Healthy Indiana Plan 2.0:
Introduction, Plan options, Cost sharing, and Benefits
Objectives

✓ After reviewing this presentation, you will understand the following aspects of HIP 2.0:
  • Program features, including the POWER account
  • Plan options
    o HIP Basic
    o HIP Plus
    o HIP Link
    o HIP State Plan
  • Cost sharing requirements
  • Benefits
Healthy Indiana Plan (HIP) Fundamentals

- Covering Hoosiers since 2008
  - Nation’s first consumer-directed health care program for Medicaid recipients
  - Small demonstration program with limited enrollment

- Health coverage benefits modeled after an employer-sponsored health insurance plan
  - Coverage provided by one of three managed care entities (MCE)
  - Members may choose MCE: Anthem, MDwise, or MHS

- Pioneering the Personal Wellness and Responsibility (POWER) account
  - Each member has a health savings-like account called the POWER account that helps pay for initial medical expenses
  - Members and the State contribute to ensure there is enough money to cover initial health expenses
  - There are incentives to manage the account & penalties for members not making contributions
Healthy Indiana Plan (HIP): Introducing HIP 2.0

- Build on existing Healthy Indiana Plan
- No limit on number of members
- Provide private market-like health insurance for healthy adults

Changes in 2015
HIP 2.0: Personal Responsibility

✔ HIP member and the State make contributions to POWER account
  • Together, member and State contributions cover the first $2,500 of health care services received each year
  • Member portion of annual contribution is approximately 2% of household income per year, ranging from $1 to $100 per month
    o Annual contribution may be split between qualifying spouses
  • Members who do not make their monthly contribution face penalties
    o Income over 100% federal poverty level (FPL):
      ▪ Unless exempt, member subject to 6 month lockout period and may not receive HIP benefits*
    o Income less than or equal to 100% FPL:
      ▪ Reduced benefits
      ▪ Must make copayments for each health service
      ▪ Failure to pay the onetime monthly contribution may make receiving health care more expensive for the member

✔ For qualifying individuals, portion of unused POWER account funding can be rolled over
  • Receive recommended preventive care each year
    o Increase roll over for HIP Plus members if receive recommended preventive care
  • May use roll over amount to reduce monthly POWER account contribution in HIP Plus the following year

*EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area.
HIP 2.0: Basics

Who is eligible for HIP 2.0?

• Indiana residents*
• Age 19 to 64*
• Income **under 138%** of the federal poverty level (FPL)*
• Not eligible for Medicare or other Medicaid categories*
• Also includes individuals currently enrolled in:
  • Family planning services (MA E)
  • Healthy Indiana Plan (HIP)
  • Hoosier Healthwise (HHW)
  • Parents and Caretakers (MAGF)
  • 19 and 20 year olds (MA T)

Monthly Income Limits for HIP 2.0 Plans

<table>
<thead>
<tr>
<th># in household</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>$973</td>
<td>$1,358.10</td>
</tr>
<tr>
<td>2</td>
<td>$1,311</td>
<td>$1,830.58</td>
</tr>
<tr>
<td>3</td>
<td>$1,650</td>
<td>$2,303.06</td>
</tr>
<tr>
<td>4</td>
<td>$1,988</td>
<td>$2,775.54</td>
</tr>
</tbody>
</table>

*Adults not otherwise Medicaid eligible who have children must make sure their children have minimum essential coverage to be eligible for HIP

**133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Information</th>
</tr>
</thead>
</table>
| **HIP Plus** | • Initial plan selection for all members  
• **Benefits**: Comprehensive, including vision and dental  
• **Cost sharing**:  
  • Must pay affordable monthly POWER account contribution: Approximately 2% of member income, ranging from $1 to $100 per month  
  • No copayment for services* |
| **HIP Basic** | • Fall-back option for members with household income less than or equal to 100% FPL only  
• **Benefits**: Meet minimum coverage standards, **no vision or dental coverage**  
• **Cost sharing**:  
  • May not pay one affordable monthly POWER account contribution  
  • Must pay copayment for doctor visits, hospital stays, and prescriptions |
| **HIP State Plan** | • Individuals who qualify for additional benefits  
• **Benefits**: Comprehensive, with some additional benefits including vision and dental  
• **Cost sharing**:  
  • HIP Plus OR HIP Basic cost sharing |
| **HIP Link** | • More information coming soon!  
• To help member pay for employer-sponsored health insurance |

