INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Presumptive Eligibility

LIBRARY REFERENCE NUMBER: PROMOD00057
PUBLISHED: MARCH 28, 2017
POLICIES AND PROCEDURES AS OF AUGUST 1, 2016
*CORE*MMIS UPDATES AS OF FEBRUARY 13, 2017
VERSION: 1.2

Revision History

Version	Date	Reason for Revisions	Completed By
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 20, 2016	Semiannual update	FSSA and HPE
1.2	Policies and procedures as of August 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 28, 2017	CoreMMIS updates	FSSA and HPE

Table of Contents

Introduction

Qualified providers (QPs) 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). Provider types that can apply to be QPs are federally qualified health centers (FQHCs), rural health clinics (RHCs), community mental health centers (CMHCs), and local county health departments. The Presumptive Eligibility (PE) coverage period begins on the date the PE QP determines an individual is presumptively eligible for coverage through the IHCP. Most PE categories are part of the fee-for-service (FFS) delivery system, except for PE Adult, which is managed care.

The 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 PE coverage begins. A completed *Indiana Application for Health Coverage* must be pending with the FSSA within that time frame to continue PE coverage.
- The member is officially determined eligible for coverage under an IHCP program by the FSSA. Eligibility for 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 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 PE eligibility after they have been determined to be conditionally eligible for Healthy Indiana Plan (HIP) coverage while they make their Personal Wellness and Responsibility (POWER) Account contribution. This allows these members to avoid a gap 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 any enrolled ICHP provider. If they are in PE Adult category, they should seek care within the managed care network they are enrolled in. 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 once 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 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 an organization or designee to complete an electronic PE application. The individual relays the necessary information to the organization designee, who enters the information online via the Provider Healthcare Portal. Enrollment is available during regular business hours. Based on the answers the individual provides during the application process, he or she receives a real-time response as to whether he or she is eligible for PE. Questions include identifying information, family size, and household income. Applicant responses are self-attested; therefore, QPs are not permitted to ask for supporting documentation to verify the applicant's eligibility.

An individual can apply for 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 QP designee informs the individual of PE approval or denial. Approved individuals have coverage for services appropriate to the designated PE aid category for the PE period.

Presumptive Eligibility Team

Several entities work together to ensure that the 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 PE QPs and maintain a list of certified PE QPs.
- Post enrolled PE QPs in the Provider Search feature at indianamedicaid.com.
- Assign the PE identification number (PE ID).
- Receive and update *Core*MMIS with IHCP eligibility information received from the FSSA.
- Provide PE training materials to PE QPs.
- Answer any questions PE QPs may have regarding the PE process.

Qualified Providers

QP responsibilities include the following:

- Verify an individual's IHCP eligibility via Provider Healthcare Portal, Interactive Voice Response System, or electronic data interchange.
- Enroll presumptively eligible individuals with PE coverage during regular business hours.
- 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 PE application.
- Enroll PE Adult members with a managed care entity (MCE).

QPs also do the following:

- 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 the understanding that all PE enrollment activities undertaken by this organization must be performed by an employee or organization's designee.

FSSA

FSSA responsibilities include the following:

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

Managed Care Entities

MCE responsibilities include the following:

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

Indiana Navigators and Application Organizations

QPs may apply to be authorized representatives or Application Organizations (AOs), but they are not required to do so. QP 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 QP staff assist the 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 QPs may choose to contract with eligibility assistance companies for completing and submitting the *Indiana Application for Health Coverage*. If the organization 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 PE participants to complete the *Indiana Application for Health Coverage*.

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

Presumptive Eligibility Provider Enrollment Requirements

Eligible Provider Type

FQHCs, RHCs, CMHCs, and local county health departments may be considered qualified providers for PE.

