INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Hospital Presumptive Eligibility

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1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 Published: December 22, 2016	Semiannual update	FSSA and HPE
1.2	Policies and procedures as of August 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: March 28, 2017	*Core*MMIS updates	FSSA and HPE

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Hospital Presumptive Eligibility

Introduction

Qualified acute care hospitals and free-standing psychiatric hospitals can enroll qualifying individuals in certain aid categories to receive temporary coverage at the point of service until eligibility for the Indiana Health Coverage Programs (IHCP) is officially determined by the Indiana Family and Social Services Administration (FSSA). The Hospital Presumptive Eligibility (Hospital PE) coverage period begins on the date the Hospital PE qualified provider (QP) determines an individual is presumptively eligible for coverage through the IHCP. Hospital PE is part of the fee-for-service (FFS) delivery system, with the exception of PE Adult, which is managed care.

The Hospital PE coverage period ends when one of the following circumstances occurs:

- The member does not complete and file an *Indiana Application for Health Coverage* by the end of the month following the month in which Hospital PE coverage begins. A completed *Indiana Application for Health Coverage* must be pending with the FSSA within that time frame to continue Hospital PE coverage.
- The member is officially determined eligible for coverage under an IHCP program by the FSSA. Eligibility for Hospital PE ends on the day after eligibility information is received from the FSSA.
- The member is officially determined ineligible for coverage under an IHCP program by the FSSA. Eligibility for Hospital PE ends on the day after the denial of eligibility information is received from the FSSA.

> ***Note:*** *Members who qualify for PE Adult will be able to retain Hospital PE eligibility after they have been determined to be conditionally eligible for Healthy Indiana Plan (HIP) coverage while they make their required Personal Wellness and Responsibility (POWER) Account contributions. This allows them to avoid gaps in coverage as long as they meet required application and payment deadlines.*

During the presumptive eligibility period, the individual will be able to receive treatment from other IHCP providers after he or she leaves the hospital. The individual must complete an *Indiana Application for Health Coverage* during the presumptive eligibility period to gain continued coverage through the IHCP. If an individual does not complete this application, he or she will lose coverage after the presumptive eligibility period ends. An individual is allowed only one presumptive eligibility coverage period per rolling 12-month period or per pregnancy.

Aid categories eligible for Hospital PE include:

- Low-income children who qualify for the IHCP
- Low-income parents or caretakers
- Non-disabled adults 19–64
- Former foster care children
- Pregnant women
- Individuals eligible for the Family Planning Eligibility Program only

Member Enrollment Process Overview

An individual seeking coverage works with a hospital designee to complete an electronic PE application. The individual relays the necessary information to the hospital designee, who enters the information online via Provider Healthcare Portal. Enrollment is available 24 hours a day, seven days a week. The hospital designee receives a real-time response on whether the individual is eligible for Hospital PE based on the answers the individual provides during the application process. The individual will be asked about his or her identifying information, family size, and household income. Applicant responses are self-attested; therefore, hospitals are not permitted to ask for supporting documentation to verify the applicants' eligibility.

An individual can apply for Hospital PE for all members in his or her family, regardless of the person's need for services at the time of application. The QP must complete a separate application for *each* individual who wants to apply for PE.

After presumptive eligibility is determined, the hospital designee informs the individual of Hospital PE approval or denial. Approved individuals have coverage for services appropriate to the designated Hospital PE aid category for the presumptive eligibility period.

Hospital Presumptive Eligibility Team

Several entities work together to ensure that Hospital PE QP and member enrollment works properly. The responsibilities of each entity are described in the following sections.

Hewlett Packard Enterprise

Hewlett Packard Enterprise responsibilities include the following:

- Maintain and provide training on the Provider Healthcare Portal.
- Enroll new Hospital PE QPs and maintain a list of certified Hospital PE QPs.
- Post enrolled Hospital PE QPs in the Provider Search feature at indianamedicaid.com.
- Assign the Hospital PE identification number (PE ID).
- Receive and update *Core*MMIS with IHCP eligibility information received from the FSSA.
- Provide Hospital PE training materials to Hospital PE QPs.
- Answer any questions Hospital PE QPs may have regarding the Hospital PE process.

Hospitals

Hospital responsibilities include the following:

- Verify an individual's IHCP eligibility via the Provider Healthcare Portal, Interactive Voice Response (IVR) system at 1-800-457-4584, or Electronic Data Interchange (EDI) 270/271 transaction.
- Enroll presumptively eligible individuals with Hospital PE coverage 24 hours a day, seven days a week.
- Make presumptive eligibility determinations consistent with state policies and procedures.
- Guide individuals on the requirements to complete and submit the *Indiana Application for Health Coverage* within 30 days of a completed Hospital PE application.

Hospitals also attest to the following:

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

FSSA

The FSSA responsibilities include the following:

- Accept and process *Indiana Applications for Health Coverage* received from a Hospital PE QP or an individual.
- Assign the IHCP Member ID (also known as RID) when eligibility is approved.

Managed Care Entities

The managed care entities (MCEs) have the following responsibilities:

- Cover all PE Adult members.
- Request Fast Track payment from PE Adult members.
- Process all claims for PE Adult-covered services.
- Provide prior authorization (PA) or precertification for services as necessary.

Indiana Navigators and Application Organizations

Qualified Hospital PE hospitals may apply to be authorized representatives or Application Organizations (AOs), but they are not required to do so. Hospital staff members helping individuals complete the *Indiana Application for Health Coverage* also need to be certified as Indiana Navigators or designated as authorized representatives. Only in those roles may the hospital staff assist the Hospital PE applicant with his or her *Indiana Application for Health Coverage*. All navigators must receive state training, undergo annual state certification, and meet state-based performance standards monitored by the Indiana Department of Insurance.

Some hospitals may choose to contract with eligibility assistance companies for completing and submitting the *Indiana Application for Health Coverage*. If the hospital contracts with an eligibility assistance company, that company should have staff that are certified as Indiana Navigators and/or designated as authorized representatives working with Hospital PE participants to complete the *Indiana Application for Health Coverage*.

For more information about the Indiana Navigators and AOs, see the *Indiana Department of Insurance* page at in.gov/idoi.

Hospital Presumptive Eligibility Provider Enrollment Requirements

Eligible Provider Type

Acute care hospitals and psychiatric hospitals may become QPs for Hospital PE.