*EXCEPTION: Using Emergency Room for routine medical care*
HIP 2.0: Treatment of Unique Populations

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| Medically Frail                 | Individuals with a disability determination, certain conditions impacting their physical or mental health or their ability to perform activities of daily living such as dressing or bathing will receive enhanced benefits  
  - HIP Basic or HIP Plus cost sharing will apply but access to vision, dental, and non-emergency transportation benefits is ensured regardless of cost sharing option  
  - Will not be locked out due to non payment of POWER account contribution |
| Pregnant Women                  | Pregnant women will have no cost sharing in either HIP Plus or HIP Basic once their pregnancy is reported and will receive additional benefits available only to pregnant women  
  - Pregnant woman may choose to stay in HIP or transfer to HIP Maternity, with comparable benefits |
| Native Americans                | By federal rule, Native Americans are exempt from cost sharing. Can receive HIP benefits without required contributions or emergency room copayments. May opt of HIP in favor of fee-for-service benefits as of April 1, 2015 |
| Transitional Medical Assistance (TMA) | Individuals who no longer qualify as low-income parents or caretakers due to an increase in pay are eligible for HIP State Plan benefits for a minimum of six months even if income is over 138% FPL |
| Low-income Parents, Caretakers, and 19-20 year olds | Individuals eligible for HIP State Plan Plus or HIP State Plan Basic benefits |
HIP 2.0 - PLAN OPTIONS AND BENEFITS
HIP 2.0: Plan Options

**HIP Plus**
Offers best value for members.
Comprehensive benefits including vision and dental.
To be eligible, members pay a monthly contribution towards their portion of the first $2,500 of health services.
Contributions are based on income – approximately 2% of household income per year – ranging from $1 to $100 per month.
No copayment required when visiting doctors or filling prescriptions.

**HIP Basic**
Fallback option for lower-income individuals.
HIP Basic benefits that cover the essential health benefits but not vision and dental services for adults.
Members pay between $4 and $75 for most health care services.
Receiving health care is more expensive in HIP Basic than in HIP Plus.

**HIP Link**
Coming Soon!
Members receive help paying for the costs of employer-sponsored health insurance.
Members with a qualified and participating employer are eligible for the employer-sponsored health insurance.
Member may choose HIP Link or other HIP plans.
HIP Link will be an option on the coverage application.

**Other benefit and cost sharing options**: Individuals who qualify may receive additional benefits through the HIP State Plan Basic & HIP State Plan Plus options, or have cost sharing eliminated per federal requirements.
HIP Plus vs. HIP Basic for Members with Income Less than or equal to 100% FPL

**HIP Plus**
- More affordable
- Predictable monthly contributions
- More benefits
- Option to earn reductions to future monthly contributions
  - May reduce future contributions by **up to 100%**

**HIP Basic**
- May be more expensive
- Unpredictable costs
- Fewer benefits
- Potential to reduce future monthly contributions for HIP Plus enrollment, but these reductions are capped at **50%**
HIP 2.0: State Plan

✓ Available for certain qualifying individuals
  • Low-income (<19% FPL) Parents and Caretakers
  • Low-income (<19% FPL) 19 & 20 year olds
  • Medically Frail
  • Transitional Medical Assistance (TMA)

✓ Benefits equivalent to current Medicaid benefits
  • All HIP Plus benefits covered with additional benefits, including transportation to doctor appointments
  • State Plan benefits replace HIP Basic or HIP Plus benefits
    o State Plan benefits are the same, regardless of HIP Basic or HIP Plus enrollment