Qualified Provider Requirements

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

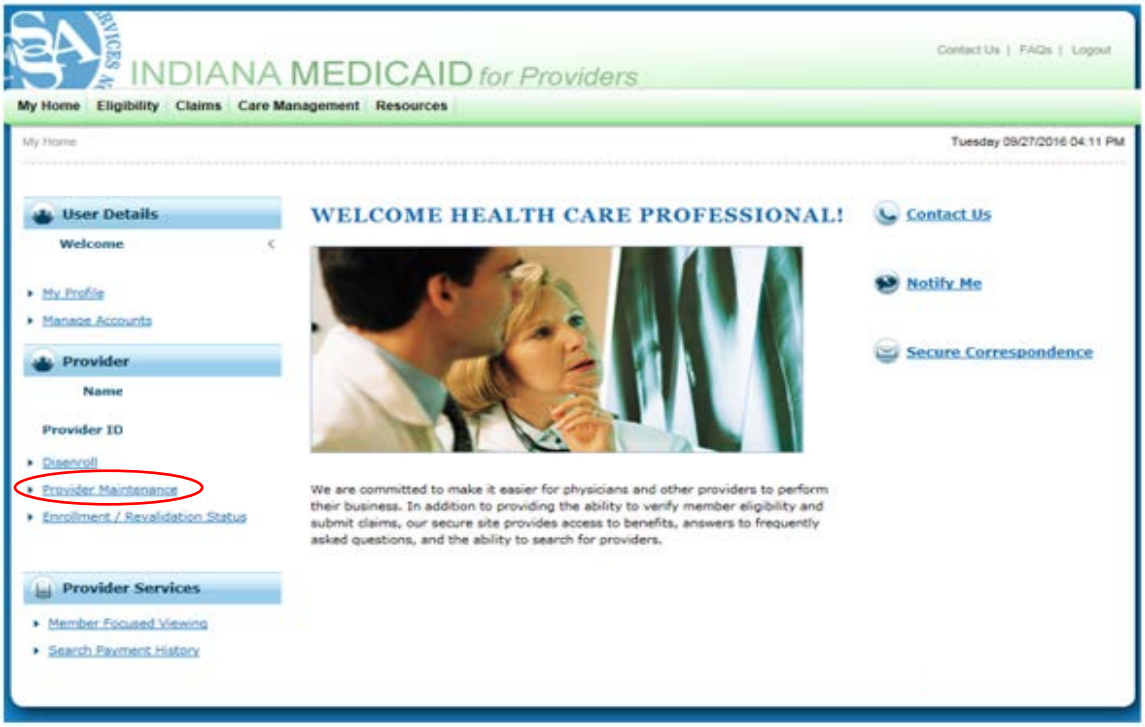
- Completes and submits PE QP eligibility attestations through the PE QP enrollment process on the Provider Healthcare Portal
- Participates in PE Provider Healthcare Portal training
- Participates in PE training
- Helps individuals complete and submit a full *Indiana Application for Health Coverage*
- Meets performance standards determined by the State and documented in *Indiana Administrative Code (IAC)*

Presumptive Eligibility Qualified Provider Enrollment Process

Organizations meeting the requirements are encouraged to enroll as PE QP as follows:

