MEM - Member Calls for Eligibility and Benefits

Purpose:
This procedure explains the process of how to handle a member's call regarding member Medicaid eligibility and benefits.

Identification of Roles:
Customer Service Representatives (CSR)

Performance Standards:
Quality Assurance for all Member Service's calls must be at least 90%. However, enrollments should be completed correctly 100% of the time.

Path of Business Procedure:
Step 1: Calls are routed by an Automated Call Distributor (ACD) into an enrollment queue and answered by the next available CSR.

Step 2: Customer Service Representative (CSR) accesses the member's file and will verify that the caller is Health Insurance Portability and Accountability Act of 1996 (HIPPA) authorized to obtain information and make changes to the member's file.

a. Verify the person calling is listed as the member, the case name or the name in Social Services Number information (SSNI).
b. Verify the mailing address on file.
c. Request the caller's current phone number.

Step 3: CSR will verify Medicaid enrollment using screen 10 in Medicaid Management Information System (MMIS).

a. Verify the Aid Type, Fund Code, and Exemption Code for member eligibility.
b. Refer to Member Services Reference Manual, Member Eligibility Verification section and the 'Medicaid Aid Types, Fund Codes, and Exception Indicators' desk guide.

Step 4: Once it has been determined that the member is eligible for Medicaid benefits, CSR may provide individual coverage and benefits information, as determined by the Aid Type, Fund Code, and Exemption Code verified above. (Refer to Member Services Reference Manual, Medicaid Benefits section and the 'Medicaid Aid Types, Fund Codes, and Exception Indicators' desk guide.)

Forms/Reports:
None

RFP References:

Interfaces:
MMIS

Attachments:
Medicaid Aid Types, Fund Codes, and Exception Indicators desk guide (August 2016)

Medicaid Aid Types, Fund Codes, and Exception Indicators

The following list of Aid Types has full Medicaid coverage and benefits:

130, 131, 137, 138, 140, 142, 143, 308, 370, 372, 373, 377, 390, 421, 423, 428, 429, 461, 462, 464, 630, 631, 632, 633, 636, 637, 640, 642, 643, 731, 732, 733, 734, 735, 920 MUST ENROLL WITH MCO

The following list of Aid Types has full Medicaid coverage as well as Waiver Services:

136, 631, 636, 638, 645, 731, 733, 734 **MUST ENROLL WITH MCO**

Below is a list of Special Aid Types and their definitions:

Aid Type	Fund Code	Exception Indicator	Enroll w/ MCO?	Definition
501 or 531	A		Yes	**BP: W – Wellness Plan Fee For Service (FFS):** Member may see any Iowa Medicaid Provider
501 or 531	A		Yes	**BP: M – Wellness Plan MCO:** Member must enroll with one of the Managed Care Organizations
501 or 531	A		Yes	**BP: S MF: 1 – Medically Exempt:** Member receives additional benefits (see Medically Exempt benefit sheet)
60M	A, C		Yes	Medicaid for Employed Persons with Disabilities (MEPD). This member pays a premium every month and is considered eligible for full Medicaid benefits.
60M	P		Yes	Medicaid for Employed Persons with Disabilities (MEPD). This member's eligibility is pending the member making their monthly premium payment.
906	A, C		Yes	This member is only eligible for the Iowa Family Planning Network (IFPN) Waiver

Dental Benefits:

501/ 531 IHAWP Dental Indicators

Please do not use the Dental Indicator field on system 10 to determine the dental provider for an Iowa Health and Wellness Plan member.

Please review System 10, Screen 4 for Dental Provider information.