✓ Keep HIP Basic or HIP Plus cost sharing requirements
  • HIP State Plan Plus: Monthly POWER account contribution
  • HIP State Plan Basic: Copayments on most services
## HIP 2.0: Plan Variations

<table>
<thead>
<tr>
<th>Population</th>
<th>Benefits</th>
<th>Cost Sharing</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults 19-64 income ≤100% FPL</td>
<td>HIP Basic or HIP Plus</td>
<td>HIP Basic or HIP Plus</td>
<td>All 19 &amp; 20 year olds receive EPSDT*</td>
</tr>
<tr>
<td>Adults 19-64 income between 100% and ~138% FPL</td>
<td>HIP Plus</td>
<td>HIP Plus</td>
<td></td>
</tr>
<tr>
<td>Low-income Parents or Caretaker Adults</td>
<td>State Plan Benefits</td>
<td>HIP Basic or HIP Plus</td>
<td></td>
</tr>
<tr>
<td>Low-Income 19 &amp; 20 Year Olds</td>
<td>State Plan Benefits</td>
<td>HIP Basic or HIP Plus</td>
<td></td>
</tr>
<tr>
<td>Medically Frail</td>
<td>State Plan Benefits</td>
<td>HIP Basic or HIP Plus</td>
<td></td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>HIP Basic or HIP Plus</td>
<td>None</td>
<td>Receive additional benefits only available to pregnant women. May choose to move to State Plan Benefits (MAGP).</td>
</tr>
<tr>
<td>Native Americans</td>
<td>HIP Plus</td>
<td>None</td>
<td>By federal law exempt from cost sharing**</td>
</tr>
<tr>
<td>Transitional Medical Assistance</td>
<td>HIP State Plan Basic or HIP State Plan Plus</td>
<td>HIP Basic or HIP Plus</td>
<td>May receive HIP Basic if income over 100% FPL</td>
</tr>
</tbody>
</table>

* Early Periodic Screening Diagnoses and Testing (EPSDT) as a benefit available to those 20 years old and younger that provides vision, dental, hearing aids, therapy, and preventive services

** Effective April 1, 2015, Native Americans may choose to opt out of HIP and into fee-for-service
# HIP 2.0: Essential Health Benefits

<table>
<thead>
<tr>
<th>Essential Health Benefits</th>
<th>HIP Plus</th>
<th>HIP Basic</th>
<th>HIP State Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory (Doctor Visits)</td>
<td>Covered – Includes coverage for Temporomandibular Joint Disorders (TMJ) 100 visit limit for home health</td>
<td>Covered – No TMJ coverage 100 visit limit for home health</td>
<td>Covered - Includes TMJ coverage &amp; chiropractic services. Home health limit does not apply</td>
</tr>
<tr>
<td>Emergency*</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Covered - Includes Bariatric Surgery</td>
<td>Covered - No Bariatric Surgery</td>
<td>Covered - Includes Bariatric Surgery</td>
</tr>
<tr>
<td>Maternity</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Covered</td>
<td>Covered - Generic Preferred</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehab &amp; Habilitation</td>
<td>Covered – 75 visits annually of physical, speech and occupational therapies 100 day limit for skilled nursing facility</td>
<td>Covered – 60 visits annually of physical, speech and occupational therapies 100 day limit for skilled nursing facility</td>
<td>Covered - Requires prior authorization but not limited to 60/75 visits annually Skilled nursing facility limit does not apply</td>
</tr>
<tr>
<td>Preventive</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pediatric</td>
<td>Early Periodic Screening Diagnosis and Testing (EPSDT) services covered for 19 &amp; 20 year olds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Includes emergency-related transportation*
## HIP 2.0: Other Benefits

