IHCP Eligibility
Agenda

• Division of Family Resources (DFR)
• Member eligibility overview
• Eligibility verification
• IHCP programs and benefits
• Other services
• Member copayments
• Helpful tools
• Questions
Division of Family Resources (DFR)
Who determines eligibility?

- Eligibility is determined by the Indiana Family and Social Services Administration (FSSA) Division of Family Resources (DFR).
- The DFR’s focus is the support and preservation of families by emphasizing self-sufficiency and personal responsibility.
- The DFR receives applications and approves eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP), and the cash assistance program, Temporary Assistance for Needy Families (TANF).
DFR – how to apply

• Applicants can apply online at www.dfrbenefits.in.gov.
• Applicants can call or fax 1-800-403-0864.
• Applicants can visit a local Division of Family Resources (DFR) office.
Health coverage

- Indiana offers several health coverage options to qualified low-income individuals and families, individuals with disabilities, and the elderly with limited financial resources.
- Each program is designed to meet the medical needs of that specific group of individuals.
- Each program uses a specific set of criteria to determine whether a person qualifies for that program.
Eligibility criteria

• To qualify, applicants must meet four main eligibility criteria:
  – Income/household size
  – Age
  – Financial resources/assets
  – Medical needs
There are 35 eligibility aid categories.

Examples:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Age Limit</th>
<th>Income Limit</th>
<th>Delivery System</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA X</td>
<td>Newborn born to mother on Medicaid</td>
<td>&lt;1</td>
<td>NA</td>
<td>HHW</td>
<td>Full</td>
</tr>
<tr>
<td>MA 2</td>
<td>Children</td>
<td>6-18</td>
<td>&lt;106% FPL</td>
<td>HHW</td>
<td>Full</td>
</tr>
<tr>
<td>MA MA</td>
<td>Pregnancy &amp; Post Partum</td>
<td>19-64</td>
<td>&lt;133% FPL</td>
<td>HIP Maternity</td>
<td>HIP State Plan</td>
</tr>
</tbody>
</table>
Member eligibility overview
IHCP programs and benefit plans

- Generally, program and service options are categorized under the fee-for-service (FFS) delivery system or the managed care delivery system.
- Some services may cross delivery systems, based on specific circumstances of individual members.
## FFS benefit plans

<table>
<thead>
<tr>
<th>Fee-for-Service Program</th>
<th>Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Medicaid</td>
<td>Full Medicaid, Package A Standard Plan</td>
</tr>
<tr>
<td>Medicare Savings Program (QMB, QDWI, QI, SLMB)</td>
<td>Qualifying Medicare premiums, copayments, and/or deductibles only, as applicable</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Package E – Emergency Services Only</td>
</tr>
<tr>
<td>Family Planning Eligibility Program</td>
<td>Family Planning Services Only</td>
</tr>
<tr>
<td>590 Program</td>
<td>590 Program Services</td>
</tr>
<tr>
<td>Traditional Medicaid Inpatient Hospital Services (Inmates)</td>
<td>Medicaid Inpatient Hospital Services Only</td>
</tr>
</tbody>
</table>
## FFS benefit plans

<table>
<thead>
<tr>
<th>Fee-for-Service Benefit Option</th>
<th>Benefit Plan</th>
</tr>
</thead>
</table>
| 1915(i) Home and Community-Based Services (HCBS) | • Adult Mental Health Habilitation services  
• Children’s Mental Health Wraparound services  
• Behavioral and Primary Healthcare Coordination services |
| 1915(c) HCBS Waiver | • Aged & Disabled services  
• Community Integration and Habilitation services  
• Family Supports services  
• Traumatic Brain Injury services |
| Medicaid Rehabilitation Option (MRO) | Medicaid Rehabilitation Option services |
## Managed care benefit plans