Federal Medicaid Regulations

Federal regulations require that a Hospital PE QP is a hospital that:

- Participates as a provider under the IHCP State Plan or a demonstration under *Section 1115* of the *Social Security Act.*
- Notifies the IHCP of its intention to make Hospital PE determinations.
- Agrees to make Hospital PE determinations consistent with state policies and procedures.

State-Specific Requirements

The State requires that a Hospital PE QP must meet the following requirements:

- Completes and submits PE QP eligibility attestations through the Presumptive Eligibility QP enrollment process on Provider Healthcare Portal
- Participates in Hospital PE Provider Healthcare Portal training
- Participates in Hospital PE training
- Helps individuals complete and submit a full *Indiana Application for Health Coverage*

Enrolling as a Hospital Presumptive Eligibility Qualified Provider

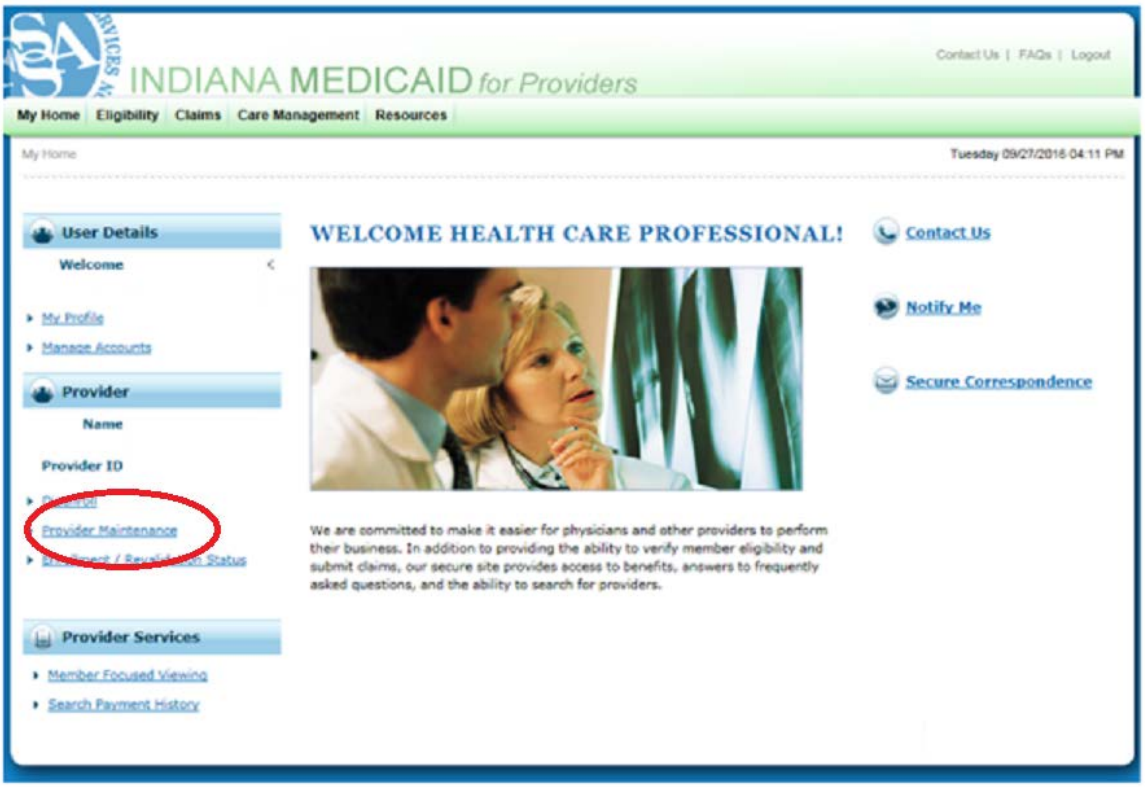
Hospitals meeting the requirements are encouraged to enroll as Hospital PE QPs through the Provider Healthcare Portal, as follows:

1. Log into the Provider Healthcare Portal at portal.indianamedicaid.com.

You must first register for the Portal before using it. See the *Provider Healthcare Portal* module if you need detailed instructions.

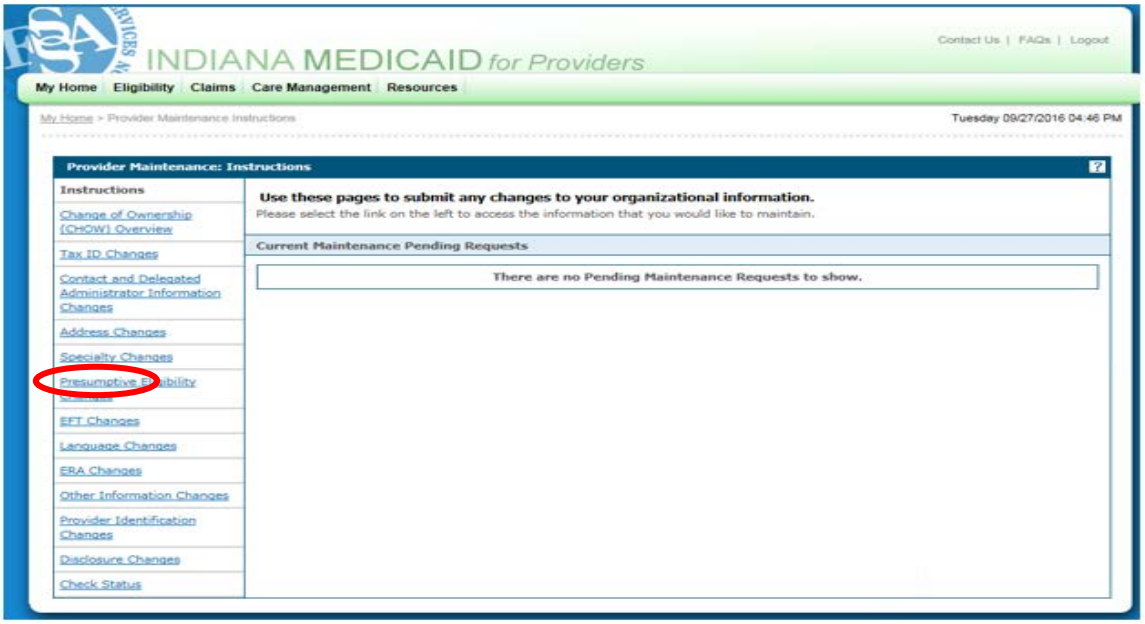
2. From the *My Home* page, click the *Provider Maintenance* link.