<table>
<thead>
<tr>
<th>Other Benefits</th>
<th>HIP Plus</th>
<th>HIP Basic</th>
<th>HIP State Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Vision</td>
<td>Covered</td>
<td>Not Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Adult Dental</td>
<td>Covered – Limited to 2 cleanings per year and 4 restorative procedures</td>
<td>Not Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Medicaid Rehabilitation Option (MRO)</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pregnancy-Only</td>
<td>Additional benefits for pregnant women including transportation and chiropractic services.</td>
<td>Additional benefits for pregnant women including transportation, vision, dental and chiropractic services.</td>
<td>Pregnant women receive access to all pregnancy-only benefits on HIP Plus or HIP Basic plan and full State Plan benefits.</td>
</tr>
</tbody>
</table>
HIP 2.0 COST SHARING - REQUIRED CONTRIBUTIONS AND COPAYMENTS
POWER Account

✓ Unique feature of the Healthy Indiana Plan (HIP)
✓ Health savings-like account
  • Members receive monthly POWER account statements
  • Used to pay for the first $2,500 of service costs
✓ HIP Plus:
  • Members make monthly contributions to POWER account
    o Contribution amount is approximately 2% of income
    o Contribution ranges from $1 to $100 per month
  • Members exempt from most other cost sharing
✓ If members leave the program early they may still receive invoices for unpaid POWER account contributions from their health plan, depending on the cost of health care services received
✓ **Rollover:** All members may reduce future HIP Plus POWER account contributions
  • Must have remaining contribution in POWER account
  • Depending on plan: requirement or bonus for receiving preventive services
POWTER Account

HIP Plus
POWER account

- Pays for $2,500 deductible
- Member contributes
- May double rollover

**Year-End Account Balance**
- Unused member contribution rollover to offset next year's required contribution
- Amount **doubled** if preventive services complete – up to 100% of contribution amount
- **Example**: Member has $100 of member contributions remaining in POWER account. This is credited to next year’s required contribution amount. Credit is doubled to $200 if preventive services were completed.

HIP Basic
POWER account

- Pays for $2,500 deductible
- Cannot be used to pay HIP Basic copays
- Capped rollover option

**Year-End Account Balance**
- If preventative services completed, members can offset required contribution for HIP Plus by up to 50% the following year
- Members may not double their rollover as in HIP Plus
- **Example**: Member receives preventive services and has 40% of original account balance remaining at year end. May choose to move to HIP Plus the following year and receive a 40% discount on the required contribution.
HIP Plus: POWER Account Contribution (PAC)

- POWER account contributions are approximately 2% of member income
  - Minimum contribution is $1 per month
  - Maximum contribution is $100 per month

- Employers & not-for-profits may assist with contributions
  - Employers and not-for-profits may pay up to 100% of member PAC
  - Payments made directly to member’s selected managed care entity

- Spouses split the monthly PAC amount

### Maximum Monthly HIP 2.0 POWER account contributions (PAC)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;22%</td>
<td>Less than $214</td>
<td>$4.28</td>
<td>Less than $289</td>
<td>$2.89 each</td>
</tr>
<tr>
<td>23%-50%</td>
<td>$214.01 to $487</td>
<td>$9.74</td>
<td>$289.01 to $656</td>
<td>$6.56 each</td>
</tr>
<tr>
<td>51%-75%</td>
<td>$487.01 to $730</td>
<td>$14.60</td>
<td>$656.01 to $984</td>
<td>$9.84 each</td>
</tr>
<tr>
<td>76%-100%</td>
<td>$730.01 to $973</td>
<td>$19.46</td>
<td>$984.01 to $1,311</td>
<td>$13.11 each</td>
</tr>
<tr>
<td>101%-138%</td>
<td>$973.01 to $1,358.70</td>
<td>$27.17</td>
<td>$1,311.01 to $1,831.20</td>
<td>$18.31 each</td>
</tr>
</tbody>
</table>

*Amounts can be reduced by other Medicaid or CHIP premium costs
**To receive the split contribution for spouses, both spouses must be enrolled in HIP
Non-payment Penalties

Members remain enrolled in HIP Plus as long as they make POWER account contributions (PACs) and are otherwise eligible.

