PE Process Guide

The purpose of this document is to provide qualified providers (QP) participating in the Indiana Health Coverage Programs (IHCP) Presumptive Eligibility (PE) process with guidance on eligibility requirements and the QP’s role in assisting applicants through the PE application.

Qualified Provider Responsibilities

A PE qualified provider (QP) is responsible for the following:

- Verifying an individual's IHCP eligibility via the IHCP Provider Healthcare Portal (Portal) or the Interactive Voice Response (IVR) system
- Making PE determinations consistent with State policies and procedures
- Guiding PE members in submitting an Indiana Application for Health Coverage within 30 days of a PE application approval.

Qualified Provider Affirmations

- Affirm that this organization understands and will abide by any published guidance regarding the performance of PE activities.
- Affirm that this organization will not knowingly or intentionally misrepresent client information in order to inappropriately gain presumptive eligibility.
- Affirm understanding that all PE QP enrollment activities undertaken in this organization must be performed by an organization’s employee or hospital designee.

Performance Standards

PE QPs will be monitored to ensure that they meet performance expectations. PE QPs that fail to meet expectations will be subject to removal from the PE program, as detailed in Indiana Administrative Code. Performance expectations are as follows:

- Ninety-five percent of PE-approved members from a QP will complete and submit an Indiana Application for Health Coverage before their PE period ends.
- Ninety percent of Indiana Applications for Health Coverage are sufficiently complete that the Division of Family Resources (DFR) can make an eligibility determination.
• Ninety-five percent of PE members who complete the Indiana Application for Health Coverage are found eligible for Medicaid.

Presumptive Eligibility Aid Categories and Benefit Packages

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Covered Services by Package

Package A Standard Plan – This plan encompasses the full array of IHCP benefits. Members on this plan are able to receive services covered by the Medicaid program.

Presumptive Eligibility for pregnant women – Pregnancy-related coverage only. This coverage is limited to ambulatory prenatal care services, including prenatal doctor visits, prescription drugs related to pregnancy, prenatal lab work, transportation to prenatal visits, and other services related to a healthy pregnancy. It does NOT cover services related to labor and delivery.

HIP Basic – This plan covers a wide range of ambulatory patient services, hospitalization, emergency room (ER) services, services for mental health and substance abuse, prescription drugs, labs, preventive care, and rehabilitative care. HIP Basic does NOT cover dental, vision, or Medicaid Rehabilitation Option (MRO) services. Members in the HIP Basic category will have copays for most services and will also select a managed care entity or be assigned to one.

Family Planning Eligibility Program – This program provides limited coverage for family planning services only. The following 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
• 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, and vasectomies

**PE Basics**

• Individuals can apply for PE for all members in their family, regardless of the person’s need for services at the time of application.

• One PE application must be completed for each person seeking coverage.

• Adults (aged 21-64) in an Institute for Mental Disease (IMD) are not eligible for PE.

• PE applications cannot be taken over the phone.

• PE approved members whose care is delivered via the fee-for-service (FFS) delivery system are able to seek services from any enrolled IHCP provider. They are not limited to the provider who completed their PE application. PE Adult members are limited to their MCEs’ in-network providers.

• Providers should complete the PE application and then provide the member with a printed copy of the member’s approval/denial letter.

**PE Duration of Coverage**

PE ends when one of the following occurs:

• A member has not filed an *Indiana Application for Health Coverage* by the last day of the month following the month in which his or her PE period began; or
• A determination has been made on the individual’s *Indiana Application for Health Coverage*.

Members who qualify for the Adult category will be able to retain presumptive eligibility after they have been determined conditionally eligible for HIP coverage until they make a timely POWER Account contribution. This allows them to avoid a gap in coverage, as long as they meet required application and payment timelines.
PE Application Step by Step

Using the Portal, a PE QP can enroll an applicant via the Presumptive Eligibility (PE) process by following these steps:

1. Use the Eligibility Verification Request feature in the Portal to verify that the individual is not already an IHCP member.
   a. Log into the Portal.
   b. Click the Eligibility tab.

2. Search by the member’s name, date of birth and/or Social Security number. Enter the date or dates when the service will be provided as the effective dates. If no active coverage is found for the individual, click the appropriate PE Application button.

