IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201728 APRIL 20, 2017

IHCP clarifies how eligibility and coverage are reported in *Core*MMIS

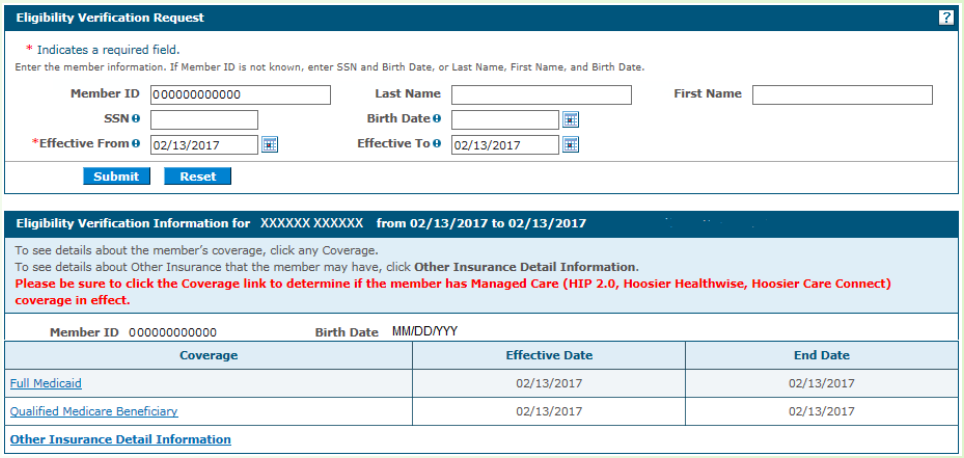
The Indiana Health Coverage Programs (IHCP) has received a number of inquiries from providers regarding the eligibility and coverage information that *Core*MMIS conveys through the IHCP Eligibility Verification System (EVS) options – the Provider Healthcare Portal (Portal), the Interactive Voice Response (IVR) system, and electronic data interchange (EDI) eligibility transactions. Eligibility and coverage information is reported differently in *Core*MMIS than it was in Indiana*AIM*.

Eligibility verification in the Portal is a two-step process

Verifying eligibility in the Portal requires a simple two-step process. First, the system verifies the member's active coverage for one or more benefit plans. Second, the system provides details and limitations about the member's coverage that providers need to know. The steps below describe this process for verifying eligibility using the Portal.

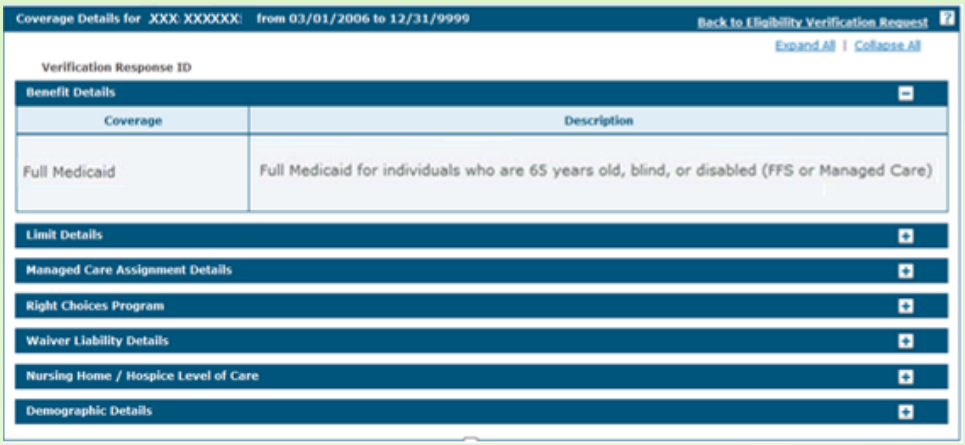
- **Step 1: Verifying Active Coverage**: When a provider searches for a member via the Eligibility Verification Request panel, the Portal displays the coverage results including the active benefit plans for which the member was eligible on the dates of service (DOS) indicated. Note that more than one benefit plan may be listed for a member (see Figure 1). If an individual is not found or is not eligible for services on the specified DOS, the Portal will display "*There are no coverage details to show based on the search criteria selected*."

