

# HIP 2.0 and Community Mental Health Center Services



## Medicaid Rehabilitation Option (MRO) Services & Adult Mental Health & Habilitation (AMHH) Services

The following information is provided to ensure Indiana Community Mental Health Centers (CMHCs) understand the basics of the Healthy Indiana Plan (HIP) and how the program impacts members receiving Medicaid behavioral health services through CMHCs. Individuals who are enrolled in the new Healthy Indiana Plan (HIP) program who have been found medically frail are exempt from mandatory enrollment in alternative benefit plans – such as *HIP Plus* and *HIP Basic* – and have access to coverage established under the *Indiana Medicaid State Plan*. This includes MRO or AMHH services. **All services in all HIP Plans are paid at Medicare or 130% Medicaid rates**, and this will include intensive behavioral health Medicaid services (MRO/AMHH/BPHC). These intensive community-based behavioral health service programs are carved out from the HIP managed care entities (MCE's) benefit responsibilities and are billed to the IHCP through the fee-for-service claims payment system.

### What is HIP State Plan?

- ▶ Provides access to comprehensive *Indiana Medicaid State Plan* services, including nonemergency transportation, MRO or AMHH services.
- ▶ Members deemed medically frail will receive *HIP State Plan* coverage and will be enrolled in *HIP State Plan – Plus*. They are required to make monthly POWER Account contributions. Contributions are determined with the same methodology used for HIP Plus.
- ▶ An individual will be transferred to *HIP State Plan – Basic* under the following situations:
  - ▶ If a member eligible for *HIP State Plan Plus* does not make his or her monthly contribution for *HIP State Plan – Plus* and the individual has income below 100% of the FPL.
  - ▶ Medically frail members in the *HIP State Plan Plus* who do not pay their contributions and have income above 100% FPL will continue to owe these contributions in lieu of lockout, AND will also owe copayments identical to those that apply in *HIP State Plan Basic*.
- ▶ Members enrolled in *HIP State Plan Basic* are required to pay a \$4 co-pay for outpatient services and most MRO or AMHH services. Certain services, like preventive care and allowed services without the member present are exempt from copayments.
- ▶ *HIP State Plan Overview Summary*:
  - ▶ *HIP State Plan – Plus* and *HIP State Plan – Basic* have the same benefits available and are available to individuals determined to be medically frail, or who are low-income parents and caretakers, or a 19 or 20 year old dependent.
  - ▶ *HIP State Plan Plus* requires monthly POWER Account contributions. Contributions are determined using the same methodology as for HIP Plus.
  - ▶ *HIP State Plan Basic* requires a co-pay for each service received.

### What is HIP Plus?

- ▶ Members pay affordable monthly contributions of approximately 2% of their incomes into their POWER Accounts.
- ▶ The minimum POWER Account contribution is \$1.
- ▶ Members in *HIP Plus* do not have to make copayments except for inappropriate use of the emergency department.
- ▶ Members receive a full commercial-market benefit package that includes coverage for vision and dental services, bariatric surgery, temporomandibular disorder (TMJ) treatment and increased visit limits for physical, speech and occupational therapies. *HIP Plus* members also receive enhanced pharmacy services, including mail order, 90 day supplies for maintenance drugs, and medication therapy management.

- ▶ 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*?

- ▶ The default plan available only to HIP members with incomes at or under 100% of the federal poverty level (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 that does not include coverage for vision, dental, bariatric surgery, TMJ treatment, or enhanced pharmacy services including mail order, 90 day supplies for maintenance drugs, and medication therapy management. *HIP Basic* members have fewer allowed visits for physical, speech, and occupational therapy services.
- ▶ 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)

#### How is a member determined medically frail?

- ▶ The *Indiana Application for Health Coverage* includes a health condition questionnaire.
- ▶ Applicants who complete the 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.
  - ▶ Verification of medically frail status is based on diagnoses codes, current treatments, and an 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.
- ▶ 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.
- ▶ MCEs will review claims of enrolled members on an ongoing basis to identify members that are not designated as medically frail who may qualify. Members identified as qualifying as medically frail will receive *HIP State Plan* benefits effective the first of the month following their identification.
- ▶ Members may self-report medically frail status to the MCE at any time and if they are determined medically frail they will receive *HIP State Plan* benefits effective the first of the month following verification.

How can community mental health centers (CMHCs) assist in ensuring consumers enrolled in HIP and needing MRO or AMHH services are determined medically frail?

- ▶ If assisting a consumer with the *Indiana Application for Health Coverage*, ensure the member completes the health condition questionnaire.
- ▶ If a consumer is being seen by your CMHC, is already enrolled in HIP and has not been 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.

Once a consumer has been confirmed as medically frail, how are MRO or AMHH services initiated?

- ▶ 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 can a CMHC verify a member has been determined medically frail and is eligible for HIP State Plan benefits, including MRO or AMHH?

- ▶ Eligibility verification for HIP is through the standard eligibility verification processes. Eligibility will be shown as Package H and identify the HIP benefit package – *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, assuming all program eligibility and service standards for MRO/AMHH have been met.

How are copayments assessed for HIP State Plan Basic members?

- ▶ *HIP State Plan – Plus* members do not have copayments. Most members in *HIP State Plan – Basic* must pay copayments for most MRO and AMHH services. The copayments are to be collected by the CMHC and claims will be paid with the \$4 copayment amount deducted from the claim amount.
- ▶ Members enrolled in *HIP State Plan Basic* will 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.
- ▶ Multiple \$4 copayments could apply if multiple distinct services are performed on the same day. The \$4 copayment applies to each distinct service performed, not one \$4 copayment per day of service regardless of the number of distinct services.
- ▶ 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.

When do the copayments and increased payment rate for services to HIP members go into effect?

- ▶ 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.

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## Behavioral and Primary Healthcare Coordination (BPHC) Service

Individuals on HIP 2.0 may apply for the BPHC program through the normal BPHC application process.

### Transitioning from HIP to BPHC

- ▶ If an applicant 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.
  - ▶ This would occur if the Division of Mental Health and Addiction (DMHA) State Evaluation Team determines the applicant meets the BPHC clinical criteria but DFR determines they do not meet the Medicaid non-clinical criteria to transition to the BPHC Medicaid eligibility group.
  - ▶ This will most likely occur in the case of an individual not having a disability determination.
  - ▶ Members in *HIP State Plan – Basic* must pay copayments for BPHC services. The copayments are to be 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.