<table>
<thead>
<tr>
<th>Managed Care Program</th>
<th>Benefit Plan</th>
</tr>
</thead>
</table>
| Healthy Indiana Plan         | • HIP 2.0 Basic  
|                              | • HIP 2.0 Plus  
|                              | • HIP 2.0 State Plan Basic  
|                              | • HIP 2.0 State Plan Plus  
|                              | • HIP Maternity  |
| Hoosier Care Connect         | • Full Medicaid  
|                              | • Package A – Standard Plan  |
| Hoosier Healthwise           | • Package A – Standard Plan  
|                              | • Package C – Children’s Health Plan (SCHIP)  |
## Other services

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Review Team (MRT)</td>
<td>Medical Review Team screening only [FFS]</td>
</tr>
<tr>
<td>Preadmission Screening and Resident Review (PASRR)</td>
<td>PASRR Individuals with Intellectual Disability; PASRR Mental Illness (MI) screening only [FFS]</td>
</tr>
</tbody>
</table>
Member identification

• Each IHCP member is issued a 12-digit identification number that is referred to as the Member ID (also known as RID).
• The Member ID is assigned by the FSSA-DFR through the automated Indiana Client Eligibility System (ICES).
• Each member also receives a member identification card.
  – The type of card received depends on the IHCP program in which the member is enrolled.
Member identification cards

- Hoosier Health Cards are issued at program enrollment.
- After the DFR determines eligibility, cards are then generated and mailed within five business days of the action updating the IHCP Core Medicaid Management Information System (CoreMMIS).
  - The member must allow five business days plus mailing time to receive the card.
- A letter to inform the member of eligibility status is system-generated within 24 hours of eligibility determination.
Member identification cards

- The card is a permanent plastic identification card that the member is expected to retain for his or her lifetime.
- Members should retain their cards even if eligibility lapses, in case eligibility is reinstated at a later date.
- Members may contact their local DFR county office or call toll-free – 1-800-403-0864 – to request a replacement Hoosier Health Card.
Member identification cards

- Managed care entities (MCEs) issue their own cards for Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise
Eligibility verification
Eligibility Verification System

- Providers are required to verify member eligibility on the date of service.
- Providers that fail to verify eligibility are at risk of claims being denied due to member ineligibility or coverage limitations.
- Viewing a Member ID card alone does not ensure member eligibility.
- If the member is not eligible on the date of service, the member can be billed for services.
- If retroactive eligibility is later established, the provider must bill the IHCP and refund any payment that the member made to the provider.
How to verify member eligibility

• Providers can verify eligibility by using one of the following Eligibility Verification System (EVS) methods:
  – Provider Healthcare Portal
  – Approved vendor software for the 270/271 batch or interactive eligibility benefit transactions
  – Interactive Voice Response (IVR) system at 1-800-457-4584

• Customer Assistance representatives and Provider Relations field consultants do not provide eligibility verification information.
Impact of verifying eligibility

- Before rendering services, providers should always check member eligibility to determine the following:
  - Whether the member is eligible for the IHCP on the date of service.
  - Whether the member has other insurance coverage (known as third-party liability, or TPL) that takes precedence over the IHCP coverage.
  - What type of IHCP coverage the member has on the date of service.
  - Whether the member has a copayment responsibility.
  - Whether a member is enrolled through a managed care program and if so, to which MCE and primary medical provider (PMP) the member is assigned.
  - Whether the member is restricted to a designated pharmacy, hospital, and PMP through the Right Choices Program.
  - What level of care (LOC) is assigned for LTC or hospice members; also, whether a member who resides in an LTC facility has a patient liability and if so, how much liability to collect from the member.
Importance of verifying eligibility

Before rendering services, providers should always check member eligibility to determine the following:

- Whether the member has a patient liability for waiver or end-stage renal disease (ESRD)
- What services are authorized under the member’s Medicaid Rehabilitation Option (MRO) or 1915(i) HCBS plan (for applicable provider types only)
- Whether member benefit limitations have been reached
The DFR authorizes and initiates actions that affect member eligibility.

