



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Presumptive Eligibility

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1.1	Policies and procedures as of August 1, 2016 Published: December 22, 2016	Scheduled 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 update	FSSA and HPE
2.0	Policies and procedures as of June 1, 2017 Published: September 28, 2017	Scheduled update: <ul style="list-style-type: none"> • Reorganized and edited text as needed for clarity • Merged information from <i>Hospital Presumptive Eligibility</i> module into this module • Changed Hewlett Packard Enterprise references to DXC Technology • Added clarification regarding PE vs. PEPW processes and benefit plan in the Introduction section • Added provider type and specialty information to the PE Qualified Provider Types section • Updated aid category names for consistency throughout the module • Updated the Qualified Providers section • Added information about claim processing and prior authorization to the DXC Technology and Managed Care Entities sections • Updated the FSSA Division of Family Resources section • Updated the Enrolling as a Presumptive Eligibility Qualified Provider section 	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> • Clarified information in the General Requirements for All PE Applicants section • Updated the Completing the Presumptive Eligibility Member Application section • Added Table 3 – PE Benefit Plan Assignment Based on Aid Category and related text under the new section heading: Presumptive Eligibility Coverage • Updated the Member Identification and Eligibility Verification section • Updated the Coordination with Presumptive Eligibility for Pregnant Women section • Added the Special Rules Regarding Presumptive Eligibility for Inmates section and subsections • Updated the Presumptive Eligibility Claim Submission section and subsections 	

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Introduction

Qualified providers (QPs) can enroll qualifying individuals in certain aid categories to receive temporary coverage at the point of service until their eligibility for the Indiana Health Coverage Programs (IHCP) is officially determined by the Indiana Family and Social Services Administration (FSSA).

During this period of *presumptive eligibility*, the individual will be able to receive treatment from the QP as well as other IHCP-enrolled providers. 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.

The IHCP offers two presumptive eligibility processes: Presumptive Eligibility (PE) and Presumptive Eligibility for Pregnant Women (PEPW). For information about the PEPW process, see the [Presumptive Eligibility for Pregnant Women](#) module.

PE Qualified Provider Types

The following provider types can apply to be QPs for the Presumptive Eligibility (PE) process:

- Federally qualified health centers (FQHCs) – Provider type 08, specialty 080
- Rural health clinics (RHCs)– Provider type 08, specialty 081
- Community mental health centers (CMHCs) – Provider type 11, specialty 111
- County health departments – Provider type 13, specialty 130
- Acute care hospitals – Provider type 01, specialty 010
- Free-standing psychiatric hospitals – Provider type 01, specialty 011

PE Aid Categories

The following aid categories are eligible for PE coverage:

- Infants (Up to age 1)
- Children (Ages 1–18)
- Adults (Ages 19–64) without Medicare
- Parents/Caretakers
- Former Foster Care Children (Ages 19–26)
- Pregnant Women
- Family Planning (Individuals eligible for the Family Planning Eligibility Program only)

See the [Specific Requirements for PE Aid Categories](#) section for qualifying criteria for each aid category, including income guidelines, where applicable.

Most PE aid categories receive coverage under the fee-for-service (FFS) delivery system, with the exception of PE Adult, which is managed care.

Note: Pregnant women may be found presumptively eligible under either the PE process or the Presumptive Eligibility for Pregnant Women (PEPW) process:

- *When a pregnant woman is enrolled through the PE process as described in this module, her coverage is FFS.*
- *When a pregnant woman is enrolled through the PEPW process, as described in the [Presumptive Eligibility for Pregnant Women](#) module, her coverage is managed care.*

PE Process Overview

PE enrollment is available from hospital QPs 24 hours a day, seven days a week, and from all other QPs during regular business hours. An individual seeking coverage works with a QP 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 (Portal), as described in the [Completing the Presumptive Eligibility Member Application](#) section of this module.

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. The Portal provides a real-time response on whether the individual is eligible for PE based responses provided during the application process.

Note: An individual can apply for PE for all members in his or her family, regardless of 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 presumptive eligibility period.