Figure 1 – Eligibility Verification Request panel and coverage results



- **Step 2: Verifying Coverage Details**: To see detailed information about the member's coverage, providers must click the links associated with the benefit plans listed under the "Coverage" column. The *Coverage Details* page displays panels with information **applicable to the benefit plan or the member's eligibility** (See Figure 2). If the panel does not display, it is not applicable.

Figure 2 – Coverage Details page showing panels that might display if the panel is applicable to the benefit plan or the member



The following summarizes the type of information providers will find under each coverage detail panel:

- **Benefit Details**: Description of the benefit plan for which the member is eligible as well as copayments associated with the benefit plan; if copayments do not display, none apply or the member has met his or her cost-sharing obligation (see Figure 3)
- **Limit Details**: Benefit limits, including the member's dollar and service limit status based on claims that are processed through *Core*MMIS
- **Managed Care Assignment Details**: Managed care information, including program name and managed care entity (MCE) and primary medical provider (PMP) assignments (See Figure 4)
- **Right Choices Program**: Information about Right Choices Program lock-in provider assignments
- **Waiver Liability Details**: Waiver liability obligation and balance for the month identified
- **Nursing Home/Hospice Level of Care**: Level-of-care (LOC) assignment for long-term care (LTC) facility or hospice members, including effective and end dates for the LOC, as well as the LTC facility patient liability or client obligation amount
- **Detail Information**: Approved Medicaid Rehabilitation Option (MRO) or 1915(i) services (*Note: Only users with the specialties related to MRO or 1915(i) services will see this panel; it is not illustrated in Figure 2*.)
- **Demographic Details**: Demographic information about the member

Figure 3 – Benefit Details panel showing copayments apply

Benefit Details

Coverage	Description
Community Integration and Habilitation HCBS Waiver	Authorized Community Integration and Habilitation Waiver services found in the Notice of Action (NOA)
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums

Coverage	Copayments	Amount
Full Medicaid	Medically Related Transportation	$2.00
Full Medicaid	Hospital - Outpatient	$3.00
Qualified Medicare Beneficiary	Medically Related Transportation	$2.00
Qualified Medicare Beneficiary	Hospital - Outpatient	$3.00

Figure 4 – Coverage Details page showing Benefit Details and Managed Care Assignment Details expanded

For complete instructions on how to verify eligibility on the Portal, see the *Eligibility* section of the *Provider Healthcare Portal* provider reference module.

Coverage under the "Full Medicaid" or "Package A – Standard Plan" benefit plans

Comprehensive Medicaid benefits are provided to qualifying individuals who are 65 years of age or older, blind, or disabled. This coverage is reported in the EVS as either "Full Medicaid" or "Package A – Standard Plan" and may be provided through the fee-for-service (FFS) delivery system or through the managed care delivery system. Providers must click the "Full Medicaid" or "Package A – Standard Plan" hyperlink to determine whether the member's benefits are covered through FFS or through managed care.

- If the *Managed Care Assignment Details* panel **does not appear** on the *Coverage Details* page, the coverage is delivered via FFS through enrollment in Traditional Medicaid.
- If the *Managed Care Assignment Details* panel **does appear** on the *Coverage Details* page, the coverage is delivered via managed care, primarily through enrollment in the Hoosier Care Connect program. See Figure 4.

Providers should be aware that the "Full Medicaid" and "Package A – Standard Plan" benefit plans will sometimes be listed in conjunction with other benefit plans. Multiple benefit plans are listed when the member qualifies for comprehensive Medicaid benefits as well as other benefits, such as Home and Community-Based Services (HCBS), MRO services, Qualified Medicare Beneficiary (QMB) services, and Specified Low-Income Medicare Beneficiary (SLMB) services.