The EVS is updated daily with member eligibility information transmitted from the ICES.

The timing of the process (with the exception of Friday’s activity) is as follows:
- Information from ICES is downloaded from all counties daily after the close of business.
- The file is passed electronically to CoreMMIS between midnight and 5 a.m. the next day.
- CoreMMIS completes file processing by 9 a.m. the same day it receives the file.
Verifying eligibility for a specific date of service

• Eligibility can be verified up to one year in the past.
• Eligibility inquiries are limited to one calendar month.
• The EVS restricts providers from accessing member eligibility information for dates of service that are not within an active IHCP provider’s program eligibility segment.
Proof of eligibility verification

- Providers should retain proof that member eligibility was verified.
- The Provider Healthcare Portal contains a time-and-date stamp used for proof of timely eligibility verification.
- If a provider is required to prove timely eligibility verification, the provider must send a screen print from the Provider Healthcare Portal to the Written Correspondence Unit with a completed claim.
- If providers use the IVR system, they should document the verification number provided and record it for future reference.
IHCP programs and benefits
FFS programs

• Programs and services provided through the FFS delivery system are delivered by enrolled IHCP providers and reimbursed directly through the IHCP fiscal agent, DXC Technology.

• FFS programs include:
  – Traditional Medicaid
  – Medicare Savings Programs
  – Emergency Services Only
  – Family Planning Eligibility Program
  – 590 Program
  – Inpatient Hospital Services Only (for inmates)
Managed care programs

- Programs and services provided through the managed care delivery system are delivered by enrolled IHCP providers participating in managed care networks.
- Services are reimbursed by managed care entities (MCEs) contracted by the State to manage the care for their members.
- Managed care programs include:
  - Healthy Indiana Plan (HIP)
  - Hoosier Care Connect (HCC)
  - Hoosier Healthwise (HHW)
  - Program of All-Inclusive Care for the Elderly (PACE)
Traditional Medicaid

- Traditional Medicaid members are eligible for full coverage of Medicaid services, as described in the Indiana Medicaid State Plan.
- In conjunction with Full Medicaid/Package A – Standard Plan benefits, Traditional Medicaid members may, under certain circumstances, also be eligible for additional services, including:
  - 1915(c) HCBS Waiver services
  - 1915(i) Home and Community-Based Services
  - Medicaid Rehabilitation Option (MRO) services
Traditional Medicaid

• The Traditional Medicaid program provides coverage for healthcare services rendered to individuals in the following groups who meet eligibility criteria, such as specific income guidelines:
  – Persons in LTC facilities and other institutions, such as a nursing facility (NF) or an intermediate care facility for individuals with intellectual disability (ICF/IID)
  – Persons receiving hospice services in nursing facilities or in the home
  – Persons receiving home and community-based waiver services, including those with a waiver liability
  – Persons with both Medicare and Medicaid (dual eligibility)
  – Persons with end-stage renal disease (ESRD), including those with a patient liability
Traditional Medicaid

- Traditional Medicaid may also cover:
  - Persons enrolled in the breast or cervical cancer treatment program
  - Refugees who do not qualify for any other aid category
  - Wards of the State who opt out of Hoosier Care Connect
  - Current and former foster children who opt out of Hoosier Care Connect
Traditional Medicaid with HCBS waiver liability

- Some individuals with income in excess of the Traditional Medicaid threshold who are approved for HCBS waiver services are enrolled in Traditional Medicaid under the waiver liability provision.
- Waiver liability is similar to a deductible and works like the former “spend-down” provisions.
Medicare Savings Programs – QMB, SLMB, QI, QDWI

- Federal law requires that state Medicaid programs pay Medicare coinsurance or copayment, deductibles, and/or premiums for certain elderly and disabled individuals through a program called the Medicare Savings Program (MSP).

