IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201524 APRIL 9, 2015

IHCP clarifies application of *HIP Basic* copayments

Per *Indiana Health Coverage Programs (IHCP) Bulletin* BT201503, individuals eligible for the Healthy Indiana Plan (HIP) who do not make their Personal and Wellness Responsibility (POWER) Account contributions and have incomes less than the federal poverty level (FPL) are enrolled in *HIP Basic*. The *HIP Basic* plan, including the *HIP State Plan – Basic,* requires copayments from most members on most services. *HIP Plus* members are not subject to these copayments; therefore, members can avoid copayments by making their POWER Account contributions at enrollment or at their annual redeterminations.

The following *HIP Basic* and *HIP State Plan – Basic* members will not have copayments applied:

- Pregnant members
- American Indian/Alaska Native members
- Members who have met their maximum cost sharing for the quarter

The following services are exempt from copayment requirements:

- Preventive services
- Maternity services
- Family planning services
- Services provided for an emergency health condition

The standard Eligibility Verification System (EVS) options and a member's managed care entity (MCE) should be consulted each time a member receives a service to determine if the member is subject to copayments. Member copayment requirements can change during the benefit period. *HIP Basic* copayment amounts are shown in Table 1.

Table 1 – HIP Basic and HIP State Plan – Basic copayments

Service	Copayment
Outpatient services (physicians/hospitals) Outpatient services (dental)	$4 per visit $4 per service
Inpatient services	$75 per admission
Preferred drugs	$4 per prescription
Nonpreferred drugs	$8 per prescription

All reimbursement to providers is reduced by the applicable copayment amount. Member cost sharing is limited to 5% of their income on a quarterly basis and copayments count toward that limit. The member's MCE will track the copayments incurred by the member and copayments will be eliminated for the remainder of a quarter if the member reaches their cost-sharing limit.

The following examples demonstrate the application of copayments for outpatient services and prescriptions for members enrolled in *HIP Basic* or *HIP State Plan – Basic* who are not exempt from copayments. Guidance on copayments for services provided by community mental health centers is addressed in *IHCP Bulletin* BT201523.

Example A

A member has an office visit with a physician and is sent to the hospital for a CT scan and to a commercial lab for multiple lab tests.

Result: The member pays a $4 copayment to the physician for the office visit, a $4 copayment to the hospital imaging center for the CT scan, and a single $4 copayment for the lab services. Separate copayments are applied for outpatient services rendered by different providers at different provider locations.

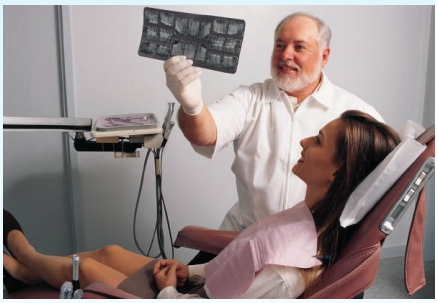
Example B

A member has an office visit with a physician where an X-ray and three lab tests are conducted in the physician's office.

Result: The member pays a single $4 copayment for the visit. Outpatient services (other than dental) rendered by a single provider at a single location are treated as a single "visit" for copayment purposes.

Example C

A member has a dental visit where screening X-rays are taken and the member receives a teeth cleaning and three fillings.



Result: Screening X-rays and cleanings are considered preventive services for which members do not owe copayments. The member owes a single $4 copayment for the three fillings; the member pays a total of $4 in copayments for the dental visit.

Example D

A member has a dental visit that includes services for three fillings and a fitting for a crown.

Result: The member owes a $4 copayment for the three fillings and a $4 copayment for the crown fitting. The member owes a total of $8 in copayments for this dental visit. Copayments for outpatient dental services are assessed for each service rendered even if they are delivered by the same provider at the same location on the same date.

Example E

A member goes to the pharmacy and has three preferred prescriptions filled.

Result: The member pays three $4 copayments, one for each preferred prescription, for a total amount of $12 in copayments. Copayments are applied per prescription filled, even if they are filled on the same date.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

Subscribe to Email Notices

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.