Healthy Indiana Plan 2.0:

Introduction, Plan options, Cost sharing, and Benefits

HEALTHY INDIANA PLAN SM

Health Coverage = Peace of Mind

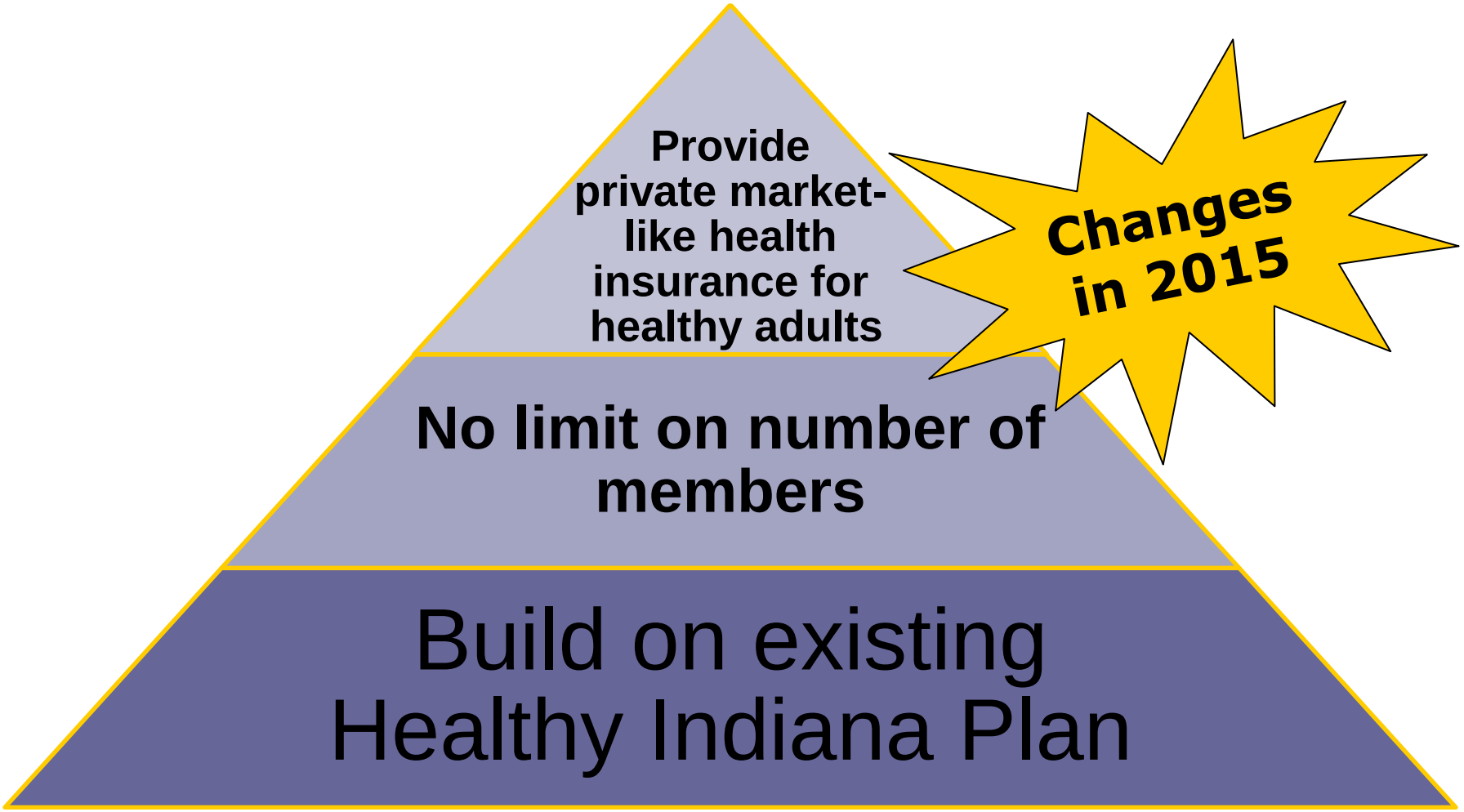
Objectives

- ✓ After reviewing this presentation, you will understand the following aspects of HIP 2.0:
  - Program features, including the POWER account
  - Plan options
    - HIP Basic
    - HIP Plus
    - HIP Link
    - 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