Figure 1– The Provider Maintenance Link on My Home Page of the Provider Healthcare Portal



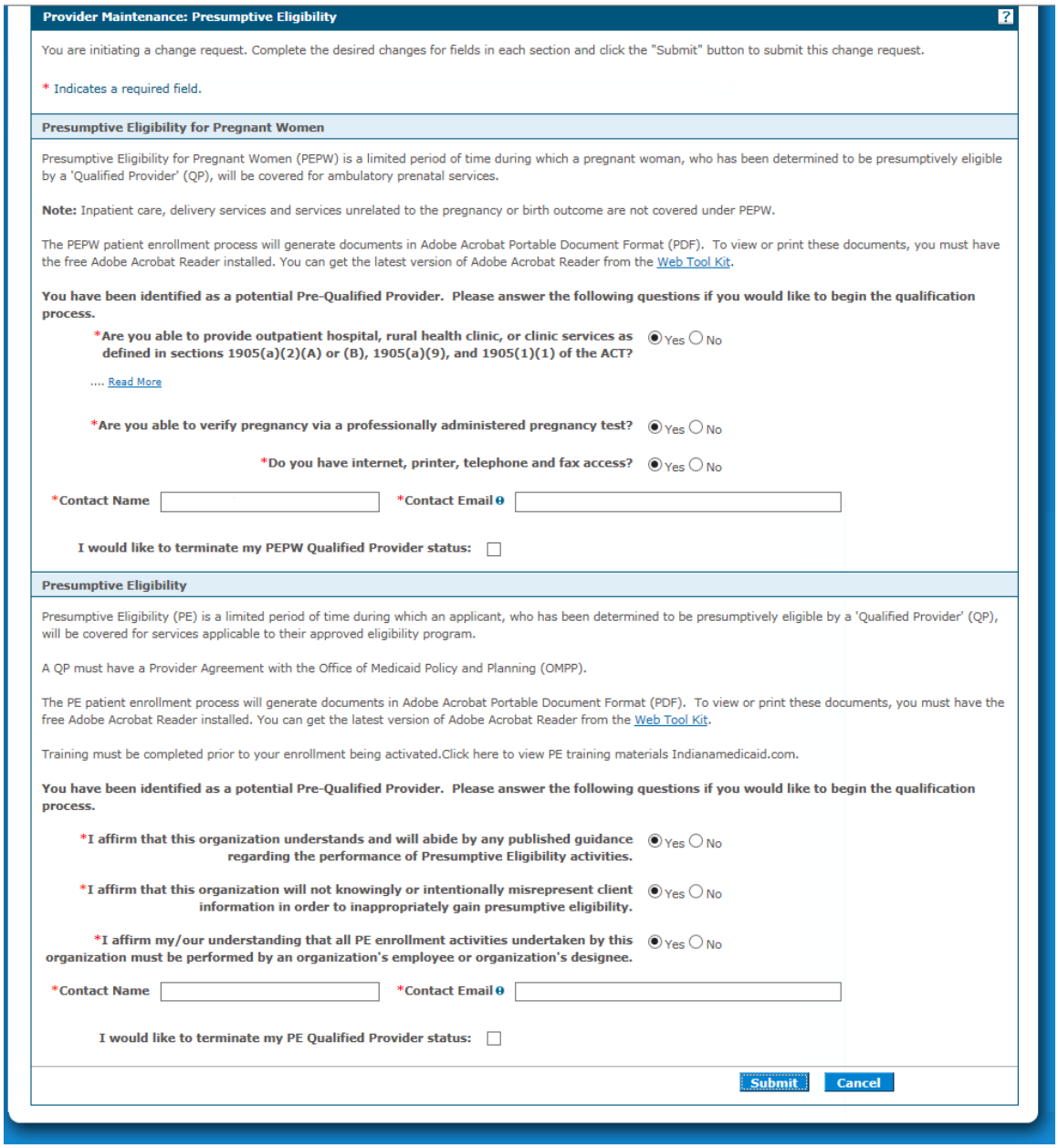
3. On the *Provider Maintenance Instructions* page, click the Presumptive Eligibility Changes link on the left side of screen.

Figure 2 – The Presumptive Eligibility Changes Link on the Provider Maintenance: Instructions Page



4. Answer the questions and complete all the fields indicated on the *Provider Maintenance: Presumptive Eligibility* page.

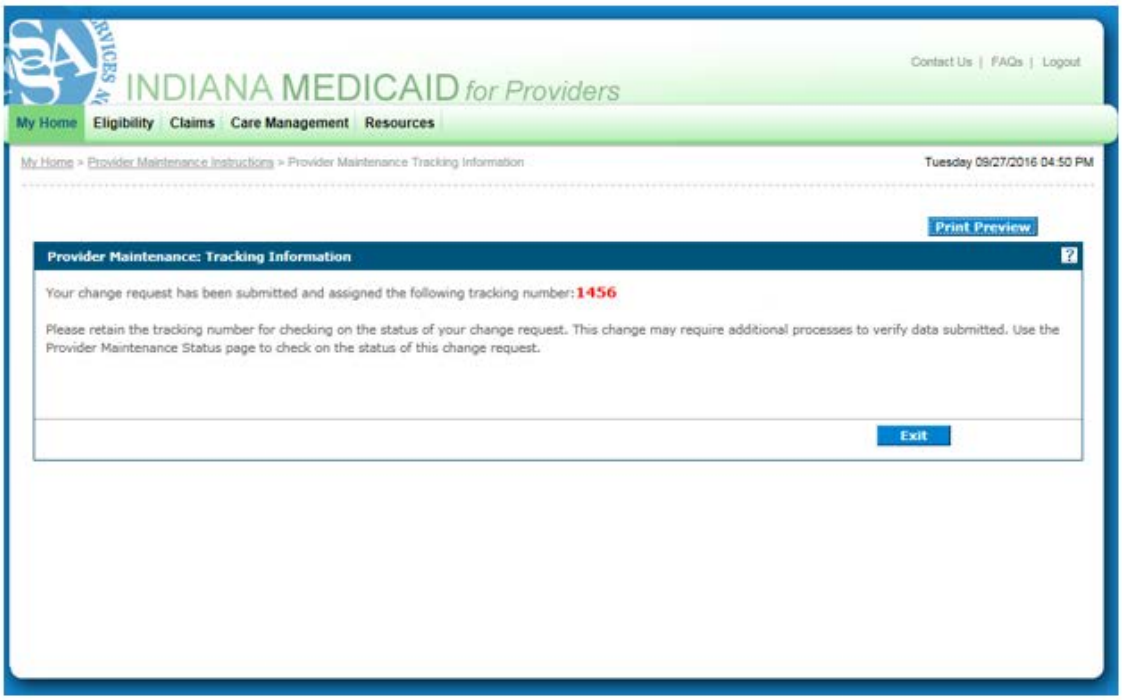
Figure 3 – The Provider Maintenance: Presumptive Eligibility Page



Note:	*The individual responding to the questions must provide his or her name and email address for the Contact Name and Contact Email fields.*

5. Click Submit.
6. On the *Provider Maintenance: Tracking Information* page, click Print Preview to print a copy of the confirmation, and then click Exit.