The PE coverage period begins on the date the QP determines an individual is presumptively eligible for coverage through the IHCP. The PE coverage period ends when one of the following circumstances occurs:

- The member does not submit an *Indiana Application for Health Coverage* within the allotted time frame. A completed *Indiana Application for Health Coverage* must be pending with the FSSA by the end of the month following the month in which PE coverage begins.
- The FSSA officially determines the member to be eligible for coverage under an IHCP program. PE coverage ends on the day after DXC Technology receives eligibility information from the FSSA.
- The FSSA officially determines the member to be ineligible for coverage under an IHCP program. Eligibility for PE ends on the day after the DXC receives denial of eligibility information from the FSSA.

Note: Members who qualify for PE Adult retain PE coverage after they have been determined to be conditionally eligible for Healthy Indiana Plan (HIP) coverage to allow time for them to make their Fast Track payment Personal Wellness and Responsibility (POWER) Account contribution or. This extension of the PE period allows these members to avoid a gap in coverage, as long as they meet required application and payment deadlines.

Presumptive Eligibility Team

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

Qualified Providers

QP responsibilities include the following:

- Verify whether individuals have current IHCP coverage by using the Eligibility Verification System (EVS) – via the Portal, Interactive Voice Response (IVR) system, or 270/271 electronic transactions.
- Enroll qualifying individuals with PE coverage as follows:
 - During regular business hours for FQHCs, RHCs, CMHCs, and county health departments
 - 24 hours a day, seven days a week, for acute care hospitals and psychiatric hospitals.
- 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* by the end of the month following the month that the PE determination was made.
- Enroll PE Adult members with a managed care entity (MCE).

For State and federal requirements for PE QPs, see the [Presumptive Eligibility Qualified Provider Requirements](#) section.

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 or designated as authorized representatives working with 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 website](#) at in.gov/idoi.

DXC Technology

As the contracted fiscal agent for the IHCP, DXC is responsible for the following:

- Maintain and provide training for the Portal.
- Enroll new PE QPs and maintain a list of certified PE QPs.
- Post enrolled PE QPs in the [IHCP Provider Locator](#) feature at indianamedicaid.com.
- Provide PE training materials to PE QPs.
- Answer any questions PE QPs may have regarding the PE process.

- Assign PE identification numbers (PE IDs).
- Process all FFS PE member claims for nonpharmacy services.
- Update the Core Medicaid Management Information System (*CoreMMIS*) with IHCP eligibility information received from the FSSA Division of Family Resources (DFR).

FFS pharmacy claims and related PA requests are handled by the contracted pharmacy benefit manager, OptumRx. All other FFS PA requests are handled by Cooperative Managed Care Services (CMCS). See the [IHCP Quick Reference Guide](#) for contact information.

Managed Care Entities

MCE responsibilities include the following:

- 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 PE Adult services, as necessary.

For certain types of managed care services, such as pharmacy and dental, claim and PA processing is handled by subcontractors. See the [IHCP Quick Reference Guide](#) for MCE and subcontractor contact information.

FSSA Division of Family Resources

DFR responsibilities include the following:

- Accept and process any *Indiana Application for Health Coverage* received from a PE QP or an individual.
- Convey official IHCP eligibility determinations to DXC and to the PE member.
- Assign the IHCP Member ID (also known as RID) when eligibility is officially approved.

Presumptive Eligibility Qualified Provider Requirements

IHCP-enrolled FQHCs, RHCs, CMHCs, county health departments, acute care hospitals, and psychiatric hospitals are eligible to become PE QPs.

The State requires that all PE QPs meet the following requirements:

- Complete and submit the PE QP eligibility attestations through the PE QP enrollment process on the Portal as follows:
 - Affirm that the organization understands and will abide by any published guidance regarding the performance of PE activities.
 - Affirm that the 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 the organization must be performed by an employee or organization's designee.
- Participate in PE Portal training
- Participate in PE QP training
- Help individuals complete and submit a full *Indiana Application for Health Coverage*

In addition, the State requires all PE QPs to meet performance standards determined by the State and documented in *Indiana Administrative Code (IAC)*.

