IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201536 MAY 28, 2015

Important information about Presumptive Eligibility and pharmacy services

This bulletin further clarifies procedures and policies pertaining to pharmacy services and the Indiana Health Coverage Programs (IHCP) Presumptive Eligibility (PE) process, including hospital-based presumptive eligibility. The IHCP recently expanded the PE process to include additional eligibility groups and add provider types that can perform PE determinations. More about these expansions can be found in *IHCP Bulletins* *BT201505*, *BT201513*, and *BT201514*.

In general, the PE process allows individuals to be determined eligible for IHCP coverage on a temporary basis. **PE is intended to quickly assess the eligibility of individuals who are facing acute healthcare issues. It is not intended to be the primary method of enrollment in the Healthy Indiana Plan (HIP) or other IHCP programs.**

The IHCP reminds providers that PE acceptance letters are proof of eligibility for PE and HPE services, including pharmacy services.

An individual may be determined presumptively eligible for IHCP coverage when he or she visits a provider that is enrolled as a qualified provider (QP) and the member answers a short list of eligibility questions, including questions about age, income, pregnancy status, and residency status. This information is quickly evaluated and a PE eligibility determination made. Individuals who are found presumptively eligible have coverage starting that same day. The QP prints the PE acceptance letter and provides it to the individual to serve as proof of coverage. Because this coverage is temporary, membership cards are not provided. The PE acceptance letter includes critical information for providers:

- Name
- Date PE coverage begins and ends
- PE ID number that starts with “600”
- The benefit package for the member
- The member’s managed care entity (MCE) and the MCE’s telephone number – if the member is in the PE Adult eligibility category

After an individual is determined presumptively eligible and has a PE acceptance letter, he or she is fully eligible for *all* services covered for his or her PE aid category, including pharmacy benefits. PE coverage is temporary, and the member is directed to apply for full coverage before the end of the following month. An individual may get PE coverage once per year or per pregnancy.

Eligibility verification and providing service to PE members

The PE determination is a real-time, immediate process. **However, it may take several days for the member's information to be fully visible in all provider eligibility systems.** This is especially true for members in the PE Adult category who are being served via MCEs. Eligibility should be visible in the different systems as follows:

- **Within one business day of PE eligibility**: A member's eligibility will be verifiable through the IHCP Eligibility Verification System options – the Automated Voice Response (AVR) system and Web interChange – and visible through the Catamaran Pharmacy Benefit Manager (PBM) system that processes fee-for-service (FFS) pharmacy claims.
- **Within three business days of PE eligibility**: A member's eligibility will be visible through the MCE's system.
- **Within five to seven business days of PE eligibility**: A member's eligibility will be visible through the MCE's PBM system.

Regardless, members are fully eligible for coverage at the point of PE determination. The State has received reports that providers are not accepting the PE letter as proof of coverage and are declining services until the person's eligibility is fully visible through the various systems. The State continues to stress to providers, including pharmacies, that the acceptance letter is proof of coverage. A member may wait to seek pharmacy services; however, if members need prescription coverage before the five- to seven-day window, they should call their MCE for assistance. As long as the member has his or her PE acceptance letter, providers can be assured that covered services rendered during the indicated PE period will be paid.

Covered services by benefit package

Members found eligible for PE are assigned to the benefit packages listed in Table 1. The members are able to seek any covered service within their benefit packages from any IHCP provider under the FFS delivery system; or from a provider enrolled in their MCE's provider network under the risk-based managed care (RBMC) delivery system.

Table 1 – PE benefit packages

Aid Category	Description	Benefits	Delivery System
HI	PE Infants	Package A	FFS
HK	PE Children	Package A	FFS
HA	PE Adult	HIP Basic	RBMC
HP	PE Parent/Caretaker	Package A	FFS
HW	PE Pregnant Women	Package P	FFS
H1	PE Former Foster Care Children	Package A	FFS
HF	PE Family Planning	Family Planning Only	FFS

If a member seeks a service that requires prior authorization (PA) (or precertification), providers should follow the FFS or the RBMC process for obtaining PA, as appropriate. Questions regarding FFS PA should be directed to ADVANTAGE Health Solutions[SM] at 1-800-269-5720. Questions regarding RBMC PA should be directed to the MCE under which the member is enrolled.