   **Note:** Depending on the member’s information, the PE Application and the PE Application for Inmates buttons or the PE Application for Pregnant Women button will be available.
3. Complete all fields of the PE application by asking the applicant for the required information. Some fields have a question mark icon “?” to click for more information. When clicking, you will be presented with a pop-up window providing guidance related to completing that field.

- **Ethnicity** – Select Hispanic or Other
- **Indiana Resident** – The applicant declares whether or not he or she is a resident of Indiana and plans to continue to live in Indiana.
- **Incarcerated** – Incarceration includes a county jail or any type of prison or correctional facility. Home detention is not incarceration.
- **U.S. Citizen** – If the “no” button is selected, a drop-down list of the following options appears:
  - Lawful permanent resident immigrant living lawfully in the U.S. for less than five years.
  - Refugee
  - Individuals granted asylum by immigration office
  - Deportation withheld by order from an immigration judge
  - Amerasian from Vietnam
  - Veteran of U.S. Armed Forces with honorable discharge
  - No immigration papers

- **Number of people in family** – The family size is based on the tax household. If the member does not file taxes, household includes the child, the child’s parents (biological, adopted, and step), and the child’s siblings (biological, adopted, and step). Number of unborn children is included in the family size for pregnant woman only.

- **Family income** – This includes income from the applicant, spouse, and parents of the applicant if he or she is under 18 and living at home. For children and dependents, if the children/dependents are not required to file taxes, then their income is not counted. Income includes the following: wages/salary, tips, self-employment, dividends, interest, rental income, Social Security, disability and retirement, unemployment compensation, retirement benefits or pension, and education income that is used for general living expenses. Disregards (not counted) – Supplemental Security Income, child support and/or alimony, veteran’s benefits, cash contributions, American Indian/Alaska Native Tribal Income Deduct from income the following: alimony paid, student loan interest paid, other allowable Internal Revenue Service (IRS) deductions

4. **Check the Attestation statement** – Attest that you have been trained and are qualified to process PE applications.

5. **Review the PE application** – Take this time to review the application data to confirm that there are no typos or data entry errors. Be sure to check that the spelling of the applicant’s name, income, date of birth, and Social Security number are all accurate.

QPs may not ask for verification documents when completing a PE application. Proof of income, residency, citizenship and any other documents is not required.
6. **Submit Application** – **PRESS THIS BUTTON ONLY ONE TIME!** If any of the required fields are blank or the data entered is invalid, a pop-up notification appears to indicate the fields at issue. Complete those required fields and press the submit button again (ONLY ONE TIME).

If the applicant is eligible for the PE Adult aid category, he or she is prompted at this point to select a managed care entity (MCE). If no MCE is chosen, one will be auto-assigned to the individual.

7. **Summary Page** – Upon validation, a summary page systematically populates. The summary page includes the data submitted for the PE applicant. A screen appears with the option to print a summary page and print the acceptance or denial letter.

8. **Acceptance/Denial Letter** – Print the acceptance or denial letter and provide a copy to the member. You must always print a copy of the acceptance/denial letter and give it to the member. QPs can save copies of the letters as PDFs for their records and then print hard copies for members. **We highly recommend this practice for record-keeping purposes.** IMPORTANT: Once you navigate away from the “print acceptance letter” screen, there is no way to retrieve or recreate the letter.

9. **Educate the member.** Review the acceptance letter with the member to ensure that he or she understands the following points:

   - **The PE coverage is temporary** – The individual must apply for longer term coverage using the *Indiana Application for Health Coverage*. The QP should have a process in place to help the member complete the full application.
   - **The approval letter is proof of coverage** – The individual needs to keep the PE approval letter as he or she would a member card. The letter needs to be presented every time members seek services during their PE period.
   - **The member is eligible for services based on his or her aid category** – If the member has a limited benefit package, such as the Family Planning Eligibility Program or PE for pregnant women package, the QP needs to emphasize that the member’s PE coverage includes only certain services. The QP should also explain where the member can find a provider and get services.

**Have Questions?**

If you have questions about being a QP or about the PE program, please refer to the *Presumptive Eligibility* provider reference module at indianamedicaid.com.

If you have questions or concerns about the CoreMMIS system or the Portal, please contact the DXC **Provider Relations Field Consultant** in your area.

You can also find a copy of the *IHCP Presumptive Eligibility (PE) Standards* on this site.