plan BASIC and HIP State Plan Plus members
 - Pregnant members never have a copayment
- Copay: The copay indicator will display, when applicable, for HIP BASIC and HIP State Plan BASIC members. If a member has met their 5 percent max cost-sharing limit, the copay value will be 'No' regardless of the member's benefit plan.

Each time a provider verifies eligibility they will also receive indication whether the member is responsible for a copayment or not. Provider claims for HIP Basic and HIP State Plan Basic members will be paid less the member copayment amount and providers are contractually obligated to not charge members more than the required copayment for HIP Basic. Providers may not refuse to render services to members with income under 100 percent of the federal poverty level who have an inability to pay and members may not use their POWER account funds to pay for copayments. The State and MCEs both conduct extensive provider education on HIP, including the copayment requirements and limitations. State bulletins issued to providers and news releases to providers can be viewed at <http://provider.indianamedicaid.com/> and additional provider information is posted at HIP.in.gov.

Tracking of POWER account and Copayments and monthly statements

- e. The state's operational plan to ensure that POWER account contributions and copayment liability (on a per visit basis) will be accurately tracked, as well as monthly statements will be provided to the beneficiary.*

In order to participate in HIP Plus or HIP State Plan Plus, members are required to help fund the \$2,500 deductible by contribution to their POWER account on a monthly basis. Required contributions shall be calculated at 2 percent of the member's gross annual household income. In no event will a member's monthly POWER account contribution be more than one hundred dollars (\$100.00) or less than one dollar (\$1.00). The State will make the determination of the individual's required monthly POWER account contribution and will notify the MCE of this amount.

The invoices that the member receives will contain information that includes the current monthly POWER account contribution owed, POWER account contributions that are past due and POWER account contributions paid to date. The member is kept aware of the amount they have paid into their POWER account and the amount of services they have received while enrolled in the program.

Per the State's contract with MCEs, each must mail POWER account statements to members on a monthly basis. The statements are required to contain information on the account balance, indicate the member's annual and monthly contribution amounts, and the State's annual contribution amount. In addition, the contract specifically allows the MCE to combine the POWER account statements with the Explanation of Benefit (EOB) information also required under the contract. One MCE combines the information, while the other two send POWER account balances separately from EOBs. The most comprehensive statements include (i) POWER account balances include all withdraws and deposits; (ii) comprehensive contribution activity; (iii) all claims activity for the period; and (iv) status towards the members preventive service target. All of the MCEs indicated that they believe members spend the time to review these statements, based on the spike in calls to the call center from members asking questions regarding account balances and claim activity.

MCEs are contractually obligated to track member cost-sharing and provide regular and add hoc reports to the state.

Debt and refund process on termination

- f. The process by which the state will determine any debts owed by the beneficiary or refunds that would be sent to the beneficiary upon early termination from HIP 2.0.*

Refunds and debt are determined by the MCE upon member termination from HIP. These processes are governed by the MCE scope of work and follow the below guidelines.

Refunds

If a member becomes ineligible for HIP, either during redetermination or at another time, the MCE must refund the member's pro rata share of his or her POWER Account balance, if any, **within sixty (60) calendar days** of the member's date of termination from HIP.

A deceased member's estate will have a right to the member's pro rata share of his or her POWER Account funds.

Except for members terminating from the program who are subject to non-payment penalties for such termination as described below, the amount payable to the member shall be determined as follows:

- Step One: Determine the amount paid into the POWER Account to date by the individual, and, if applicable the individual's employer or a nonprofit on the individual's behalf
- Step Two: Determine the total amount paid into the individual's POWER Account from all sources
- Step Three: Divide the amount determined in Step One by the amount determined in Step Two

- Step Four: Multiply the ratio determined in Step Three by the total amount remaining in the POWER Account
- Step Five: Subtract member debt owed to the Contractor pursuant to Section 5.8, if any.

A member who does not otherwise meet any of the lockout exceptions will be subject to a penalty on the member's refund amount if such member is either terminated from HIP due to non-payment or voluntarily withdraws from HIP prior to the end of the member's benefit period. Such member will forfeit to the State 25 percent of his or her pro rata share of any funds remaining in the member's POWER Account. This means that upon member termination from HIP due to non-payment, the MCE shall be required to refund only a portion of the member's pro rata share of the POWER Account. The amount payable to the member shall be determined as follows:

- Step One: Determine the amount paid into the POWER Account to date by the individual, and, if applicable, the individual's employer or a nonprofit entity on the individual's behalf
- Step Two: Determine the total amount paid into the individual's POWER Account from all sources
- Step Three: Divide the amount determined in Step One by the amount determined in Step Two
- Step Four: Multiply the ratio determined in Step Three by the total amount remaining in the POWER Account
- Step Five: Subtract member debt owed to the Contractor pursuant to Section 5.8, if any
- Step Six: Multiply the amount determined under Step Five by seventy-five hundredths (.75 or 75%)

Any funds remaining in the POWER Account after the member rebate must be credited to the State via the 820 transaction. The MCE will have one hundred and twenty (120) calendar days from the member's date of termination from the plan to report the amount to the State.

In the event of member termination, the POWER Account reconciliation process occurs in two stages:

- Member refund: Sixty (60) calendar days from date of member termination
- State refund: One-hundred and twenty (120) calendar days from date of member termination

Power Account Debt

POWER account contributions are member contributions towards a deductible and are not a monthly premium. Member debt is based on the percent of the deductible the member was

responsible for and how much of the POWER account was spent to pay the deductible. Based on the HIP 2.0 STCs member debt is subject to maximum liability limitations as detailed below.

Member pro rata share

Member pro rata share is equal to the proportion of the POWER account the member is responsible for contributing.

This proportion is calculated by:

$$\text{Total member annual POWER account contribution} / \$2,500$$

Taking the resulting proportion and multiplying it by any claims incurred yields member pro rata share of claims.

Debt for members under 100 percent FPL

The amount of debt a member under 100 percent FPL may accrue will be capped at an amount equal to (i) the amount of their pro rata share, less contributions made by the member during the coverage term, whatever is less or (ii) the amount of the members missed contributions for the months they received HIP Plus and did not pay their contributions, whatever is less.

Example 1: Member A has an annual POWER account contribution responsibility of \$120 which the member pays in monthly \$10 installments. Member A pays their POWER account contribution for the first two months of coverage and then stops paying. After a 60 day non-payment grace period the member is moved from HIP Plus to HIP Basic effective the first of the month after the expiration of the grace period. The member has incurred \$500 in claims during their HIP Plus enrollment.

Calculation of debt for Member A:

Member pro rata share	$\$120 / \$2,500 = .048$
Member pro rata share of claims	$\$500 * .048 = \24
Member contributions paid	$2 * \$10 = \20
True Debt: Member remaining share of claims	$\$24 - \$20 = \$4$
Debt Cap: Member missed contributions	$2 * \$10 = \20
Maximum debt check	$\$4 < \$20 = \text{TRUE}$
Member debt	\$4

In this example the members pro rata share of claims incurred is less than the unpaid contributions for the months they had Plus coverage without paying a contribution. **The member debt is the lesser amount of \$4.**

Example 2: Member B has an annual POWER account contribution responsibility of \$60 which the member pays in monthly \$5 installments. Member B pays their POWER account contribution for the first month of coverage and then stops paying. After a 60 day non-payment grace period the member is moved to from HIP Plus to HIP Basic effective the first of the month after the expiration of the grace period. The member has incurred \$1,500 in claims.

Calculation of debt for Member A:

Member pro rata share	$\$60/\$2,500 = .024$
Member pro rata share of claims	$\$1,500 * .024 = \36
Member contributions paid	$1 * \$5 = \5
True Debt: Member remaining share of claims	$\$36 - \$5 = \$21$
Debt Cap: Member missed contributions	$2 * \$5 = \10
Maximum debt check	$\$21 < \$10 = \text{FALSE}$
Member debt	\$10

In this example the members pro rata share of claims incurred is more than the member contributions for the months they received HIP Plus and did not pay. **The member debt is the lesser amount of \$10.**

Over 100 percent FPL

The amount of debt a member over 100 percent FPL may accrue will be capped at an amount equal to (i) the members pro rata share of claims incurred, less contributions made by the member or (ii) 10 percent of the cost of services received, whichever is less.

Example 3: Member C has an annual POWER account contribution responsibility of \$240 which the member pays in monthly \$20 installments. Member C pays their POWER account contribution for the first 3 months of coverage and then stops paying. The member will be subject to non-payment lockout effective the first of the month following the end of their 60 day grace period. The member has incurred \$1,000 in claims during their HIP Plus enrollment.

Calculation of debt for Member C:

Member pro rata share	$\$240/\$2,500 = .096$
Member pro rata share of claims	$\$1,000 * .096 = \96
Member contributions paid	$3 * \$20 = \60
Member remaining share of claims incurred	$\$96 - \$60 = \$36$
Maximum debt check	$\$36 < (\$1,000 * 10\%) = \text{True}$

Member debt **\$36**

In this example the members pro rata share of claims incurred is less than 10 percent of the cost of services received. **The member debt is the lesser amount of \$36.**

Example 4: Member D has an annual POWER account contribution responsibility of \$300 which the member pays in monthly \$25 installments. Member D pays their POWER account contribution for the first month of coverage and then stops paying. The member will be subject to non-payment lockout effective the first of the month following the end of their 60 day grace period. The member has incurred \$2,000 in claims during their HIP Plus enrollment.

Calculation of debt for Member D:

Member pro rata share	$\$300/\$2,500 = .12$
Member pro rata share of claims	$\$2,000 * .12 = \240
Member contributions paid	$1 * \$25 = \25
Member remaining share of claims incurred	$\$240 - \$25 = \$215$
Maximum debt check	$\$215 < (\$2,000 * 10\%) = \text{FALSE}$
Member debt	$(\$2,000 * .10) = \text{\$200}$

In this example the members pro rata share of claims incurred is more than 10 percent of the cost of services received. **The member debt is the lesser amount of \$200.**

Collection of Past due POWER account contribution process

g. The process by which the MCO will collect past due POWER account contributions including how the MCOs will collect the debt, which beneficiaries will be subject to collection, and the timeframe for which the debt collection must occur.

MCE billing, collection and notification of past due POWER account contributions and debt is outlined in the HIP Scope of Work.

For completing billing and collection of HIP members MCEs must meet the below requirements:

- Creating and maintaining HIPAA compliant POWER Account contribution billing services;
- Generating and mailing invoices, although members may opt-in to receiving electronic invoices;
- Receiving and posting payments;
- Monitoring and tracking missed payments;

- Processing returned checks;
- Stopping or placing collections on hold as directed by the State;
- Generating past due notices and other notifications;
- Generating other informational materials as requested by the State;
- Providing documentation of account activities and other financial reports;
- Processing and mailing fast track prepayment and/or POWER Account contribution refunds;
- Transferring collected funds as requested by the State;
- Documentation and reconciliation of funds received and transferred;
- Establishing and handling a lockbox for HIP payments;
- Providing services online that support and interface with the State's current website;
- Ensuring the integrity and accuracy of data exchanged with or provided to the State, and that the data is compatible with other software, hardware or systems used by the State;
- Ensuring compliance with current bankruptcy rules, the Cash Management Improvement Act of 1990 guidelines (Public Law 101-453), confidential information and electronic transaction processing procedures;
- Adhering to established health care industry standards, in addition to any Medicaid rules, regulations and or mandates, as well as amendments thereto;
- Date stamping mail received; and
- Forwarding all change of address notifications and mail returned as undeliverable as specified by the State.

