IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201814 APRIL 24, 2018

IHCP reminds providers to regularly verify eligibility and coverage for members in ICFs

Individuals with an intellectual disability, who have Indiana Health Coverage Programs (IHCP) coverage and are served in an intermediate care facility (ICF), must be assigned to the correct aid category (eligibility) and benefit plan (coverage) for reimbursement of ICF services. The member must have a disability or level-of-care (LOC) determination to be assigned the proper eligibility category. The member must be covered under one of the following benefit plans through the fee-for-service (FFS) delivery system for ICF services to be covered:

- *Full Medicaid*
- *Package A – Standard Plan*

Members with the proper coverage would have no managed care assignment indicated in their eligibility file. Figures 1 and 2 illustrate how coverage for *Full Medicaid* and *Package A – Standard Plan* would display for these members when verifying member eligibility on the IHCP Provider Healthcare Portal (Portal). The *Managed Care Assignment Details* panel will not display, which indicates the member is covered through the FFS delivery system.

Figure 1 – Eligibility screen for members with Full Medicaid coverage in the FFS delivery system

Coverage Details for Participant Name **from 02/23/2018 to 02/23/2018**

Member ID 12 Digit RID **Birth Date** MM/DD/YYYY Expand All | Collapse All

Verification Response ID

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	02/23/2018	02/23/2018
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	02/23/2018	02/23/2018

Figure 2: Eligibility screen for members with Package A – Standard Plan in the FFS delivery system

Coverage Details for Participant Name **from 11/30/2017 to 11/30/2017**

Member ID 12 Digit RID **Birth Date** MM/DD/YYYY Expand All | Collapse All

Verification Response ID

Benefit Details

Coverage	Description	Effective Date	End Date
Package A-Standard Plan	Package A-Standard Plan	11/30/2017	11/30/2017

Provider responsibilities and actions

Providers serving IHCP members in ICF settings are responsible for verification of the member's active eligibility and coverage status at the onset of service delivery as well as on an ongoing basis. At a minimum, facility providers should verify this information monthly. Because most changes to eligibility or coverage status occur at the beginning of calendar months, it is recommended that eligibility verifications be timed accordingly. Providers can use any of the IHCP Eligibility Verification System (EVS) options – the Portal, the Interactive Voice Response (IVR) system, or 270/271 electronic transactions – to determine active eligibility and coverage status.

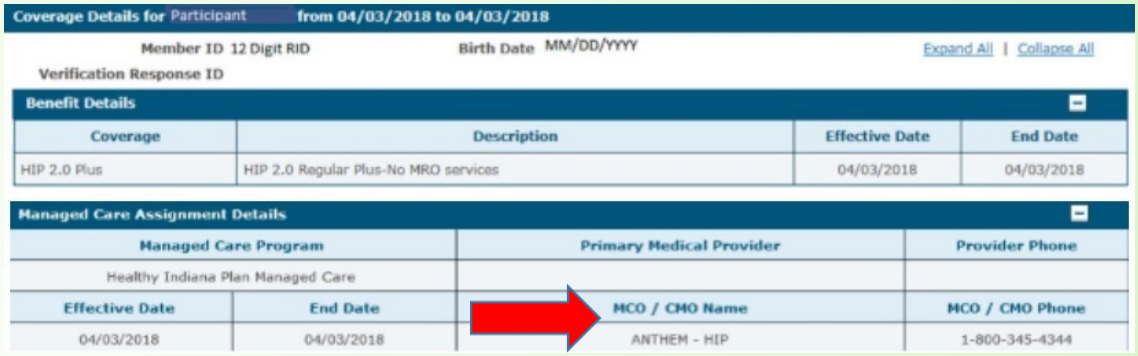
If a provider discovers that a member's IHCP eligibility or coverage status has changed inappropriately, the provider must immediately contact the Division of Family Resources (DFR). There may be instances where the provider first becomes aware of a member's eligibility or coverage change when claims for the member begin to deny. Although the DFR cannot correct or address reimbursement issues, if the reimbursement issue is eligibility-related, the latter must be resolved first. Providers should be aware that if a member's eligibility and coverage status changes to a managed care category, in some instances the eligibility/coverage resolution **cannot be made retroactive,** which means ICF services rendered during the affected time period cannot be reimbursed by the IHCP.