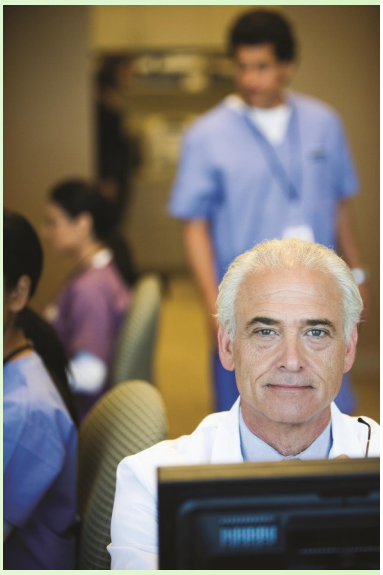
To further clarify how to interpret QMB and SLMB coverage when combined with "Full Medicaid" or "Package A – Standard Plan," providers should be aware that:

- If a member is eligible for either the "Full Medicaid" or the "Package A" benefit plan and **also** the "Qualified Medicare Beneficiary" or the "Specified Low Income Medicare Beneficiary" benefit plan, the member's coverage is

referred to as "QMB Also" or "SLMB Also." (*Note: These members are considered to be dually enrolled in Medicare and Medicaid.)*

- If a member is eligible for only the "Qualified Medicare Beneficiary" benefit plan or only the "Specified Low Income Medicare Beneficiary" benefit plan – and **not also** for either the "Full Medicaid" or the "Package A" benefit plan – the member's coverage is referred to as "QMB Only" or "SLMB Only." *(Note: These members are not considered to be dually enrolled in Medicare and Medicaid – they are considered to be enrolled in Medicare only.)*

MRT and PASRR coverage



With *Core*MMIS, providers may see the following benefit plans:

- Medical Review Team
- PASRR Mental Illness (MI)
- PASRR Individuals with Intellectual Disabilities

Note: These benefit plans were not displayed in IndianaAIM; instead, a member eligible for these benefits was identified by his or her member identification number (RID).

The Medical Review Team (MRT) and Preadmission Screening and Resident Review (PASRR) benefit plans indicate that the individual is eligible for medical testing, evaluation, or prescreening to determine IHCP eligibility or level-of-care needs. Participation as an MRT provider requires qualified providers to enroll with the IHCP specifically to provide these services. PASRR providers must be approved and certified by the appropriate state agency and enrolled with the IHCP to specifically provide these services. **Only providers enrolled with the IHCP as MRT or PASRR providers can bill for these services**. The member is not eligible for other services under that benefit plan, but may be eligible for services under additional benefit plans, if other coverage is indicated for the member.

For example, if an eligibility verification displays only "Medical Review Team" as the benefit plan for a member, the member is only eligible for services related to the MRT assessment process for the DOS. If an eligibility verification displays both "Medical Review Team" and "Full Medicaid," the member is eligible for MRT assessment services **and** full Medicaid benefits for that DOS.

*Core*MMIS eligibility and coverage information

*Core*MMIS reports IHCP member eligibility based on an individual's active coverage for a specified DOS. If an individual has active eligibility on the specified DOS, *Core*MMIS will report coverage details for each active benefit plan found for the member. Providers can refer to Table 1 for a comprehensive list of benefit plans and coverage descriptions that exist in *Core*MMIS. Additional information about IHCP programs and benefit plans can be found in the *Member Eligibility and Benefit Coverage* provider reference module at indianamedicaid.com.

