Answers to questions were provided by Matthew Cesnik, Eligibility Director at Indiana Family and Social Services Administration, Office of Medicaid Policy & Planning. For more information and updates about HIP 2.0, please visit www.HIP.IN.gov or www.indianapca.org/?page=OEHIP2HUB.
1. **Who is eligible for HIP 2.0?**

   Indiana residents ages 19 and 64 with income below ~138% FPL may be eligible for the Healthy Indiana Plan (HIP). These individuals cannot be eligible for Medicare or any other Medicaid categories. HIP 2.0 also provides coverage for individuals previously enrolled in Family Planning services, HIP 1.0, and Hoosier Healthwise members (low-income parents and caretakers, low-income 19- and 20-year-olds, and individuals receiving transitional medical assistance).

2. **What are the income limits for HIP 2.0 applicants?**

<table>
<thead>
<tr>
<th>Household Size</th>
<th>HIP Basic (Income up to 100% FPL)</th>
<th>HIP Plus (Income up to ~138% FPL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$981</td>
<td>$1,370.25</td>
</tr>
<tr>
<td>2</td>
<td>$1,328</td>
<td>$1,854.30</td>
</tr>
<tr>
<td>3</td>
<td>$1,675</td>
<td>$2,338.35</td>
</tr>
<tr>
<td>4</td>
<td>$2,021</td>
<td>$2,822.40</td>
</tr>
</tbody>
</table>

3. **What are the HIP 2.0 Plan options?**

   Please see this [chart](#) developed by the State which compares the different HIP 2.0 options. Additionally, this brochure in [English](#) and [Spanish](#) provides a general overview of the program.

4. **What is a POWER Account?**

   In the HIP program, the first $2,500 of covered medical expenses is paid out of a special savings account called a Personal Wellness and Responsibility (POWER) Account. This state will pay most of this amount; however, HIP Plus members are required to make a small contribution each month. Typically, Plus members will pay approximately 2% of household income; Basic members cannot use their POWER Accounts for copayments. See this [infographic](#) for more information.

5. **Will there be any funding provided to community non-profits to assist with HIP education and enrollment?**

   At this point, FSSA is directing their efforts at the state level. No funding is currently available for community organizations. The state plans on launching a marketing campaign in June 2015.

6. **If a consumer has State Plan Basic, will he or she owe separate copays for each service rendered in a day? For example, if a patient saw their PMP, received lab services, and had an x-ray would the charges total $12?**

   No, if the member received all three services in their PMP’s office, then he or she would just be charged $4 for the visit. Please view this [IHCP bulletin](#) (BT201524) for clarification on HIP Basic copayments.

7. **How should a federally qualified health center (FQHC) manage failure to pay copayments for HIP Basic or HIP State Plan Basic members?**

   This issue is up to the individual provider. Indiana Medicaid requires that services cannot be refused if a patient is below 100% of the federal poverty level (FPL).
8. **What is considered the household for Medicaid purposes?**
   For Medicaid, household is the taxpayer and their dependents. It is tricky because the application wants to know all people living with the applicant; however, when completing information, notice that only names, relationships, date of birth, and if they want to apply for health coverage are required. All other information is optional and not needed for a determination if the applicant is not a dependent of another member of the household. There is even a note on the bottom of the application that appears when all required fields are satisfied. A separate application is required for all tax groups, even if they live under the same roof.

9. **Are individuals ages 19-26 claimed as dependents eligible for HIP?**
   Yes they may be eligible. If the individual between ages 19-26 is claimed as a dependent, then the parent(s) are included in the tax household and must be included on the application. The application must also include the parent(s) income and information about other household dependents.

10. **How are dental and vision benefits managed?**
    Dental benefits are through DentaQuest, and vision is through Vision Service Providers (VSP) (Anthem), OptiCare (MHS), or DST (MDwise).
    Vision is covered for HIP Plus members, pregnant members and members in HIP Basic Plans ages 19 and 20. Coverage includes one vision exam per year and glasses (or contacts when medically necessary) every two years.