Additionally, while MCEs are not required to promote cash payment by mail as a payment option, they must be equipped to accept cash payments, including cash payment by mail, if submitted by the member. Further, the State encourages arrangements with local entities to facilitate the collection of contributions, including no-cost options for collecting cash contributions.

Members receive regular invoices and reminder letters when they have late payments. All member invoices and reminder letters include:

- Plan name and contact information;
- First name, last name and address of member;
- Current monthly POWER account contribution owed;
- POWER account contribution past due;

- Overpayment shown as credit;
- POWER account contribution due date;
- RID number of the person responsible for payment;
- Consequences of not paying the POWER account contribution;
- Notice to send payment in one of the accepted forms, such as check, money order, on-line payment, unlimited electronic check or debit card via telephone, payroll deduction, automatic draft withdrawal from a designated account, cash payments or automated clearinghouse (ACH), etc. including instructions on how to perform the transaction;
- How to notify the plan of an address or other change;
- How to notify the plan when individuals or families have billing questions or concerns; and
- Legal statement regarding bankruptcy, if applicable.

Members who lose eligibility for HIP Plus for failure to pay a POWER account contribution may owe a debt to the MCE. This debt is limited to the amounts specified in the preceding section. Having debt does not prevent member reenrollment in HIP Plus. MCEs may attempt to collect debt owed to them through permissible methods, including requesting payment from the former HIP Plus member through mail and phone correspondence.

Renewal Process

h. The process by which renewals will occur under HIP 2.0.

HIP members will have their eligibility renewed on an annual basis. The member renewal process initiates 90 days before the end of the member's 12 month benefit period. Members will receive a notice of their upcoming redetermination, the fact that they may change plans at their redetermination, and as applicable for HIP Basic members that they may transfer to HIP Plus for their next 12 month benefit period.

A Medicaid redetermination mailer will be sent to the member 75 days prior to the expiration of the benefit period. This mailer will be dynamically generated and will only include HIP related questions. As applicable member information will be prepopulated including information received through electronic verifications. The mailer will note if there is action required by the member, including submission of additional verifications for information that cannot be verified electronically.

While information will be verified electronically where possible, some members will still be required to provide verifications before the redetermination can be completed. Members required to provide additional information must return the Medicaid mailer 30 days prior to the end of their benefit period. Members for who the state has all applicable information to redetermine eligibility will have their renewals processed 30 days prior to the expiration of their current benefit period. If the member remains eligible the State will pass the members new

POWER account contribution amount to their selected MCE and the member will receive an invoice for the first month of their new 12 month benefit period prior to the expiration of their previous benefit period. Members who do not provide all needed information for the renewal on time may not be able to have their eligibility redetermined prior to the end of their 12 month period. These members may have their coverage closed at the end of their benefit period. These members may still submit their Medicaid redetermination mailer with the requested information up to 90 days after the expiration of the benefit period.

Members who are in HIP Basic at redetermination will have the opportunity to transition to HIP Plus. Members will receive an invoice for their HIP Plus POWER account contribution and may receive HIP Plus coverage if they pay this invoice within 60 days. If the member does not pay the POWER account contribution they will remain in HIP Basic.

Process to remit POWER account contributions

i. The process by which beneficiaries will be able to remit POWER Account contributions, including ways individuals who cannot pay by check will be accommodated.

The current HIP program builds on existing HIP infrastructure for individuals to pay their POWER account contributions. HIP members use a variety of payments methods. In general, most members pay their monthly POWER account contributions by mail, with either money order, personal check, credit card or debit card. HIP members can pay with cash, however MCEs note that this is not a common payment method for members. All MCEs noted that they believe a portion of their members use prepaid Visa credit or debit cards that they reload on a monthly basis, although it is impossible for them to know an exact percentage since the transaction processes the same as any other credit card transaction. In addition, all MCEs allow payments to be made electronically through the online member portal, although, utilization of this feature to make payments is relatively low within the HIP population. All MCEs reported that members make payments by phone with some frequency.

Each of the MCEs have attempted to develop relationships with third parties to assist in the collection of member payments, and each have had varied experiences, as describe below.

1. One MCE allows members to pay at any 5/3rd bank branch.
2. Another MCE has had an arrangement with Walmart since 2011, whereby Walmart will collect and remit monthly POWER account contributions to the MCE. The MCE used a company called FiServ to set up payments through the retail stores. They used the FiServ “CheckFree” product line. More information about the service can be found at www.fiserv.com. The MCE stated that the relationship was relatively easy to develop for the HIP program, as the company already had the required system and processes in place to facilitate the transactions. The relationship has worked very well, as Walmart stores are convenient and available across the state, even in rural areas. Most importantly, the systems and policies have been consistently applied at all participating store locations. The MCE also described two previous unsuccessful attempts at developing third party community relationships. First, they contracted with several banks, however, found that banking institutions, in general, did not provide sufficient access for their members, both

in terms of geographic access and hours of availability. Secondly, check cashing stores were unsuccessful due to the high transaction fees charged to members.

3. The third MCE has developed a relationship with Western Union to collect member payments. However, it is unclear how successful the relationship has been, as they have had very few members (less than five) use this payment option, likely due to the higher fees associated with processing the transaction.

All MCEs reported allowing members to set up an automatic recurring payment. In addition, all of the MCEs engage in active outreach when a member is delinquent on payments. Two of the MCEs contract with third party entities to manage this aspect of the program. One of the MCE's reported that due to this active outreach, they have been able to maintain a ninety eight percent (98 percent) payment rate among their HIP enrollees. All of the MCEs report actively calling members who become delinquent, typically around thirty days after the payment is due. They reported a high success rate at obtaining member contributions with active outreach, which generally lead to the transfer of the member to the payment department for immediate payment via the phone.

All MCEs are working on arrangements that allow members to pay at Wal-mart and this feature will soon be available regardless of the member's MCE enrollment.

Change in income process

j. The state's process for acting on changes in income as it relates to the POWER account contributions.

All member notices, member handbooks, and letters to members who are late on payments include instructions on how to report changes and what types of changes the member is required to report. Language provided to members on notices is pasted below and can be viewed in context in the sample notices attached in Enclosure 2.

During your HIP enrollment period you are required to report changes in your circumstances. You must report the following changes in your circumstances within 10 days of when the change occurs:

- *You move to a new address or change mailing addresses.*
- *Your family income or family size changes.*
- *You lose your job, change jobs or get a new job.*
- *You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.*
- *You become insured under other health insurance, either private or Medicare.*
- *Any other change that you think may affect your eligibility or benefits for HIP.*

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfr

Members are directed to report changes to the state however, a process exists to ensure that member changes reported to the MCE are accounted for without requiring the members to report the change a second time. Member reported changes are subject to verification. Verifications may come through electronic data sources or through documentation provided by the member, as applicable. The member receives a notice from the state of each verified change and if this change impacts the member's cost-sharing or benefits.

The state acts on each reported changes. Changes in member income, regardless of amount, will result in a recalculation of the member's POWER account contribution amount. This recalculated amount will then be passed to the member's MCE and member invoices will be adjusted as needed. Members will be informed by the state of their new POWER account obligation and will receive an invoice for the new amount from their MCE. Changes to POWER account amounts are effective the first of the month following the verification of the change. If the member POWER account amount went down the MCE will apply any member overpayments to future POWER account contributions, and if the POWER account amount went up the MCE will invoice the member for the additional amount owed. Members own their POWER account contributions and may receive refunds for their remaining contribution amounts if they leave HIP and may rollover their balances as discussed above.

Education, notices, appeals, rights and responsibilities

k. The state's implementation plan for the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries' rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with state officials for discrepancies or other issues that arise regarding the beneficiaries' cost sharing obligations.

Sample notices describing beneficiaries' rights and responsibilities, appeal rights and processes, and instructions for interacting with the state are attached in Enclosure 2. In addition FSSA has worked with a wide ranging coalition of health care providers, enrollment organizations and social services providers beginning last summer to develop a comprehensive public education strategy.

- FSSA will continue to engage and educate these stakeholders, including Indiana's statewide network of over 1,100 certified navigators.
- Letters were mailed to existing HIP members and non-disabled adults who will be transitioning to HIP 2.0 that contained extensive education on the HIP program including the difference between Basic and Plus and the importance of paying the POWER account contribution.

- www.HIP.IN.gov has been updated so that it now contains information about HIP 2.0, including a calculator to help Hoosiers know if they are eligible for coverage. Hoosiers were also able to apply starting immediately. The website also includes training information for stakeholders such as health care providers and navigators. Information continues to be added.
- In the coming months, FSSA will promote and sponsor events around the state where Hoosiers can learn about HIP 2.0 in person from health coverage experts. FSSA will also support the statewide outreach efforts of the stakeholder organizations as they execute their own plans to engage Hoosiers now eligible for the Healthy Indiana Plan.
- FSSA will also execute a traditional marketing campaign starting this spring including collateral materials, training, TV and radio advertising, etc., and ongoing media outreach around the state to help ensure awareness of HIP 2.0.

HIP Basic and HIP Plus Member Education

1. Materials for use in educating beneficiaries about the difference between HIP Plus and HIP Basic.

The distribution of information about the differences between HIP Basic and HIP Plus is extensive. Standard language has been developed and distributed to all relevant stakeholders that describes the difference between HIP Plus and HIP Basic. The language has been submitted to CMS prior to completion of this protocol and is also included as Enclosure 3. This language is the base for the language the MCEs use in development of their member educational materials including invoices, reminder letters, member handbooks and website content. The language also is used to develop state notices, call scripts and training. Training documents detailing the differences between HIP Basic and HIP Plus and the other aspects of the HIP program have been developed and distributed to internal staff, including call center staff, the enrollment broker, and MCEs. These training documents are also available to the public through the HIP website, including Navigators, members, providers, and any other interested party.

In addition to standard language and trainings there are many other resources for members and stakeholders at www.hip.in.gov including FAQs, brochures, plan comparisons, and other general educational material. Furthermore, MCEs conduct member and provider education on the differences between HIP Basic and HIP Plus, the benefits and features of the HIP program, and the importance of making the POWER account contribution. MCE information, including member handbooks are available at:

Anthem: <http://www.anthem.com/inmedicaid/>

MHS: <http://www.mhsindiana.com/>

MDwise: <http://www.mdwise.org/for-members/healthy-indiana-plan/>

POWER Account Member Education

m. The state's strategy for educating beneficiaries on how to use the POWER account statements, and understand that their health care expenditures will be covered.