Table 1 – IHCP member benefit plans and descriptions

Coverage	Description
590 Program	590 Program – Residents in State Mental Health Facilities
Adult Mental Health Habilitation	Authorized Adult Mental Health Habilitation services found in the Notice of Action (NOA)
Aged and Disabled HCBS Waiver	Authorized Aged and Disabled Waiver services found in the Notice of Action (NOA)
Autism HCBS Waiver*	Authorized Autism HCBS Waiver services found in the Notice of Action (NOA)
Behavioral and Primary Healthcare Coordination	Authorized Care Coordination services found in the Notice of Action (NOA)
CA PRTF Demonstration Grant*	Authorized CA PRTF Demonstration Grant services found in the Notice of Action (NOA)
Children's Mental Health Wraparound	Authorized Children's Mental Health services found in the Notice of Action (NOA)
Community Integration and Habilitation HCBS Waiver	Authorized Community Integration and Habilitation Waiver services found in the Notice of Action (NOA)
Family Planning Eligibility Program	Family Planning services only
Family Supports HCBS Waiver	Authorized Family Supports HCBS Waiver services found in the Notice of Action (NOA)
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)
HIP 2.0 Basic	HIP 2.0 Regular Basic-No MRO services
HIP 2.0 Plus	HIP 2.0 Regular Plus-No MRO services
HIP 2.0 State Plan Basic	HIP 2.0 State Plan Basic
HIP 2.0 State Plan Plus	HIP 2.0 State Plan Plus
HIP 2.0 State Plan Plus Copay	HIP 2.0 State Plan Plus Copay
HIP Employer Link	HIP Employer Link
Medicaid Inpatient Hospital Services Only	Inpatient Hospital services only for members in a County/State/Federal Facility
Medicaid Rehabilitation Option	Medicaid Rehabilitation Option services
Medical Review Team	Medical Review Team procedure codes only
MFP Community Integration and Habilitation	Authorized MFP Community Integration and Habilitation services found in the Notice of Action (NOA)
MFP Demonstration Grant [Aged and Disabled]	Authorized MFP [Aged and Disabled] Demonstration Grant services found in the Notice of Action (NOA)
MFP PRTF transition from PRTF	Authorized MFP PRTF Transition from PRTF services found in the Notice of Action (NOA)
MFP Transition from State Owned Facility*	Authorized MFP Transition from State Owned Facility services found in the Notice of Action (NOA)
MFP Traumatic Brain Injury	Authorized MFP Traumatic Brain Injury services found in the Notice of Action (NOA)

* *These coverage benefit plans are no longer active but are included in CoreMMIS historical records.*

Table 1 – IHCP member benefit plans and descriptions (Continued)

Coverage	Description
Package A – Standard Plan	Package A – Standard Plan
Package B – Pregnancy Coverage Only*	Package B – Pregnancy Coverage Only
Package C – Children's Health Plan (SCHIP)	Package C – Children's Health Plan (SCHIP)
Package E – Emergency Services Only	Covered services are limited to those designated as an emergency service
PASRR Individuals with Intellectual Disability	Pre-Admission Screening and Resident Review (PASRR) Individuals with Intellectual Disability (IID) claims processing for community mental health centers (CMHC) and diagnostic and evaluation (D&E) teams
PASRR Mental Illness (MI)	Pre-Admission Screening and Resident Review (PASRR) Mental Illness claims processing for community mental health centers (CMHC) and diagnostic and evaluation (D&E) teams
Presumptive Eligibility Family Planning services Only	Family Planning services Only
Presumptive Eligibility for Pregnant Women	Pregnancy Related services Only
Presumptive Eligibility – Adult	Mirrors HIP 2.0 Regular Basic-No MRO services
Presumptive Eligibility – Package A Standard Plan	Presumptive Eligibility – Package A Standard Plan
Program of All-Inclusive Care for the Elderly	Covered services are limited to those of the PACE Program Provider
PRTF Transition Waiver*	Authorized PRTF Transition Waiver services found in the Notice of Action (NOA)
Qualified Disabled Working Individual (QDWI)	The member's benefit is payment of the Medicare Part A Premium only
Qualified Individual	The member's benefit is payment of the Medicare Part B Premium only
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary – Members for whom coinsurance and deductibles are paid as well as Medicare Part B premiums
Specified Low Income Medicare Beneficiary	Specified Low Income Medicare Beneficiary – Members for whom Medicare Part B premiums are paid
Traumatic Brain Injury HCBS Waiver	Authorized Traumatic Brain Injury HCBS Waiver services found in the Notice of Action (NOA)

** These coverage benefit plans are no longer active but are included in CoreMMIS historical records.*

QUESTIONS?

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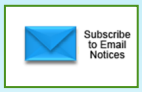

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