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### **3.1 Eligible Populations**

The Medicaid population is comprised of many different coverage groups that are defined by Federal regulations. Each of the coverage groups has specific eligibility criteria. However, in general, the Medicaid Program provides health care coverage to:

- a) Low-income individuals who are aged (sixty-five or older), blind or disabled;
- b) Low-income families, children, and pregnant women; and
- c) Other low-income individuals.

The low-income aged, blind and disabled (ABD) individual receives coverage through the traditional Medicaid fee-for-service program.

All other Medicaid coverage groups, who are not ABD, receive coverage through the Hawaii QUEST Program, for which the Department contracts with managed plans to provide coverage.

#### *3.1.1 Newborn Eligibility*

Newborn children under the age of one are deemed eligible for Medicaid as long as the mother was eligible for and receiving Medicaid benefits at the time of the child's birth. The mother and newborn will remain covered by Medicaid for at least the first sixty- (60) and thirty days (30) respectively, after the child's birth. In addition, the newborn shall continue to remain eligible for one year, provided the newborn continues to be a member of the mother's household and the mother remains eligible for medical assistance, or would have remained eligible if she were still pregnant.

Payments may be made only if the newborn is added to the Medicaid eligibility files with an effective date to cover the dates of services and is issued a recipient ID number.

Recipients should be encouraged to request that their DHS caseworker add the newborns as eligible members of their families as soon as possible to avoid any potential problems regarding the newborn's eligibility under Medicaid.

#### *3.1.2 Qualified Medicare Beneficiary*

The Department of Human Services provides Qualified Medicare Beneficiary (QMB) coverage to recipients with Medicare meeting Medicaid eligibility criteria.

Under this program there are two different categories of recipients and it is important to understand the difference between the two categories to ensure correct claims processing. The two categories are:

### *3.1.2.1 QMB-Only*

“QMB only” refers to a recipient who is not eligible for the regular Medicaid program, but is eligible for QMB coverage. Under QMB, the Department will only provide coverage of Medicare premiums, deductibles and coinsurance amounts.

### *3.1.2.2 QMB-Plus*

“QMB-Plus” refers to a recipient who is eligible for both the regular Medicaid program and QMB coverage. For services covered by Medicaid, the QMB-Plus recipient can be treated by providers, as would any other Medicaid recipient. For non-Medicaid services, which are Medicare covered, providers may seek coverage of Medicare deductibles and coinsurance amounts under the recipient’s QMB eligibility.

### *3.1.3 Dental Only Coverage*

Medicaid eligible recipients that receive medical services through the QUEST Program will receive dental services through the FFS Program.

### *3.1.4 Medicaid Eligible for Prisoners*

Inmates of correctional facilities administered by the Department of Public Safety or the Hawaii Youth Correctional Facility are not eligible for Medicaid, except for acute inpatient services for which they are admitted to hospitals or medical facilities.

## **3.2 Eligibility Determination**

Eligibility of each recipient receiving services under the Medicaid Program is determined by the State of Hawaii’s, Department of Human Services (DHS) and is dependent on financial factors (income and assets) and other public assistance criteria (e.g., blindness, disability, age or a family with dependent children).

If a patient is unable to pay for services and has not applied for Medicaid benefits, the provider may refer the patient or his/her representative to contact the Medical Applications Unit on their island. Phone and Fax numbers are in Appendix 1.

If immediate medical assistance is required, the provider should complete Form 1149 certifying the medical emergency (see Appendix 2 for Form 1149 and instructions).

DHS uses the Hawaii Automated Welfare Information (HAWI) system, to assign case/identification numbers to recipients eligible for assistance.

### *3.2.1 Cost Share*

Some recipients that do not fully meet the financial requirements for Medicaid eligibility may be allowed to pay a portion of their medical expenses each month or “spend-down”, in order to be eligible for Medicaid. The portion of medical expenses the recipient must pay each month is

referred to as their “cost share” and these recipients are eligible once they have met their cost share.

All cost share cases are required to pay for their own health care needs at the start of each new month. DHS eligibility workers review recipient records to determine whether the recipient has incurred medical expenses equal to or greater than the excess income available to the recipient. When the recipient provides evidence that he/she has spent-down the cost share amount, a coupon will be issued with an effective date and spend-down amount.

Spend-down cases should be considered private-paying patients until they are eligible for Medicaid. If the recipient has a cost share amount equal to or greater than claim charges, the claim should not be billed to the Medicaid Program, as the entire amount is collectible from the patient.

### **3.3 Emergency Processing of Medical Assistance Applications**

DHS will expedite processing medical assistance applications in emergency situations when accompanied by a physician’s written confirmation statement on Form DHS 1149. The DHS 1149 form may be obtained from the Med-QUEST Applications Unit on the island. A sample of this form is in Appendix 2. Completion of the DHS 1149 form expedites the determination of eligibility for medical assistance but does not guarantee payment for services provided to the patient.