    Dental coverage is illustrated through the chart below.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP Plus</td>
<td>• Oral exams every six months and emergency oral exams</td>
</tr>
<tr>
<td></td>
<td>• Dental x-rays (Complete set once every three years and Bite-wing x-rays once every 12 months)</td>
</tr>
<tr>
<td></td>
<td>• Teeth cleaning once every six months</td>
</tr>
<tr>
<td></td>
<td>• Minor restorative services like fillings</td>
</tr>
<tr>
<td></td>
<td>• Major restorative services like crowns</td>
</tr>
<tr>
<td>HIP Basic (age 19 or 20) or HPE</td>
<td>• Oral exams every six months</td>
</tr>
<tr>
<td></td>
<td>• Emergency oral exams</td>
</tr>
<tr>
<td></td>
<td>• Dental x-rays (Complete set once every three years and Bite-wing x-rays once every 12 months)</td>
</tr>
<tr>
<td></td>
<td>• Teeth cleaning once every six months</td>
</tr>
<tr>
<td>HIP State Plan Basic, HIP State Plan Plus, All Pregnancy Plans</td>
<td>• Oral exams every six months and emergency oral exams</td>
</tr>
<tr>
<td></td>
<td>• Dental x-rays Complete set once every three years</td>
</tr>
<tr>
<td></td>
<td>• Bite-wing x-rays once every 12 months</td>
</tr>
<tr>
<td></td>
<td>• Teeth cleaning once every six months</td>
</tr>
<tr>
<td></td>
<td>• Minor restorative services such as fillings</td>
</tr>
<tr>
<td></td>
<td>• Dentures and denture repairs</td>
</tr>
<tr>
<td></td>
<td>• Extractions</td>
</tr>
</tbody>
</table>
11. Will HIP Dental include coverage for prostheses like dentures or partials?
Under HIP Plus, dentures and partials are not covered. They are covered under HIP State Plan benefits.

12. Are extractions covered?
HIP Plus members may receive any combination of four (4) restorations/extractions per year. HIP State Plan members have no limitations on restorations or extractions.

13. What is transitional medical assistance?
Transitional Medical Assistance (TMA) is a Medicaid program that offers continued coverage of benefits for certain low-income parents and caretakers who would otherwise lose Medicaid coverage due to increased earnings. If a low-income parent/caretaker in HIP 2.0 has an increase in earnings that puts them over the converted AFDC income standards (approximately 19% FPL), they will go in HIP 2.0 with TMA indicator and receive six (6) months of coverage as long as they have a dependent child under 18 in the home. These individuals can then get up to an additional six (6) months of coverage in HIP 2.0 (TMA indicator) based on periodic reports that must be submitted at three (3), six (6), and nine (9) months. The children will also enroll in TMA but in the TMA category for children. Please see slides 16 and 17 of this presentation for more information.

14. If an enrollee is cut-off HIP for nonpayment, can he or she apply for HIP 2.0 if his or her income meets the guidelines?
HIP 2.0 members that have income at/below 100% FPL and have been in HIP Plus but fail to make the next required contribution within 60 days will be discontinued from HIP Plus benefits but will transition to HIP Basic benefits. HIP 2.0 members who have income above 100% FPL and fail to make a required contribution within 60 days will be discontinued from HIP 2.0 and will be subject to a 6-month lockout period. There is an exemption for medically frail individuals. There are also exceptions at reapplication in which the 6-month lockout period can be waived (medically frail, obtained and subsequently lost private insurance coverage, had a loss of income after disqualification due to increased income, took up residence in another state and later returned, is a victim of domestic violence, residing in county subject to disaster). The lockout provision does not apply to members at/under 100% FPL.

15. How do enrollees sign up for the Gateway to Work Program?
HIP members who are unemployed or working less than 20 hours a week will be referred to available employment, work search, and job training programs that will assist them in securing new or potentially better employment. Gateway to Work is a voluntary program; CMS did not approve a work requirement as part of this agreement. As of May 2015, HIP members will be notified if they have been referred to the program. Eligibility for HIP coverage is not affected if a member chooses to not participate. Those interested in participating in Gateway to Work should call 1-800-403-0864 and select Option 1 for the health coverage menu and then Option 6 for Gateway to Work.