- For all QMBs, the IHCP pays the Medicare Part B premiums and Medicare Part A (as necessary).

- For Medicare covered services, the IHCP pays the lower of:
  - The excess of the Medicaid “allowable” over the Medicare payment or
  - The sum of the Medicare deductible/coinsurance/copay

- The member is never responsible for the amount disallowed (paid at zero) when Medicare paid more than the IHCP-allowed amount for the service.
MSP Categories

- QMB Only (Qualified Medicare Beneficiary)
- QMB Also without HCBS waiver liability
- QMB Also with HCBS waiver liability
- SLMB Only (Specified Low-Income Medicare Beneficiary)
- SLMB Also without HCBS waiver liability or ESRD patient liability
- SLMB Also with HCBS waiver liability or ESRD patient liability
- QI (Qualified Individual)
- QDWI (Qualified Disabled Working Individual)
Emergency Services Only – Package E

- Emergency Services Only (Package E) is for individuals who are otherwise eligible for Medicaid but who may not meet citizenship or immigration-status requirements for the program.
- Health coverage under Package E is limited to treatment for medical emergency conditions, defined as:
  - A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member’s health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any organ or part.
## Package E billing instructions

<table>
<thead>
<tr>
<th>Claim Form</th>
<th>Form Field and Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS-1500 Claim Form</strong></td>
<td>Field 24C: EMG – Enter Y for Yes for emergency services.</td>
</tr>
</tbody>
</table>
| **ADA 2006 Dental Claim Form**      | Field 2: PREDETERMINATION/PREAUTHORIZATION NUMBER – Enter the word Emergency in this field to indicate an emergency situation.  
Field 45: TREATMENT RESULTING FROM – Use this field to indicate if the treatment is a result of an occupational illness or injury, an auto accident, or other accident. |
| **UB-04 Claim Form**                | Field 14: ADMISSION TYPE – For inpatient claims, enter a type code of 1 for an emergency admission.  
Field 67: [PRINCIPAL DIAGNOSIS CODE] – For outpatient claims, enter the appropriate emergency diagnosis code. |
| **IHCP Drug Claim Form**            | Field 03: EMERGENCY – Enter YES for emergency services.                                              
Field 11: DAYS SUPPLY – Days supply must be less than 5 for emergency services.                       |
| **IHCP Compounded Prescription Claim Form** | Field 04: EMERGENCY – Enter YES for emergency services.                                                
Field 13: DAYS SUPPLY – Days supply must be less than 5 for emergency services.                      |
Family Planning Eligibility Program

• The Family Planning Eligibility Program only provides family planning services to qualifying men and women.
• The Family Planning aid category includes men and women of any age who:
  – Do not qualify for any other category of Medicaid
  – Are not pregnant
  – Have not had a hysterectomy or sterilization
  – Have income that is at or below 141% of the federal poverty level
  – Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens
Family Planning Eligibility Program

- Services rendered to members in the Family Planning Eligibility Program are reimbursed through the FFS delivery system.
- The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy.
590 Program

- Covers certain healthcare services provided to members 21 to 64 years of age who are residents of State-owned facilities
- Facilities operated under the direction of Division of Mental Health and Addiction (DMHA) and the Indiana State Department of Health (ISDH)
- Incarcerated individuals residing in Department of Correction (DOC) facilities are not covered.
- Members enrolled are eligible for the full array of benefits, with the exception of transportation services (which are provided by facility).

* Only 590-enrolled providers can render services to 590 members.
The IHCP covers inpatient services for IHCP-eligible inmates admitted as inpatients to an acute care hospital, nursing facility, or intermediate care facility.

Eligibility for IHCP coverage requires the inmate to meet standard eligibility criteria, as determined by the DFR.

When an inmate is admitted to the inpatient facility, the medical provider will assist the inmate in completing the Indiana Application for Health Coverage.