If a written statement is not available, the name and telephone number of a physician or dentist able to confirm the existence of any serious medical condition must be furnished. This verbal verification must be followed by a written statement by the physician or dentist.

#### **a) Qualifications for Emergency Processing**

Emergency processing of applications is available for applicants suffering from a medical condition for which Medicaid coverage is available and which, if untreated, could result in:

- Serious risk of disease
- Threat to life or impairment of a vital function
- Serious health complication
- Serious irreparable harm

The patient’s physician or dentist must confirm the existence of any such condition and that, without a determination of Medicaid eligibility, the required medical services will not be provided.

b) Provider Assistance for Emergency Processing

Provider cooperation in emergency processing of medical assistance applications is solicited in the following areas:

- Provision of Services - Providers are requested to provide urgent and medically necessary services to those persons who do not have medical assistance at the time care is sought.
- Referrals - If providers are unable to provide the urgent or necessary medical services to a person unable to pay for such services, they may refer the person to DHS.
- Confirmation of Medical Emergency - Providers must certify on Form DHS 1149 the need for urgent and necessary medical care. All requested information must be provided and the form signed by the certifying physician. This form must be attached to the application for medical assistance.

c) Emergency Processing Procedures

- DHS processes emergency applications within a 48-hour period or 2 working days.
- At the end of the processing period, an eligible person is issued a Coupon to receive the necessary medical care.
- An applicant whose eligibility cannot be determined within the allotted time period is issued a Coupon that provides coverage only for that condition which prompted the emergency processing of the application.

### **3.4 Restricted Recipients**

Misutilization, over-utilization or abuse of Medicaid services by a recipient results in restriction to a "primary care physician" of the recipient's choice, with the primary care physician's consent.

Recipients may be restricted from the freedom to see providers of their choice for any or a combination of the following reasons:

- a) When a recipient over-utilizes medical services;
- b) When a recipient has been shown to be over-utilizing controlled drugs with multiple prescriptions filled at more than one pharmacy and written by multiple prescribers;

- c) When a recipient has been determined to be using excessive medical services provided by multiple physicians.

*3.4.1 Criteria*

Freedom of choice in selecting health care providers shall not include the expedient utilization or over-utilization of the community's health care providers and supplies.

When a recipient over-utilizes medical services, the department shall request the recipient's voluntary cooperation in curbing abusive utilization practices and shall monitor the recipient's case for no less than six months.

When a recipient has been shown to be over-utilizing controlled drugs with multiple prescriptions filled at one or more pharmacies and/or written by multiple prescribers, the department shall require the recipient to choose one primary care physician and one pharmacy to be the only approved providers of usual care. The department also reserves the right to ask the recipient to choose another provider if the physician is known to the department to be over-prescribing medication or medical services. Refer to Section 3.4.2 for specific details regarding restrictions.

When a recipient has been determined to be using excessive medical services provided by multiple physicians, the department may assist the recipient in receiving appropriate coordinated care. As a result, the department shall ask the recipient to choose one primary care provider to coordinate all usual services for the recipient and make referrals to other providers, as needed.

*3.4.2 Restrictions*

If over-utilization or abuse continues, the recipient shall be administratively restricted for no less than twenty-four months to a primary care physician who is:

- a) Of the client's choice;
- b) Willing to provide and coordinate services to the client; and
- c) Certified by the department to participate in the medical assistance program.

A recipient who over-utilizes services which are provided by psychotherapists, pharmacies and dentists shall also be restricted to those providers if necessary, to further curb recipient abuse.

The individual who is restricted shall be afforded advance notice and appeals process.

Emergency medical services shall not require the referral, assistance, or approval of the designated primary care physician.

If a recipient fails to select a primary care physician within thirty days following receipt of notice of medical service restrictions, the department shall select a physician who is in good standing with the medical program.

When a physician willing to participate as the primary care physician cannot be found, the department's medical consultant shall provide prior approval for all health services required by the restricted recipient with the exception of emergency care. The designated physician shall:

- a) Provide and coordinate all medical services to the client, except for emergency services;
- b) Make referrals for other needed health services; and
- c) Inform the department when the designated physician is no longer able to provide medical services to the recipient.

A recipient shall continue to be restricted to a designated provider(s) until:

- a) There is documented evidence of that individual's compliance of at least one full year: and
- b) The primary care physician and the department's medical consultant concur.

When the decision is made to continue restriction, the recipient shall be afforded advance notice and the appeals process.

The recipient whose restriction has been terminated shall be monitored for no less than twenty-four months and placed back on restriction if there is evidence of recurrent over-utilization or abuse of medical services during that period.