For PE QPs that are acute care hospitals or psychiatric hospitals, federal regulations require that the hospital do the following:

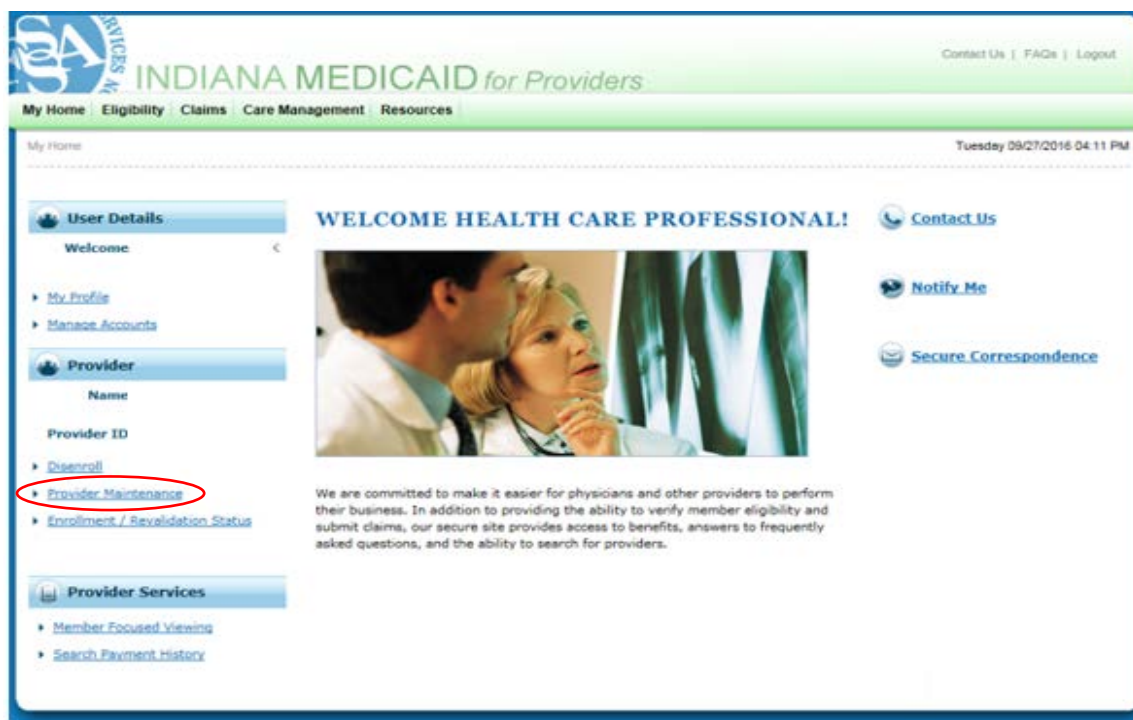
- Participate as a provider under the IHCP State Plan or under a demonstration project as described in *Section 1115 of the Social Security Act*.
- Notify the IHCP of its intention to make PE determinations.
- Agree to make PE determinations consistent with State policies and procedures.

Enrolling as a Presumptive Eligibility Qualified Provider

IHCP-enrolled organizations meeting the requirements are encouraged to enroll as PE QPs as follows:

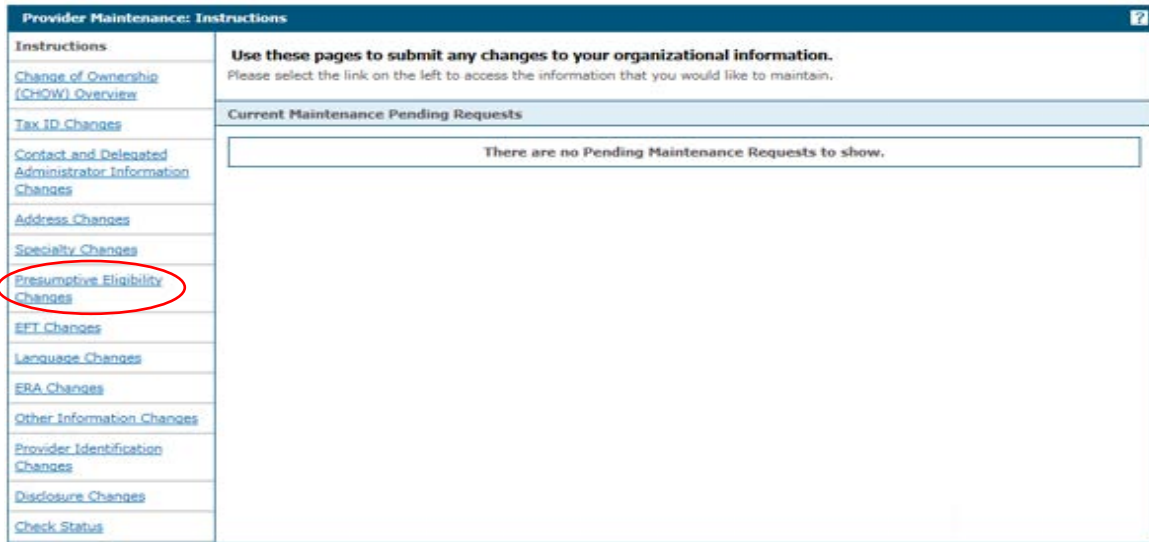
1. Log in to the [Provider Healthcare Portal](#) at portal.indianamedicaid.com.
Providers must first register for the Portal, as described in the [Provider Healthcare Portal](#) module.
2. From the *My Home* page, click the **Provider Maintenance** link.

Figure 1 – The Provider Maintenance Link on the Portal's *My Home* Page



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

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



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

Figure 3 – The *Provider Maintenance: Presumptive Eligibility* Page

Provider Maintenance: Presumptive Eligibility

You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request.

* Indicates a required field.

Presumptive Eligibility

Presumptive Eligibility (PE) is a limited period of time during which an applicant, who has been determined to be presumptively eligible by a 'Qualified Provider' (QP), will be covered for services applicable to their approved eligibility program.

A QP must have a Provider Agreement with the Office of Medicaid Policy and Planning (OMPP).

The PE patient enrollment process will generate documents in Adobe Acrobat Portable Document Format (PDF). To view or print these documents, you must have the free Adobe Acrobat Reader installed. You can get the latest version of Adobe Acrobat Reader from the [Web Tool Kit](#).

Training must be completed prior to your enrollment being activated. [Click here to view PE training materials Indianamedicaid.com.](#)

You have been identified as a potential Pre-Qualified Provider. Please answer the following questions if you would like to begin the qualification process.

*I affirm that this organization understands and will abide by any published guidance regarding the performance of Presumptive Eligibility activities. Yes No

*I affirm that this organization will not knowingly or intentionally misrepresent client information in order to inappropriately gain presumptive eligibility. Yes No

*I affirm my/our understanding that all PE enrollment activities undertaken by this organization must be performed by an organization's employee or organization's designee. Yes No