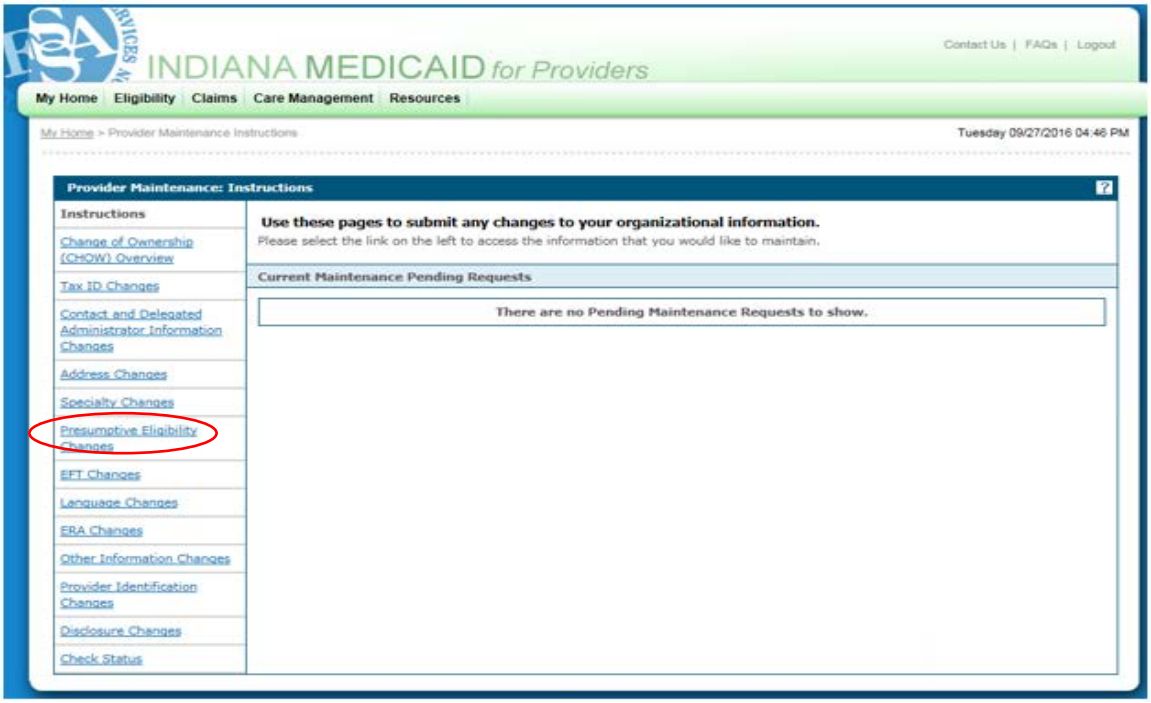
1. Log into the Provider Healthcare Portal.
2. From the My Home page, click the Provider Maintenance link.

Figure 1 - The Provider Maintenance Link on the *My Home* Page in the Provider Healthcare Portal



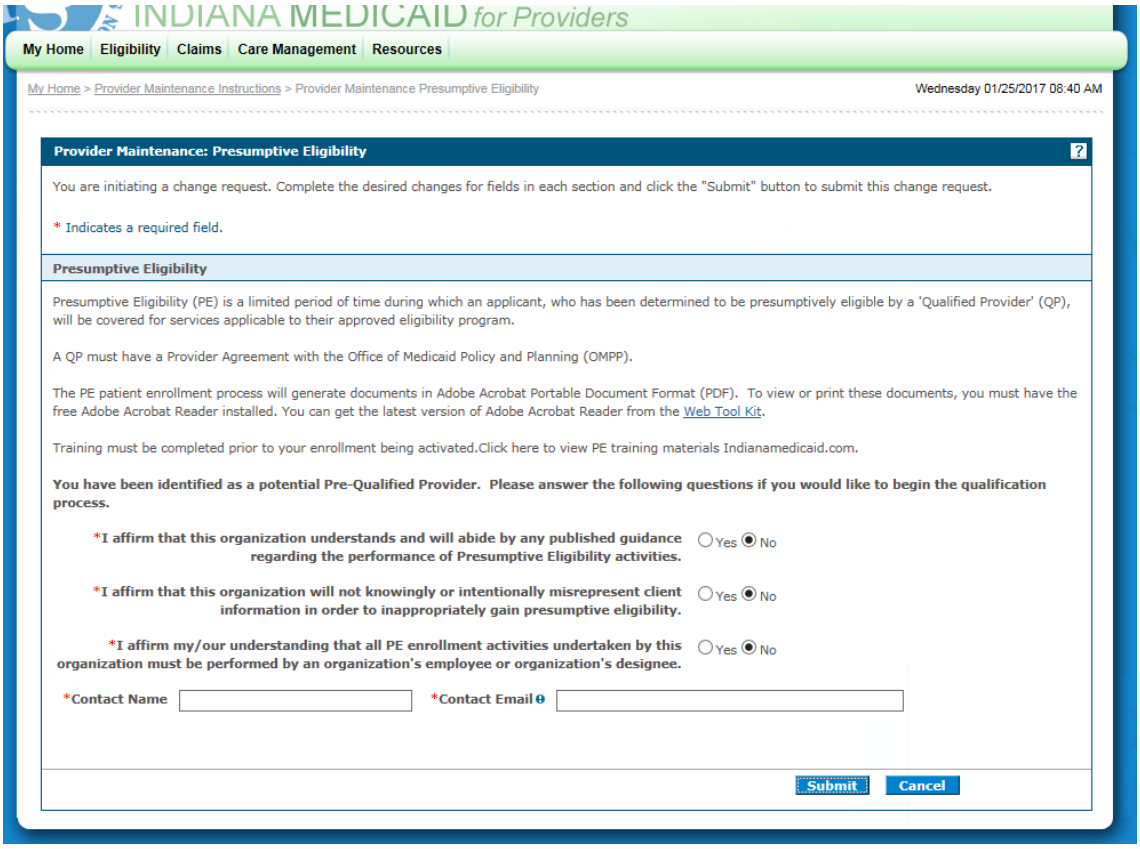
3. On the *Provider Maintenance: Instructions* page, click the Presumptive Eligibility Changes link in the column of the left side of the page.