Figure 4 – Provider Maintenance: Tracking Information page



If the provider answers "yes" to the three questions and enters a contact name and email address, a Provider Relations representative contacts the prequalified Hospital PE QP within 10 days to schedule a Provider Healthcare Portal training session.

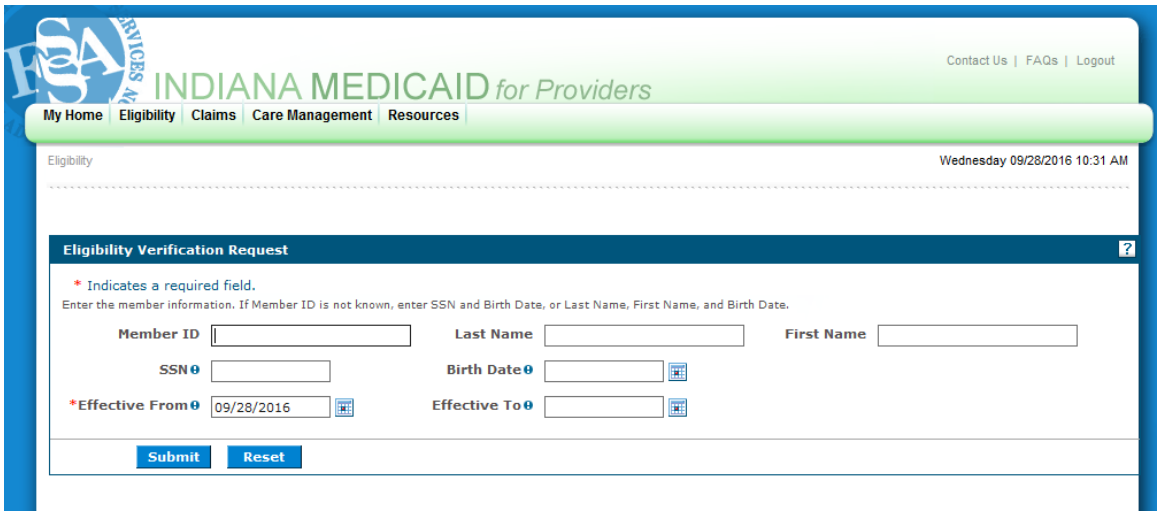
The Provider Relations representative also provides the hospital with a printed copy of and electronic link to the Hospital PE Process Training. After the web training is completed, the Provider Enrollment unit will activate the certified QP in *Core*MMIS. The Hospital PE QP may then provide services under the Hospital PE process.

Completing the Hospital Presumptive Eligibility Member Application

The Hospital PE QP uses the Provider Healthcare Portal to verify that the individual is not already an IHCP member and then submit an application for the individual. The following is a step-by-step process for the Hospital PE applicant enrollment process.

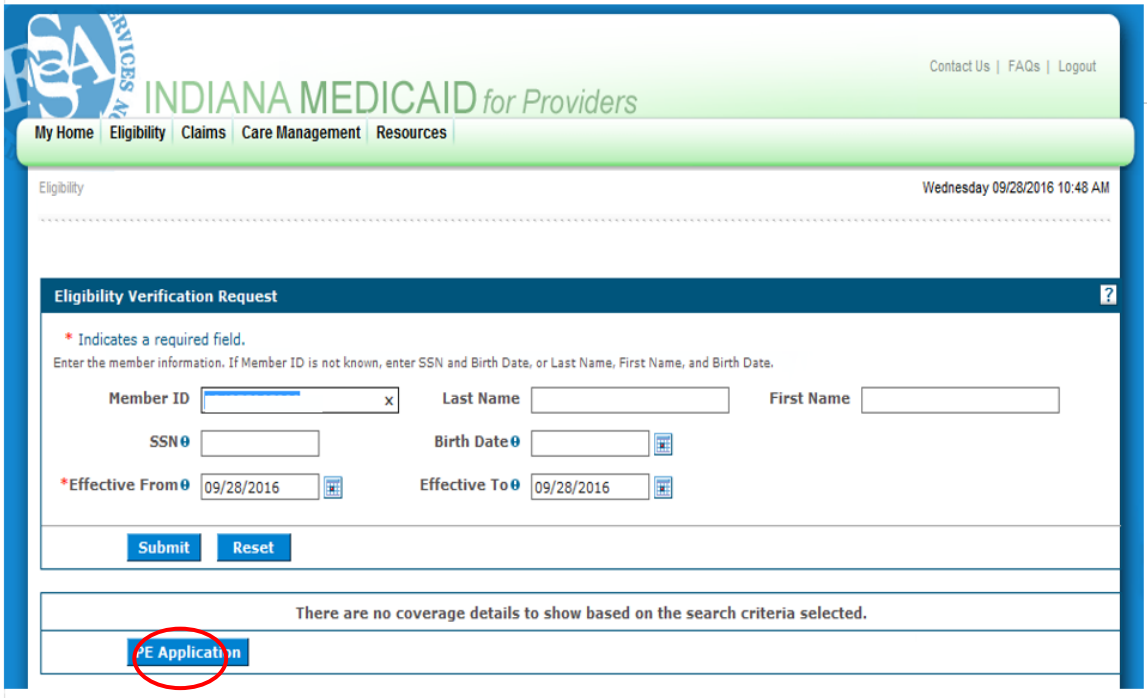
1. Log in to the Provider Healthcare Portal.
2. Select the Eligibility tab from the menu bar.
3. In the *Eligibility Verification Request* panel, enter the applicant's Social Security number (SSN) and birth date or the applicant's last name, first name, and birth date. (If the applicant has a Member ID related to previous coverage it may be used in place of the preceding fields.)

Figure 5 – Eligibility Verification Request



4. Click Submit.
5. After the system confirms that no coverage exists for the individual, click the PE Application button.