All member educational material explains that the HIP POWER account covers the first \$2,500 in member expenditures and that the member's manage care entity covers expenses for any covered services beyond this amount. Education on the use of member statements is primarily a function of the MCEs. MCE member handbooks include information on how members can use their POWER accounts and what types of transactions are detailed on member statements. Member statements note the total funds available in the POWER account, and show debits due to claims paid from the POWER account in the applicable month and for HIP Plus members, credits for member contributions. MCE call centers are experienced at taking member calls and questions on their HIP POWER account statements and providing answers to members' questions or concerns regarding their POWER accounts. Based on experience with the current HIP program, MCEs experience shows that HIP members take time to review statements based on a spike in call volumes after statements are mailed. HIP members primarily ask questions about statement balances and claim activity. Links to HIP member handbooks are provided above, and member handbooks, plus the MCE online resources and call centers are the best resource for members to understand what benefits are covered and how these benefits are paid for between the POWER account and the MCE.

Reporting Changes in Income

n. The state's strategy for educating beneficiaries on how to self-report changes in income and the importance of doing so.

As noted in the income change process (j):

All member notices, member handbooks, and letters to members who are late on payments include instructions on how to report changes and what types of changes the member is required to report. Member educational material explains that POWER account contributions are based on member income. Language provided to members on notices is pasted below and can be viewed in context in the sample notices attached in Enclosure 2.

During your HIP enrollment period you are required to report changes in your circumstances. You must report the following changes in your circumstances within 10 days of when the change occurs:

- You move to a new address or change mailing addresses.*
- Your family income or family size changes.*
- You lose your job, change jobs or get a new job.*
- You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.*

- *You become insured under other health insurance, either private or Medicare.*
- *Any other change that you think may affect your eligibility or benefits for HIP.*

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/df

HIP Link Education

o. The state's strategy for educating beneficiaries and employers on the HIP Link program.

HIP Link education and outreach will be addressed in the HIP Link Protocol.

Enclosure 1: POWER Account Reporting

General Report Description	
MO-PR1 and MO-PR2 POWER Account Contribution - Employer Participation Summary	
Purpose	To monitor the participation of employers' and non-profit organizations' contributions towards the POWER account on behalf of HIP members.
Format	Excel template
Qualifications/ Definitions	This is a monthly and year to date report. The MCE must submit the report by the date designated on the reporting catalogue.
Performance Measures	An employer's contribution must not exceed 50% of the member's annual contribution amount.
MO-PR1 Data Elements	
Item 1	Number of Employers Participating
Description	Indicate the total number of employers that made member contributions on behalf of a member during the reporting period. Enter a whole number.
Item 2	Number of Members on Whose Behalf an Employer Made a Contribution
Description	Indicate the total number of members on whose behalf an employer has made one or more member contribution payments during the reporting period. Enter a whole number.
Item 3	Total Amount of Employer Contributions
Description	Indicate the total amount of employer contributions made on behalf of a member during the reporting period. Enter a dollar value.
Item 4	Average Amount of Employer Contributions
Description	Indicate the average amount of employer contributions made on behalf of a member during the reporting period. Enter a dollar value.
Formula	<ul style="list-style-type: none"> • Numerator = Item 3 • Denominator = Item 2

MO-PR2 Data -PR2 Data Elements	
Item 1	Number of Non-Profit Organizations Participating
Description	Indicate the total number of non-profit organizations that made member contributions on behalf of a member during the reporting period. Enter a whole number.
Item 2	Number of Members on Whose Behalf a Non-Profit Organization Made a Contribution
Description	Indicate the total number of members on whose behalf a non-profit organization has made one or more member contribution payments during the reporting period. Enter a whole number.
Item 3	Total Amount of Non-Profit Organization Contributions
Description	Indicate the total amount of non-profit organization contributions made on behalf of a member during the reporting period. Enter a dollar value.
Item 4	Average Amount of Non-Profit Organization Contributions
Description	Indicate the average amount of employer contributions made on behalf of a member during the reporting period. Enter a dollar value.
Formula	<ul style="list-style-type: none"> • Numerator = Item 3 • Denominator = Item 2

General Report Description							
QR-PRPAY1 Aggregate POWER Account Contribution Detail							
Purpose	To monitor the POWER account contribution activity.						
Format	Excel template						
Qualifications/ Definitions	<p>This is a quarterly report. The MCE must submit the report by the last day of the month following the end of the reporting quarter.</p> <p>This report is broken into categories including the source of the contribution:</p> <ul style="list-style-type: none"> • Member • State • Third party sources including employers and non-profit organizations <p>It is also separated by the payment methods:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td style="text-align: center;">Electronic Transfer</td></tr> <tr><td style="text-align: center;">Payroll Deduction</td></tr> <tr><td style="text-align: center;">Paper Check</td></tr> <tr><td style="text-align: center;">Money Order</td></tr> <tr><td style="text-align: center;">Credit Card</td></tr> <tr><td style="text-align: center;">Other</td></tr> </table>	Electronic Transfer	Payroll Deduction	Paper Check	Money Order	Credit Card	Other
Electronic Transfer							
Payroll Deduction							
Paper Check							
Money Order							
Credit Card							
Other							
Performance Measures	The plan must deposit checks no later than 10 calendar days after receipt.						
QR-PRPAY1 Data Elements							
Item 1	Number of Initial Member POWER Account Contributions Received						
Description	<p>Indicate the number of initial member contributions received by the plan during the reporting period by FPL. The initial member contribution is the first contribution due after an individual is determined to be conditionally eligible for HIP, and is required before coverage under the plan begins. The sum of all members under all FPLs equals the total number of initial member contributions received by the plan during the reporting period.</p> <p>Enter a whole number.</p>						

Item 2	Number of Initial Member POWER Account Contributions Pending From Previous Reporting Period
Description	Enter the total number of initial member contributions received in previous reporting periods that were pending as of the last day of the previous reporting period. Enter a whole number.
Item 3	Number of Member POWER Account Contributions Processed
Description	Enter the total number of initial member contributions processed during the reporting period. Enter a whole number.
Item 4	Average Number of Days to Process Initial Member Contribution
Description	Indicate the average length of time in calendar days to process initial member contributions in the reporting period.
Formula	To accurately calculate the processing time period, the plan must identify the Julian date of the lockbox deposit of the initial member contribution then subtract (-) the Julian date the plan notified HP that the member's payment has been processed. <ul style="list-style-type: none"> • Numerator = Total number of days • Denominator = Total number of payments processed
Item 5	Number of Initial Member Contributions Pending Deposit
Description	Indicate the total number of initial contributions that are pending deposit as of the last day of the reporting period. Enter a whole number.
Item 6	Number of Lockbox Deposits
Description	Indicate the total number of Lockbox deposits made as of the last day of the reporting period. Enter a whole number.
Item 7	Total Amount of Lockbox Deposits

	Enter the total amount of all lockbox deposits during the reporting period, sorted by source (i.e. / member and employer) and method of deposit (i.e., electronic transfer, payroll deduction, paper check, money order, other). Enter a dollar value.
Item 8	Average Amount of Lockbox Deposits
Description	To calculate the average amount of lockbox deposits, sum the amounts of all lockbox deposits during the reporting period and divide by the total number of lockbox deposits made during the reporting period. Sort by source (i.e./ member and third party) and method of deposit (i.e., electronic transfer, payroll deduction, paper check, money order, other). Enter a dollar value.

General Report Description					
QR-PRREF1 Aggregate POWER Account Contribution Refund Detail					
Purpose	To monitor the number and amounts of power account contributions that result in a refund.				
Format	Excel template				
Qualifications/ Definitions	<p>This is a quarterly report. The MCE must submit the report by the last day of the month following the end of the reporting quarter.</p> <p>This report is broken into addressee:</p> <ul style="list-style-type: none"> • Member • State <p>It is also separated by the payment methods:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Electronic Transfer</td> </tr> <tr> <td style="text-align: center;">Paper Check</td> </tr> <tr> <td style="text-align: center;">Credit Card</td> </tr> <tr> <td style="text-align: center;">Other</td> </tr> </table>	Electronic Transfer	Paper Check	Credit Card	Other
Electronic Transfer					
Paper Check					
Credit Card					
Other					
QR-PRREF1 Data Elements					
Item 1	Number of Refunds				

Description	Indicate the number of contribution payment refunds that were returned during the reporting period. Enter a whole number.
Item 2	Total Amount of Refunds
Description	Indicate the total dollar value for all refunds returned during the reporting period. Enter a dollar value.
Item 3	Average Amount of Refunds
Description	Indicate the average amount of the refund returned. Enter a dollar value.
Formula	<ul style="list-style-type: none"> • Numerator = Item 2 • Denominator = Item 1
Item 4	Average Number of Days to Process Refund
Description	Indicate the average length of time to process a power account contribution refund.
Formula	To accurately calculate the processing time period, the plan must identify the Julian date for which a refund was required then subtract (-) the Julian date the plan mailed/returned the payment contribution as a refund.
Item 5	Returned Member Refunds

Description	Itemize all member refunds distributed that subsequently were returned to the plan. Include the following elements: Item No. Member RID# Amount of Refund Date of Refund Date of Returned Refund Reason for Return Insurer Follow-up
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General Report Description	
QR-PRTERM1 Non-Payment of POWER Account Contributions – Initial Payment	
Purpose	To monitor initial POWER account payment cycles to ensure members are making payments and plans are accurately applying contributions.
Format	Excel template
Qualifications/ Definitions	This is a quarterly report. The MCE must submit the report by the last day of the month following the end of the reporting quarter.
Performance Measures	Conditionally eligible and HIP enrollees who are 60 days delinquent in making a full member contribution payment must be terminated from HIP coverage.
QR-PRTERM1 Data Elements	
Item 1	Termed Due to No Payment
Description	<p>Enter the number of individuals reported to the plan as conditionally eligible who were terminated during the reporting period for being 60 days late in making their first member contribution. Indicate the total number of individuals failing to make any payment by FPL tier:</p> <ul style="list-style-type: none"> a) < 22% FPL b) 23% FPL - 50% FPL c) 51% FPL – 75% FPL d) 76% FPL – 100% FPL e) 101% FPL – 138% FPL <p>Enter a whole number.</p>
Item 2	Termed Due to NSF Payment
Description	<p>Enter the number of individuals reported to the plan as conditionally eligible who were terminated during the reporting period for being 60 days late in making their first member contribution. Indicate the total number of individuals terminated due to an NSF (non-sufficient funds) payment of the initial payment by FPL tier:</p> <ul style="list-style-type: none"> a) > 22% FPL b) 23% FPL - 50% FPL c) 51% FPL – 75% FPL d) 76% FPL – 100% FPL e) 101% FPL – 138% FPL <p>Enter a whole number.</p>

Item 3	Total Termed
<p>Description</p>	<p>Enter the number of HIP enrollees who were terminated during the reporting period for being 60 days late in making a full subsequent member contribution payment. Total those terminated for making either no payment or an NSF payment by FPL tier:</p> <ul style="list-style-type: none"> a) > 22% FPL b) 23% FPL - 50% FPL c) 51% FPL – 75% FPL d) 76% FPL – 100% FPL e) 101% FPL – 138% FPL <p>Enter a whole number.</p>
Item 4	Amount Owed in Aggregate – First Payments
<p>Description</p>	<p>Enter the total value of member contributions owed by individuals who were terminated during the reporting period for being 60 days late in making their first member contribution by FPL tier:</p> <ul style="list-style-type: none"> a) > 22% FPL b) 23% FPL - 50% FPL c) 51% FPL – 75% FPL d) 76% FPL – 100% FPL e) 101% FPL – 138% FPL <p>Enter a dollar value.</p>
Item 5	Average Amount Owed Per Delinquent Eligible
<p>Description</p>	<p>Indicate the average amount of contribution that was owed by those individuals terminated for being 60 days late in making their first member contribution by FPL tier:</p> <ul style="list-style-type: none"> a) > 22% FPL b) 23% FPL - 50% FPL c) 51% FPL – 75% FPL d) 76% FPL – 100% FPL e) 101% FPL – 138% FPL <p>Enter a dollar value.</p>

