



Iowa Department of Human Services

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GENERAL LETTER NO. 8-M-45

ISSUED BY: Bureau of Financial, Health and Work Supports
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 8, Chapter M, **MEDICAID SERVICES**, pages 4, 5, 10, 18, 43, 53, 57, and 61, revised.

Summary

Chapter 8-M is revised to:

- ◆ Remove references to the IowaCare program.
- ◆ Update the names of forms.

Effective Date

Upon receipt.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 8, Chapter M:

<u>Page</u>	<u>Date</u>
4, 5	January 2, 2015
10	November 18, 2011
18	January 17, 2014
43	January 2, 2015
53	December 3, 2010
57	August 17, 2012
61	August 17, 2012

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

To begin the enrollment and certification process, the provider must submit form 470-4990, *Application for Authorization to Make Presumptive Medicaid Eligibility Determination for Children*, which is available on line at <http://dhs.iowa.gov/ime/providers/forms>.

After receiving form 470-4990, the Department will determine if the applicant meets the criteria to become a qualified entity. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See ***Medicaid All Providers Manual***, [Chapter II](#), for copies of these forms.

Qualifying to Determine Presumptive Eligibility for Pregnant Women

Legal reference: 441 IAC 75.1(30)“a”

For the purposes of determining presumptive Medicaid eligibility for pregnant women, a “qualified provider” is a Medicaid provider who has made application and has been specifically designated by the Department in writing.

To be designated, a provider must:

- ◆ Provide one or more of the following services:
 - Outpatient hospital services
 - Rural health clinic services
 - Clinic services furnished by or under the direction of a physician
- ◆ Participate or receive funds under one of the following:
 - The state perinatal program
 - The Migrant Health Centers or Community Health Centers Program
 - The Maternal and Child Health Services Program
 - The Health Services for Urban Indians Program
 - The Special Supplemental Food Program for Women, Infants, and Children
 - The Commodity Supplemental Food Program
 - The Indian Health Service or health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act

In Iowa, these providers are primarily maternal and child health centers operated under the Department of Public Health. However, other providers, such as migrant health centers and rural health clinics, may also meet the criteria.

Refer anyone asking about applying to be a qualified provider to the IME Provider Enrollment Unit at 1-800-338-7909 (option 2), or locally (Des Moines) at 515-256-4609 (option 2) or by e-mail at imeproviderservices@dhs.state.ia.us.

To begin the enrollment and certification process, the provider must submit form 470-2579, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations for Pregnant Women*, which is available on line at <http://dhs.iowa.gov/ime/providers/forms>.

After receiving form 470-2579, the Department will determine if the applicant meets the criteria to become a qualified provider. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See ***Medicaid All Providers Manual***, [Chapter II](#), for copies of these forms.

Qualifying to Determine Presumptive Eligibility for BCCT

Legal reference: 441 IAC 75.1(40)“c”(1)

For the purposes of determining presumptive Medicaid eligibility for women who need treatment for breast or cervical cancer, a “qualified provider” is a Medicaid provider who has made application and has been specifically designated by the Department in writing.

To be qualified to do presumptive eligibility determinations, a provider must be eligible for payment under the Medicaid program and either:

- ◆ Have been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the Department of Public Health; or
- ◆ Have a cooperative agreement with the Department of Public Health to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the “Care for Yourself” breast and cervical cancer early detection program.

How Members Are Enrolled

Once eligibility is established, members in managed care counties receive an informational mailing from the IME. This mailing includes:

- ◆ Comm. 218 or Comm. 218(S), *Managed Health Care, It's Your Choice!*
- ◆ A list of participating MediPASS providers. (Providers who are not accepting new patients or who are new to the program may not appear on the list.)
- ◆ Information about HMOs available in that county (if any).
- ◆ A letter telling members that they must enroll in one of the managed health care plans and giving a tentative provider assignment.
- ◆ An enrollment form (a postage-paid self-mailer).

The IME Member Services Unit assigns members to an HMO or MediPASS provider in their area, based on their age and sex. In counties with one or more HMO options available, tentative assignments are divided equally between the HMO options and the MediPASS providers.

Members may choose another provider by calling, mailing, or faxing their choice to the IME Member Services Unit before the date on their notice. Members have a minimum of ten days to make a choice. If the member does not make a choice, the member is assigned to the tentative provider selection or plan listed on their notice.