Traditional Medicaid/ 60M / 37E / and Presumptive Eligibility may see any Iowa Medicaid Dental Provider

Aid Type	Fund Code	Exception Indicator	Enroll w/ MCO?	Definition
900, 902	9	Q	No	Qualified Medicare Beneficiary (QMB). This member is only eligible for their Medicare premiums, coinsurance, and deductibles to be covered.
900, 902	9	E, H, L	No	Specified Low-income Medicare Beneficiary (SLMB). This member is only eligible for their Medicare Part B premiums to be paid and is not eligible for any Medicaid Benefits.
37E	A, C		No	This is a member who is medically needy and either does not have a spenddown or their spenddown has been met. This member has full Medicaid benefits.
37E	P		No	This is a member who has a spenddown that has not been met. Eligibility is pending until they have met their spenddown.
37E	S		No	This person is a Medically Needy Responsible Relative and will never be eligible. Their bills can be used to meet another person on the case's spenddown.
882			No	**PRESUMPTIVE ELIGIBILITY**: Former Foster Care (only up to age 26)

884			No	**PRESUMPTIVE ELIGIBILITY**: Infant or child who may qualify for a Medicaid Program
885			No	**PRESUMPTIVE ELIGIBILITY**: Infant or child who may qualify for a Medicaid Program
886			No	**PRESUMPTIVE ELIGIBILITY**: Parents/ Caretakers

Aid Type	Fund Code	Exception Indicator	Enroll w/ MCO?	Definition
888			No	**PRESUMPTIVE ELIGIBILITY**: This member is presumptively eligible under the pregnant women policy. They have coverage for all services except Inpatient Hospital care.
889			No	**PRESUMPTIVE ELIGIBILITY**: This member is eligible for Breast and Cervical Cancer services and has full Medicaid benefits.
88F	A, C		No	**BLENDED AID TYPE WITH PRESUMPTIVE ELIGIBILITY:** This member has Iowa Family Planning Network Waiver and is presumptively eligible under the pregnant women policy. (Combination of 906 & 888)
89F			No	**BLENDED AID TYPE WITH PRESUMPTIVE ELIGIBILITY:** This member has Iowa Family Planning Network Waiver and is presumptively eligible for breast & cervical cancer treatment. (Combination of 906 & 889)

84F, 85F			No	**BLENDED AID TYPE WITH PRESUMPTIVE ELIGIBILITY:** This member has Iowa Family Planning Network Waiver and has children who are presumptively eligible.
86F			No	**BLENDED AID TYPE WITH PRESUMPTIVE ELIGIBILITY:** This member has Iowa Family Planning Network Waiver and is presumptively eligible as a parent or caretaker.
82F			No	**BLENDED AID TYPE WITH PRESUMPTIVE ELIGIBILITY:** This member has Iowa Family Planning Network Waiver and is presumptively eligible for Expanded Medicaid for Independent Young Adults.
881 or 883			No	**PRESUMPTIVE ELIGIBILITY:** Members who may qualify for Wellness Plan (They Receive **Wellness Plan Benefits**). Dental is through IA Medicaid

Aid Type	Fund Code	Exception Indicator	Enroll w/ MCO?	Definition
81F			No	This member has Iowa Family Planning Network Waiver and if presumptively eligible for IHAWP (**Wellness Plan Benefits**). Dental is through IA Medicaid

Fund Codes and Exception Indicators

"S" - The recipient is a Medically Needy Responsible Relative and will **never be eligible.**

"P" - The member is Medically Needy and has not met their spenddown or the member is on MEPD and has not paid their premium for the month.

"9" – The member is not eligible.

"9" – If the Exception Indicator is an **E, H or L,** the member is **SLMB.**

"9" – If the Exception Indicator is a **Q**, the member is **QMB** and is only eligible for payment of Medicare Co-Insurance and Deductibles.

"A, C, R, 1, 2, 3, 4" – If the Exception is **B, C, or E,** the member is an **Alien** and only has coverage for a 3- day emergency or delivery of a baby. **DOES NOT ENROLL WITH MCO**

"A, C, R, 1, 2, 3, 4" – If the Exception Indicator is **O, D, I, M,** the member is **eligible,** however check to see if the member has **Medicare, LTC/Waiver, Lock-In, or Managed Care**