PE Process Guide

The purpose of this document is to provide Qualified Providers (QP) participating in the Presumptive Eligibility (PE) program 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 Indiana Health Coverage Programs (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:

- 95% of PE approved members from a QP will complete and submit an *Indiana Application for Health Coverage* before their PE period ends.
- 90% of *Indiana Applications for Health Coverage* are sufficiently complete, so DFR can make an eligibility determination.
- 95% of PE members who complete the *Indiana Application for Health Coverage* are found eligible for Medicaid.
Presumptive Eligibility Aid Categories and Benefit Packages

<table>
<thead>
<tr>
<th>HPE/PE Category</th>
<th>Description</th>
<th>Service Package</th>
<th>Delivery System</th>
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</thead>
<tbody>
<tr>
<td>HI</td>
<td>Infants</td>
<td>Package A</td>
<td>Fee-For-Service</td>
</tr>
<tr>
<td>HP</td>
<td>Parents/Caretakers</td>
<td>Package A</td>
<td>Fee-For-Service</td>
</tr>
<tr>
<td>HK</td>
<td>Children (Ages 1-18)</td>
<td>Package A</td>
<td>Fee-For-Service</td>
</tr>
<tr>
<td>HA</td>
<td>Adults (19-64)</td>
<td>HIP Basic</td>
<td>Managed Care</td>
</tr>
<tr>
<td>HW</td>
<td>Pregnant Women</td>
<td>PEPW Package</td>
<td>Fee-For-Service</td>
</tr>
</tbody>
</table>

| H1              | Former Foster Care Children                | Package A       | Fee-For-Service      |
| HF              | Family Planning services only             | Family Planning | Fee-For-Service      |
|                 | Eligibility Program                       |                 |                      |

Covered Services by Package

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

**PEPW Package** Pregnancy-related only: This coverage is limited to ambulatory prenatal care services. This includes 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 covers a wide range of ambulatory patient services, hospitalization, ER, 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 this category will have co-pays for most services. Members in this category will select a managed care entity or be assigned to one.

**Family Planning** - This is 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 whom are fee-for-service (FFS), are able to seek services from any enrolled IHCP provider. They are *not* limited to the provider who did the PE application. PE Adult members are limited to in-network providers with their MCE.

- Providers should complete the PE application and then provide the member with a print out of his or her approval/denial letter.

PE Duration of Coverage

PE will end 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 their 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 in 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 Hospital PE and/or PEPW button options may be available.

![Image of Indiana Medicaid Provider System](image)

3. **Complete all fields of the PE application by asking the applicant for the required information.** Some fields have an additional “?” 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/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.

*QPs may not ask for verification documents when completing a PE application. Proof of income, residency, citizenship and any other documents are not required.*
• **U.S. Citizen** – If the “no” button is selected, a drop-down list of the following options will appear:
  - Lawful permanent resident immigrant living lawfully in the U.S. for less than 5 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 you do 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, 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 load interest, other allowable 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

6. **Submit Application - HIT THIS BUTTON ONLY ONE TIME!** If any of the required fields are blank or the data entered is invalid, a pop-up notification will appear to indicate the fields at issue. Complete those required fields and hit the submit button again (ONLY ONE TIME).

If the applicant is eligible for the PE Adult aid category, he or she will be 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. **Upon validation, a summary page will systematically populate.** The summary page includes the data submitted for the PE applicant. A screen will appear with the option to print a summary page and print the acceptance or denial letter.

8. **Print the denial/acceptance letter and provide a copy to the member.** You must always print a copy and give it to the member. QP can save a copy of the letter as a PDF for their records and then print a hard copy for the member. **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.** You should review acceptance letters with members 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 facilitate the member in completing the full application.
   - **The approval letter is proof of coverage** – The individual needs to hold onto the PE approval letter like he or she would a member card. It will need to be presented every time the member seeks services during their PE period.
   - **The member is eligible for services based upon his or her aid category** – If the member has a limited benefit package, such as the Family Planning Eligibility Program or PEPW package, the QP needs to emphasize that the member’s PE coverage only includes certain services. The QP should also explain where the member can find a provider and get services.

