

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201619 APRIL 5, 2016

FSSA modifies process for making HIP medically frail determinations

As announced in *Indiana Health Coverage Programs (IHCP) Bulletin [BT201507](#)*, the Healthy Indiana Plan (HIP) includes enhanced coverage for members who have been identified as medically frail. A HIP member is considered medically frail if the individual has one or more of the following:

- 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)



BT201507 indicated that an individual could be identified for medically frail screening in one of three ways – through the IHCP application process, as a result of claim reviews, or by self-report. In October 2015, however, the Indiana Family and Social Services Administration (FSSA) discontinued using the health condition questionnaire during the IHCP application process to identify applicants who may have a qualifying condition. In December 2015, at the direction of the Centers for Medicare & Medicaid Services (CMS), the questionnaire was removed from the IHCP application process entirely. The only medically frail determination that continues to be made through the application process is for individuals with a disability determination from the SSA; these individuals are automatically assigned a medically frail status.

The IHCP continues to rely on claim reviews and self-reporting as mechanisms for identifying medically frail members. Providers may also report on potentially medically frail members. The member's managed care entity (MCE) is responsible for conducting health-risk assessments and making medically frail determinations for identified members.

Members are determined medically frail by their MCE through a health-risk assessment. If you believe a member's medical condition would qualify him or her for enhanced coverage under the medically frail status, please advise the member to reach out to his or her MCE or contact the MCE directly to report on the member's health condition.

Medically frail assessment

Each HIP MCE has processes in place for members to self-report and for providers to notify the MCE of members who may have a qualifying condition. Potentially medically frail members may be reported to the MCE at any time during the members' HIP benefit period. MCEs may also identify potentially medically frail members based on medical or pharmacy claim reviews. MCEs have 30 calendar days from the date a member self-reports or from the date a provider reports a member to the MCE to make a medically frail determination.

Members must be notified of the assessment outcome within three business days of the completed assessment. Written notification must be provided to members who self-report but who are not confirmed medically frail.

The medically frail assessment process uses *Milliman's Medical Underwriting Guidelines*. The guidelines assign a point value to health conditions, including behavioral health and substance use disorders. Members who meet the criteria using the Milliman guidelines will receive State Plan benefits (*HIP State Plan – Plus* or *HIP State Plan – Basic*) effective

from the date of determination. Although the same *HIP Plus* or *HIP Basic* cost-sharing structures are in place, the *State Plan* benefit package for medically frail members provides additional benefits that are not covered under the *HIP Plus* or *HIP Basic* plans. Unless there is a change in the member's condition, he or she will remain active in the medically frail category for 12 months from the MCE's determination date. A member's medically frail status must be reconfirmed by the member's MCE every 12 months.



QUESTIONS?

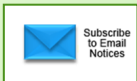
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