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



4. Answer the questions and complete 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 in the Contact Name and Contact Email fields.*

1. Click Submit.
2. The Provider Relations representative contacts the prequalified PE QP within 10 days to schedule a Provider Healthcare Portal training session.
3. The Provider Relations representative also provides the QP with a printed copy and electronic link of the PE Process Training. After the training session is complete, the Provider Enrollment unit will activate the certified QP in *Core*MMIS. The PE QP may then provide services under the PE process.

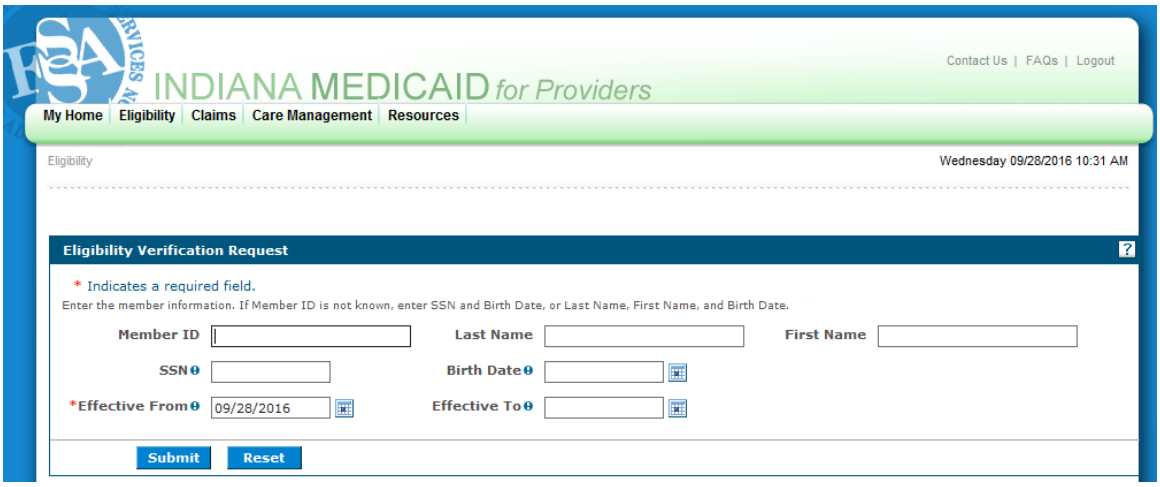
Qualified Provider Completing a Member Presumptive Eligibility Application

The 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 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 a Member ID or, if the Member ID is not known, enter the applicant's Social Security number (SSN) and birth date or the applicant's last name, first name, and birth date.