Penalties for members not making the PAC contribution:

- **≤100% FPL**
  - Moved from HIP Plus to HIP Basic
  - Copays for all services

- **>100% FPL**
  - Dis-enrolled from HIP*
  - Locked out for six months**

*EXCEPTION: Individuals who are medically frail.
**EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area. If an individual locked out of HIP becomes medically frail, he/she should report the change to his/her former health plan to possibly qualify to return to HIP early.
Exceptions to Non-payment Penalties

Exceptions to penalties for select HIP Plus members with household income over 100% FPL who stop paying their POWER account contributions (PACs)

- Native Americans
  - No required contributions
  - No copayments for using the emergency room for routine care
  - May opt out of managed care and into fee-for-service at any time, effective April 1, 2015

- Medically frail
  - Must pay copayments until outstanding PAC is paid

- Individuals qualified for Transitional Medical Assistance
  - Move to HIP State Plan Basic
  - HIP State Plan Basic copayments apply
When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic members are responsible for the following copayments for health and pharmacy services.

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Basic Copay Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income ≤100% FPL</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$75</td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td>$4</td>
</tr>
<tr>
<td>Non-preferred drugs</td>
<td>$8</td>
</tr>
<tr>
<td>Non-emergency ER visit</td>
<td>Up to $25</td>
</tr>
</tbody>
</table>

Copayments may not be more than the cost of services received.
HIP Plus Contributions Are Not Premiums

✓ Unlike premiums, members own their contributions

✓ If members leave the program early with an unused balance, the portion of the unused balance they are entitled to is returned to them
  • Members reporting a change in eligibility and leaving the program (e.g. move out of state) will retain 100% of their unused portion
  • Members leaving for non-payment of the POWER account will retain 75% of their unused portion

✓ If members leave the program early but incurred expenses, they may receive a bill from their health plan for their remaining portion of the health expenses

✓ Members remaining in the program may be eligible to receive a rollover of their remaining contributions
  • Rollover is applied to the required contribution for the following year
5% of income limit

✓ Member cost sharing is subject to a 5% of income limit
  • Members are protected from paying more than 5% of their quarterly income toward HIP cost sharing requirements, including the total of all:
    o POWER account contributions (PAC)
    o Emergency Room copayments
    o HIP Basic copayments

✓ Members meeting their 5% of income limit on a quarterly basis will have cost sharing responsibilities eliminated for the remainder of the quarter
  • Individuals meeting the 5% limit and enrolled in HIP Plus will receive the minimum $1 minimum monthly contribution for the remainder of the quarter

RECOMMENDATION:
Members should keep record of their expenses and if they think they have met their 5% of income limit, they should contact their managed care entity (e.g. Anthem, MDwise, MHS)
HIP Employer Benefit Link
COMING SOON!

✓ NEW EMPLOYER PLAN OPTION
• Families can choose to enroll in employer-sponsored health insurance
• Employer must sign up and contribute 50% of member’s premium

✓ POWER ACCOUNT
• Member makes contributions to POWER account
• Defined contribution from State to allow individuals to
  o Pay for employer plan premiums &
  o Defray out-of-pocket expenses

Promote family coverage in private market
Promote HIP member health coverage choices
Leverage POWER account potential
## Primary HIP Eligibility Categories