The IHCP EVS indicates a benefit plan of Medicaid Inpatient Hospital Services Only for inmates with this coverage.
HCBS waivers cover a variety of home and community-based services not otherwise reimbursed by the IHCP.

Available to members who require the level-of-care (LOC) services provided in a nursing facility, hospital, or ICF/IID, but choose to remain in the home.

Eligibility requires the following:
- Must meet eligibility guidelines for Traditional Medicaid
- Member would require institutionalization in the absence of the waiver services.
- If enrolled in managed care, the member must be disenrolled from managed care and enrolled in Traditional Medicaid.
1915(i) HCBS nonwaiver services

- **Section 1915(i)** of the *Social Security Act* (SSA) gives states the option to offer a wide range of home and community-based services to members through state Medicaid plans.

- States can offer services and supports to a target group of individuals to help them remain in the community:
  - Serious mental illness
  - Emotional disturbance
  - Substance use disorders

- Eligible individuals may receive authorized services in conjunction with Traditional Medicaid, HIP State Plan, Hoosier Care Connect, or Hoosier Healthwise benefits.
Medicaid Rehabilitation Option (MRO) Services

- MRO services must be provided by community mental health centers (CMHCs).
- MRO services include outpatient mental healthcare for the seriously mentally ill or seriously emotionally disturbed, partial hospitalization services, and case management services.
- Outpatient mental health services may include clinical attention in the member’s home, workplace, mental health facility, emergency department, or wherever needed.
Presumptive Eligibility (PE)

• The Presumptive Eligibility (PE) process allows hospitals, physician offices, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and local health departments to make PE determinations for certain eligibility groups to receive temporary health coverage under the IHCP until official eligibility is determined.

• Aid categories eligible for PE include:
  – Low-income infants and children
  – Low-income parents or caretakers
  – Low-income adults
  – Low-income pregnant women
  – Former foster care children
  – Individuals eligible for family planning services only
Presumptive Eligibility (PE)

- After enrollment, the individual receives PE coverage until the last day of the month following his or her month of enrollment or until a determination is made on his or her completed *Indiana Application for Health Coverage*.
- The individual receives temporary coverage reimbursed on a fee-for-service (FFS) or managed care basis, appropriate to the aid category under which he or she qualifies.
Medical Review Team

- Individuals determined by the Social Security Administration to be disabled are considered disabled for Medicaid purposes.
- For all others, the DFR is responsible for determining initial and continuing eligibility for Medicaid disability.
- To meet the disability requirement, a person must have an impairment that is expected to last a minimum of 12 months.
- The Medical Review Team (MRT) determines whether an applicant meets the Medicaid disability definition, based on medical information that the DFR collects and provides to the MRT.
The goal of the RCP is to provide quality care through healthcare management, ensuring that the right service is delivered at the right time and in the right place for members who have been identified as using services more extensively than their peers.

The RCP member remains eligible to receive all medically necessary, covered services allowed by the IHCP, under his or her benefit plan.

Services are reimbursed only when rendered by the member’s assigned RCP providers or when rendered by a specialist who has received a valid, written referral from the member’s primary RCP physician.
The Preadmission Screening and Resident Review (PASRR) process is a requirement for all residents of IHCP-certified nursing facilities.

The screening identifies individuals who may have:
- Mental illness (MI)
- Intellectual disability/developmental disability (ID/DD)
- Mental illness/intellectual disability/developmental disability (MI/ID/DD)

PASRR coverage is identified in the EVS as PASRR Mental Illness (MI) or PASRR Individuals with Intellectual Disability (IID).
Member copayments
Member copayments

• Some Indiana Health Coverage Programs (IHCP) members are required to contribute a copayment for certain services.

• The copayment is made by the member and collected by the provider at the time the service is rendered.