### *3.4.3 Coordination of Restricted Recipient's Medical Care*

Providers must coordinate services with the primary care physician. Non-emergent services provided without the direct referral of the primary care physician are not payable by Medicaid. Emergency services do not require referral, assistance or approval from the primary care physician; however, evidence of emergent situation should be noted on the claim. Emergency medications should be limited in amounts sufficient to cover the recipient's immediate needs until the next business day when the patient may again contact his/her primary care physician. Information as to whether a recipient's freedom to see the provider of their choice is restricted is available via the Automated Voice Response System (AVRS). Refer to the AVRS Program Guide for detailed information or to Appendix 1 for the toll-free phone number.

### **3.5 Medicaid Recipient Identification**

The Medicaid program will only reimburse providers for services rendered to eligible Medicaid recipients. If a provider is unable to verify a recipient's eligibility at the time of service, the

provider renders the service at his/her own risk. If the individual is later found to be ineligible for Medicaid coverage, the Medicaid Program will not reimburse the provider. Patients whose Medicaid coverage cannot be verified should be considered private patients.

### *3.5.1 Medicaid Identification Card*

A plastic Medicaid identification card (ID Card) will be issued by the Fiscal Agent to each recipient when initial Medicaid eligibility has been determined by DHS. The ID card will only list the recipient's name, Medicaid number and date of birth. The ID Card will not list the recipient's eligibility dates. As a result, ID Cards will not serve as evidence of current eligibility as recipients will keep their ID Card throughout any changes in eligibility dates. Providers must verify each recipient's eligibility. In addition, eligibility for other members in a case must be verified using that case member's individual recipient identification number.

To assist providers in verifying recipient eligibility, DHS has developed several ways for a provider to verify eligibility:

- Automated Voice Response System (AVRS)
- Provider Call Center

Providers may use the AVRS for verifying recipient eligibility. This service is provided free of charge. Providers will dial a toll-free phone number located on the back of the ID Card to verify a recipient's eligibility 24 hours a day, 7 days a week, 365 days a year. By using the AVRS, providers are able to verify a recipient's eligibility on the date of service, if the recipient is enrolled in a QUEST managed care plan or fee-for-service, other insurance coverage (TPL), cost share and other eligibility information by a combination of name and other identifiers such as the recipient's social security number or birth date. Refer to the AVRS Program guide for detailed information or to Appendix 1 for the toll-free number. In addition, providers are able to continue to call the provider call center for eligibility information (see Appendix 1 for the phone number). The ID Card will have a magnetic stripe on the back of the card for use with Point of Service (POS) devices. For more information regarding the POS system contact the POS vendor (refer to Appendix 1 for contact information).

Recipients who have lost their ID Card should be directed to contact the Enrollment Call Center at DHS (refer to Appendix 1 for the phone number). A reduced sample of the ID Card is in Appendix 1 (Sample Medicaid ID Card.)

#### *3.5.1.1 Information on the ID Card*

##### a) Recipient ID Number

This field will list a ten-digit recipient number for each eligible person. This is the number that must appear on claims submitted to Medicaid.

## b) Recipient Name

The recipient's full name will be listed.

## c) Birth Day

The birth day will be listed for the recipient.

If any of the above fields change, an updated ID Card will be issued to the recipient.

Early Periodic Screening Diagnosis and Treatment (EPSDT) information will not appear on the Medicaid ID Card. All recipients under the age of 21 are eligible for EPSDT. EPSDT providers are encouraged to provide EPSDT services to recipients under the age of 21.

### 3.5.2 *Medical Assistance Coupon (Coupon)*

The Medical Assistance Coupons serves as a temporary identification card to assist in identifying an individual. The coupon does not itself verify the eligibility of an individual and therefore, does not guarantee that Medicaid will cover any medical services.

Using information on the coupon, a provider may confirm the eligibility of a patient by accessing the AVRS. An eligibility file in the claims system, HPMMIS (Hawaii Prepaid Medicaid Management Information System) is required for a Medicaid claim to be processed.

Because eligibility will be current and accessible by providers, the DHS anticipates the requirement for coupons to decrease. Generally, a coupon should not be issued if eligibility exists in HPMMIS. However, the DHS has identified a few instances where the eligibility in HPMMIS may not be current and therefore, a coupon must be issued.

Coupons must be entirely completed with all the information. Providers should also check the following features to verify the validity of a coupon. Providers should not accept invalid coupons but request that a correctly completed coupon be presented.

- a) Designated Provider – A coupon specifying a provider is to be used only by that provider and cannot be used on claims from other providers.
- b) Coupons must be signed by an adult member of the case. If an adult member is unable or unwilling to sign the coupon, an authorized DHS staff may sign the coupon on the recipient's behalf. Coupons signed in this manner must indicate the DHS staff's title and unit number.

Recipients who have lost their coupon should be directed to contact their DHS eligibility worker. A reduced sample of the coupon is pictured in Appendix 1 (Medical Assistance Coupon).