4. Enter the date, or date range, for which eligibility is being checked:
   - If no date is entered in the Effective From field, this field defaults to the current date.
   - The Effective To field is optional. If a date is entered, it must be on or after the date in the Effective From field and must be within the same calendar month as that date. If a date is not entered in this field, it will default to the date in the Effective From field.

Figure 4 – Eligibility Verification Request



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

Figure 5 – Eligibility Verification Request – PE Application Button

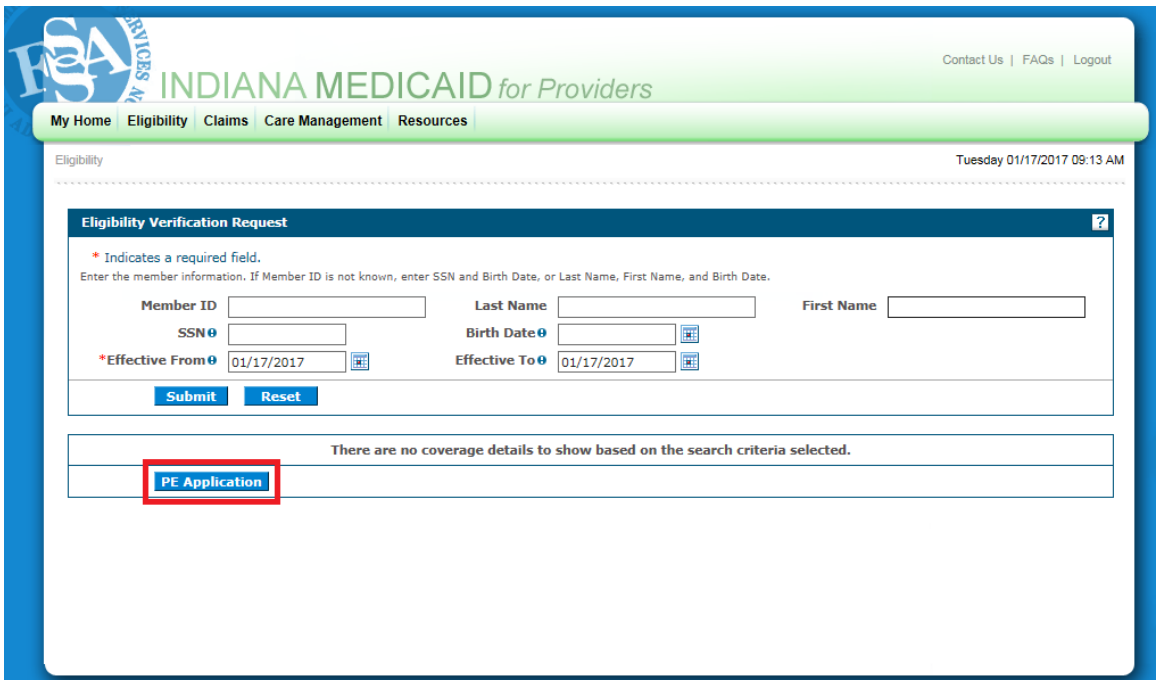
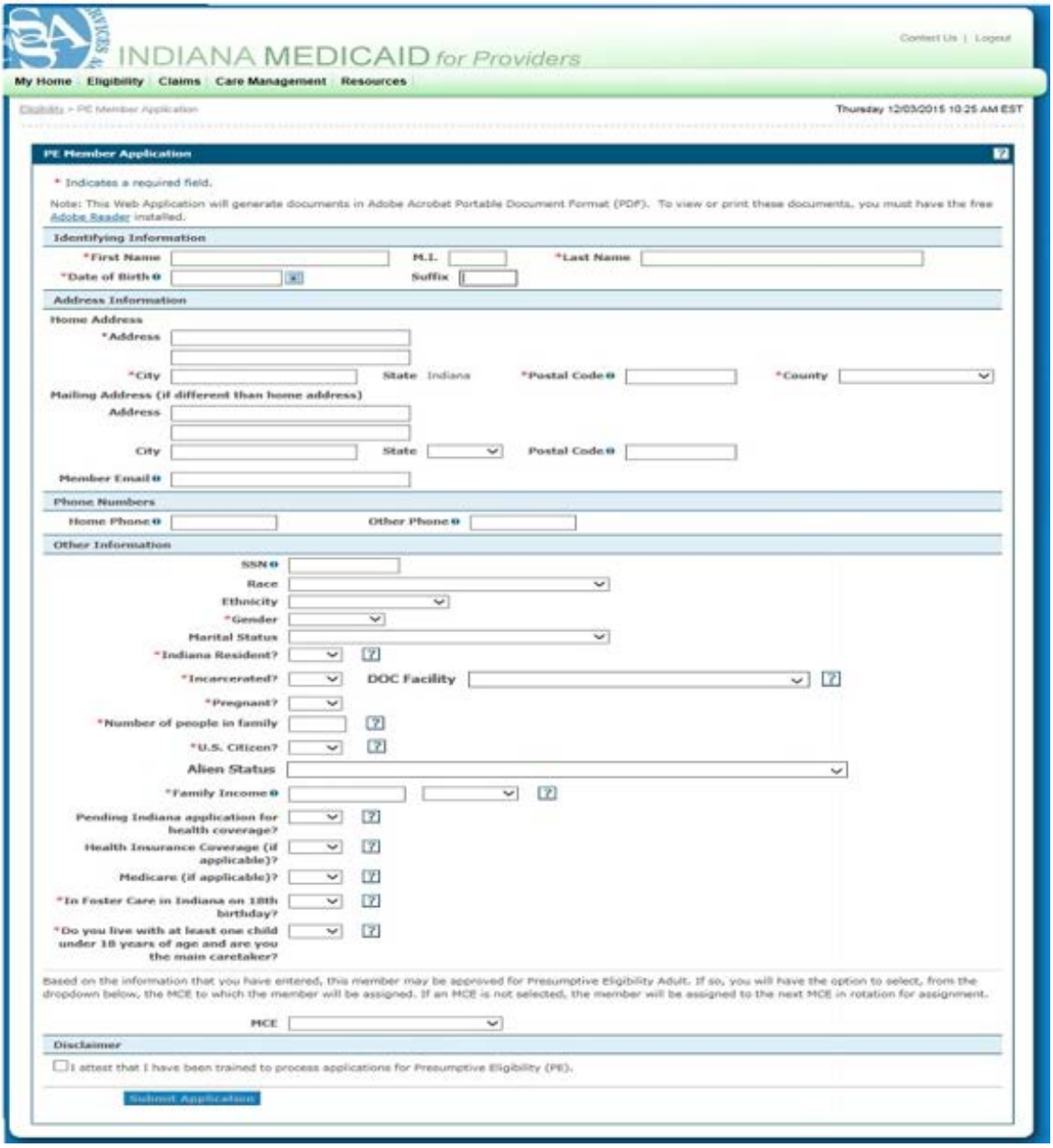