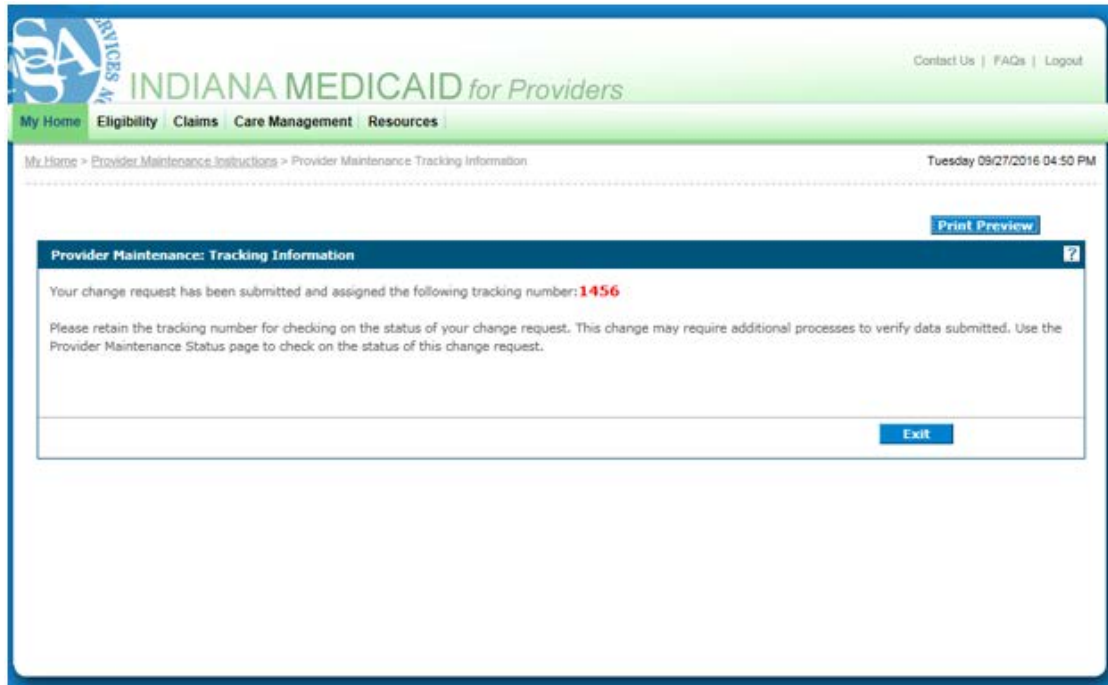
*Contact Name *Contact Email

I would like to terminate my PE Qualified Provider status:

Submit **Cancel**

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

7. If the provider answered “yes” to the three questions and entered a contact name and email address, a Provider Relations consultant contacts the prequalified PE QP within 10 days to schedule a Portal training session.
8. The Provider Relations consultant also provides the QP with a printed copy of and electronic link to the PE process training presentation. After the training session is completed, the Provider Enrollment unit will activate the certified QP in CoreMMIS. The PE QP may then provide services under the PE process.

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 Portal.

General Requirements for All PE Applicants

PE is based on the following criteria that the applicant must meet:

- 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
- Be an Indiana resident
 - An Indiana address must be provided on the application.
- Not be a current IHCP member, including a member of HIP
- Not be enrolled in the presumptive eligibility process (PE or PEPW), currently or within time-frame restrictions (Individuals are allowed only one presumptive eligibility coverage period per rolling 12 months or pregnancy.)
- Not be currently incarcerated. (For exceptions specific to hospital PE QPs, see the [Special Rules Regarding Presumptive Eligibility for Inmates](#) section.)
- Not be an adult (aged 21–64) admitted to or a resident of an Institute for Mental Disease (IMD)
- Meet the income level requirements specific to certain aid categories, as outlined in Table 1
- Meet any additional requirements specific to certain aid categories, as described in the subsections that follow

Table 1 – Aid Category and Income Limit

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

Note: 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.

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

Although 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.

Specific Requirements for PE Aid Categories

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

Infants

- Individual must be under 1 year of age.
- 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.
- Individual must have income less than converted MAGI equivalent limits.

Former Foster Care

- Individual must be between the ages of 18 through 25 (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.

Note: When calculating percentage of FPL, the pregnant woman's unborn child or children should be counted toward family size.

Family Planning

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

Completing the Presumptive Eligibility Member Application

The PE QP uses the Portal to verify that the individual is not already an IHCP member and then to submit an application for the individual.

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

The following is a step-by-step process for the PE applicant enrollment process.

1. Log in to the [Provider Healthcare Portal](http://portal.indianamedicaid.com) at portal.indianamedicaid.com.
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.)

The Effective From field defaults to the current date.

Figure 5 – Eligibility Verification Request Panel

The screenshot shows the 'Eligibility Verification Request' form. It includes a header with a question mark icon. Below the header, there is a note: '* Indicates a required field. Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.' The form contains several input fields: Member ID (empty), SSN (empty), Last Name (empty), First Name (empty), Birth Date (empty), Effective From (09/28/2016), and Effective To (empty). At the bottom of the form are 'Submit' and 'Reset' buttons.

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

Figure 6 – PE Application Button

This screenshot shows the same 'Eligibility Verification Request' form as Figure 5, but with the 'Effective From' field set to 01/17/2017 and the 'Effective To' field also set to 01/17/2017. Below the form, a message states: 'There are no coverage details to show based on the search criteria selected.' A blue button labeled 'PE Application' is highlighted with a red rectangular box.