Formula	<ul style="list-style-type: none"> • Numerator = Item 3 • Denominator = # of Conditionally HIP Eligible Persons Terminated (Item 1 + Item 2)
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General Report Description						
QR-PRTERM2 Non-Payment of POWER Account Contributions – Subsequent Payment						
Purpose	To monitor subsequent POWER account payment cycles to ensure members are making payments and plans are accurately applying contributions.					
Format	Excel template					
Qualifications/ Definitions	<p>This is a quarterly report. The MCE must submit the report by the last day of the month following the end of the reporting quarter.</p> <p>This report indicates members that were termed from HIP Plus due to non-payment of a subsequent POWER account contribution. Members under 100% FPL would transfer to HIP Basic. The terminations are also monitored and divided into the following population and income level groups:</p> <ol style="list-style-type: none"> 1. Medically Frail 2. Section 1931 Low Income Parent Caretaker 3. HIP Plus <table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td style="text-align: center;"><22% FPL</td></tr> <tr><td style="text-align: center;">23-50% FPL</td></tr> <tr><td style="text-align: center;">51-75% FPL</td></tr> <tr><td style="text-align: center;">76-100% FPL</td></tr> <tr><td style="text-align: center;">101-138% FPL</td></tr> </table>	<22% FPL	23-50% FPL	51-75% FPL	76-100% FPL	101-138% FPL
<22% FPL						
23-50% FPL						
51-75% FPL						
76-100% FPL						
101-138% FPL						
Performance Measures	Conditionally eligible and HIP enrollees who are 60 days delinquent in making a full member contribution payment must be terminated from HIP coverage.					
QR-PRTERM2 Data Elements						

Item 1	Termed due to No Payment
Description	Enter the number of HIP enrollees who were terminated during the reporting period for being 60 days late in making a subsequent member contribution payment. Enter a whole number.
Item 2	Termed Due to NSF Payment
Description	Enter the number of HIP enrollees who were terminated during the reporting period for being 60 days late in making a full subsequent member contribution payment. Indicate those terminated for making an NSF payment. Enter a whole number.
Item 3	Total Termed
Description	Enter the number of HIP enrollees who were terminated during the reporting period for being 60 days late in making a full subsequent member contribution payment. Total those terminated for making either no payment or an NSF payment. Enter a whole number.
Item 4	Amount Owed in Aggregate – Subsequent Payments
Description	Indicate the total value of member contributions owed by individuals who were terminated during the reporting period for being 60 days late in making a subsequent member contribution. Enter a dollar value.
Item 5	Average Amount Owed Per Delinquent Eligible
Description	Indicate the average amount of subsequent contributions owed by individuals who were terminated due to non-payment or insufficient payment. Enter a dollar value.
Formula	<ul style="list-style-type: none"> • Numerator = Item 4 • Denominator = Item 3
Item 6	Average Number of Months on HIP before Termination

Description	<p>Indicate the average number of coverage months a member received prior to program termination due to non-payment or insufficient payment.</p> <p>Enter a whole number.</p>
Formula	<ul style="list-style-type: none"> • Numerator = Total number of coverage months for HIP Enrollees terminated during the reporting period due to delinquent or insufficient payment of subsequent member contributions • Denominator = Total number of HIP enrollees terminated during the reporting period due to delinquent or insufficient payment of subsequent member contributions

Enclosure 2: Sample Notices

MARP conditional approval:

Congratulations! You have been conditionally approved for the Healthy Indiana Plan (HIP) Plus program.

Your HIP Plus health coverage will begin on the first day of the month in which your first monthly POWER account payment is received and processed by your health plan. In a few days, your health plan will send you the bill for your first monthly POWER account payment. If you do not make your payment on time, you risk being placed into the HIP

Basic benefit plan. The sooner you make your payment, the sooner your benefits will begin.

Under HIP Plus, you will have coverage for comprehensive benefits including vision and dental services. Other than your monthly POWER account payment, in HIP Plus you will not be charged anything for visiting the doctor or filling prescriptions. The only other cost associated with getting health care in HIP Plus is a copayment for visits to the Emergency Room if the health condition is not an emergency.

INFORMATION ABOUT POWER ACCOUNT PAYMENTS

To become fully eligible for HIP Plus, you need to make your first monthly POWER account payment. The POWER account payment for you and your spouse is based on your combined countable monthly income of \$1,002.51. Your POWER account contribution is approximately two (2) percent of your income, which requires an annual POWER account obligation of \$120.00. This amount can be paid in monthly installments of \$10.00. This amount is shared between you and your spouse.

In the HIP program, the first \$2500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The State will pay most of this amount, but you will also be responsible for paying a portion of your initial health care costs. Your portion is paid through an affordable, monthly contribution to your POWER account based on income and could be as low as \$1.

Managing your account well and getting preventive care can reduce your future costs. If your annual health care expenses are less than \$2500 per year, you may rollover your remaining contributions to reduce your monthly payment for the next year. You can also have this reduction doubled if you complete preventive services. Your health plan will inform you what preventive care services are recommended for you. If your annual health care expenses are more than \$2500, the first \$2500 is covered by your POWER account, and expenses for additional health services over \$2500 are fully covered at no additional cost to you.

In HIP, your contributions to your POWER account will be yours, and you could receive a portion back if you leave the program. Since your contributions are based on a projected annual amount, you may also owe your

health plan for any remaining months of enrollment if you leave the program

INFORMATION ABOUT ELIGIBILITY AND ENROLLMENT IN THE HEALTHY INDIANA PLAN

Once you have made your initial POWER account payment and you are enrolled in HIP, you are eligible to receive benefits for a period of twelve (12) months. We will redetermine your eligibility annually or during the benefit period when we become aware of a change in your circumstances. Certain changes in circumstances may impact your eligibility for HIP, your level of benefits or your monthly POWER account payment. It is important that you report any change in circumstances during your benefit period.

Changes You Must Report

You must report the following changes in your circumstances within 10 days of when the change occurs:

- You move to a new address or change mailing addresses.
- Your family income or family size changes.
- You lose your job, change jobs or get a new job.
- You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.
- You become insured under other health insurance, either private or Medicare.
- Any other change that you think may affect your eligibility or benefits for HIP.

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfr

Your health plan will specify the due dates in your monthly invoices. If you do not make your monthly POWER account payment, you will be enrolled in HIP Basic. In HIP Basic, you will not have coverage for vision or dental benefits and will be required to make a payment called a copayment for most health services you receive including doctors' visits, prescriptions and hospital stays. These payments will range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. Contact your health plan if you have questions about making payments and using your POWER account.

If you have questions about this notice please, contact the Family and Social Services Administration at 1-800-403-0864.

IMPORTANT NOTICE: The Affordable Care Act (ACA) expands access to health insurance coverage through improvements to the Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Marketplaces, and the assurance of coordination between Medicaid, CHIP, and the Marketplaces. The ACA also mandates the use of the Modified Adjusted Gross Income (MAGI) financial methodology when determining Medicaid income eligibility for most parents and other caretakers, children and pregnant women. Individuals who are not eligible for Medicaid may be eligible for health insurance coverage through the Marketplace, including assistance with paying premiums and other cost sharing requirements.

If you disagree with our decision

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. You cannot appeal the change in law that authorized the new HIP requirements and available benefits. We have included in this notice an appeal request form for you to complete and instructions for mailing for your convenience. Please read this information carefully.

Timelines and process for appealing

You must file your appeal in writing by close of business within 33 days of the date of the notice or the adverse action, whichever is later. Please note that close of business means 4:30 PM local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. If you mail your appeal, your appeal will be considered received on the date of receipt and not on the postmarked date.

An administrative law judge (ALJ) will notify you in writing of the date, time and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

How will the appeal impact my benefits?

As a result of your conversion into the new HIP and our determination, you became eligible to receive a certain level of benefits. You will be able to receive HIP Plus benefits while your appeal is pending if you continue making the required monthly POWER account payments. Your appeal does not remove this requirement. If you do not make your required POWER account payment during your appeal, you will lose access to HIP Plus benefits and you may lose your HIP eligibility.

Back payments for HIP POWER account

If you become ineligible for any HIP services and the ALJ rules in your favor, your coverage will be restored back to the date of discontinuance or the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account payments that accrued during your appeal. You will lose HIP eligibility if you do not repay this amount timely.

How to file an appeal

You can mail, fax, or hand deliver your written appeal request.

To appeal, please sign and date the appeal form below or send a letter with your signature, along with a copy of this entire notice if possible. Please choose only one method to file your appeal.

1. Mail your appeal to

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or,

2. Fax your appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

APPEAL FORM

HEALTH COVERAGE UNDER THE HEALTHY INDIANA PLAN

Name: XXXX X XXXXXX

Case Number: 1111111111 MARP 01

Date of Notice: 02/12/15

County: 84

I wish to appeal the action to deny, stop or reduce my benefits. I understand that a fair hearing will be scheduled for me and that I will be able to explain why I disagree with the action taken on my benefits.

Signature

date

My current address: _____

Local Office of Family Resources

VIGO COUNTY DFR
1800 FORT HARRISON RD
SUITE 17
TERRE HAUTE, IN 47804

PHONE: 1-800-403-0864

MASP conditional approval:

Congratulations! You have been conditionally approved for the Healthy Indiana Plan (HIP) State Plan Plus program.

Our records indicate that you are a low-income parent or caretaker of a child under 18 years old. This qualifies you for coverage for additional benefits including vision, dental and non-emergency transportation services as part of HIP State Plan Plus. Your eligibility for these additional benefits may change in the future if you are no longer a low-income parent or caretaker of a child under 18 years old.

Your HIP State Plan Plus health coverage will begin on the first day of the month in which your first monthly POWER account payment is received and processed by your health plan. In a few days, your health plan will send you the bill for your first monthly POWER account payment. If you do not make your payment on time, you risk being placed into the HIP State Plan Basic benefit plan. The sooner you make your payment, the sooner your benefits will begin.

Under HIP State Plan Plus, you will have coverage for comprehensive benefits including vision, dental services, and non-emergency transportation. Other than your monthly POWER account payment, in HIP State Plan Plus you will not be charged anything for visiting the doctor or filling prescriptions. The only other cost associated with getting health care in HIP State Plan Plus is a copayment for visits to the Emergency Room if the health condition is not an emergency.

INFORMATION ABOUT POWER ACCOUNT PAYMENTS

To become fully eligible for HIP Plus, you need to make your first monthly POWER account payment. Your POWER account payment is based on your countable monthly income of \$0.00. Your POWER account contribution is approximately two (2) percent of your income, which requires an annual POWER account obligation of \$12.00. This amount can be paid in monthly installments of \$1.00.