Figure 6 – PE Member Application



7. The QP staff completes the application with the information provided by the individuals applying for PE. The following questions are asked on the application:
   - First name
   - Middle initial
   - Last name
   - Date of birth
   - Suffix
   - Home address
   - Mailing address (if different from home address)
   - Member email

- Phone numbers
- Social Security number (SSN)
- Race
- Ethnicity
- Gender
- Marital status
- Is the applicant an Indiana resident?
- Is the applicant incarcerated?
- Is the applicant pregnant?
- Number of people in applicant's family
- Is the applicant a U.S. citizen?
- Family income
- Does the applicant have health insurance coverage?
- Does the applicant have Medicare coverage?
- Does the applicant have a pending *Indiana Application for Health Coverage* on file?
- 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

Note:	*The QP must complete a separate application for each individual who wants to apply for PE.* *Information on the PE application is self-attested by the individual. QPs may not ask for verification documents when completing a PE application. Proof of income, residency, citizenship, and any other documents are not required. The individual responding to the questions must provide his or her name and email address in the appropriate fields.*

8. Click Submit Application.
9. The PE Member Application Submission window appears.

Figure 7 – PE Member Application Submission

10. Click *Print Acceptance Letter* to print the Presumptive Eligibility determination notice and give the Member a copy to use as their Member ID.

11. Click Close.

Note:	*If the member is on PE Adult on HIP Basic, the QP should alert the member to the Fast Track option and let the member know that his or her MCE will contact the individual to make a $10 Fast Track payment. The payment is optional, but there are benefits to making that payment. Individuals who are enrolled as presumptively eligible will not have a gap in coverage between PE coverage and their HIP coverage if they are found eligible. An individual's $10 Fast Track payment counts toward his or her first POWER Account contribution.* *The provider should alert the member that, after making the payment, the individual may not change his or her health plan. If the person wishes to change his or her health plan before paying the Fast Track invoice, the individual should call 1-877-GET-HIP-9.*

Specific Information for Fee-for-Service PE

If the individual files an *Indiana Application for Health Coverage*, his or her presumptive eligibility period lasts until a final eligibility determination from FSSA has been made. Without a completed application, the PE period lasts until the end of the month following the month in which the PE determination was made. For example, if the PE determination was made on 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 from other IHCP providers. It is imperative that the QP informs the individual that he or she needs to complete the *Indiana Application for Health Coverage* before the temporary eligibility period ends and facilitates a process for the individual to 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 presumptively eligible
- Online from the *DFR Benefits* page at in.gov
- Over the telephone at 1-800-403-0864
- At an FSSA Division of Family Resources (DFR) local office

Specific Information for Managed Care PEs (Adult)

- PE coverage for PE Adult members who do not complete an *Indiana Application for Health Coverage* by the end of the month will end on the last day of the second month following the month PE was established.
- A PE Adult member who completes an *Indiana Application for Health Coverage* by the end of the month following the month PE was established will have coverage for up to 60 days provided application and payment timelines are met. This time frame allows members to make a Fast Track payment or regular POWER Account contribution and gain full HIP coverage without a gap in coverage. If the member is approved for HIP and his or her income is less than 100% of the federal poverty level (FPL) and he or she fails to make a payment (Fast Track or regular POWER Account), he or she will be enrolled in *HIP Basic* coverage. A member with an income greater than 100% of the FPL who fails to make a payment will lose coverage.
- PE Adult members will be enrolled with an MCE. If the member is determined PE eligible and receives emergency services in a hospital that is not with the MCE network, the MCE is obligated to make arrangements to pay for services rendered. PE Adult members who seek further care during their

PE period should seek care within the MCE network. They can call their MCE for assistance in finding a provider.

- PE Adult members may notice a lag between their PE eligibility and the time when their information is visible in all MCE vendor systems. Please advise the member that it will take at least 24 hours before they are visible to pharmacy systems. If the member is in need of a prescription fill immediately, he or she must contact their 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 presumptively eligible
- Online from the *DFR Benefits* page at in.gov
- Via telephone at 1-800-403-0864
- At an FSSA DFR local office

Eligibility Verification System

As part of the PE process, PE QPs use the Eligibility Verification System (EVS) to determine if 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 – Interactive Voice Response (IVR) system and Provider Healthcare Portal – accept the PE identification number.