Once engaged in the Gateway to Work program, members may receive case management services, participate in a structured job readiness program and receive help with their job search. Additional training, volunteer work experiences and/or education may be provided, as appropriate. Gateway to Work participants will also be invited to attend hiring events with employers.
16. **Do employers face a potential fine (like in the Marketplace) if an employee enrolls in HIP 2.0?**

   No.

17. **Are paper applications being discouraged?**

   The preferred application is through the Department of Family Resources (DFR) Benefit Portal. This is the fastest and easiest method.

18. **Should assisters submit documentation verification (such as paystubs, proof of citizenship, etc.) with application?**

   The DFR Benefits portal uses electronic sources to verify income, citizenship, and other eligibility factors. If the DFR cannot confirm information through these sources, then an individual may be notified and required to submit further documentation. Therefore, faxing or mailing documents upon application submission may speed up the process. It is important to either write the case number or the applicant’s name and Social Security Number on each document you submit.

19. **Should applicants expect to have an interview once application is submitted?**

   Interviews are typically not scheduled for any Indiana Medicaid program unless the individual is receiving TANF, food stamps or is disabled. For example, if an individual is disabled and possibly eligible for HIP, he or she may have an interview.

20. **Under HIP 2.0, will transportation available for medical needs?**

   Transportation is available for some categories and populations of HIP 2.0. This includes:

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women in a HIP 2.0 plan</td>
</tr>
<tr>
<td>Any member in HIP State Plan Plus</td>
</tr>
<tr>
<td>Any member in HIP State Plan Basic</td>
</tr>
</tbody>
</table>

   Some MCEs offer additional transportation services to their members. For instance, Anthem offers 20 one-way trips (≤50 miles) annually for HIP Basic and HIP Plus members.

21. **Which is the best avenue to complete HIP 2.0 applications? Via Healthcare.gov or DFR Benefits Portal?**

   The best avenue to complete HIP 2.0 applications is through the Department of Family Resources Benefits Portal. However, if you are concerned about the individual’s income (around ~138% of the federal poverty level), then you may want to apply through HealthCare.gov if during the open enrollment period or if the individual may qualify for a special enrollment period. If the individual does not meet the initial application entity’s eligibility requirements, then the application file will be transferred to the appropriate entity (either HealthCare.gov or DFR).
22. Is there any guidance to help consumers with the 38 points they are asked to agree with at the beginning of the Indiana Application for Health Coverage (IAHC)?

As an Indiana Navigator, it is a good idea to become familiar with the 38 points (Notice Regarding Rights and Responsibilities for Health Coverage, State Form 55367) and develop a summary for consumers. One suggestion is to have a paper copy available for applicants to read through before or during the application process. If an applicant has hesitations about any of the rights or responsibilities, then take your time to explain and answer questions before submitting the application.

23. Can consumers be “double covered” with HIP 2.0?

Yes, members can have other insurance coverage as long as it is not Medicare. HIP 2.0 follows normal Medicaid rules, so HIP 2.0 would be the payer of last resort. If an individual has Medicare, he or she cannot be eligible for HIP 2.0 as the program follows the regulations set forth in in 42 CFR 435.119(b)(3).

24. Can nonprofits contribute 100% of an individual’s monthly contribution into their POWER account?

Yes; organizations such as employers, nonprofits and hospitals can contribute up to 100% of member POWER account contribution (PAC). Payments are made directly to the member’s selected managed care entity (MCE).

25. Does coverage begin the 1st day of the month in which payment is made?

Yes. If for example a consumer makes their POWER account contribution on February 23rd, and the MCE receives and processes the payment before the month ends, then coverage began February 1st.

26. Do the HIP State Plans include chiropractic, unlike the HIP Basic and Plus plans?

Yes, enrollees of the HIP State Plan receive chiropractic services and the same coverage as Hoosier Healthwise Package A.

27. How does HIP Link work, and when will it be implemented?

HIP Link will allow eligible employees and spouses to get coverage through their employer’s plan if the employer is enrolled in HIP Link, and the employee and/or spouse meet HIP 2.0 eligibility requirements. This program will be implemented in June 2015, tentatively.