In the HIP program, the first \$2500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The State will pay most of this amount, but you will also be responsible for paying a portion of your initial health care costs. Your portion is paid through an affordable, monthly contribution to your POWER account based on income and could be as low as \$1.

Managing your account well and getting preventive care can reduce your future costs. If your annual health care expenses are less than \$2500 per year, you may rollover your remaining contributions to reduce your monthly payment for the next year. You can also have this reduction doubled if you complete preventive services. Your health plan will inform you what preventive care services are recommended for you. If your annual health care expenses are more than \$2500, the first \$2500 is covered by your POWER account, and expenses for additional health services over \$2500 are fully covered at no additional cost to you.

In HIP, your contributions to your POWER account will be yours, and you could receive a portion back if you leave the program. Since your

contributions are based on a projected annual amount, you may also owe your health plan for any remaining months of enrollment if you leave the program early.

INFORMATION ABOUT ELIGIBILITY AND ENROLLMENT IN THE HEALTHY INDIANA PLAN

Once you have made your initial POWER account payment and you are enrolled in HIP, you are eligible to receive benefits for a period of twelve (12) months. We will redetermine your eligibility annually or during the benefit period when we become aware of a change in your circumstances. Certain changes in circumstances may impact your eligibility for HIP, your level of benefits or your monthly POWER account payment. It is important that you report any change in circumstances during your benefit period.

Changes You Must Report

You must report the following changes in your circumstances within 10 days of when the change occurs:

- You move to a new address or change mailing addresses.
- Your family income or family size changes.
- You lose your job, change jobs or get a new job.
- You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.
- You become insured under other health insurance, either private or Medicare.
- Any other change that you think may affect your eligibility or benefits for HIP.

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfp

Your health plan will specify the due dates in your monthly invoices. If you do not make your monthly POWER account payment, you will be enrolled in HIP State Plan Basic. In HIP State Plan Basic, you will be required to make a payment called a copayment for most health services you receive including doctors' visits, prescriptions and hospital stays. These payments will range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. Contact your health plan if you have questions about making payments and using your POWER account.

If you have questions about this notice please, contact the Family and Social Services Administration at 1-800-403-0864.

IMPORTANT NOTICE: The Affordable Care Act (ACA) expands access to health insurance coverage through improvements to the Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Marketplaces, and the assurance of coordination between Medicaid, CHIP, and the Marketplaces. The ACA also mandates the use of the Modified Adjusted Gross Income (MAGI) financial methodology when determining Medicaid income eligibility for most parents and other caretakers, children and pregnant women. Individuals who are not eligible for Medicaid may be eligible for

health insurance coverage through the Marketplace, including assistance with paying premiums and other cost sharing requirements.

If you disagree with our decision

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. You cannot appeal the change in law that authorized the new HIP requirements and available benefits. We have included in this notice an appeal request form for you to complete and instructions for mailing for your convenience. Please read this information carefully.

Timelines and process for appealing

You must file your appeal in writing by close of business within 33 days of the date of the notice or the adverse action, whichever is later. Please note that close of business means 4:30 PM local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. If you mail your appeal, your appeal will be considered received on the date of receipt and not on the postmarked date.

An administrative law judge (ALJ) will notify you in writing of the date, time and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

How will the appeal impact my benefits?

As a result of your conversion into the new HIP and our determination, you became eligible to receive a certain level of benefits. You will be able to receive HIP Plus benefits while your appeal is pending if you continue making the required monthly POWER account payments. Your appeal does not remove this requirement. If you do not make your required POWER account payment during your appeal, you will lose access to HIP Plus benefits and you may lose your HIP eligibility.

Back payments for HIP POWER account

If you become ineligible for any HIP services and the ALJ rules in your favor, your coverage will be restored back to the date of discontinuance or the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account payments that accrued during your appeal. You will lose HIP eligibility if you do not repay this amount timely.

How to file an appeal

You can mail, fax, or hand deliver your written appeal request.

To appeal, please sign and date the appeal form below or send a letter with your signature, along with a copy of this entire notice if possible. Please choose only one method to file your appeal.

1. Mail your appeal to

FSSA Document Center

PO Box 1810
Marion, IN 46952

Or,

2. Fax your appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

APPEAL FORM

HEALTH COVERAGE UNDER THE HEALTHY INDIANA PLAN

Name: XXXXX X XXXXXX

Case Number: 111111111 MASP 01

Date of Notice: 02/12/15

County: 45

I wish to appeal the action to deny, stop or reduce my benefits. I understand that a fair hearing will be scheduled for me and that I will be able to explain why I disagree with the action taken on my benefits.

Signature

date

My current address: _____

Local Office of Family Resources

LAKE COUNTY DFR
5255 HOHMAN AVE
HAMMOND, IN 46320-1721

PHONE: 1-800-403-0864

Your health coverage under the Healthy Indiana Plan (HIP) Basic program begins on MARCH 01, 2015. You are eligible only for HIP Basic benefits because your health plan did not receive your POWER account contribution to qualify you for HIP Plus benefits. In HIP Basic you do not have coverage for dental and vision benefits and you will be required to make a payment, called a copayment, for most doctors' office visits, hospital stays and prescription drugs. These payments may range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay.

When you are approved for HIP, your enrollment period is 12 months. Your eligibility will be redetermined annually. When the time comes for your annual redetermination, you will have another opportunity to enroll in HIP Plus, which includes vision and dental benefits and requires a monthly POWER account contribution. Unlike HIP Basic, HIP Plus does not require you to make copayments when you visit the doctor, fill a prescription or go to the hospital.

Please contact your health plan if you have questions about:

- What benefits are covered by HIP Basic,
- How much services will cost,
- What preventive services are recommended for you, or
- How to find a doctor.

In the HIP program, the first \$0000 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The State will pay most of this amount, but you will also be responsible for paying a portion of your initial health care costs. Your portion is paid through an affordable, monthly contribution to your POWER account based on income and could be as low as \$1.

Managing your account well and getting preventive care can reduce your future costs. If your annual health care expenses are less than \$0000 per year, you may rollover your remaining contributions to reduce your monthly payment for the next year. You can also have this reduction doubled if you complete preventive services. Your health plan will inform you what preventive care services are recommended for you. If your annual health care expenses are more than \$0000, the first \$0000 is covered by your POWER account, and expenses for additional health services over \$0000 are fully covered at no additional cost to you.

In HIP, your contributions to your POWER account will be yours, and you could receive a portion back if you leave the program. Since your contributions are based on a projected annual amount, you may also owe your health plan for any remaining months of enrollment if you leave the program early.

INFORMATION ABOUT ELIGIBILITY AND ENROLLMENT IN THE HEALTHY INDIANA PLAN

You are eligible to receive benefits for a period of twelve (12) months. We will redetermine your eligibility annually or during the benefit period when we become aware of a change in your circumstances. Certain changes in circumstances may impact your eligibility for HIP, your level

of benefits or your monthly POWER account payment. It is important that you report any change in circumstances during your benefit period.

CHANGES YOU MUST REPORT

You must report the following changes in your circumstances within 10 days of when the change occurs:

- You move to a new address or change mailing addresses.
- Your family income or family size changes.
- You lose your job, change jobs or get a new job.
- You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.
- You become insured under other health insurance, either private or Medicare.
- Any other change that you think may affect your eligibility or benefits for HIP.

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfr

For questions about your eligibility, please contact the Family and Social Services Administration at 1-800-403-0864.

IMPORTANT NOTICE: The Affordable Care Act (ACA) expands access to health insurance coverage through improvements to the Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Marketplaces, and the assurance of coordination between Medicaid, CHIP, and the Marketplaces. The ACA also mandates the use of the Modified Adjusted Gross Income (MAGI) financial methodology when determining Medicaid income eligibility for most parents and other caretakers, children and pregnant women. Individuals who are not eligible for Medicaid may be eligible for health insurance coverage through the Marketplace, including assistance with paying premiums and other cost sharing requirements.

If you disagree with our decision

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. You cannot appeal the change in law that authorized the new HIP requirements and available benefits. This notice includes an appeal request form for you to complete and instructions for mailing for your convenience. Please read this information carefully.

Timelines and process for appealing

You must file your appeal in writing by close of business within thirty-three (33) days of the date of the notice or the adverse action, whichever is later. To continue receiving your current benefits (to the extent they are still available), you must file an appeal within ten (10) days as of the date of this notice as described below. Please note that close of business means 4:30 PM local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal

by the next business day. If you mail your appeal, your appeal will be considered received on the date of receipt and not on the postmarked date.

An administrative law judge (ALJ) will notify you in writing of the date, time and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

How will the appeal impact my benefits?

As indicated in this approval letter, you are eligible to receive a certain level of benefits in the new HIP program. You will be able to continue to receive this level of benefits while your appeal is pending. However, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contributions during your appeal in order to maintain HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you may lose access to HIP Plus or HIP State Plan Plus benefits or you may lose your HIP eligibility.

Can I maintain my previous benefits during the appeal?

As indicated in this notice, you are approved to receive services under the new HIP program. Changes in law may have eliminated your previous health program and its health benefits. If that is the case and you decide to appeal our determination of your eligibility for the new HIP program, you cannot maintain the benefits you received under the previous program as they are no longer available.

However, if your previous health program has not been eliminated as a result of the changes in law, you may be able to maintain either your previous benefits or benefits available under the new HIP program during your appeal.

To receive those benefits, you must file an appeal within 10 (ten) days of the date of this notice. You may request not to maintain your previous benefits by stating so in your appeal request or on the appeal request form. If the ALJ agrees with the agency, you may be responsible for repaying any benefits you received during your appeal under your previous coverage.

Back payments for HIP POWER account

If you become ineligible for any HIP services during your appeal and the ALJ rules in your favor, your coverage will be restored back to the date of discontinuance or the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account payments that accrued during your appeal. You will lose HIP eligibility or access to HIP Plus benefits if you do not repay this entire amount timely.

How to file an appeal

You can mail, fax, or hand deliver your written appeal request.

To appeal, please sign and date the appeal form below or send a letter with your signature, along with a copy of this entire notice if possible. Please choose only one method to file your appeal.

1. Mail your appeal to

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or,

2. Fax your appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

APPEAL FORM

HEALTH COVERAGE UNDER THE HEALTHY INDIANA PLAN

Name: XXXX X XXXXXX

Case Number: 1111111111 MARB 03

Date of Notice: 02/09/15

County: 02

I wish to appeal the action to deny, stop or reduce my benefits. I understand that a fair hearing will be scheduled for me and that I will be able to explain why I disagree with the action taken on my benefits.

Signature

date

My current address: _____

Local Office of Family Resources

ALLEN COUNTY DFR
201 E. RUDISILL BLVD.
SUITE 302
FORT WAYNE, IN 46806

PHONE: 1-800-403-0864

MARP Approval notice:

Congratulations! You have now been enrolled in the Healthy Indiana Plan (HIP) Plus. Your health plan has received your first contribution to your POWER account. Your health coverage under the HIP Plus program begins on FEBRUARY 01, 2015.

As long as you continue to make your monthly POWER account contributions, you will continue in the HIP Plus program. HIP Plus gives you coverage for comprehensive benefits including vision and dental services.