<table>
<thead>
<tr>
<th>Plan</th>
<th>Income Requirements</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP Plus (MARP)</td>
<td>Household income up to ~138% FPL</td>
<td>Best value plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pay monthly POWER account contribution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No copayments for most medical services</td>
</tr>
<tr>
<td>HIP Basic (MARB)</td>
<td>Household income less than or equal to 100% FPL</td>
<td>No POWER account contribution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pay copayments for most medical services</td>
</tr>
<tr>
<td>HIP State Plan Plus (MASP)</td>
<td>Income under 138% FPL and:</td>
<td>Medically Frail, OR</td>
</tr>
<tr>
<td></td>
<td>- Medically Frail, OR</td>
<td>Low-income Parents/Caretakers, OR</td>
</tr>
<tr>
<td></td>
<td>- Low-income 19 &amp; 20 year olds OR</td>
<td>Low-income 19 &amp; 20 year olds, OR</td>
</tr>
<tr>
<td></td>
<td>- Transitional Medical Assistance (TMA)*</td>
<td>Make monthly POWER account contribution</td>
</tr>
<tr>
<td>HIP State Plan Basic (MASB)</td>
<td>Income less than or equal to 100% FPL** and:</td>
<td>Medically Frail, OR</td>
</tr>
<tr>
<td></td>
<td>- Medically Frail, OR</td>
<td>Low-income Parents/Caretakers, OR</td>
</tr>
<tr>
<td></td>
<td>- Low-income 19 &amp; 20 year olds, OR</td>
<td>Low-income 19 &amp; 20 year olds, OR</td>
</tr>
<tr>
<td></td>
<td>- TMA*</td>
<td></td>
</tr>
</tbody>
</table>

*No household income limit for first six months. Income cannot exceed 185% FPL for additional six months of coverage. Individual may have additional coverage options if also medically frail.

**EXCEPTION: TMA does not have to have income under 100% to be eligible for HIP State Plan Basic**
HIP Access to Intensive Behavioral Health Programs (MRO/AMHH)

✓ HIP State Plan – Plus and Basic

➢ Eligibility Criteria
  o Enrolled in HIP
  o Deemed Medically Frail

➢ Impact
  o Exempt from mandatory enrollment in alternative benefit plans (HIP Plus and HIP Basic)
  o Have access to coverage under Indiana Medicaid State Plan (MRO/AMHH)
Reimbursement for HIP State Plan Services

- All services paid at Medicare/or 130% Medicaid rates (MRO/AMHH/BPHC)

- Intensive Community based programs (MRO/AMHH/BPHC) carved out from the HIP MCE benefit responsibilities

- Claims go to the IHCP through the fee-for-service claims payment system
HIP Plus

- Members with income over 100% FPL are subject to a non-payment lockout of six months if they do not make their monthly POWER account contribution.

- This lockout will not apply for individuals who are medically frail, living in a state declared disaster area, or residing in a domestic violence shelter.

- Individuals in *HIP State Plan Plus* are eligible for MRO or AMHH services but individuals in *HIP Plus* are not eligible for these services.
What is *HIP Basic*?

- Available only to HIP members with incomes at or under 100% (FPL) who lose *HIP Plus* because the member did not make the required POWER Account contribution.

- *HIP Basic* members have coverage for limited commercial-market benefits.

- Most members are assessed a copayment for each service received or prescription filled. Certain services, like preventive care are exempt from copayments.

- Individuals in *HIP State Plan Basic* are eligible for MRO or AMHH services but individuals in *HIP Basic* are not eligible for these services.
Who is considered medically frail?

✓ Individuals with **one or more** of the following conditions are medically frail:
  
  - 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
  
  - Disability determination from the Social Security Administration (SSA)
Medically Frail Determination

- Applicants who complete the *Indiana Application for Health Coverage* health condition questionnaire and indicate a qualifying condition will be enrolled in *HIP State Plan* on a temporary basis (60 days in 2015 and 30 days in subsequent years).

- Once assigned to a HIP managed care entity (MCE), the MCE will verify the member’s medical condition by completing a health risk assessment, reaching out to providers and reviewing claims.
Medically Frail Determination

✓ Verification of medically frail status is based on:
  o diagnoses codes,
  o current treatments,
  o assessment of risks and needs using a confidential algorithm.

✓ This independent eligibility determination process for medically frail status is conducted by the MCEs and overseen by the State.
Medically Frail Determination

✓ Members with a confirmed medically frail determination will continue to be enrolled in *HIP State Plan* for the remainder of the benefit period.