28. There is now a HIP pregnancy category, so are pregnant women over 138% still able to get Medicaid?

MAGP is the Medicaid pregnancy category. If under approximately 138% FPL, the Indiana Health Coverage Program (IHCP) will market as “HIP Maternity,” but it is MAGP. If an individual is above 138% FPL but below 208%, then she may be eligible under this category. If above 138% FPL, the IHCP will not market as “HIP Maternity.” If under 138% FPL, “HIP Maternity” (MAGP) women will be able to transition to HIP 2.0 after end of post-partum period (60 days after delivery or end of pregnancy). It is important that pregnant women report delivery or termination of pregnancy as soon as possible since this period is when the IHCP will send the invoice to enroll into HIP 2.0 to avoid a gap in coverage.
29. Will a consumer's application on the Marketplace be transferred to HIP? Eligibility results state, "You may be eligible for Hoosier Healthwise or HIP, and you'll be contacted by those agencies," but should these individuals complete the separate IAHC anyway?
If a Marketplace applicant is found potentially eligible for Hoosier Healthwise or the Healthy Indiana Plan, then their application will be sent to the Department of Family Resources (DFR) for eligibility determination for Indiana Health Coverage Programs (IHCP). There is no need to submit a separate application through the DFR Benefits Portal. The State may request further documentation from the consumer to make their eligibility determination.

30. What happens to everyone who is enrolled in a Marketplace plan between 100-138% FPL? Will they receive notices from the Marketplace and be transitioned to HIP 2.0?
The state will send letters to Hoosiers with incomes between 100 and 138% FPL that explain the Marketplace enrollee’s eligibility for HIP Plus. The notices will also urge immediate action to avoid tax penalty and explain how the enrollee should “report a life change” on the Marketplace. After taking these steps, the enrollee will receive notification that the Marketplace is sending their information to DFR for eligibility determination. Once approved, the member will need to contact their current Marketplace plan and cancel their coverage. They should use their HIP coverage start date to choose when to end their Marketplace plan to avoid a gap in coverage.

31. How and where to report changes (application says: “You are required to report changes in circumstances to the DFR...You must report changes within 10 days of the date on which you are aware of the change...You will be given a form describing your reporting requirements.”
A HIP enrollee must report changes within 10 days of knowing of the change. Members should call or fax information to the FSSA Document Center at 1-800-403-0864, submit online, OR mail to:

FSSA Document Center
PO Box 1810
Marion, IN 46952

<table>
<thead>
<tr>
<th>Reportable Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving to a new address or change in mailing address</td>
</tr>
<tr>
<td>Family income or family size changes</td>
</tr>
<tr>
<td>Losing a job, change in jobs or a new job</td>
</tr>
<tr>
<td>Becoming pregnant, delivering a baby or when pregnancy ends</td>
</tr>
<tr>
<td>Becoming insured under other health insurance (private or Medicare)</td>
</tr>
</tbody>
</table>

32. What form of proof is needed to prove a case of domestic violence to prevent lockout due to nonpayment?
The individual can submit proof of residence in a domestic violence shelter, a doctor statement, or a police report.
33. If denied HIP due to too much income, will the application be sent to the Marketplace? Is this a qualifying event for a special enrollment period (SEP)?

If an individual is denied HIP due to income above approximately 138% of the federal poverty level, then his or her application will be sent to the Marketplace. A special enrollment period is only granted if an individual is discontinued from IHCP coverage for reasons like income or household size changes.

34. How will the fast-track prepayments work, and when will it be implemented? Will Navigators assist with this?

After five days of the application date, the DFR will enter the applicant’s information to potentially identify individuals who are eligible for a fast-track payment. A fast-track prepayment means an optional ten dollar POWER account contribution, which, upon the DFR eligibility determination is either:

a. Refunded to a pending applicant determined ineligible for the plan OR
b. Applied toward the member’s required POWER account contribution in the case of a pending applicant determined eligible for the plan

The fast-track prepayment program is scheduled to be effective on April 1, 2015. Individuals can make a contribution to HIP plan prior to DFR eligibility determination. After 5 days of the application date, the DFR will enter the applicant’s information to potentially identify individuals who are eligible for a fast-track payment. Those individuals would receive an invoice approximately five (5) days from the plan that they chose on the application, so they have the opportunity to make the payment as soon as possible.