• The amount of the copayment is automatically deducted from the provider’s payment; therefore, the provider should not subtract the copayment from the submitted charge.
Member copayments

• Providers may not deny services to any member due to the member’s inability to pay the copayment amount on the date of service.
• This service guarantee does not apply to a member who is able to pay, nor does a member’s inability to pay eliminate his or her liability for the copayment.
• It is the member’s responsibility to inform the provider that he or she cannot afford to pay the copayment on the date of service.
  • The provider may bill the member for copayments not paid on the date of service.
Copayment limitations

- Members with cost-sharing obligations (such as copayments, contributions, premiums, deductibles, or other Medicaid-related charges) are not required to pay more than 5% of the family’s total countable income toward these charges.
- Limit is based on calendar quarters.
- Members reaching this limit will receive written notice informing them that cost-sharing obligations are suspended for the remainder of the current quarter.
- Members are instructed to present their notice to IHCP providers in lieu of paying a copayment.
Reminder
Claim filing limit

The IHCP will mandate a 180-day filing limit for fee-for-service (FFS) claims, effective January 1, 2019. Refer to **BT201829**, published on June 19, 2018, for additional details.

• The 180-day filing limit will be effective based on date of service:
  – Any services rendered on or after January 1, 2019, will be subject to the 180-day filing limit.
  – Dates of service before January 1, 2019, will be subject to the 365-day filing limit.

*Watch for additional communications!*
Helpful tools
**Helpful tools**

**Provider Relations Consultants**

<table>
<thead>
<tr>
<th>REGION</th>
<th>FIELD CONSULTANT</th>
<th>EMAIL</th>
<th>TELEPHONE</th>
<th>COUNTRIES SERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jean Downs</td>
<td><a href="mailto:INIXRegion1@dxc.com">INIXRegion1@dxc.com</a></td>
<td>(317) 488-5071</td>
<td>Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St.Joseph, Starke, Steuben, Whitley, Chicago, Watseka, Sturgis</td>
</tr>
<tr>
<td>2</td>
<td>Shari Galbreath</td>
<td><a href="mailto:INIXRegion2@dxc.com">INIXRegion2@dxc.com</a></td>
<td>(317) 488-5080</td>
<td>Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountaininn Grant, Howard, Hutington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White, Danville</td>
</tr>
<tr>
<td>3</td>
<td>Crystal Woodson</td>
<td><a href="mailto:INIXRegion3@dxc.com">INIXRegion3@dxc.com</a></td>
<td>(317) 488-5324</td>
<td>Boonem Hamilton, Hendricks, Johnson, Marion, Morgan</td>
</tr>
<tr>
<td>4</td>
<td>Ken Guth</td>
<td><a href="mailto:INIXRegion4@dxc.com">INIXRegion4@dxc.com</a></td>
<td>(317) 488-5153</td>
<td>Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderbirgh, Vermillion, Vigo, Warrick, Owensboro</td>
</tr>
<tr>
<td>5</td>
<td>Virginia Hudson</td>
<td><a href="mailto:INIXRegion5@dxc.com">INIXRegion5@dxc.com</a></td>
<td>(317) 488-5186</td>
<td>Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne, Louisville, Cincinnati, Harrison, Hamilton, Oxford</td>
</tr>
<tr>
<td></td>
<td>Judy Green</td>
<td></td>
<td>(317) 488-5026</td>
<td>All other out of state areas not previously listed</td>
</tr>
<tr>
<td></td>
<td>Team Lead</td>
<td>Jenny Atkins</td>
<td>(317) 488-5032</td>
<td></td>
</tr>
</tbody>
</table>
Helpful tools

IHCP website at indianamedicaid.com:
• IHCP Provider Reference Modules
• Medical Policy Manual
• Contact Us – Provider Relations Field Consultants

Customer Assistance available:
• Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
• 1-800-457-4584

Secure Correspondence:
• Via the Provider Healthcare Portal
• Written Correspondence:
  DXC Technology Provider Written Correspondence
  P.O. Box 7263
  Indianapolis, In 46207-7263
Questions

Following this session, please review your schedule for the next session you are registered to attend.