There are a number of situations that might cause a member's eligibility or coverage to change. Common situations are outlined in the following sections and require attention or action by the facility provider as noted:

Eligibility and coverage changes at age 19

Members served in a State-certified facility (ICF or group home) should apply for adult disability benefits with the Social Security Administration (SSA) before the member's 18th birthday. If a member residing in such a facility turns 19 years of age, and there is no SSA disability determination on file, the member's eligibility will automatically be reconsidered and the member likely will be systematically reassigned to the Healthy Indiana Plan (HIP), which serves qualifying nondisabled adults. Figure 3 illustrates how coverage under HIP would display when verifying member eligibility on the Portal. In this instance, the *Managed Care Assignment Details* panel displays, listing the member's managed care entity (MCE).

Figure 3 – Eligibility screen for members with HIP coverage in the managed care delivery system



HIP does not cover institutional services such as those provided in a group home or ICF setting. After a member is enrolled in HIP, changes to restore their *Full Medicaid* coverage cannot be made retroactive. ICF providers should anticipate the aging of members to ensure proactive steps are taken to maintain the members' eligibility for ICF services. If a provider discovers that a member's IHCP eligibility or coverage status has been changed to HIP, the provider must immediately contact the DFR and request that the member's eligibility be reconsidered for the "Disabled" aid category.

Eligibility and coverage changes due to Social Security status

If there is a change in the member's status with the SSA or their SSA benefits, this change may also affect a member's IHCP eligibility and coverage status. Notices of such changes and requests for information or follow-up action from the SSA must be addressed in a timely manner by a member's authorized representative (AR) to prevent changes to or termination of IHCP coverage. Additional information regarding ARs is provided in this bulletin.

Eligibility and coverage changes due to issues originating at the DFR

Similar to changes with the SSA, any notifications or requests of action by the DFR must be addressed in a timely manner. Notification that a member's eligibility or coverage is changing or ending, or that additional information is needed by the DFR to prevent termination of benefits signals the need for a timely response from the member's designated AR.

Authorized representative considerations

If the provider is the designated AR for the member, the provider has additional responsibility to ensure the member's eligibility and coverage status remain current and accurate. The provider must have familiarity with the member to the extent the provider can correctly and accurately respond to specific, detailed questions and requests for information. Providers that serve as ARs should be aware of the following:

- A person can have more than one AR.
- For individuals 18 years of age and older, no information can be released to a third party (including parents, case managers, providers, and so on) unless an AR form for that party is on file with the DFR.
- ARs must have working knowledge of the member's information including income, resources, residency, and so on.
- It is necessary to keep the DFR updated of AR changes, such as address and telephone number changes. Failure to do so could result in DFR notices not being sent to the AR and consequently in loss of IHCP coverage. Please go to the *DFR Forms* page at the in.gov/fssa website to obtain an AR form.

A provider designated as the AR must follow up immediately and directly with the DFR on any notifications, requests for information, or updates related to an individual.

Follow up with the DFR

If a provider identifies an eligibility or coverage change for a member, or believes the incorrect eligibility or coverage has been assigned for a member, the provider should immediately contact the DFR at 1-800-403-0864 to request a review of the issue. If the submitting provider is not on file as an AR, the DFR will review the case but the DFR cannot release any findings back to the provider directly. Additional contact information can be found on the DFR website at in.gov/fssa. Please note that the DFR is unable to resolve claim-related issues or answer questions about specific claim submission requirements. The entity responsible for the member's care can assist with these inquiries.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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