35. Are individuals with a drug felony eligible for HIP 2.0?

A drug felony is not an eligibility disqualification for HIP 2.0.

36. Will payer IDs are remaining the same for claim submissions?

The answer to this question is pending.

37. What is medically frail? Who qualifies for this status, and what HIP 2.0 coverage will they receive?

A medically frail individual has one or more certain serious physical, mental and behavioral health conditions (examples below). These individuals are federally required to have access to standard Medicaid benefits, so they receive HIP State Plan benefits.

<table>
<thead>
<tr>
<th>Disabling mental disorders (including serious mental illness)</th>
<th>Serious and complex medical conditions</th>
<th>A disability determination from the Social Security Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic substance use disorders</td>
<td>A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more</td>
<td>* Activities of daily living include bathing, dressing, eating, etc.</td>
</tr>
</tbody>
</table>
The Indiana Application for Health Coverage uses answers from the Health Coverage Questionnaire (State Form 55641) to make a preliminary determination for medically frail status. The enrollee’s MCE then makes the final determination for medically frail status by reviewing the member’s responses to the questionnaire, initial health screen or health assessment, present or historical medical claims data and any other information relevant to their health condition. Please see slides 7-12 of this presentation for more information.

38. Can an enrollee purchase over-the-counter (OTC) medications with the POWER account?

OTC medicines or vitamins are not covered under HIP unless they are on the preferred drug list (PDL) for the plan. HIP Plus or HIP State Plan Plus member’s POWER account should cover the expenses of OTC drugs. However, if the member is in HIP Basic or HIP State Plan Plus, he or she may be required to make a copayment.

39. Since applicants who are below 100% FPL are automatically enrolled in HIP Basic, how do they opt into HIP Plus?

New applicants are not actually automatically enrolled into HIP Basic. New applicants will be “conditional HIP Plus or HIP State Plan Plus” regardless if over or under 100% and will have 60 days to pay the first contribution. If the first contribution is made within 60 days, the HIP Plus coverage will begin on the first of the month in which the first contribution was made and processed. If the individual is at/under 100% and does not make a contribution within 60 days, the individuals will default to HIP Basic or HIP State Plan Basic benefits effective the month after the month in which the 60 day period expired.

40. If a Marketplace application is completed and the applicant is eligible for HIP, is it recommended to complete a separate, online HIP application?

It is not recommended to submit an additional application through the State as the federal Marketplace will send the application file to the State for processing under Medicaid/HIP 2.0. If someone does also apply directly to the State, one of the applications may be considered a “duplicate” application and may be denied for that reason. The state has been receiving approximately 200-1200 Marketplace applications per day for the last several weeks, so applications from the Marketplace are not being delayed if assessed eligible for Medicaid/HIP 2.0.

41. If a consumer pays their first premium on the Marketplace and returns to the Marketplace to report that he or she is now eligible for HIP due to income (below ~138% FPL), will their Marketplace coverage automatically cancel, or does he or she need to cancel their Marketplace coverage themselves?

Coverage on the Marketplace will not be automatically cancelled after the consumer reports the change. The Marketplace will issue a notice that the individual’s application is being sent to the State. Next, the application will be considered for Medicaid/HIP 2.0 coverage. The State may
require additional information to determine eligibility and medically frail status. If found eligible for HIP, the individual will then need to contact his or her current health insurance Marketplace plan to cancel coverage. The individual should use the HIP coverage start date to choose when to end the Marketplace plan to avoid a gap in coverage.

The individual will not face a tax penalty provided that the Marketplace coverage is cancelled prior to beginning to HIP coverage. FSSA assumes that some individuals may have overlapping coverage of Marketplace and HIP 2.0 for a month or two in some circumstances. New guidance for Hoosiers currently enrolled in Marketplace coverage that may be IHCP eligible was issued in April 2015 by FSSA. "An Indiana resident who is currently receiving Advance Payments of the Premium Tax Credit (APTC) to help purchase a Marketplace plan and who will be eligible for HIP 2.0 will not face a tax penalty solely because he or she does not apply for HIP 2.0 in 2015. This remains the case so long as the individual has not been determined eligible for HIP or a Medicaid plan by Indiana FSSA." Read more about this here.