**IMPORTANT NOTE FOR MEMBERS IN THE ADULT PE CATEGORY:** Adult PE members eligible for HIP Basic benefits will be contacted by their MCE with the option to make a “Fast Track” POWER Account contribution. This will allow them to gain HIP Plus coverage more quickly. HIP Plus is the most comprehensive and affordable HIP plan Members should know that once they make a “Fast Track” contribution or pay into their POWER Account, they cannot change their MCE until their next open enrollment.

**Have Questions?**

If you have questions about being a QP or about the PE program policies please refer to the provider reference modules 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. Find contact information at indianamedicaid.com. To find the consultant for your area see the Contact Us page at indianamedicaid.com.
Caution: The PE member application system is a live production environment. Providers should not create test cases and use the live application for training purposes.

### Monthly Income Maximum Amounts (Effective March 1, 2017)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Parents/Caretakers</th>
<th>213% FPL Infants (Under 1)</th>
<th>163% FPL Children (Under 19-24)</th>
<th>138% FPL Adults (19-64)</th>
<th>213% FPL Pregnant Women</th>
<th>146% FPL Family Planning</th>
<th>Former Foster Care Children (18-25)</th>
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<tr>
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</table>

### Frequency Limitations

Individuals receive presumptive eligibility with the following limitations:
- Only one PE determination per rolling 12-month period
- Only one PE determination per pregnancy

### General Presumptive Eligibility Applicant Requirements

To qualify for Presumptive Eligibility, an applicant must:
- Be a U.S. citizen, qualified noncitizen, or a qualifying immigrant
- Be an Indiana resident
- Not be a current Indiana Health Coverage Programs (IHCP) member, including Healthy Indiana Plan (HIP)
- Not be enrolled through the presumptive eligibility process (Hospital Presumptive Eligibility, Presumptive Eligibility for Pregnant Women, or Presumptive Eligibility) currently or within timeframe restrictions
- Not be currently incarcerated
- Must meet the income level requirements specific to certain aid categories.

### Presumptive Eligibility Period

BEGINs - On the date a QP determines an individual presumptively eligible for coverage through IHCP

ENDs - On the last day of the month following the month the individual was found presumptively eligible, unless the individual has filed an Indiana Application for Health Coverage with DFR (coverage ends when an eligibility determination by DFR has been made)

IMPORTANT NOTE: PE Adult members will receive a letter from their chosen MCE requesting a $10 Fast Track contribution payment within 60 days. This payment, along with a completed Indiana Application for Health Coverage, will allow a member found eligible for HIP to begin his or her coverage on the first of the month following the PE period.

### Presumptive Eligibility Benefit Packages

- **Package A - Standard Plan**
  - All covered services available under Package A - Standard Plan
  - Only one PE determination per pregnancy

### Managed Care Entity Phone Numbers

- **Anthem**
  - (866) 408-6131
- **MDwise**
  - (800) 356-1204
- **MHS**
  - (877) 647-4848
- **CareSource**
  - (844) 607-2831

### Copay Amounts

- Outpatient Visits: $4.00
- Inpatient Visits: $75.00
- Preferred Drugs: $4.00
- Non-Preferred Drugs: $8.00
- Non-Emergency ER Visit (1st): $8.00
- Non-Emergency ER Visit (Additional): $25.00

### Completing the Indiana Application for Health Coverage

A PE individual must complete an Indiana Application for Health Coverage:
- At the provider where he/she was found presumptively eligible
- Online at www.dfrbenefits.in.gov
- Over the phone by calling (800) 403-0864
- At a Division of Family Resources (DFR) local office

To change a PE Adult member’s MCE:
- Call (877) GET-HIP-9 (1-877-438-4479)
- Visit www.HIP.IN.gov

For more information about HIP covered services and required copays:
- Visit www.HIP.IN.gov

More information is available in the PE provider reference modules at provider.indianamedicaid.com.