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
    - Annual contribution may be split between qualifying spouses
  - Members who do not make their monthly contribution face penalties
    - Income over 100% federal poverty level (FPL):
      - Unless exempt, member subject to 6 month lockout period and may not receive HIP benefits*
    - 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
    - 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

# in household	HIP Basic Income up to 100% FPL	HIP Plus Income up to ~138% FPL**
1	$973	$1,358.10
2	$1,311	$1,830.58
3	$1,650	$2,303.06
4	$1,988	$2,775.54

*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.

HIP 2.0: Plan Options

Best Value

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 to100% 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

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
    - 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

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

* 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

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

*Includes emergency-related transportation

HIP 2.0: Other Benefits

Other Benefits	HIP Plus	HIP Basic	HIP State Plan
Adult Vision	Covered	Not Covered	Covered
Adult Dental	Covered – Limited to 2 cleanings per year and 4 restorative procedures	Not Covered	Covered
Transportation	Not Covered	Not Covered	Covered
Medicaid Rehabilitation Option (MRO)	Not Covered	Not Covered	Covered
Pregnancy-Only	Additional benefits for pregnant women including transportation and chiropractic services.	Additional benefits for pregnant women including transportation, vision, dental and chiropractic services.	Pregnant women receive access to all pregnancy-only benefits on HIP Plus or HIP Basic plan and full State Plan benefits.

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
    - Contribution amount is approximately 2% of income
    - 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

POWER 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)

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- ✓ 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)

FPL	Monthly Income, Single Individual	Maximum Monthly PAC*, Single Individual	Maximum Monthly Income, Household of 2	Maximum Monthly PAC, Spouses**
<22%	Less than $214	$4.28	Less than $289	$2.89 each
23%-50%	$214.01 to $487	$9.74	$289.01 to $656	$6.56 each
51%-75%	$487.01 to $730	$14.60	$656.01 to $984	$9.84 each
76%-100%	$730.01 to $973	$19.46	$984.01 to $1,311	$13.11 each
101%-138%	$973.01 to $1,358.70	$27.17	$1,311.01 to $1,831.20	$18.31 each

*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

HIP Basic Plan: Cost Sharing

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.

Service	HIP Basic Copay Amounts Income ≤100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	Up to $25

Copayments may not be more than the cost of services received.

HIP Plus Contributions Are Not Premiums

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- ✓ 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:
    - POWER account contributions (PAC)
    - Emergency Room copayments
    - 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!

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- ✓ **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
    - Pay for employer plan premiums &
    - 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

HIP Plus (MARP)

- Household income up to ~138% FPL
- Best value plan
- Pay monthly POWER account contribution
- No copayments for most medical services

HIP Basic (MARB)

- Household income less than or equal to 100% FPL
- No POWER account contribution
- Pay copayments for most medical services

HIP State Plan Plus (MASP)

- Income under 138% FPL and:
  - Medically Frail, OR
  - Low-income Parents/Caretakers, OR
  - Low-income 19 & 20 year olds OR
  - Transitional Medical Assistance (TMA)*
- Make monthly POWER account contribution

HIP State Plan Basic (MASB)

- Income less than or equal to 100% FPL** and:
  - Medically Frail, OR
  - Low-income Parents/Caretakers, OR
  - Low-income 19 & 20 year olds, OR
  - TMA*

*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 :
  - diagnoses codes,
  - current treatments,
  - 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.**

HIP and Behavioral and Primary Healthcare Coordination (BPHC)

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

HIP and Behavioral and Primary Healthcare Coordination (BPHC)

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.