6. Complete the *PE Member Application* by entering information provided by the individual applying for PE. See Table 2 for a list of information needed and corresponding instructions.

Note: 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.

Table 2 – Presumptive Eligibility Member Application Descriptions

Field	Description
*First Name	Enter the applicant's first name. Up to 13 characters, alphanumeric. Allows space, dash, and period.
M.I.	Enter the applicant's middle initial. Allows one character, alphanumeric.
*Last Name	Enter the applicant's last name. Up to 15 digits, alphanumeric. Allows space, dash, and period.
Suffix	Enter suffix if applicable.
*Date of Birth	Enter the applicant's date of birth.
*Home Address	Enter the applicant's home street address. Up to 30 characters, alphanumeric. Allows space, dash, and period.
*(Home) City	Enter home-address city. Up to 15 characters, alphanumeric. Allows space, dash, and period.
*(Home) Postal Code	Enter home-address ZIP Code. Requires five digits.
*(Home) County	Select home-address county from the drop-down list.
Mailing Address	If the applicant's mailing address is different from his or her street address, enter the mailing street address. Up to 30 digits, alphanumeric. Allows space, dash, and period.
(Mailing) City	Enter mailing-address city. Up to 15 digits, alphanumeric. Allows space, dash, and period.
(Mailing) State	Select mailing-address state from the drop-down list.
(Mailing) Postal Code	Enter mailing-address ZIP Code. Requires five digits
Member Email	Enter the applicant's email address.
Home Phone	Enter the applicant's home telephone number. 10 digits, numeric.
Other Phone	Enter any other telephone number for the applicant. 10 digits, numeric.
SSN	Enter the applicant's nine-digit Social Security number (SSN).
Race	Select the applicant's race from the drop-down list options: African American, Asian, Caucasian, Hispanic, Other.
Ethnicity	Select the applicant's ethnicity from the drop-down list options: Hispanic, Non-Hispanic, Other.
*Gender	Select the applicant's gender from the drop-down list options: Male, Female.
Marital Status	Select the applicant's marital status from drop-down list options: Married, Single.

Field	Description
*Indiana Resident?	Select Yes or No to indicate whether the applicant lives in Indiana.
*Incarcerated? DOC facility	<p>Select Yes or No to indicate whether the applicant is incarcerated. Incarceration includes a county jail or any type of prison or correctional facility. It excludes home detention and persons on parole.</p> <p>If Yes is selected, select the Department of Corrections (DOC) facility in which the member is incarcerated.</p>
*Pregnant?	Select Yes or No to indicate whether the applicant is pregnant.
*Number of People in Family	Enter the applicant's family size. Up to two digits, numeric. Family size is based on the tax household. If the applicant does not file taxes, the household includes the child, the child's parents (biological, adopted, and step), and the child's siblings (biological, adopted, and step). For pregnant applicants, the number of unborn children is included in the family size.
*U.S. Citizen? Alien Status	<p>Select Yes or No to indicate whether the applicant indicates that he or she is a U.S. citizen.</p> <p>If No is selected, choose one of the following options from the Alien Status drop-down list:</p> <ul style="list-style-type: none"> • Lawful permanent resident immigrant living lawfully in U.S. for five years or longer • Lawful permanent resident immigrant living lawfully in 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 (includes persons in the country illegally, persons with visas of any kind, and so forth)