42. When a member becomes pregnant and has selected a PMP, can she go to an OB/GYN of her choice or need a referral to see the OB/GYN? If her PMP does OB services can she go to a different OB/GYN if she chooses?
OB services are not self-referral services. The member will need to work with their health plan in order to resolve provider questions. Each health plan may have different requirements regarding their providers.

43. Will HIP members have retroactive coverage since their plan will start the month they make their first contribution?
There will be no retroactive coverage for HIP 2.0, but coverage will go back to the month the first contribution is made and processed. Also, fast-track eligibility and hospital presumptive eligibility (HPE) will be available to provide coverage as quickly as possible. The HIP 2.0 waiver agreement does not provide retroactive coverage but does allow payment for medical expenses incurred in the 90 days prior to HIP 2.0 coverage for the low income parent/caretaker and low income 19- and 20-year-old dependents to be reimbursed if claims are submitted within 90 days after the receipt of the bill for such services (please note that this process is being developed but is indicated in Emergency Rule LSA Document #15-38(E), Section 41(b).

44. Can an undocumented immigrant apply for HIP 2.0?
Anyone can apply for health coverage. Adults that meet all of the eligibility requirements for HIP 2.0, except that they are not a U.S. citizen and not a lawful permanent resident (LPR) in the U.S. for at least five years or are not qualified aliens, are entitled to “emergency services only” (Package E) under HIP 2.0. The immigrant will not have a POWER account contribution like Plus nor copayments like under Basic.

45. What are the citizenship requirements for HIP 2.0?
Citizenship requirements for HIP 2.0 are the same as all other Medicaid categories. Individuals that meet all of the eligibility requirements for HIP 2.0 and are U.S. citizens or are lawful permanent residents (LPRs) in the U.S. for at least five years, and other “qualified” aliens are entitled to full
coverage benefits under HIP 2.0. All other individuals, including “undocumented aliens, “unverified” aliens, and LPRs in the U.S. less than five years are only entitled to “emergency services only.”

46. Can providers who previously accepted Medicaid patients now see HIP patients? Or is there a process they must go through in order to see HIP covered patients going forward
The provider will need to be enrolled with the health plan of the HIP-covered patients they are serving.

47. Is a medically frail individual eligible for Medicaid regardless of income? (i.e. SSDI) and resources?
No; the individual has to meet all of the eligibility requirements for HIP 2.0 and be determined medically frail. The individual will have State Plan benefits and will be subject to the applicable cost sharing—if in Plus, contributions; if in Basic, copayments.

48. Will the state be sending applications outside of Marketplace open enrollment?
Yes, the state will send applications of individuals who do not meet IHCP, including HIP 2.0, eligibility requirements to the Marketplace year-round.

49. Are the insurers adding other coverage in addition to what the state provides?
Yes, the Managed Care Entities (MCE) may offer additional benefits. For example, Anthem offers magazine subscriptions, a SafeLink cell phone, and other benefits for qualifying members. MDwise offers a program called MDwise Rewards in which enrollees can earn points which can be redeemed for gift cards. MHS also offers a free SafeLink cell phone and a rewards card called CentAccount® which can be used at Dollar General, Family Dollar, Meijer and Rite Aid Pharmacy.

50. Are provider networks the same in HIP Plus and HIP Basic?
The provider networks do remain the same, and the enrollee will not be required to select a new primary medical provider (PMP) if they are transferred from Plus to Basic.

51. Will consumers get a bill of how much to pay and where to send payment for HIP Plus?
Initially, consumers will receive a notice of eligibility determination which will also include their monthly POWER account contribution. Consumers will receive a monthly statement from their MCE which will detail how and where to remit payments. The MCEs offer payment online, payroll deductions, automatic bank drafts, by mail (check or money order) and by phone. MCEs may make other payment methods available; for example, Anthem offers payment at any Indiana Walmart for an additional 88 cents.