Figure 6 – The PE Application Button

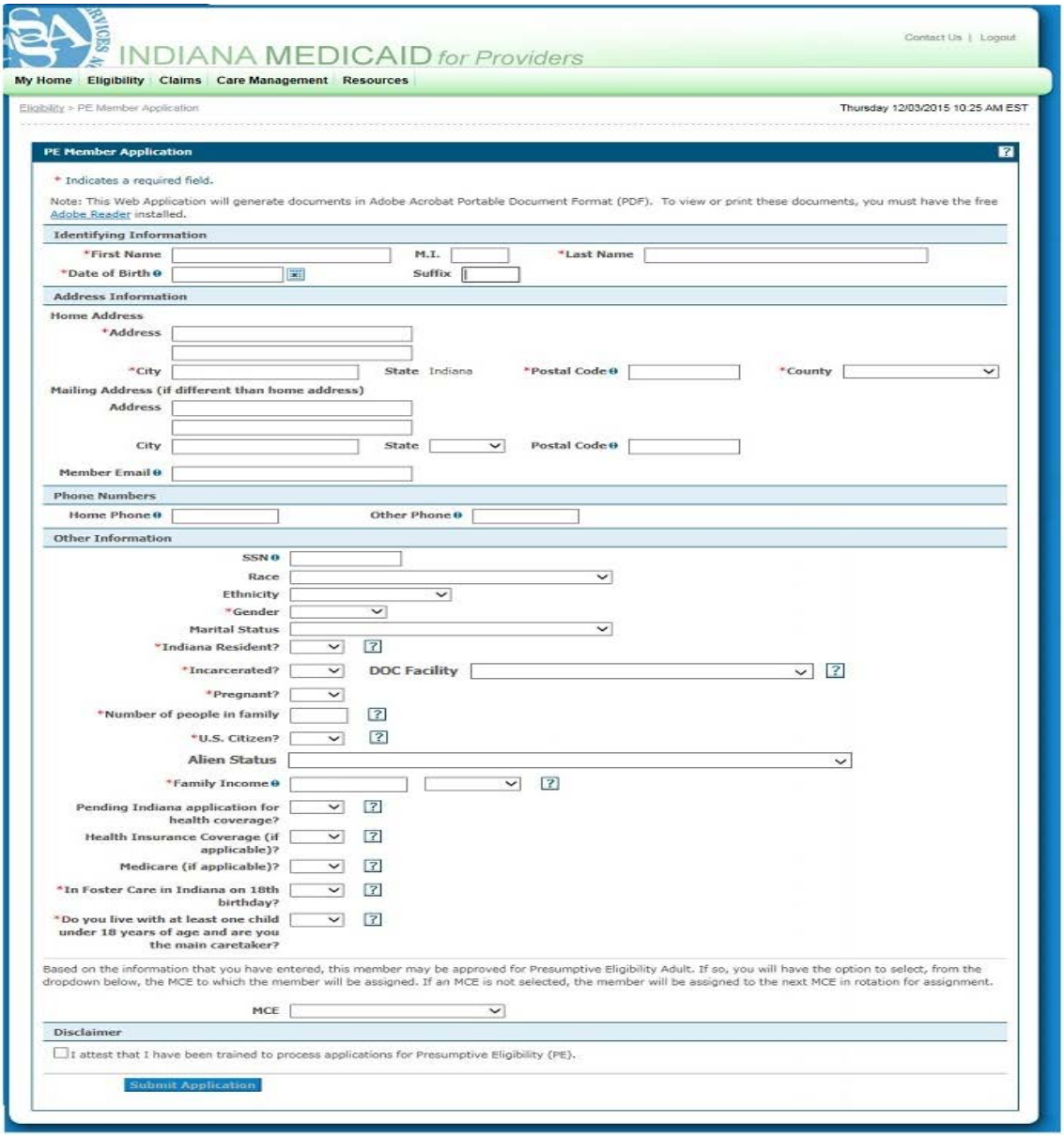


6. Complete the PE Member Application by entering information in the fields.

   Provide the following information about the applicant (an asterisk (*) indicates a required field):

   - First name*
   - Middle initial
   - Last name*
   - Suffix
   - Date of birth*
   - Home address*
   - Mailing address (if different than home address)
   - Email address
   - Phone numbers
   - Social Security number (SSN)
   - Race
   - Ethnicity
   - Gender*
   - Marital status
   - Is the applicant an Indiana resident?*
   - Is the applicant incarcerated?* If yes: Department of Corrections (DOC) facility
   - Is the applicant pregnant?*
   - Number of people in applicant's family*
   - Is the applicant a U.S. citizen?*
   - Alien status
   - Family income*
   - Does the applicant have a pending *Indiana Application for Health Coverage* on file?
   - Does the applicant have health insurance coverage?
   - Does the applicant have Medicare coverage?
   - Was the applicant in foster care in Indiana on his or her 18th birthday, under the responsibility of the State of Indiana, and was the applicant enrolled in an IHCP program on his or her 18th birthday?*
   - Is the applicant the parent or legal guardian living in the same household of at least one child under 18 years of age and is the primary caretaker?*
   - MCE

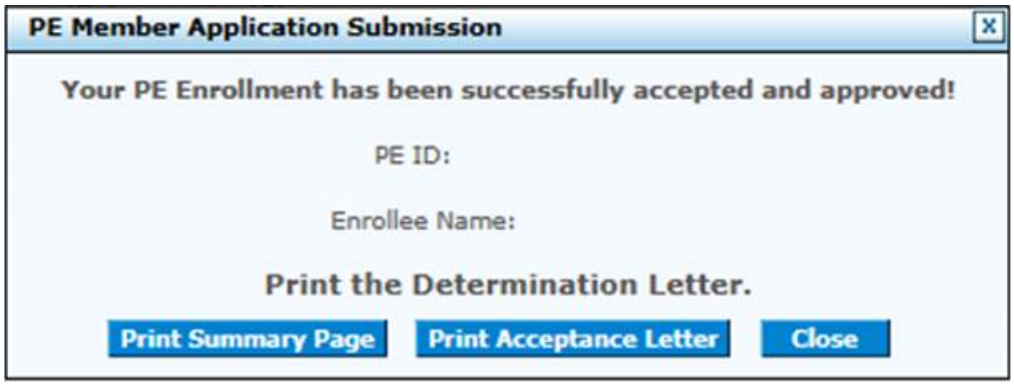
Figure 7 – PE Member Application



Note:	*The QP must complete a separate application for* each *individual who wants to apply for PE.*

7. Select the I Attest That I Have Been Trained to Process Applications for Presumptive Eligibility (PE) check box to attest that you have been trained on this process.
8. Review the information entered with the individual and click the Submit Application button.
9. The *PE Member Application Submission* window appears.