Enrollment can also be processed in the following ways:

- ◆ At a MediPASS provider's office. Each MediPASS provider has enrollment forms available. Members may enroll with the provider or change providers by voluntarily completing the form and mailing it to the IME.
- ◆ At an HMO provider office if an HMO is available in the county of the member's residence. The member may elect to enroll in an HMO after receiving enrollment information and a form from the HMO provider.
- ◆ At the local Department office. (Although you do not directly enroll members, give an enrollment form to members and provide assistance as requested to complete it.)
- ◆ Through the Member Services Unit's toll-free telephone number, 1-800-338-8366, or local number 515-256-4606 in the Des Moines area. Members may call this number for information about choices and provider availability. They can also enroll directly during this call.

Application Processing

Legal reference: 441 IAC 76.1(249A), 441 IAC 88.84(1)

The IM worker determines income and resource eligibility for PACE based on a Medicaid application. A prospective PACE enrollee wanting to apply for PACE services must complete:

- ◆ An application online at <https://dhsservices.iowa.gov/apsspssp/spp.portal>, or
- ◆ Form 470-5170 or 470-5170(S), *Application for Health Coverage and Help Paying Costs*.

Determine if the applicant resides in a county served by a PACE provider. All other application policies and general eligibility requirements, other than those described under [Who Can Be Enrolled](#), are the same for people applying for PACE services.

Follow the processing procedures described in 8-B, [APPLICATION PROCESSING](#), and the eligibility requirements found in the following:

- ◆ 8-C, [NONFINANCIAL ELIGIBILITY](#),
- ◆ 8-D, [RESOURCES](#),
- ◆ 8-E, [INCOME](#),
- ◆ 8-F, [COVERAGE GROUPS](#), and
- ◆ [8-I, When Applying for or Receiving Waiver or PACE Services](#).

Provide the applicant a copy of Comm. 316, *PACE - Program of All-Inclusive Care for the Elderly*.

Level of Care

Legal reference: 441 IAC 88.84(1)

PACE enrollees must meet the nursing facility level of care. The PACE provider coordinates completion of form 470-4490, *Level of Care Certification for PACE Program*:

- ◆ By the applicant's active physician for the initial certification, and
- ◆ By the PACE physician for annual recertifications.

System codes that indicate pay and chase for coverage by absent parents are located on the SSNI or MMIS screen.

The absent parent indicator is located in the second position of the medical resource code on the SSNI screen. The codes are H, K, and 8. Field 10 on the MMIS screen has an indicator of absent parent insurance for the insurance coverage that is described on the page open for viewing. Each page has information on a different health insurance policy.

Review of Trauma Claims

Legal reference: 441 IAC 75.2(1)

The IME Revenue Collection Unit screens Medicaid claims indicating an accidental injury or "trauma" in order to pursue potential third-party liability for the costs of treatment. The Unit reviews all Medicaid claims over \$250 submitted with an ICD diagnosis code indicating an accident or injury.

When additional information is needed regarding the accident or injury, the Revenue Collection Unit worker sends computer-generated form 470-0398, *Accident Injury Request*, to the injured person. The form asks the person to supply details of the accident or injury.

Upon receipt of the completed letter, the Revenue Collection Unit worker:

- ◆ Reviews the member's response to determine if a third party is available to pay for part or all of the medical expenses.
- ◆ Follows up with the third-party resources identified to substitute the Department's claim for that of the injured person. (This process is called "subrogation.")

- ◆ Charges by immediate relatives or household members.
- ◆ Homemaker services except when part of hospice care.
- ◆ Meals delivered to the home.
- ◆ Surgical services for which a second opinion is required but not obtained.
- ◆ Items or services for which Medicare is the secondary payer. This includes situations where the beneficiary has worker's compensation or an employer group health plan, or is entitled to compensation from an automobile or liability insurance plan.

Medicare Buy-In

Legal reference: 42 CFR 431.625, 441 IAC 75.1(29)

The Department pays the Medicare Part B premium for Medicaid members. This "buy-in" transfers some medical costs from the Medicaid program, which is partially state-funded, to the Medicare program, which is funded by the federal government and premiums.