✓ Members who are not confirmed medically frail by their MCE have full appeal rights to the MCE and the State.

✓ Medically frail status is reconfirmed by the MCE every 12 months.
Identification of Individuals Who May Qualify as Medically Frail continued

✓ MCEs routinely review claims to identify members that are not designated as medically frail who may qualify.

✓ *HIP State Plan* benefits are effective the first of the month following the medically frail determination.

✓ Members may self-report medically frail status to the MCE at any time.

✓ If determined medically frail, *HIP State Plan* benefits effective the first of the month following verification.
How Can CMHCs Assist Behavioral Health Consumers Access MRO/AMHH?

- Ensure the member completes the *Indiana Application for Health Coverage* health condition questionnaire.

- If a consumer is already enrolled in HIP and not identified as medically frail, assist the member in contacting their MCE to self-report a qualifying condition if applicable.

- If your CMHC receives a request for documentation of member condition or medical records from a HIP MCE, provide prompt response.
How are MRO or AMHH services initiated for consumers who are determined as medically frail?

- The normal MRO/AMHH assessment and service package authorization process applies.

- MCEs are not responsible for claims reimbursement for MRO or AMHH; CMHCs will continue to bill IHCP through the fee-for-service claims payment system. As with all HIP services, **MRO and AMHH services will be reimbursed at 130% Medicaid rates for HIP members.**
How to verify a member has been determined medically frail.

- Use the standard eligibility verification processes.
- Eligibility is shown as – HIP Plus, HIP Basic, HIP State Plan Plus or HIP State Plan Basic.
- If HIP State Plan Plus or HIP State Plan Basic is displayed, the member is eligible to receive MRO/AMHH services, if all program eligibility and service standards for MRO/AMHH have been met.
Copayments for HIP State Plan Basic

- Most members in *HIP State Plan – Basic* must pay copayments for most MRO and AMHH services.

- The copayments are collected by the CMHC and claims will be paid with the $4 copayment amount deducted from the claim amount.

- Members in *HIP State Plan Basic* owe a $4 copayment for each distinct service received, regardless of whether they are received on the same day.

- If the same service is received multiple times or if more than one unit is used within the same day, only one $4 copayment will be owed.
Copayments for HIP State Plan Basic continued

- Multiple $4 copayments may apply if multiple distinct services are performed on the same day.

- Service activities on behalf of the member that do not involve the member being present do not have the $4 copayment applied.

- Members that are pregnant or have hit their cost sharing maximum limit will be exempt from the copayment requirement.

- The electronic verification system will indicate if the member has a copayment or not.
Copayments for HIP State Plan Basic continued

- The 30 percent increased payment rate for HIP members and the copayments for HIP State Plan Basic members were effective February 1, 2015.

- Some claims may have been paid without these factors being taken into account.

- Payments for these services will be retroactively adjusted to account for the 30 percent increased payment rate and the application of the $4 per service copayment for HIP State Plan Basic members.
Transitioning from HIP to BPHC

✓ If a consumer enrolled in HIP goes through the BPHC application process and is found to meet the BPHC service member clinical and Medicaid eligibility criteria as described in Section 5 of the BPHC Program Provider Manual and outlined below, he or she will be transitioned out of HIP.

✓ Transition will occur the following month after all the criteria has been met for BPHC.
  • Target criteria
  • Needs-based criteria
  • Financial criteria
  • Medicaid eligibility requirements
  • Disability determination
Receipt of the BPHC service while on HIP

✓ **Some individuals may remain on HIP and be eligible to receive the BPHC service** if they:
  • meet BPHC clinical criteria but
  • do not meet Medicaid non-clinical criteria.

✓ Most likely, this may occur when an individual does not have a disability determination.

✓ Members in *HIP State Plan – Basic* must pay copayments for BPHC services.

✓ The copayments are collected by the CMHC. All of the policies related to copayment responsibilities described above for MRO and AMHH apply to BPHC if the member is enrolled in *HIP State Plan* services.