Figure 8 – PE Member Application Submission



10. Click the Print Acceptance Letter button to print the Determination Letter and give copy to applicant to use as their member identification.
11. After discussing the coverage period and providing guidance on how the hospital will help the member complete the full *Indiana Application for Health Coverage*, the QP can print the summary page or close the application.

Presumptive Eligibility Period

Member Identification

Members who are found eligible through the Hospital PE process receive letters that serve as proof of coverage during their presumptive eligibility period. These members do not receive IHCP member identification cards. The letter clearly indicates the dates the member's presumptive eligibility period begins and ends, the member's PE ID, and, if applicable, the member's MCE. It may take a few days for the member's coverage to be visible to pharmacy providers. For this reason, the original presumptive eligibility approval letter is sufficient to validate temporary coverage even if the member is not listed in the appropriate eligibility system.

Admission Date and PE Eligibility

Member presumptive eligibility begins on the date that the PE application is submitted and the approval determination is made. Services delivered prior to this date are not covered. This also applies to hospital admission dates that predate the PE eligibility start date. If a hospital admission date is prior to the PE eligibility start date, no portion of that stay will be considered a PE covered service.

Fee-for-Service Hospital PE

If the individual has filed an *Indiana Application for Health Coverage*, his or her presumptive eligibility period lasts until a final eligibility determination from the FSSA has been made. Without a completed application, the PE period lasts until the end of the month following the month in which the presumptive eligibility determination was made. For example, if the presumptive eligibility determination was made March 10, the individual would remain eligible as though he or she were fully enrolled in the IHCP until April 30. All services that are covered by the IHCP within the designated PE aid category are covered during the presumptive eligibility period.

During the presumptive eligibility period, the eligible individual is also able to receive treatment within his or her benefit package from other IHCP providers after he or she leaves the hospital. It is imperative that

the hospital employee informs the individual that he or she needs to complete the *Indiana Application for Health Coverage* before the temporary eligibility period ends, and provides information on how the individual can do so. As explained on the acceptance letter, the individual may complete the *Indiana Application for Health Coverage* in one of the following ways:

- At the provider where the individual was determined to be presumptively eligible
- Online from the *DFR Benefits page* at in.gov
- Via telephone at 1-800-403-0864
- At an FSSA Division of Family Resources (DFR) local office

Managed Care PE Adult

A PE Adult member who does not complete an *Indiana Application for Health Coverage* by the end of the month following the month PE was established has his or her PE coverage end on the last day of the second month. A PE Adult member who completes an *Indiana Application for Health Coverage* by the end of the month following the month PE was established has coverage after he or she has been determined to be conditionally eligible for HIP coverage while they make his or her required POWER Account contributions. This allows him or her to avoid gaps in coverage as long as he or she meets required application and payment timelines.

PE Adult members are enrolled with a managed care entity. If the member is determined to be PE-eligible and receives services in a hospital that is not within the MCE network, the MCE is obligated to make arrangements to pay for services rendered. A PE Adult member who seeks further care during his or her PE period should seek care within the MCE network. The member should call his or her MCE for assistance in finding a provider.

A PE Adult member may notice a lag between his or her Hospital PE eligibility and the time when his or her information is visible in all MCE vendor systems. The QP should advise the member that his or her information will not be visible to pharmacy systems for up to four business days. If the member needs a prescription filled immediately, the member must contact his or her MCE.

As explained on the acceptance letter, the individual may complete the *Indiana Application for Health Coverage* in one of the following ways:

- At the provider where the individual was determined to be presumptively eligible
- Online at the *DFR Benefits page* at in.gov
- Via telephone at 1-800-403-0864
- At an FSSA DFR local office

Eligibility Verification

As part of the Hospital PE process, Hospital PE QPs use the Provider Healthcare Portal to determine whether the applicant is already covered through the IHCP.

Individuals are allowed only one presumptive eligibility coverage period per rolling 12 months or pregnancy, whichever is applicable. As with all IHCP members, providers serving individuals who have previously been determined presumptively eligible must verify the individual's eligibility on each date of service. The EVS options – Provider Healthcare Portal and IVR system and – accept the PE identification number.

Hospital PE is identified by the following aid categories:

- PE Infants
- PE Children
- PE Adult
- PE Parent/Caretaker
- PE Pregnant Women
- PE Former Foster Care Children
- PE Family Planning

If the FSSA approves an individual for IHCP eligibility, his or her benefit package changes from the Hospital PE package assigned during the Hospital PE process to the appropriate IHCP benefit package. He or she also receives a Hoosier Health Card with his or her Member ID. Hospital PE coverage ends on the day after Hewlett Packard Enterprise receives notification of IHCP eligibility from the FSSA, whether approved or denied, with the exception of PE Adult, as explained previously in the *Managed Care PE Adult* section

IHCP Presumptive Eligibility Processes and Coordination with Presumptive Eligibility for Pregnant Women

Presumptive Eligibility for Pregnant Women (PEPW)

Similar to Hospital PE, PEPW is a process through which pregnant women can be presumptively eligible for temporary IHCP coverage. These women receive ambulatory prenatal services through a simplified application while the *Indiana Application for Health Coverage* is processed. The PEPW process was introduced in July 2009.

Presumptive Eligibility (PE)

Similar to Hospital PE, Presumptive Eligibility (PE) is a process where individuals can be found presumptively eligible for temporary IHCP services through a simplified application while the *Indiana Application for Health Coverage* is processed. In PE, however, members are enrolled by federally qualified health centers (FQHCs), rural health clinics (RHCs), community mental health clinics (CMHCs), and local county health departments rather than acute care or freestanding psychiatric hospitals.

Comparison of Presumptive Eligibility Processes

Table 1 describes the most significant differences between Hospital PE, PE, and PEPW.