*3.5.2.1 Explanation of Coupons*

To help identify invalid coupons that should not be accepted for Medicaid claim processing an explanation of each field and the most common conditions that invalidate a coupon are listed below. If a coupon contains any of these conditions, request that the patient obtain a corrected coupon from his/her eligibility worker. If a claim is denied and it was submitted with a coupon, refer to the following conditions to determine why the coupon was invalid. Then, contact the recipient or the recipient's eligibility worker for a corrected coupon.

a) Recipient ID No.

This field will list a ten-digit recipient number.

- If this field is blank, the coupon is invalid.
- If the number listed is not 10-digits long, the coupon is invalid.

b) Eligible Person

This field will list the eligible individual that is covered by this coupon.

- If this field is blank, the coupon is invalid.
- If this field lists only a first or a last name, the coupon is invalid (both names are required).

c) Date of Birth

The date of birth for the eligible individual should be listed in format mm/dd/yyyy.

- If this field is blank, the coupon is invalid.
- If this field does not identify the month and year of birth, the coupon is invalid.

d) Sex

The applicable sex code should be listed for the eligible individual.

e) PGM-Cat

The actual program category of the eligible individual. (e.g., AF, SF-GA, etc.)

- If this field is blank, the coupon is invalid.

f) SEC/UNIT/WKR

Identification codes of the section, unit and worker issuing the coupon.

- If this field is blank, the coupon is invalid.

g) Coupon Restrictions

- General Assistance (GA) Disability Evaluation/Reevaluation – An “X” in this block indicates the coupon is issued to an applicant to obtain the disability evaluation required to determine GA eligibility.
- Foster Care Evaluation – An “X” in this block indicates the coupon is issued to obtain an evaluation for a foster child.
- Coverage prior to enrollment – An “X” in this block indicates the coupon is issued to cover health care services prior to enrollment in a QUEST plan.
- Other – If an “X” is made in this block, the type of service authorized should be indicated.

h) Cost Share/Spenddown

The amount of the cost share or spenddown that the client is responsible to pay to a specific provider. If there is no cost share or spenddown, this field will be blank. If the entry in this field is not a numeric value, the coupon is invalid. (A blank field does not invalidate the coupon).

i) Specified provider

Coupons are only valid for specific providers. Coupons can only be used by the provider listed in this field.

j) Effective date

This field represents the actual first date of service valid for the coupon. If the coupon is issued to cover a one day service, the date should be the same as in the Expiration date field.

- If the effective date is missing, the coupon is invalid.
- If the effective date is not a valid date (i.e. 13/10/99) the coupon is invalid.
- If the effective date is after the expiration date, the coupon is invalid.

- If the effective date does not note the month, day and year, the coupon is invalid.

k) Expiration date

This field represents the actual last date of service valid for the coupon. If the coupon is issued to cover a one day service, the date should be the same as in the Effective date field.

- If the expiration date is missing, the coupon is invalid.
- If the expiration date is not a valid date (i.e. 13/10/99) the coupon is invalid.
- If the expiration date is before the effective date, the coupon is invalid.
- If the expiration date does not note the month, day and year, the coupon is invalid.

l) Case number

The case number of the eligible individual. The number should be ten-digits. If the case number is missing, the coupon is invalid.

m) Case Name

The name of the individual that is the head of the case.

n) Address

The address that is on file for the case.

o) Third Party Liability

This field lists the name of the carrier, effective date and policy number of any known third party liabilities.

- If the fields are blank but the third party indicators following the birthdate are completed, the coupon is invalid.
- If the TPL effective date, code, or name of the other insurance is missing, the coupon is invalid.

p) Signature

The coupon must be signed to be valid. In general, a coupon will be considered invalid for the following reasons:

- It has corrections
- It is a photocopy
- It is intended for use by another provider (the provider name will be indicated on the coupon)
- There is missing or incomplete coupon information

For assistance in obtaining corrected coupons, contact the patient's eligibility worker.

*3.5.2.2 Coupons for Foster Children*

Social workers are authorized to complete and issue coupons for children who are under the custody of the Department of Human Services. With this authorization, DHS social workers may issue coupons to immediately provide medical coverage regardless of a child's assistance status within the program.

All foster children coupons will have the term "Foster Child" in the column Recipient ID No. below any number that may appear in that column. The special-handled coupons with the unique recipient number "FC44444444" are used when a child under the Department's custody needs medical care and the DHS social worker is unable to obtain the necessary case information. The DHS social worker may issue a medical coupon whether or not the child is currently receiving any financial or medical assistance from DHS. The social worker shall complete, sign and submit a Medical Assistance Application form prior to or on the date of the required medical service.

- a) The DHS Social Services Division, Child Welfare Services Section Administrator, or Supervisor will sign all coupons. The coupon will identify the social worker, his/her section and unit number.