To be eligible for the buy-in, a person must be a full Medicaid member and be eligible to enroll in Medicare. People in the following "limited benefit" aid types are **not** eligible for buy-in:

Eligibility	Aid Type
Chronic care group	77-7 (rare)
Concurrent eligibility under two or more limited benefit aid types (blended aid types shown on SSNI)	86E, 86H, 87B, 87H, 87P, 88E, 88F, 88H, 88P, 88T, 89E, 89F, 89H, 89P, 89T, 8BE, 8BH, 8PE, 8PP
Family planning	90-6
Medically Needy with spenddown	37-E with fund code "9," "S," or "P"
Presumptive eligibility for breast and cervical cancer treatment (BCCT)	88-9
Presumptive eligibility for children	88-7
Presumptive eligibility for pregnant women	88-8
Qualified working disabled person	90-0 or 90-2 with "W" in the SSNI SP (special claims processing) field

Health Insurance Premium Payment Program (HIPP)

The Health Insurance Premium Payment (HIPP) Program uses Medicaid funds to pay for health insurance coverage through an employer-related plan or an individual plan. Medicaid then becomes the secondary payer of claims.

The HIPP Unit, at the Iowa Medicaid Enterprise (IME), determines if it is cost-effective to pay for a member to get and keep group or individual health insurance coverage or for Medicaid to pay for the services. If the insurance is determined cost-effective, the HIPP program pays the premium directly to the employee, the employer, or the health insurance company on behalf of the member.

IM duties concerning HIPP include:

- ◆ Distributing the combined English and Spanish pamphlet Comm. 255 and 255(S), “Benefits of the Health Insurance Premium Payment Program,” to all Medicaid applicants and to any person who reports new or beginning employment.
- ◆ Distributing Comm. 91, “The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients” upon request. This brochure contains form 470-2875, *Health Insurance Premium Payment Program Application*.
- ◆ Making referrals to the HIPP Unit when insurance is available to:
 - Applicants or members at application or when new employment is reported.
 - Parents in Medicaid households with children who are Medicaid-eligible.

See [Situations Not Covered by HIPP](#), later in this chapter for a list of when not to make a referral to the HIPP Unit.

How to make a referral to the HIPP Unit:

- From the TD03 screen on the ABC system use the PF6 key, labeled “REF MENU” (see [14-C, Adding a HIPP Referral](#)); or
- E-mail form 470-2844, *Employer’s Statement of Earnings*, to hipp@dhs.state.ia.us.

Inform the HIPP Unit of changes in the household that may affect HIPP eligibility or the health insurance coverage. To report a change, contact the HIPP Unit as follows:

Phone: toll-free 1-888-346-9562; local (515) 974-3282

Fax: (515) 725-0725

Interoffice mail: IME/HIPP

E-mail: HIPP@dhs.state.ia.us

U.S. mail: HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

Situations Not Covered by HIPP

Legal reference: 441 IAC 75.21(5) and 75.21(9)

If one of the following circumstances applies, premiums will not be paid by the HIPP program:

- ◆ On the date HIPP eligibility is determined, no one covered by the insurance is a Medicaid member.
- ◆ On the date HIPP eligibility is determined, the coverage is no longer cost-effective.
- ◆ The only Medicaid-eligible member has Medicare.
- ◆ Is eligible for Medicaid only under one or more of the following coverage groups:
 - Family Planning Waiver
 - Medicaid for Kids with Special Needs (MKSIN)
 - Medically Needy with a spenddown

If one of the following circumstances applies, you do not need to make a referral to the HIPP program:

- ◆ Insurance is provided by the Health Insurance Plan Iowa (HIPIOWA).
- ◆ Another entity is maintaining health insurance on the Medicaid member (e.g., an absent parent is maintaining insurance on the Medicaid member children, or when the policyholder is not in the Medicaid household).
- ◆ The insurance plan is designed to provide coverage for a temporary period.
- ◆ The insurance plan is an indemnity policy that supplements the policyholder's income or pays a predetermined amount for medical services, e.g., \$50 per day for hospital services instead of 80% of the charge.
- ◆ The insurance plan is offered on the basis of attendance or enrollment at a school.
- ◆ The policyholder is an absent parent. CSRU is responsible for obtaining cash and medical support for children in households where a parent is absent.
- ◆ The health insurance premium is used as a deduction in computing the client participation.
- ◆ The policyholder or potential policyholder is an undocumented alien.