PE is identified by the following aid categories:

- HI – PE Infants
- HK – PE Children
- HA – PE Adult
- HP – PE Parent/Caretaker
- HW – PE Pregnant Women
- H1 – PE Former Foster Care Children
- HF – PE Family Planning

If the FSSA approves an individual for IHCP eligibility, his or her benefit package changes from the PE package assigned during the PE process to the appropriate IHCP benefit package. He or she also receives a member card with his or her Member ID. PE coverage ends on the day after Hewlett Packard Enterprise receives notification of IHCP eligibility from the FSSA, whether approved or denied, except for PE Adult, as explained previously.

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 would begin after the admission or initial date of service, the patient may complete a full IHCP application and try to obtain an eligibility date that is retroactive to a date before the admission. This can occur if the member is HIP-eligible and makes a Fast Track payment.*

IHCP Presumptive Eligibility Programs Overview

The IHCP operates three presumptive eligibility programs.

- **Presumptive Eligibility for Pregnant Women (PEPW)** – PEPW is a process by which pregnant women can be presumptively eligible for temporary IHCP coverage for ambulatory prenatal services through a simplified application while their *Indiana Application for Health Coverage* is processed. For more information, see the *Presumptive Eligibility for Pregnant Women* module.
- **Hospital Presumptive Eligibility (Hospital PE)** – Hospital PE is a process where acute care hospitals and psychiatric hospitals can complete a simplified application to find an individual presumptively eligible for Medicaid. The coverage is temporary, and a member must complete a full *Indiana Application for Health Coverage* to retain coverage. For more information, see the *Hospital Presumptive Eligibility* module.
- **Presumptive Eligibility (PE)** – PE allows a broader range of provider types to perform presumptive eligibility for individuals. The PE process is similar to the Hospital PE process and uses the same simplified application and web-based tool to determine eligibility. The coverage is temporary and a member must complete a full *Indiana Application for Health Coverage* to retain coverage.

Table 1 – PEPW, Hospital PE, and PE comparison

	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 (QP)	• 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

Presumptive Eligibility Applicant Requirements

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

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 HIP
- Must not be enrolled in the presumptive eligibility process – Hospital PE, PE, or PEPW
- Must not be currently incarcerated
- Must not be an adult (21–64) admitted 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 disregard that will be disregarded from the individual's income based on the applicable income standard if the individual would have otherwise been ineligible when a full application is submitted to DFR.*

Specific Requirements for PE Aid Categories

For each of the following aid categories, an individual must meet all listed criteria to be eligible:

Infants

- Individual must be under the age of one.
- The individual's family income must be less than 213% of the FPL.

Children

- Individual must be under the age of 19.
- The individual's family income must be less than 163% of the FPL.

Adults

- Individual must be age 19–64.
- Individual cannot have Medicare.
- Individual cannot have a HIP conditional status.
- The individual's family income must be less than 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 less than 213% of the FPL.
- Individual's family size must be at least two members – the individual and her unborn child or children.

Family Planning

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

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

Medicaid Coverage per Aid Category

PE benefit packages vary based on the category for which the member is eligible. The following explains each PE 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 are:
  - Outpatient services: $4
  - Inpatient services: $75
  - Preferred drugs: $4
  - Nonpreferred drugs: $8
  - Nonemergency ER visit: $8/$25
- PE 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 Codes* on 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 Codes* on 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
  - 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 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.

Presumptive Eligibility Claim Submission

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

Fee for Service

Claims for PE services are submitted with the PE identification 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. QPs 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.

Members in the fee-for-service PE categories will have at least a 24-hour delay before they are visible in the eligibility system. Therefore, they may have difficulty getting prescriptions filled in the first 24 hours of coverage.

Managed Care (PE Adult Only)

Claims for services for members found eligible for PE Adult should be submitted to the appropriate MCE. Claims should be submitted using the PE identification number starting with a 6. QPs should submit claims compliant with applicable program standards. A member in the PE Adult category 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.

Members of Managed Care PE may have up to a three-day delay before they are visible in the MCE and Pharmacy systems. If a member requires prior authorization or urgent medications before the three days are up, providers should call the MCE.