IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201523 APRIL 2, 2015

IHCP clarifies CMHC behavioral health services for HIP members

The Indiana Health Coverage Programs (IHCP) is providing clarification about how the Healthy Indiana Plan (HIP) program affects members receiving behavioral health services through community mental health centers (CMHCs). Individuals who are enrolled in HIP 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 coverage includes intensive community-based behavioral health services.

Medicaid Rehabilitation Option and Adult Mental Health and Habilitation services

Medicaid Rehabilitation Option (MRO) and Adult Mental Health and Habilitation (AMHH) services are offered through the *HIP State Plan* option.

What is the HIP State Plan option?

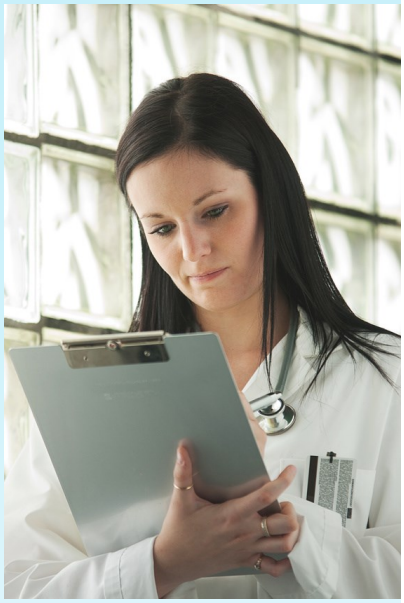
- The *HIP State Plan* option provides access to comprehensive *Indiana Medicaid State Plan* services, including nonemergency transportation, MRO, and AMHH services.
- Members deemed medically frail will receive *HIP State Plan* coverage. Members will be enrolled in *HIP State Plan – Plus* and required to make monthly Personal Wellness and Responsibility (POWER) Account contributions. Contributions are determined with the same methodology used for *HIP Plus* and are approximately 2% of income with a minimum contribution of $1.
- Medically frail members in *HIP State Plan – Plus* will be transferred to *HIP State Plan – Basic* if the member does not make his or her monthly POWER Account contribution and the individual has income below 100% of the federal poverty level (FPL).
- Medically frail members in the *HIP State Plan – Plus* who do not pay their contributions and have income above 100% of the 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*.
- Most members enrolled in *HIP State Plan – Basic* are required to pay a $4 copayment for outpatient services and most MRO and AMHH services. Certain services such as preventive care and services allowed without the member present are exempt from copayments.

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).
- After the member is 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 diagnosis 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 who are not designated as medically frail but 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. If the members are determined medically frail, they will receive *HIP State Plan* benefits effective the first of the month following verification.

How can CMHCs assist consumers enrolled in HIP and needing MRO or AMHH services?

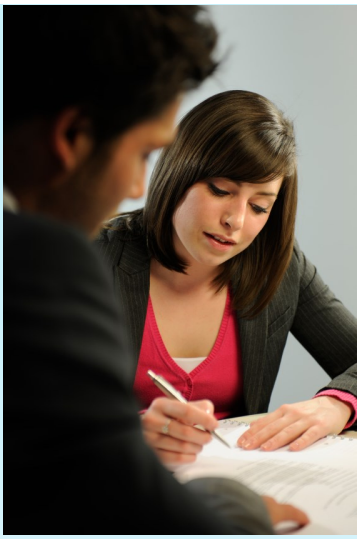
- If assisting a consumer with the *Indiana Application for Health Coverage,* ensure the individual completes the health condition questionnaire.
- If a consumer is being seen by your CMHC, is already enrolled in HIP, and has not been identified as medically frail, assist the member in contacting their 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 a prompt response.

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

- The normal MRO and AMHH assessment and service package authorization process applies.
- MCEs are not responsible for claims reimbursement for MRO or AMHH; CMHCs will continue to bill the IHCP through the fee-for-service claims payment system. As with all HIP services**, for HIP members MRO and AMHH services will be reimbursed at Medicare or 130% of Medicaid rates if no Medicare rate exists**.

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 made through the standard eligibility verification processes. Eligibility will 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 or AMHH services, assuming all program eligibility and service standards for MRO or AMHH have been met.



How are copayments assessed for HIP State Plan – Basic members?

- *HIP State Plan – Plus* members do not have copayments as long as they make the required POWER Account contributions. 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 separate $4 copayment for each distinct service rendered, even if they are rendered on the same date of service (DOS). If the same distinct service is rendered multiple times on a single DOS or if more than one unit of a distinct service is rendered on a single DOS, only one $4 copayment will be owed.
- Service activities on behalf of the member that do not involve the member being present do not have the $4 copayment applied. A list of the exempt procedure codes for MRO, AMHH, and BPHC services are listed in Table 1, Table 2, and Table 3 respectively, attached to this bulletin.
- Members who are pregnant or have hit their cost-sharing maximum limit will be exempt from the copayment requirement. The Eligibility Verification System will indicate whether the member has a copayment or not.

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

HIP payment rates and applicable copayments were effective for new HIP plan members on February 1, 2015. The HIP payment rates and applicable copayments would apply to *HIP State Plan* members receiving MRO and AMHH services through CMHCs on that same date. Some claims for HIP members may have been paid without these factors being taken into account. Payments for these services will be adjusted automatically by the IHCP to account for the greater HIP payment amount as well as the application of the $4 per-service HIP copayment, as appropriate. CMHCs do not need to resubmit affected claims.