Table 1 – A Comparison of Hospital PE, PE, and PEPW

	PEPW	Hospital PE	PE
Aid categories	Pregnant women only	• Infants • Children • Pregnant women • Adults 19–64 • Parents/caretakers • Former foster care children • Individuals seeking family planning services	• Infants • Children • Pregnant women • Adults 19–64 • Parents/caretakers • Former foster care children • Individuals seeking family planning services
Qualified providers (QPs)	• Advanced practice nurse practitioners • Family/general practitioners • Certified nurse midwives • General internists • Obstetricians or gynecologists • General pediatricians • FQHCs • RHCs • Medical clinics • Family planning clinics • Local health departments • Hospitals	• Acute care hospitals • Psychiatric hospitals	• FQHCs • RHCs • Community mental health centers CMHCs • Local county health departments
Enrollment broker requirement	Pregnant women found presumptively eligible must contact the enrollment broker, MAXIMUS, to select a primary medical provider (PMP) and MCE on the same day that a woman is found presumptively eligible.	No requirement	No requirement
Delivery system	Managed care	Fee-for-service, except PE Adult, which is managed care	Fee-for-service, except PE Adult, which is managed care

Current PEPW QPs

Hospitals currently enrolled as PEPW QPs retain their ability to determine presumptive eligibility for pregnant women under the PEPW process. When accessing the Provider Healthcare Portal, these providers see PEPW and Hospital PE verbiage and data fields for individuals.

Non-PEPW QPs

Hospitals that are not currently enrolled as PEPW QPs are not eligible to enroll in the PEPW process. Going forward, hospitals will only be eligible to enroll as QPs under Hospital PE. When accessing Provider Healthcare Portal, these providers will see only Hospital PE verbiage and data fields for individuals.

Whether to Use Hospital PE or PEPW

Acute care hospitals that are enrolled as QPs in PEPW and Hospital PE are able to enroll qualified pregnant women through the PEPW or Hospital PE process, whichever the pregnant woman chooses. The following examples are suggestions when determining which process to use:

1. Is the pregnant woman seeking acute care or routine care?
   - If the pregnant woman is seeking acute care that was not scheduled or inpatient care, it is recommended that the QP use the Hospital PE process.
   - If the pregnant woman goes to the hospital to use the clinic within the hospital for routine prenatal care, it is recommended that the QP use the PEPW process.
2. Where is the pregnant woman receiving services?
   - If the pregnant woman is seeking care in an emergency room or acute care setting, it is recommended that the QP use the Hospital PE process.
   - If the pregnant woman is seeking prenatal care through an OB-GYN's office or clinic, it is recommended that the QP use the PEPW process.
3. When is the pregnant woman seeking services?
   - If the pregnant woman is seeking services before 8 a.m. or after 6 p.m. Monday–Friday, or on a weekend, it is recommended that the QP use the Hospital PE process.
   - If the pregnant woman is seeking services during the hours of 8 a.m.–6 p.m., Monday–Friday, the Hospital PE and PEPW processes are equally recommended.

When using the PEPW process, QPs must follow the instructions provided in the *Presumptive Eligibility for Pregnant Women* module.

Hospital Presumptive Eligibility Applicant Requirements

Note:	*Qualified providers may not ask for verification documents when performing Hospital PE tasks. Proof of income, residency, citizenship, and any other documents for eligibility verification are not required at the time of application for Hospital PE.*
Note:	*Although verification is not allowed, providers must not enter information they know to be false into the Provider Healthcare Portal.*

Hospital PE is based on the following criteria. The applicant:

- Must be a U.S. citizen, qualified noncitizen, or a qualifying immigrant with one of the following immigration statuses:
  - Lawful permanent resident immigrant living lawfully in the United States for five years or longer
  - Refugee
  - Individual 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
  - Other qualified alien
- Must be an Indiana resident
  - An Indiana address must be provided on the application.
- Must not be a current IHCP member, including a member of the Healthy Indiana Plan (HIP)
- Must not be enrolled in the presumptive eligibility process – Hospital PE, PE, or PEPW
- Must not be currently incarcerated. (For information surrounding coverage of incarcerated individuals, see the *Special Rules Regarding Presumptive Eligibility for Inmates* section.)
- Must not be an adult (aged 21–64) admitted to or a resident of an Institute for Mental Disease (IMD)
- Must meet the income level requirements specific to certain aid categories, as outlined in Table 2
- Must meet any additional requirements specific to certain aid categories, as described in Table 2

Table 2 – Aid Category and Federal Poverty Level Limit

Aid Category Description	FPL Limit
PE Infants	213%
PE Children (Ages 1 to 18)	163%
PE Adults (Ages 19 – 64)	138%
PE Parents/Caretakers	Converted Modified Adjusted Gross Income (MAGI) equivalent limit
PE Former Foster Care Children	No FPL Requirement
PE Pregnant Women	213%
PE Family Planning	146%

Note: *These percentages include a 5% income disregard. When completing a full application, the 5% income disregard is applied only if an individual is otherwise ineligible for IHCP.*

These percentages include an addition of 5 percentage points to roughly estimate the 5% income that will be disregarded from the individual's income. This disregard is based on the applicable income standard if the individual would have otherwise been ineligible when a full application is submitted to the DFR.

Specific Requirements for Hospital PE Aid Categories

For the following categories, all of the eligibility requirements listed must be met.

Infants

- Individual must be under the age of one.
- The individual's family income must be under 213% of the federal poverty level (FPL).

Children

- Individual must be under the age of 19.

- The individual's family income must be under 163% of the FPL.

Adults

- Individual must be 19–64.
- Individual cannot have Medicare.
- Individual cannot have a HIP conditional status.
- The individual's family income must be under 138% of the FPL.

Parents/Caretakers

- Individual must live with a person under the age of 18 and must be the individual taking care of the minor person.
- Individual must have income less than converted MAGI equivalent limits.

Former Foster Care

- Individual must be between the ages of 18 through 25 years old (up to 26th birthday).
- Individual must have been in foster care at age 18.
- Individual must have been enrolled in the IHCP at age 18.

Pregnant Women

- Individual must be pregnant, but the pregnancy does not need to be medically verified.
- Individual must have income below 213% of the FPL.
- Individual's family size must be at least two members – the individual and her unborn child(ren).

Family Planning

- Individual must not be eligible for any other Hospital PE category.
- Individual must have income below 146% of the FPL.

The Hospital PE QP enters the applicant's monthly income and family size into the Hospital PE application. The application systematically determines if the Hospital PE applicant meets the income criteria for each Hospital PE aid category.

Although Hospital PE is systematically determined, QPs can refer to the *Eligibility Guide* on the IHCP member website at indianamedicaid.com to find actual income guidelines for the eligibility groups. The monthly income limits are also available at indianamedicaid.com through the *IHCP Presumptive Eligibility (PE) Standards* document.