The benefits covered under the designated packages are as follows:

- Package A – Standard Plan: This package encompasses the full array of IHCP benefits. Members on this plan are able to receive any services covered by Traditional Medicaid.
- Package P – Pregnancy Only: The coverage under this package is limited to ambulatory prenatal care services only. These services include prenatal doctor visits, prescription drugs related to pregnancy, prenatal lab work, and transportation to prenatal visits. This package *does not* cover services related to labor and delivery.
- *HIP Basic* – This package covers a wide range of ambulatory patient services, hospitalization, emergency room (ER), mental health and substance abuse, prescription drugs, labs, preventive care, and rehabilitative care. *HIP Basic does not* cover dental, vision, nonemergency transportation, or Medicaid Rehabilitation Option (MRO) services. Most members in this category will have copays for most services. Prescription copay amounts are $4 for preferred drugs and $8 for nonpreferred drugs.
- Family Planning – This package provides very limited coverage for family planning services only. The following services are covered:
  - Family planning visits
  - Laboratory tests (if medically indicated as part of the decision-making process regarding contraceptive methods)
  - Limited health history and physical exams
  - Pap smears
  - Initial diagnosis of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs)
  - Follow-up care for complications associated with contraceptive methods
  - Food and Drug Administration (FDA)-approved oral contraceptives, devices, and supplies
  - Screening, testing, counseling, and referral of members at risk for human immunodeficiency virus (HIV)
  - Tubal ligations
  - Hysteroscopy sterilization
  - Vasectomies

Frequently asked questions (FAQs) for pharmacy providers

When I check the member's presumptive eligibility/hospital-based presumptive eligibility, I cannot find his or her PE ID in Web interChange. How can I confirm that I will be reimbursed for a prescription?

The PE acceptance letter clearly indicates the date a member's coverage begins and ends and the managed care plan to which the member belongs, if applicable. **As long as members have their PE acceptance letters, providers can be assured that covered services rendered during the indicated PE period will be paid.** If the member is eligible under the PE Adult aid category, pharmacy providers can contact the MCE listed on the letter. Another option is to provide the member with a three-day emergency fill.

Where can a PE member receive services?

The member is not limited to receiving services only from the provider location or hospital where he or she was determined presumptively eligible. Most PE members can receive covered services from any IHCP-enrolled provider. PE Adult members should seek nonemergency care through providers in their MCE network.

What if a member's eligibility for services is denied via a pharmacy's point-of-sale system?

A member with a PE letter **should not be denied services.** Although it may take several days for a member's eligibility status to be visible in all eligibility systems, particularly in the eligibility systems of the MCE pharmacy benefit managers, **the member is eligible to receive services.** The eligibility verification letter clearly indicates the date a member's coverage begins and ends and serves as a member's proof of eligibility. If a member is presumptively eligible under the PE Adult aid category, the letter also indicates the member's MCE. If the pharmacy provider is unsure of the member's status, the provider can contact the MCE listed in the letter for guidance.

How do I know if the member's letter is legitimate?

The PE acceptance letter is printed on Indiana Family and Social Services Administration (FSSA) letterhead. The letter presented should be an original and not a photocopy. Each letter is printed at the location where the PE determination was made, so some letters may be in color and others in black and white. Each letter is tailored to the specific aid category to which the member is assigned. A printed sample of the PE acceptance letter for PE Adult members who receive *HIP Basic* coverage is provided as an attachment to this bulletin for your reference. PE acceptance letters for other aid categories are on the same letterhead, but are tailored to the specific coverage of those categories. See Sample PE acceptance letter.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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Michael R. Pence, Governor
State of Indiana

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MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Your PE ID:

Effective to only.

Managed Care Entity:

Phone:

Important Notice: you have been approved for short term health coverage. You must complete an Indiana Application for Health Coverage to keep your health benefits.

Take this form with you if you seek medical care.

Has been approved for Presumptive Eligibility (PE) Adult. **This is short term coverage that begins today and will end on .** You can only qualify for presumptive eligibility once per year, and this coverage is temporary. You may qualify for continued health coverage. However, to maintain health benefits, you must submit an Indiana Application for Health Coverage.

This coverage includes all benefits covered under HIP Basic, such as visits to a doctor, lab work, emergency services and prescription drugs. Please be aware that a copay is required for most services. It may take a few days for your coverage to be visible to pharmacy providers. **If you need a prescription filled today, please call your managed care entity (listed above).** To learn more about covered services and required copays, please visit www.HIP.IN.gov.

You will receive a letter from your chosen health plan requesting a $10 "fast track" payment. This payment becomes a contribution towards your first POWER account contribution. This payment is optional but provides great benefits. If you make this $10 payment and are found eligible for HIP, your HIP Plus coverage will begin sooner and you will not have a gap in coverage.

You may change your health plan at any point during your temporary coverage before you make your $10 payment or first POWER account contribution. Once you have made a payment, you may not change your health plan. For more information about available health plans or to change your plan, call 1-877-GET-HIP-9 (1-877-438-4479).

Next Step

You must submit a full application in order to keep coverage. You should do this right away.

You can submit an application:

- At the provider where you were found presumptively eligible;
- Online at www.dfrbenefits.in.gov;
- Over the phone 1-800-403-0864; or
- At a Division of Family Resources (DFR) local office