52. Is that normal for a person to get denied from HIP because they went to the ER for treatment when they were not even on the HIP plan yet?
No, a consumer’s use of an emergency room is not a factor of eligibility.
53. **Do Marketplace consumers have to pay the APTC back?**
   An Indiana resident who is currently receiving Advance Payments of the Premium Tax Credit (APTC) to help purchase a Marketplace plan and who will be eligible for HIP 2.0 will not face a tax penalty solely because he or she does not apply for HIP 2.0 in 2015. This remains the case so long as the individual has *not* been determined eligible for HIP or a Medicaid plan by Indiana FSSA.” Read more about this [here](#).

54. **Is there a deadline for Marketplace individuals making switch to HIP 2.0 in order to avoid tax penalty?**
   FSSA released guidance in April 2015 stating that an Indiana resident who is currently receiving Advance Payments of the Premium Tax Credit (APTC) in 2015 to help purchase a Marketplace plan and who will be eligible for the Healthy Indiana Plan will not face a tax penalty solely because he or she does not apply for HIP in 2015. Read more about this [here](#).

55. **Can an enrollee change MCEs before they make payment?**
   Yes, the health plan choice selection can be changed if done before the first POWER account payment is received by the MCE.

56. **When will a Spanish version of the online application become available?**
   Currently, a Spanish version of the Indiana Application for Health Coverage is not available. However, an application can be downloaded and printed in Spanish by visiting the DFR Benefits Portal and selecting “Print an Application for Health Coverage, SNAP, and/or Cash Assistance to be mailed to you.” The application must be faxed to 1-800-403-0864 or mailed to the address listed under Question 23.

57. **Can organizations use the HIP logo for marketing purposes?**
   Yes, organizations can use HIP logos for marketing and educational purposes. Click [here](#) to download a zip file of HIP logos, and [here](#) to download FSSA’s HIP 2.0 promotional kit.

58. **Consumers who do not have income will be required to pay $1 a month for Plus; how does this work with the 5% cap?**
   Members are protected from paying more than 5% of their quarterly income toward HIP cost-sharing requirements, including the total of all POWER account contributions, emergency room copayments, and HIP Basic copayments. However, HIP Plus and HIP State Plus members will be required to pay $1 per month even if the 5% cap is met in order to receive HIP Plus or HIP State Plus benefits. This is an exception to the 5% cost-sharing cap.

59. **Individuals with breast and cervical cancer may receive MA12, Option 3 benefits. Are there any changes with HIP 2.0 implementation? Do these individuals qualify as medically frail?**
   The MA12 program will remain the same; these individuals do not transition. If these individuals become ineligible, then they may be considered for other Medicaid programs. A cancer patient will need to complete the IAHC and indicate a positive response in the health coverage application, and then they will be considered conditionally medically frail. These individuals will receive the HIP
State Plan benefits until the MCE confirms the medically frail status by contacting the individual and using claims information and other data.

60. **Does IHCP consider annual income or monthly income?**

IHCP considers currently monthly income for eligibility; however, POWER account contributions are based on annual income. Therefore it is extremely important for members to report changes in income immediately.

61. Prior, with the old HIP application, we had an enrollment center number for the Medicaid application and one for the HIP application. Which number do we use now that it is all streamlined?

*The answer to this question is pending.*

62. **If an applicant lives in a shelter, should that address be used on the application?**

A shelter address can be used for the application. The applicant can also use an address of a relative or friend.

63. **If a PMP recommends an in-network specialist is there a cost?**

If the member is in HIP Basic, he or she would have a $4 copayment to see a specialist that is in-network. If the member is in HIP Plus, he or she would not have a copayment; the service would be covered under his or her POWER account.

64. **Are emergency services covered out-of-state?**

Services for *medical emergencies* are covered out-of-state.

65. **Will duplicated applications be deleted?**

The DFR may deny an application as a “duplicate” application if there is already a pending application, either Marketplace or IAHC. However, prior to denying such an application, DFR must review the application and determine if the application shows any change in information different from the original application. This may include income, change in family size, etc. Consequently, this may also prompt DFR to request verification for something new that may be indicated on the application.

66. **How long does it take to process a HIP application?**

Applicants can expect an eligibility determination within 45 days. It may take up to 90 days for individuals with a disability.