Medicaid Coverage per Aid Category

Presumptive eligibility benefit packages are based on the aid category of an individual's full eligibility benefit package, except for those in the PE Pregnant Women and PE Family Planning eligibility groups. The following explains each presumptive eligibility benefit package:

- PE Infants and Children includes all covered services available under *Hoosier Healthwise Package A.*

- PE Adults includes all covered services available under *HIP Basic*, including copayments for covered services. Copayments do not apply to pregnant members, American Indian/Alaskan Native, or members who have met their maximum cost sharing for the quarter. Copayments are:
  - Outpatient services (physician/hospital): $4 per visit
  - Inpatient services: $75 per admission
  - Preferred drugs: $4 per prescription
  - Nonpreferred drugs: $8 per prescription
  - Copayments will not apply to preventative services, maternity services, family planning services, or services provided for an emergency health condition. Nonemergency ER visit: $8/$25
- Parents/Caretakers includes all covered services available under *Hoosier Healthwise Package A*.
- PE Former Foster Care Children includes all services available under *Hoosier Healthwise Package A*.
- PE Pregnant Women is limited to ambulatory prenatal care services only, defined under *Package P*. The following items and services are covered under PE Pregnant Women (for codes, see the *Presumptive Eligibility for Pregnant Women* code table at the *Code Sets* page at indianamedicaid.com):
  - Doctor visits for prenatal care
  - Prescription drugs related to pregnancy
  - Prenatal lab work
  - Transportation to prenatal visits
- PE Family Planning is limited to family planning services only, defined under the Family Planning Eligibility Program benefit package. The following items and services are covered under PE Family Planning (for codes, see the *Family Planning Eligibility Program* code table document at the *Code Sets* page at indianamedicaid.com):
  - 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

All Hospital PE categories are reimbursed through the fee-for-service delivery system, with the exception of PE Adult. The Adult group is reimbursed through the risk-based managed care delivery system.

Note:	*For presumptive eligibility benefit packages that include inpatient hospital coverage, if a hospital admission date is before the PE start date, and the inpatient service is reimbursed using the Diagnosis-Related Grouper (DRG) methodology, no portion of that member's inpatient stay will be considered a PE-covered service. If a hospital admission date is before the PE start date, and the inpatient service is reimbursed on a level-of-care (LOC) per diem basis, dates of service (DOS) on or after the member's PE start date will be covered. DOS before the member's PE start date are not covered.*

> *If the PE eligibility date is after the admission or initial DOS, the patient should complete a full IHCP application with an effective date of the treatment or admission. If the patient is deemed eligible, the eligibility date is retroactive to the initial DOS.*

Special Rules Regarding Presumptive Eligibility for Inmates

Certain incarcerated individuals can receive limited Medicaid coverage through the PE for Inmates process. This process allows Hospital PE QPs to enroll eligible individuals into the IHCP for temporary coverage of authorized inpatient hospitalization services. The following sections describe the specific rules and restrictions regarding the PE for Inmates process.

Eligible Individuals

The PE for Inmates process is available to individuals who meet the following requirements:

- Be an inmate from an Indiana Department of Correction (IDOC) facility or county jail operating under a memorandum of understanding (MOU) or contract with the Indiana FSSA
- Not be on house arrest
- Not be pregnant or admitted for labor and delivery
- Be under the age of 65
- Meet all other standard PE requirements

Aid Category

Incarcerated individuals enrolled under the PE for Inmates process will be placed into the aid category appropriate for their individual circumstances. For inmates younger than 19, the appropriate HPE category based on their age would apply. However, all services for individuals enrolled through this process are paid on a fee-for-service (FFS) basis, so no inmates will be assigned to the PE Adult aid category.

Covered Services

Individuals enrolled through the PE for Inmates process will only be eligible for inpatient hospitalization services. This coverage will be effective for up to one year or until the offender is released, whichever is sooner. If an individual remains incarcerated beyond 12 months, he or she may reapply for coverage through the PE for Inmates process. These individuals must also complete an *Indiana Application for Health Coverage*. Upon release, an individual is allowed to utilize the standard Hospital PE process without regard to any PE for Inmates eligibility obtained within the past 12 months.

Specific Application Instructions

When completing the PE application for incarcerated individuals, QPs should:

- Use the correctional facility's address and telephone number as the applicant's home address and telephone number

- Select **Yes** in the *Currently Incarcerated?* Field. The DOC Facility drop-down menu will appear that lists all eligible correctional facilities. To be on the list, the correctional facility must have a signed memorandum of understanding (MOU) or contract with the Indiana FSSA. Select the inmate's correctional facility from the drop-down menu.
- Complete the rest of the application as currently instructed. If the incarcerated individual meets all the eligibility requirements, he or she will be enrolled under the PE aid category appropriate to his or her individual circumstances.

Billing Services

Individuals enrolled through the PE for Inmates process will receive a "600" PE ID. This number should be used to bill for all inpatient hospitalization services while the individual is eligible for services. Providers are reminded to always verify members' eligibility before rendering services.

Eligibility can be verified using the Provider Healthcare Portal, the IVR system, or the 270/271 electronic transaction.

Hospital Presumptive Eligibility Claim Submission

As noted previously, Hospital PE QPs should use the EVS to determine if the individual is already covered by the IHCP. Additionally, Hospital PE QPs should verify if the individual has other health insurance before submitting claims for Hospital PE services, as Medicaid is always the payer of last resort.

Fee-for-Service Claims

Claims for PE services are submitted with the PE ID number starting with a "6." QPs should submit claims compliant with applicable program standards. If a PE member is officially determined eligible for coverage under the IHCP, QPs should use the Member ID, not the PE ID.

Hospitals are reimbursed at regular IHCP rates for services rendered during the presumptive eligibility period. Reimbursement for covered services rendered during the presumptive eligibility period is allowable, even if the person ultimately fails to complete the *Indiana Application for Health Coverage* application, or if the FSSA determines the individual to be ineligible for the IHCP.

Managed Care (PE Adult Only) Claims

Claims for services for members found eligible for PE Adult should be submitted to the appropriate MCE. Claims should be submitted using the PE ID number starting with a "6." QPs should submit claims compliant with applicable program standards. A PE Adult member is eligible for a service package that mirrors the *HIP Basic* program and is subject to copays. Copay amounts will be applied. Providers will be reimbursed HIP program rates for members in the PE Adult category.