Field	Description
*Family Income	<p>Enter the amount of family income, up to six digits, as stated by the applicant.</p> <p>Select Monthly or Annually from the drop-down list to indicate if the amount entered is a monthly or annual income amount.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p><i>Note: To convert weekly income to monthly income, multiply the weekly amount by 4.3. For example, \$350 per week converts to (\$350 x 4.3) \$1,505 per month. To convert biweekly income, multiply the weekly amount by 2.15.</i></p> </div> <p>In the amount entered in the box, include all income before taxes are deducted (gross income) from the applicant and his or her spouse. If the applicant is under age 19, unmarried, and living with one or more parents, include the income of the applicant and that of his or her parents. Other than the applicant or spouse, do not count income of children under age 19, unless the children are expected to be required to file a federal tax return.</p> <p>Include all the following types of income in the amount entered in the box:</p> <ul style="list-style-type: none"> • Wages/Salaries • Tips • Self-employment • Dividends • Interest • Alimony • Social Security • Unemployment compensation • Sick benefits, retirement benefits or pensions • Rental income
Pending <i>Indiana Application for Health Coverage</i> ?	Select Yes or No to indicate whether the applicant has said that he or she has an <i>Indiana Application for Health Coverage</i> pending.
Health Insurance Coverage (if applicable)?	Select Yes or No to indicate whether the applicant currently has health insurance coverage (excluding Medicare).
Medicare (if applicable)?	Select Yes or No to indicate whether the applicant currently has Medicare coverage.
*In Foster Care in Indiana on 18 th birthday?	Select Yes if the applicant was in foster care in Indiana on his or her 18th birthday, under the responsibility of the State of Indiana, and was enrolled in an IHCP program on his or her 18th birthday. Otherwise, select No.
*Do you live with at least one child under 18 years of age and are you the main caretaker?	Select yes if the applicant lives with at least one child under 18 years old and is the main caretaker of that child. Otherwise, select No.
MCE	If applicable, select the applicant's choice of managed care entity (MCE) from the drop-down list. (If no MCE is selected, PE Adult members will be auto-assigned to an MCE.)

Figure 7 – PE Member Application

PE Member Application

* Indicates a required field.

Note: This Web Application will generate documents in Adobe Acrobat Portable Document Format (PDF). To view or print these documents, you must have the free [Adobe Reader](#) installed.

Identifying Information

*First Name M.I. *Last Name
 *Date of Birth Suffix

Address Information

Home Address
 *Address
 *City State: Indiana *Postal Code *County

Mailing Address (if different than home address)
 Address
 City State Postal Code

Member Email

Phone Numbers

Home Phone Other Phone

Other Information

SSN
 Race
 Ethnicity
 *Gender
 Marital Status
 *Indiana Resident? ?
 *Incarcerated? DOC Facility ?
 *Pregnant?
 *Number of people in family ?
 *U.S. Citizen? ?
 Alien Status
 *Family Income ?
 Pending Indiana application for health coverage? ?
 Health Insurance Coverage (if applicable)? ?
 Medicare (if applicable)? ?
 *In Foster Care in Indiana on 18th birthday? ?
 *Do you live with at least one child under 18 years of age and are you the main caretaker? ?

Based on the information that you have entered, this member may be approved for Presumptive Eligibility Adult. If so, you will have the option to select, from the dropdown below, the MCE to which the member will be assigned. If an MCE is not selected, the member will be assigned to the next MCE in rotation for assignment.

MCE

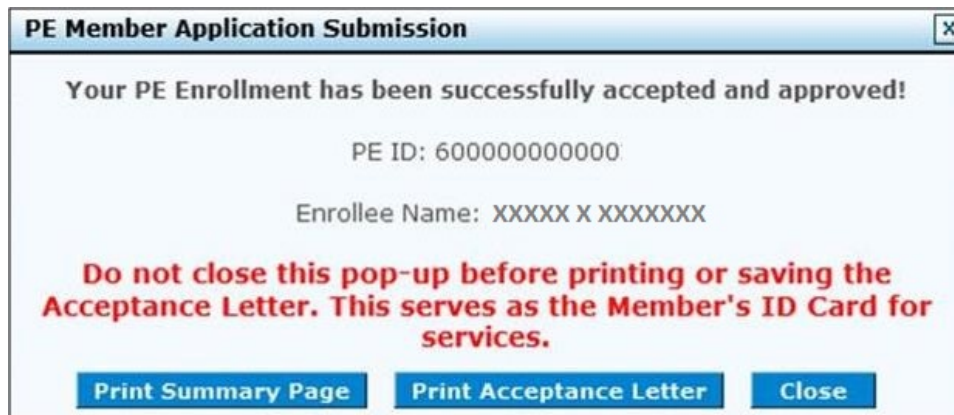
Disclaimer

I attest that I have been trained to process applications for Presumptive Eligibility (PE).