Under HIP Plus, you will have coverage for comprehensive benefits including vision and dental services. Other than your monthly POWER account payment, in HIP Plus you will not be charged anything for visiting the doctor or filling prescriptions. The only other cost associated with getting health care in HIP Plus is a copayment for visits to the emergency room if the health condition is not an emergency. Contacting your health plan before visiting the emergency room may eliminate this payment.

You must continue making timely monthly POWER account payments. You will be disenrolled from HIP and not be allowed to reenroll for a period of six (6) months if you do not make your monthly POWER account payment on time or if you withdraw from the program. This reenrollment lock-out will not apply if you are medically frail, residing in a domestic violence shelter or in a state declared disaster area. Your health plan will specify the due dates on your monthly invoices. Contact your health plan if you have questions about making payments and using your POWER account.

In the HIP program, the first \$2500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The State will pay most of this amount, but you will also be responsible for paying a portion of your initial health care costs. Your portion is paid through an affordable, monthly contribution to your POWER account based on income and could be as low as \$1.

Managing your account well and getting preventive care can reduce your future costs. If your annual health care expenses are less than \$2500 per year, you may rollover your remaining contributions to reduce your monthly payment for the next year. You can also have this reduction doubled if you complete preventive services. Your health plan will inform you what preventive care services are recommended for you. If your annual health care expenses are more than \$2500, the first \$2500 is covered by your POWER account, and expenses for additional health services over \$2500 are fully covered at no additional cost to you.

In HIP, your contributions to your POWER account will be yours, and you could receive a portion back if you leave the program. Since your contributions are based on a projected annual amount, you may also owe your health plan for any remaining months of enrollment if you leave the program early.

INFORMATION ABOUT ELIGIBILITY AND ENROLLMENT IN THE HEALTHY INDIANA PLAN

You are eligible to receive benefits for a period of twelve (12) months. We will redetermine your eligibility annually or during the benefit period when we become aware of a change in your circumstances. Certain

changes in circumstances may impact your eligibility for HIP, your level of benefits or your monthly POWER account payment. It is important that you report any change in circumstances during your benefit period.

CHANGES YOU MUST REPORT

You must report the following changes in your circumstances within 10 days of when the change occurs:

- You move to a new address or change mailing addresses.
- Your family income or family size changes.
- You lose your job, change jobs or get a new job.
- You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.
- You become insured under other health insurance, either private or Medicare.
- Any other change that you think may affect your eligibility or benefits for HIP.

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfr

For questions about your eligibility, please contact the Family and Social Services Administration at 1-800-403-0864.

IMPORTANT NOTICE: The Affordable Care Act (ACA) expands access to health insurance coverage through improvements to the Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Marketplaces, and the assurance of coordination between Medicaid, CHIP, and the Marketplaces. The ACA also mandates the use of the Modified Adjusted Gross Income (MAGI) financial methodology when determining Medicaid income eligibility for most parents and other caretakers, children and pregnant women. Individuals who are not eligible for Medicaid may be eligible for

health insurance coverage through the Marketplace, including assistance with paying premiums and other cost sharing requirements.

If you disagree with our decision

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. You cannot appeal the change in law that authorized the new HIP requirements and available benefits. This notice includes an appeal request form for you to complete and instructions for mailing for your convenience. Please read this information carefully.

Timelines and process for appealing

You must file your appeal in writing by close of business within thirty-three (33) days of the date of the notice or the adverse action, whichever is later. To continue receiving your current benefits (to the extent they are still available), you must file an appeal within ten (10) days as of the date of this notice as described below. Please note that

close of business means 4:30 PM local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. If you mail your appeal, your appeal will be considered received on the date of receipt and not on the postmarked date.

An administrative law judge (ALJ) will notify you in writing of the date, time and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

How will the appeal impact my benefits?

As indicated in this approval letter, you are eligible to receive a certain level of benefits in the new HIP program. You will be able to continue to receive this level of benefits while your appeal is pending. However, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contributions during your appeal in order to maintain HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you may lose access to HIP Plus or HIP State Plan Plus benefits or you may lose your HIP eligibility.

Can I maintain my previous benefits during the appeal?

As indicated in this notice, you are approved to receive services under the new HIP program. Changes in law may have eliminated your previous health program and its health benefits. If that is the case and you decide to appeal our determination of your eligibility for the new HIP program, you cannot maintain the benefits you received under the previous program as they are no longer available.

However, if your previous health program has not been eliminated as a result of the changes in law, you may be able to maintain either your previous benefits or benefits available under the new HIP program during your appeal.

To receive those benefits, you must file an appeal within 10 (ten) days of the date of this notice. You may request not to maintain your previous benefits by stating so in your appeal request or on the appeal request form. If the ALJ agrees with the agency, you may be responsible for repaying any benefits you received during your appeal under your previous coverage.

Back payments for HIP POWER account

If you become ineligible for any HIP services during your appeal and the ALJ rules in your favor, your coverage will be restored back to the date of discontinuance or the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account payments that accrued during your appeal. You will lose HIP eligibility or access to HIP Plus benefits if you do not repay this entire amount timely.

How to file an appeal

You can mail, fax, or hand deliver your written appeal request.

To appeal, please sign and date the appeal form below or send a letter with your signature, along with a copy of this entire notice if possible. Please choose only one method to file your appeal.

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Marion, IN 46952

Or,

2. Fax your appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

APPEAL FORM

HEALTH COVERAGE UNDER THE HEALTHY INDIANA PLAN

Name: XXXXX X XXXXXXXX

Case Number: 1111111111 MARP 01

Date of Notice: 02/09/15

County: 10

I wish to appeal the action to deny, stop or reduce my benefits. I understand that a fair hearing will be scheduled for me and that I will be able to explain why I disagree with the action taken on my benefits.

Signature

date

My current address: _____

Local Office of Family Resources

CLARK COUNTY DFR
1021 YOUNGSTOWN
SHOPPING CENTER
JEFFERSONVILLE, IN 47130

PHONE: 1-800-403-0864

MASP Approval notice:

Congratulations! You have now been enrolled in the Healthy Indiana Plan (HIP) State Plan Plus. Your health plan has received your first contribution to your POWER account. Your health coverage under the HIP State Plan Plus program begins on FEBRUARY 01, 2015.

As long as you continue to make your monthly POWER account contributions, you will continue in the HIP State Plan Plus program.

If you stop paying your monthly POWER account payment, you will be enrolled in HIP State Plan Basic. In HIP State Plan Basic, you will be required to make a payment called a copayment for most health services you receive including doctors' visits, prescriptions and hospital stays. These payments may range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. Contact your health plan if you have questions about making payments and using your POWER account.

Please contact your health plan if you have questions about:

- What benefits are covered by HIP State Plan Plus,
- What preventive services are recommended for you, or
- How to find a doctor.

Under HIP State Plan Plus, you will have coverage for comprehensive benefits including vision, dental services, and non-emergency transportation. Other than your monthly POWER account payment, in HIP State Plan Plus you will not be charged anything for visiting the doctor or filling prescriptions. The only other cost associated with getting health care in HIP State Plan Plus is a copayment for visits to the emergency room if the health condition is not an emergency. Contacting your health plan before visiting the emergency room may eliminate this payment.

In the HIP program, the first \$2500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The State will pay most of this amount, but you will also be responsible for paying a portion of your initial health care costs. Your portion is paid through an affordable, monthly contribution to your POWER account based on income and could be as low as \$1.

Managing your account well and getting preventive care can reduce your future costs. If your annual health care expenses are less than \$2500 per year, you may rollover your remaining contributions to reduce your monthly payment for the next year. You can also have this reduction doubled if you complete preventive services. Your health plan will inform you what preventive care services are recommended for you. If your annual health care expenses are more than \$2500, the first \$2500 is covered by your POWER account, and expenses for additional health services over \$2500 are fully covered at no additional cost to you.

In HIP, your contributions to your POWER account will be yours, and you could receive a portion back if you leave the program. Since your contributions are based on a projected annual amount, you may also owe your health plan for any remaining months of enrollment if you leave the program

early.

INFORMATION ABOUT ELIGIBILITY AND ENROLLMENT IN THE HEALTHY INDIANA PLAN

You are eligible to receive benefits for a period of twelve (12) months. We will redetermine your eligibility annually or during the benefit period when we become aware of a change in your circumstances. Certain changes in circumstances may impact your eligibility for HIP, your level of benefits or your monthly POWER account payment. It is important that you report any change in circumstances during your benefit period.

CHANGES YOU MUST REPORT

You must report the following changes in your circumstances within 10 days of when the change occurs:

- You move to a new address or change mailing addresses.
- Your family income or family size changes.
- You lose your job, change jobs or get a new job.
- You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.
- You become insured under other health insurance, either private or Medicare.
- Any other change that you think may affect your eligibility or benefits for HIP.

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfr

For questions about your eligibility, please contact the Family and Social Services Administration at 1-800-403-0864.

IMPORTANT NOTICE: The Affordable Care Act (ACA) expands access to health insurance coverage through improvements to the Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Marketplaces, and the assurance of coordination between Medicaid, CHIP, and the Marketplaces. The ACA also mandates the use of the Modified Adjusted Gross Income (MAGI) financial methodology when determining Medicaid income eligibility for most parents and other caretakers, children and pregnant women. Individuals who are not eligible for Medicaid may be eligible for health insurance coverage through the Marketplace, including assistance with paying premiums and other cost sharing requirements.

If you disagree with our decision

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. You cannot appeal the change in law that authorized the new HIP requirements and available benefits. This notice includes an appeal request form for you to complete and instructions for mailing for your convenience. Please read this information carefully.

Timelines and process for appealing

You must file your appeal in writing by close of business within thirty-three (33) days of the date of the notice or the adverse action, whichever is later. To continue receiving your current benefits (to the extent they are still available), you must file an appeal within ten (10) days as of the date of this notice as described below. Please note that close of business means 4:30 PM local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. If you mail your appeal, your appeal will be considered received on the date of receipt and not on the postmarked date.

An administrative law judge (ALJ) will notify you in writing of the date, time and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

How will the appeal impact my benefits?

As indicated in this approval letter, you are eligible to receive a certain level of benefits in the new HIP program. You will be able to continue to receive this level of benefits while your appeal is pending. However, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contributions during your appeal in order to maintain HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you may lose access to HIP Plus or HIP State Plan Plus benefits or you may lose your HIP eligibility.

Can I maintain my previous benefits during the appeal?

As indicated in this notice, you are approved to receive services under the new HIP program. Changes in law may have eliminated your previous health program and its health benefits. If that is the case and you decide to appeal our determination of your eligibility for the new HIP program, you cannot maintain the benefits you received under the previous program as they are no longer available.

However, if your previous health program has not been eliminated as a result of the changes in law, you may be able to maintain either your previous benefits or benefits available under the new HIP program during your appeal.

To receive those benefits, you must file an appeal within 10 (ten) days of the date of this notice. You may request not to maintain your previous benefits by stating so in your appeal request or on the appeal request form. If the ALJ agrees with the agency, you may be responsible for repaying any benefits you received during your appeal under your previous coverage.

Back payments for HIP POWER account

If you become ineligible for any HIP services during your appeal and the ALJ rules in your favor, your coverage will be restored back to the date of discontinuance or the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account payments that accrued during your appeal. You will lose HIP eligibility or access to HIP Plus benefits if you do not repay this entire amount timely.