Behavioral and Primary Healthcare Coordination services

Individuals enrolled in HIP may apply for the Behavioral and Primary Healthcare Coordination (BPHC) program through the normal BPHC application process.

Transitioning from HIP to BPHC

An applicant enrolled in HIP will be transitioned out of HIP if he or she goes through the BPHC application process and is found to meet the BPHC service member clinical and nonclinical eligibility criteria as described in Section 5 of the *BPHC Program Provider Manual* and listed below. Transition will occur the following month after it is determined that all the criteria for BPHC have been met:

- Target criteria
- Needs-based criteria
- Financial criteria
- Medicaid eligibility requirements
- Disability determination

Receipt of BPHC service while in HIP

Some individuals may remain in HIP and be eligible to receive the BPHC service. This situation would occur if the Division of Mental Health and Addiction (DMHA) State Evaluation Team determines the applicant meets the BPHC **clinical criteria**, but the Division of Family Resources (DFR) determines the applicant does not meet the **nonclinical criteria** to transition to BPHC. This scenario is most likely to occur in the case of an individual who does not have a disability determination.

Members in *HIP State Plan – Plus* who are receiving BPHC services must make monthly POWER Account contributions. Most members in *HIP State Plan – Basic* must pay copayments for BPHC 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. All policies related to copayment responsibilities described previously for MRO and AMHH apply to BPHC if the member is enrolled in *HIP State Plan – Basic*.

All services under HIP plans are paid at Medicare or 130% of Medicaid rates if no Medicare rate exists, including intensive behavioral health services through BPHC. These intensive community-based behavioral health service programs are carved out from the HIP MCE's benefit responsibilities and are billed to the IHCP through the fee-for-service claims payment system.

For more information

More details about HIP coverage for the medically frail can be found in the *IHCP Bulletin* BT201507. For more information about the HIP expansion in general, including descriptions of the plan options and cost-sharing structures, see *IHCP Bulletin* BT201503.

QUESTIONS?

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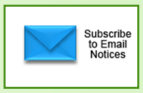

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Table 1 − MRO procedure codes with modifiers that do not require a copayment under HIP

Procedure code	Modifiers	Service title
H0004	HW HS	Individual Family/Couple Counseling and Therapy without the Consumer Present, per 15 minutes
H0004	HW HS U1	Group Family/Couple Counseling and Therapy without the Consumer Present, per 15 minutes
H0005	HW HS	Addiction Counseling, Family/Couple (Group Setting), without Consumer Present, per hour
H0034	HW	Medication Training and Support, Individual, per 15 minutes
H0034	HW U1	Medication Training and Support, Group, per 15 minutes
H0034	HW HS	Medication Training and Support, Family/Couple (Individual Setting), without the Consumer Present, per 15 minutes
H0034	HW HS U1	Medication Training and Support, Family/Couple (Group Setting), without the Consumer Present, per 15 minutes
H0034	HW HR	Medication Training and Support, Family/Couple (Individual Setting), with the Consumer Present, per 15 minutes
H0034	HW HR U1	Medication Training and Support, Family/Couple (Group Setting), with the Consumer Present, per 15 minutes
H0038	HW	Peer Recovery Services, per 15 minutes
H2014	HW HS	Skills Training and Development, Family/Couple (Individual Setting), without the Consumer Present, per 15 minutes
H2014	HW HS U1	Skills Training and Development, Family/Couple (Group Setting), without the Consumer Present, per 15 minutes
H2019	HW UA	Psychiatric Assessment and Intervention, non face-to-face, physician, per 15 minutes
H2035	HW HS	Addiction Counseling, Family/Couple (Individual Setting), without Consumer Present, per hour
T1016	HW	Case Management, per 15 minutes

Table 2 − AMHH procedure codes with modifiers that do not require a copayment under HIP

Procedure code	Modifiers	Service title
H2014	UB; HS	Home and Community-based Habilitation and Support Services-Family/Couple without the Member Present (Individual Setting); 15 minute unit
H2014	UB; U1; HS	Home and Community-based Habilitation and Support Services-Family/Couple without Member Present (Group Setting); 15 minute unit
H0004	UB; HS	Therapy and Behavioral Support Services – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes
H0004	UB; U1; HS	Therapy and Behavioral Support Services – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes
H2035	UB; HS	Addiction Counseling – Family/Couple without Member Present (Individual Setting); 1 Unit = 1 hour
H2035	UB; U1; HS	Addiction Counseling – Family/Couple without Member Present (Group Setting); 1 Unit = 1 hour
H0038	UB	Peer Support Services; 1 Unit = 15 minutes
T1016	UB	Care Coordination Services; 1 Unit = 15 minutes
H0034	UB	Medication Training and Support – Individual Setting; 1 Unit = 15 minutes
H0034	UB; HR	Medication Training and Support – Family/Couple with Member Present (Individual Setting); 1 Unit = 15 minutes
H0034	UB; HS	Medication Training and Support – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes
H0034	UB; U1	Medication Training and Support – Group Setting; 1 Unit = 15 minutes
H0034	UB; U1; HR	Medication Training and Support – Family/Couple with Member Present (Group Setting); 1 Unit = 15 minutes
H0034	UB; U1; HS	Medication Training and Support – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes

Table 3 − BPHC procedure codes with modifiers that do not require a copayment under HIP

Procedure code	Modifiers	Service description
T1016	UC	Case Management for BPHC BPHC- Tier 1: 1 Unit = 15 minutes
T1016	UC; U3	Case Management for BPHC BPHC- Tier 2: 1 Unit = per 15 minutes