



A GUIDE TO UNDERSTANDING MEDICALLY FRAIL



MHS is a health insurance provider that has been proudly serving Indiana residents for two decades through Hoosier Healthwise, the Healthy Indiana Plan and Hoosier Care Connect. MHS is your choice for affordable health insurance. Learn more at mhsindiana.com.

If you need this or any other information in another language or format, or have any problems reading or understanding this information, please call MHS Member Services Monday – Friday from 8 a.m. to 8 p.m. at 1-877-647-4848 (TTY/TDD 1-800-743-3333).

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What is medically frail?

- Medically frail is a federal title.
- It is for people with serious physical, mental, substance abuse or behavioral health conditions.
- Being medically frail means that you can have standard Medicaid benefits. This is called HIP State Plan.

The Healthy Indiana Plan (HIP) serves nondisabled low-income adults ages 19–64. HIP members have incomes at or below 133% of the federal poverty level (FPL). Members who are medically frail will have greater coverage through HIP State Plan.

What conditions make someone medically frail?

Federal regulations define medically frail as individuals with one or more of the following:

- Disabling mental disorders (including serious mental illness)
- Chronic substance abuse disorders
- Serious and complex medical conditions
- A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living like bathing, dressing or eating
- A disability determination from the Social Security Administration (SSA)

Members who meet the condition guidelines can be enrolled into HIP State Plan. HIP State Plan benefits include:

- Transportation to and from doctor visits
- Enhanced dental and vision coverage
- Enhanced behavioral health/MRO services
- Chiropractic care

Individuals with a qualifying condition will be assessed to decide if they are medically frail. You may be assessed:

- Through claims review
- By self-report by completing the Health Needs Screening (HNS)
- At the request of your provider

Through claims review: MHS looks at member claims to find out who might be medically frail. Those individuals will be enrolled in HIP State Plan. Expect enrollment to begin the first of the month after the determination.

By self-report: You may self-report to MHS that you have a qualifying condition at any time. Then MHS has 30 days to look at claims and talk to you and your providers. If you are deemed medically frail, you will be enrolled in HIP State Plan. Expect enrollment to begin the first of the month after the determination.

At the request of your provider: MHS will look at claims and clinical records submitted by your provider. If you are deemed medically frail, you will be enrolled in HIP State Plan. Expect enrollment to begin the first of the month after the determination.

Additional info: Your medically frail status must be reconfirmed by MHS every 12 months.



POWER Up with HIP Plus Understanding HIP Plus vs. HIP Basic

Members who have State Plan benefits will not lose coverage due to non-payment of their POWER Account. But, MHS wants you to understand the benefits of HIP Plus.

HIP Plus is the preferred plan for all HIP members. It is the plan for the best VALUE. HIP Plus provides health coverage for a low, predictable monthly cost. With HIP Plus, you do not have copays when you visit the doctor, fill a prescription or go to the hospital for an emergency. The only other cost you may have for health care in HIP Plus is a payment if you visit the Emergency Room for a non-emergency condition.

On average, HIP Plus members spend less money on their health care expenses than HIP Basic members. With HIP Plus you save money!

Take charge of your health and POWER Up with HIP Plus.

Make sure you pay your POWER Account contribution to get HIP Plus benefits.