How to file an appeal

You can mail, fax, or hand deliver your written appeal request.

To appeal, please sign and date the appeal form below or send a letter with your signature, along with a copy of this entire notice if possible. Please choose only one method to file your appeal.

1. Mail your appeal to

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or,

2. Fax your appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

APPEAL FORM

HEALTH COVERAGE UNDER THE HEALTHY INDIANA PLAN

Name: XXXXX X XXXXXX

Case Number: 1111111111 MASP 01

Date of Notice: 02/13/15

County: 82

I wish to appeal the action to deny, stop or reduce my benefits. I understand that a fair hearing will be scheduled for me and that I will be able to explain why I disagree with the action taken on my benefits.

Signature

date

My current address: _____

Local Office of Family Resources

VANDERBURGH COUNTY DFR
711 JOHN STREET, SUITE C
EVANSVILLE, IN 47713

PHONE: 1-800-403-0864

Enclosure 3: HIP Educational Language

#	Topic	Proposed Standard Language
1.	HIP 2.0	<p>In the Healthy Indiana Plan (HIP), the first \$2,500 of medical expenses for covered benefits are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The state will contribute most of this amount, but you will also be responsible for making a small contribution to your account each month. The amount of your contribution amount is based on your income.</p> <p>Managing your account well and getting preventive care can reduce your future costs. If your annual health care expenses are less than \$2,500 per year, you may roll over your remaining contributions to reduce your monthly payment for the next year. You can also have this reduction doubled if you complete preventive services. Your health plan will let you know what preventive care services are recommended for you. If your annual health care expenses are more than \$2,500, the first \$2,500 is covered by your POWER account, and expenses for additional health services over \$2,500 are fully covered at no additional cost to you (unless you are in the HIP Basic program and are responsible for any copayments).</p> <p>In HIP, your contributions to your POWER account will be yours, and you could receive a portion back if you leave the program.</p>
2.	HIP 2.0 POWER Account-Alternative	<p>Part of the money you contribute to your POWER account will be used to pay each medical claim for the first \$2,500 of your medical bills. If your annual health care costs are more than \$2,500, and you use your POWER account entirely, additional covered health services over \$2,500 are fully covered at no additional cost to you (unless you are in the HIP Basic program and are responsible for any copayments).</p> <p>You are responsible for managing your entire POWER account, including the money contributed by the state. Your contributions to your POWER account will be yours. If there is money left in the account at the end of the year, you can use this money to lower what you owe if you continue in the HIP program for another year.</p> <p>[SEE ROLLOVER LANGUAGE #17 &#18]</p>

3.	HIP Plus	<p>HIP Plus is the preferred plan for all HIP members. HIP Plus provides the best value coverage and includes vision and dental services. In HIP Plus, members pay affordable monthly contributions of approximately 2 percent of income and do not pay any other costs or copayments unless they visit the emergency room when they don't have an emergency health condition. Members who don't pay or miss their monthly POWER contribution will lose their HIP Plus coverage. In most cases, members that lose HIP Plus coverage won't be able to get HIP Plus again until the end of their 12 month enrollment period. HIP Basic members that qualify for rollover will have an extra option to get the better HIP Plus benefits.</p>
4.	HIP Basic	<p>HIP members who do not pay their monthly POWER account contributions are disenrolled from HIP Plus. Those with incomes of \$973 or less per month for an individual or \$1,988 or less per month for a family of four will receive HIP Basic benefits. HIP Basic benefits provide coverage for all required services but are more limited and do not provide vision or dental coverage along with some other benefits. In HIP Basic, you have to make a payment every time you receive a health care service, such as going to the doctor, filling a prescription and staying in the hospital. These payments may range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. HIP Basic can be much more expensive than HIP Plus.</p>
5.	HIP Plus Cost Sharing	<p>The HIP Plus program provides health coverage for a low, predictable monthly cost. HIP Plus allows you to make a monthly contribution to your POWER account based on your income. If both you and your spouse are enrolled in HIP Plus, the monthly contribution amount will be shared between the two of you.</p> <p>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.</p>
6.	HIP Basic Cost Sharing	<p>If you do NOT make your POWER account contribution and your income is under \$973 per month for an individual or \$1,988 per month for a family of four, you will LOSE HIP Plus benefits and MOVE to HIP Basic. In HIP Basic, you will be responsible for making a payment every time you receive a health care service including doctors' visits, hospital stays or prescription drugs. This is called a "copayment." These payments will range from \$4 to \$8 per physician service or prescription filled and may be as high as \$75 per hospital stay. In HIP Basic, you will be billed a copayment for most health services, so the HIP Basic</p>

7.	HIP Plus Benefits	<p>plan could cost more than paying the HIP Plus monthly POWER account contribution.</p> <p>HIP Plus provides MORE benefits including vision and dental services. HIP Plus gives more visits for physical, speech and occupational therapists than the HIP Basic program, and coverage for additional services like bariatric surgery and Temporomandibular Joint Disorders (TMJ) treatments are included. With HIP Plus you can get 90 day refills on prescriptions you take every day and receive medication by mail order. You will also benefit from additional medication therapy management services that are available in HIP Basic.</p>
8.	HIP Basic Benefits	<p>HIP Basic provides coverage for minimum services but does not cover everything that Plus covers. HIP Basic does not provide coverage for vision or dental services, bariatric surgery or Temporomandibular Joint Disorders (TMJ). HIP Basic benefits also allow for fewer visits to physical, speech and occupational therapists. Unlike HIP Plus, HIP Basic has more limited options for getting medication and you are limited to a 30 day supply and cannot have mail order medications delivered. HIP Basic also does not provide additional medication therapy management services. These services are only available in HIP Plus through paying your POWER account contribution.</p>
9.	HIP State Plan Benefits	<p>The HIP State Plan Plus gives you a different set of benefits that work best for your situation or medical condition for a low, predictable monthly cost. HIP State Plan Plus allows you to receive these benefits by making a monthly contribution to your POWER account based on your income. If both you and your spouse are enrolled in HIP Plus, the monthly contribution amount will be shared between the two of you.</p> <p>HIP State Plan 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.</p> <p>If you do NOT make your POWER account contribution you will not receive HIP State Plan Plus benefits. If your income is at or below \$973 per month for an individual or \$1,988 per month for a family of four, you will still have access to the same HIP State Plan benefits in HIP State Plan Plus but you will be responsible for making a payment every time you receive a health care service including doctors' visits, hospital stays or prescription drugs. This is called a "copayment." These payments will range from \$4 to \$8 per physician</p>

		<p>service or prescription filled and may be as high as \$75 per hospital stay. You will be billed a copayment for most health services, so the HIP Basic plan could cost more than paying the HIP Plus monthly POWER account contribution. You will still have access to the same HIP State Plan benefits but there will be a cost to you each time you seek the benefits.</p>
10.	Potential Plus for Under 100% FPL	<p>To become fully eligible for HIP Plus, you need to make your first monthly POWER account payment. Your POWER account payment is based on your income and payment is required each month. If you do not make your first POWER account payment, and your income is at or below \$973 per month for an individual or \$1,988 per month for a family of four, you will be enrolled in HIP Basic. You can start coverage sooner if you make your payment. In HIP Basic, you will not have enhanced coverage for vision or dental benefits and will be required to make a payment called a copayment for most health services you receive including doctors' visits, prescriptions and hospital stays. These payments will range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay. Contact your health plan if you have questions about making payments and using your POWER account.</p>
11.	POWER Account Intro	<p>In the HIP program, the first \$2,500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The state will contribute most of this amount, but you will also be responsible for making a small contribution to your account each month. The amount of your contribution amount is based on your income.</p>
12.	POWER Account Contributions	<p>Your HIP Plus coverage begins the first of the month in which you pay your first POWER account contribution. For example, if you pay your contribution in January your coverage starts in January.</p> <p>To keep your HIP Plus benefits active, you need to continue to make your monthly contribution on time. Paying your HIP Plus contribution each month means that when you go to the doctor, fill a prescription or go to the hospital, HIP Plus will cover the full cost of your health care. With HIP Plus, as long as you do not use the emergency room when you do not have an emergency health condition, your monthly contribution is your only health care cost.</p> <p>Your employer and not-for-profit organizations, like a church or foundation, can help you pay your contribution.</p>
13.	POWER Account	<p>When you pay your monthly POWER account contribution, it is deposited into your</p>

	Functionality Plus	POWER account. The money in this account will pay for the first \$2,500 in covered health care you receive. You will receive monthly statements that show you how much money you have remaining in your Power account. If you manage your health and your POWER account wisely, you may have money left in your account after 12 months that can be used to lower your contributions for the next year of coverage. Every 12 months, you will get a new \$2,500 POWER account to pay for HIP covered medical expenses. If you have money left after 12 months, your cost to continue in HIP may be reduced.
14.	Plus Lockout Over 100%	If you do not pay your POWER account contribution on time you will be disenrolled from HIP Plus coverage and will not be able to reenroll for six months. This reenrollment lock-out will not apply if you are medically frail, residing in a domestic violence shelter or in a state declared disaster area.
15.	Plus Lockout Under 100%	If you do not pay your POWER account contribution on time you will be disenrolled from HIP Plus coverage and will not be able to reenroll in HIP Plus until your next regularly scheduled annual redetermination period. During this time that you are ineligible for HIP Plus, you will can only receive HIP Basic benefits. HIP Basic does not provide coverage for vision or dental services, bariatric surgery or Temporomandibular Joint Disorders (TMJ). HIP Basic benefits also allow for fewer visits to physical, speech and occupational therapists. Unlike HIP Plus, HIP Basic has more limited options for getting medication and you are limited to a 30 day supply and cannot have mail order medications delivered. HIP Basic also does not provide additional medication therapy management services. These services are only available in HIP Plus through paying your POWER account contribution
		In HIP Basic, you will also be responsible for making a payment every time you receive a health care service including doctors' visits, hospital stays or prescription drugs. This is called a copayment. These payments will range from \$4 to \$8 per physician service or prescription filled and may be as high as \$75 per hospital stay. In HIP Basic, you will be billed a copayment for most health services, so the HIP Basic plan could cost more than paying the HIP Plus monthly POWER account contribution.
		Making your POWER account contribution on time each month means that you receive the best benefits and will not have to pay each time you receive a covered health service.
16.	POWER Account Functionality Basic	Your HIP Basic coverage gives you a POWER account that pays for the first \$2,500 in health care you receive. The POWER account cannot be used to pay the copayments you must make at a doctor's office, pharmacy or hospital. When you need health care you will pay

your copayment to the health care provider and then the funds in the POWER account will be used to pay for any balance, up to \$2,500. All covered benefits over \$2,500 will be fully paid for, but you are responsible for making your required copayment to the doctor or pharmacy.

After 12 months in HIP, you will be able to enroll in HIP Plus by paying your monthly contribution. If you manage your health and your POWER account wisely, you may have money left in your account after 12 months. If you have money left over and complete your recommended preventive care, including your annual wellness exam, you can reduce the amount of your HIP Plus POWER account contribution.

HIP Plus is cheaper and has more benefits. Enrolling in HIP Plus would mean you do not have to pay a copayment each time you visit the doctor, fill a prescription or go to the hospital.

As long as you remain HIP eligible, every 12 months you will get a new \$2,500 POWER account to help pay for your HIP covered services.

17. Rollover Plus

If you have money left over in your POWER account after 12 months then the amount of your monthly POWER account contribution can be reduced in the future. For example if half (50 percent) of your POWER account remains after 12 months, then you can get a 50 percent reduction in your required contribution in the future. If you complete the preventive services recommended for you by your health plan then the reduction to your required contribution is doubled. For example, if half (50 percent) of your POWER account remains after 12 months, and you receive your recommended preventive services you could eliminate your required contribution.

Since it can take up to four months for your doctors and your health plan to settle all payments from the POWER account these reductions will be available to you in the fifth month of your next 12 month period of HIP enrollment.

18. Rollover Basic

If you are in the HIP Basic program you will have the opportunity to enroll in HIP Plus at the end of your 12 month enrollment period by starting to pay the required POWER account contributions. If you have money remaining in your POWER account after 12 months *and* you receive your recommended preventive services you can enroll in HIP Plus with a reduced monthly POWER account contribution. You can reduce the cost of future

		<p>enrollment in HIP Plus by up to 50 percent. For example if three quarters (75 percent) of your POWER account remains after 12 months <i>and</i> you receive your recommended preventive services then you can get a 50 percent reduction on your HIP Plus contribution amount.</p> <p>Since it can take up to four months for your doctors and your health plan to settle all payments from the POWER account, these reductions will be available to you in month five (5) of your next twelve (12) month HIP enrollment period. This means that if you qualify, you will be given a chance to enroll in HIP Plus at that time.</p>
19.	Copay for Non-Emergency Use of the ER	<p>If you choose to use the emergency room when you do not have an emergency health condition you will have to pay a copayment. The first time you use the emergency room when you do not have an emergency health condition this copayment will be \$8. After the first time, you will have to pay \$25 every time you use the emergency room when the health condition is not an emergency. If you call the 24hour nurse helpline and are told to go to the emergency room then you will not be responsible for making any copayment.</p>
20.	Redeterminations Plus	<p>When you enroll in HIP you are eligible for 12 months. Seventy-five days before the end of your 12 month enrollment period the state will begin a process to see if you are still eligible for HIP. If there is not enough information available to the state to determine if you remain eligible for HIP Plus you will receive a request for additional information. You must complete and return the requested information to remain eligible.</p>
21.	Redeterminations Basic	<p>When you enroll in HIP you are eligible for 12 months. Seventy-five days before the end of your 12 month enrollment period the State will begin a process to see if you are still eligible for HIP. After 12 months of enrollment you will have the opportunity change from HIP Basic to HIP Plus by paying a required contribution to your POWER account.</p>
22.	Reporting changes	<p>During your HIP enrollment period you are required to report changes in your circumstances. You must report the following changes in your circumstances within 10 days of when the change occurs:</p> <ul style="list-style-type: none"> - You move to a new address or change mailing addresses. - Your family income or family size changes. - You lose your job, change jobs or get a new job. - You become pregnant. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.

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- You become insured under other health insurance, either private or Medicare.
 - Any other change that you think may affect your eligibility or benefits for HIP.

If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfc

23. Medically Frail - qualifying

Individuals with complex medical or behavioral health conditions, called ‘medically frail’ are eligible to receive a benefit package called the “State Plan,” which is more appropriate for their health care conditions. Please contact your health plan or go online to <http://www.in.gov/fssa/hip/> for information on these additional benefits.

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.

Your access to the State Plan is temporary while your health plan confirms your status as medically frail. If your health plan confirms your status as medically frail, you will continue receiving State Plan benefits. If your health plan does not confirm your status as medically frail, you will no longer receive this package. You must make your first POWER account payment in order to access HIP State Plan Plus benefits.

You must contact us in order to confirm your health condition. If your health condition cannot be confirmed, you will still receive full benefits including coverage for vision and dental through HIP Plus, as long as you continue to make your monthly POWER account payment. However, the HIP State Plan benefits will not be available to you.

24. Medically Frail – not frail You recently reported that you may be medically frail. 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.

Your health condition cannot be confirmed at this time. You will still receive full benefits through the HIP program but will no longer receive additional benefits only available to individuals that are medically frail.

If you have additional information that confirms your medically frail status, or questions about the benefits you will be receiving please contact us at XXXXX. If you disagree with our decision, you may contact us for reconsideration.

25. Pregnant – Basic move to MAGP at Redet Because you are pregnant, you are eligible for HIP Maternity benefits effective XXXX. With HIP Maternity you are guaranteed additional benefits including non-emergency transportation services to medical appointments.

While covered under HIP Maternity you will not be responsible for any copayments when you receive health care services. These copayments will be suspended for the remainder of your pregnancy.

At the completion of your pregnancy, you will be given an additional 60 days of post-partum coverage without any copayments or required contributions. However, you must report the end of your pregnancy to the Division of Family Resources as soon as possible so that, upon the end of your post-partum period, so your regular HIP benefits may be started again. If you do not report the end of your pregnancy, you may face a gap in coverage at the end of your post-partum coverage and you may need to reapply.

26.	Pregnant – Plus to MAGP at Redet	<p>Because you are pregnant, your health coverage will change from Healthy Indiana Plan (HIP) Plus to HIP Maternity effective XXXX. With HIP Maternity you will receive additional benefits including non-emergency transportation services to medical appointments.</p> <p>While covered under HIP Maternity, you no longer have a monthly required contribution to your POWER account. This contribution will be suspended for the remainder of your pregnancy.</p> <p>At the end of your pregnancy, you will receive an additional 60 days of post-partum coverage. At the conclusion of your 60 day post-partum period, you will be reenrolled in HIP Plus without a gap in coverage as long as you:</p> <ul style="list-style-type: none"> • Report the end of your pregnancy to the Family and Social Services Administration by calling 1-800-403-0864 within ten (10) days after the pregnancy ends; and • Make your required POWER account contribution prior to the end of the post-partum period. • Once reenrolled in HIP Plus, you will need to resume making your monthly POWER account contributions. <p>If you do not take the above actions, you may face a gap in coverage at the end of your post-partum coverage and you may need to reapply.</p>
27.	Pregnant women to HIP Plus over 100% FPL after 60 day post-partum period	<p>You may continue your Healthy Indiana Plan (HIP) benefits for comprehensive coverage under HIP Plus.</p> <p>To continue your benefits with the HIP Plus program, you will need to start making your required contribution to your POWER account after your pregnancy has ended. You will receive a bill for the contribution amount. If you make the required contribution to your POWER account by the due date indicated on the bill you will have continued enrollment in HIP Plus. If you do not make this payment on time, your HIP Plus benefits will end, and you may not be allowed to re-enroll in the program for six months.</p>
28.	Pregnant women to HIP Plus under 100% FPL after 60 day post-partum period	<p>You may continue your Healthy Indiana Plan (HIP) benefits and receive comprehensive coverage under HIP Plus. HIP Plus includes vision and dental benefits and only requires a monthly POWER account contribution.</p> <p>To continue eligibility in HIP Plus, you will need to start making your required contribution to your POWER account. You will receive a bill for this contribution amount. If you make</p>

		<p>the required contribution to your POWER account by the due date indicated on the bill you will have continued enrollment in HIP Plus. In HIP Plus, your costs are predictable monthly amount, and you do not have copayments when you visit the doctor or fill a prescription. If you do not make this payment, your HIP Plus benefits will end and you will be moved to the HIP Basic plan where you will not have coverage for vision and dental services and will have required copayments ranging from \$4 to \$8 for most health services and prescriptions to up to \$75 for hospital stays. The HIP Plus plan is typically more cost effective than HIP Basic.</p>
29.	Pregnant woman: stays in HIP Basic	<p>Coverage during your pregnancy or post-partum period provides additional benefits like vision and dental coverage and non-emergency transportation services to medical appointments.</p> <p>You will no longer be asked to make copayments when you visit the doctor, go to the hospital or fill a prescription. These required copayments will be suspended for the remainder of your pregnancy and during the 60 day post-partum period. You must report the end of your pregnancy to the Family and Social Services Administration within ten (10) days of the pregnancy ending so that, upon the end of your post-partum period, your HIP coverage may continue without interruption. You can report this change by calling 1-800-403-0864.</p>
30.	5% cost-sharing max	<p>HIP members' healthcare expenses are limited to 5 percent of their family income each benefit quarter. Your health plan will be tracking your contributions. However, if you feel that you have paid more than 5 percent of your family's income for the quarter on healthcare, please contact us immediately at XXXXX.</p>
31.	5% cost-sharing max met	<p>HIP members' healthcare expenses are limited to 5 percent of their family income each quarter. We have confirmed that you have met your 5 percent maximum expense limit for the quarter. Effective XXXXX you will have no further [choose: POWER Account contributions/co-payments] for the remainder of the quarter. Your costs will be reinstated at the beginning of the following quarter as normal.</p>
32.	Plan Transfer Conditional Period	<p>Once you are found eligible for HIP you may change your health plan at any point before you pay your first POWER account contribution. For more information about available health plans or to change your plan call 1-877-GET-HIP-9 (1-877-438-4479).</p>

33.	Plan Transfer HPE Period (Initial)	You selected or were assigned a health plan when your temporary coverage began. You may change your plan at any point during your temporary coverage up until you make your first POWER account contribution. For more information about available health plans or to change your plan, call 1-877-GET-HIP-9 (1-877-438-4479).
34.	Plan Transfer HPE Period (Fast Track)	You selected or were assigned a health plan when your temporary coverage began. You were sent a fast track enrollment invoice to expedite your enrollment process in HIP in the event you are found eligible. You may change your plan at any point prior to paying this fast track enrollment invoice. For more information about available health plans or to change your plan, call 1-877-GET-HIP-9 (1-877-438-4479).
35.	Plan Transfer Post Enrollment	<p>Once you have paid your first POWER account contribution and your HIP coverage has begun, you must stay with your current health plan for a period of 12 months unless you have special circumstances and have exhausted your health plan’s internal grievance procedures. Special circumstances that may qualify you for a plan transfer after you pay your initial POWER account contribution include:</p> <ul style="list-style-type: none"> • You lack access to medically necessary covered services available in your HIP benefit plan. This could mean that the service is not available through your health plan’s network, that access to a particular drug or medication is not available through your health plan’s formulary; or that you have other issues with accessing health care providers. • Your health plan does not, for moral or religious objections, cover a service that you need. • You need different services performed at the same time and they are not all available in your health plan’s network and receiving the services separately would cause unnecessary risk. • You cannot access health care providers experienced in dealing with your health care needs. • You receive poor quality of care. Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers. • Your primary care physician is no longer covered by your MCE’s network and the MCE cannot provide a new primary care physician suitable to your needs. The location of the new primary care physician may be a suitable reason.

If one of these situations applies to you, you may contact 1-877-GET-HIP-9 (1-877-438-

4479) for more information about available health plans or how to change you plan. You may only change your plan during your benefit period if you have exhausted your health plans internal grievance procedures and your transfer is approved by the State. If your transfer request is not approved by the State you will have the right to appeal this decision.

HIP Basic Copay Table

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