[Submit Application](#)

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 applicant to confirm that it is accurate.
9. Click **Submit Application**.
10. The PE Member Application Submission window appears, indicating whether the PE enrollment was successfully accepted and approved and, if so, showing the assigned PE ID.

Figure 8 – PE Member Application Submission Window



Note: The PE ID begins with the digit 6, except in cases where the applicant is found to have had previous IHCP coverage, in which case, the applicant's originally assigned IHCP Member ID becomes his or her PE ID.

11. Click **Print Acceptance Letter** to print the PE determination notice for approved applicants.
QPs must ensure that the presumptive eligibility determination notice (acceptance letter or denial letter) prints successfully before clicking Close.
12. Click **Print Summary Page** to print a copy of the application for your records.
13. Click **Close**.
14. Give a copy of the determination notice to the applicant. The acceptance letter serves as the PE member identification during the PE coverage period.

Review PE coverage information with the member and provide guidance to help ensure that he or she submits the full *Indiana Application for Health Coverage* by the end of the month following the month in which the PE determination was made. As explained in the acceptance letter, the individual may complete the *Indiana Application for Health Coverage* in one of the following ways:

- Online at the [DFR Benefits page](#) at in.gov
- In person at a local FSSA DFR office or with the provider where the presumptively eligible was determined
- By telephone at 1-800-403-0864

Note: If the member is approved through the PE Adult aid category, 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 MCE. If the person wishes to change his or her MCE before paying the Fast Track invoice, he or she should call 1-877-GET-HIP-9.

Presumptive Eligibility Coverage

Members determined to be presumptively eligible for coverage through the PE process are assigned to the appropriate benefit plan based on their aid category, as shown in Table 3. Incarcerated individuals determined to be presumptively eligible through the PE for Inmates process are an exception; these members are assigned to the Medicaid Inpatient Hospital Services Only benefit plan, as described in the [Special Rules Regarding Presumptive Eligibility for Inmates](#) section.

Table 3 – PE Benefit Plan Assignment Based on Aid Category

PE Aid Category	PE Benefit Plan	Delivery System
Infants	Presumptive Eligibility – Package A Standard Plan	FFS
Children		
Parents/Caretakers		
Former Foster Care Children		
Adults	Presumptive Eligibility – Adult	Managed Care
Pregnant Women	Presumptive Eligibility for Pregnant Women	FFS*
Family Planning	Presumptive Eligibility Family Planning Services Only	FFS
<p><i>*Note: When the Presumptive Eligibility for Pregnant Women benefit plan is assigned via the PEPW process, rather than the PE process, it is delivered on a managed care basis through the Hoosier Healthwise program. See the Presumptive Eligibility for Pregnant Women module for details.</i></p>		

All PE benefit plans are reimbursed through the fee-for-service delivery system, with the exception of Presumptive Eligibility Adult, which is reimbursed through the managed care delivery system.

Coverage under the assigned plan begins on the date that the PE determination is made. Services delivered prior to this date are not covered.

Fee-for-Service PE Benefit Plans

During the presumptive eligibility period, the FFS PE member is able to receive services covered within his or her benefit plan from any IHCP-enrolled provider.

If the individual files an *Indiana Application for Health Coverage*, his or her presumptive eligibility period lasts until an official 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 on March 10, the individual would retain PE coverage until April 30 if no *Indiana Application for Health Coverage* is submitted.

It is imperative that the QP informs the individual that he or she must complete the *Indiana Application for Health Coverage* before the temporary eligibility period ends and provides information on how the individual can do so.

Presumptive Eligibility – Package A Standard Plan

Presumptive Eligibility – Package A Standard Plan benefits (for Infants, Children, Parents/Caretakers, and Former Foster Care Children aid categories) include all covered services available under Hoosier Healthwise Package A.

Presumptive Eligibility for Pregnant Women

The Presumptive Eligibility for Pregnant Women benefit plan (for the Pregnant Women aid category) is limited to ambulatory prenatal care services only, including the following:

- Doctor visits for prenatal care
- Prescription drugs related to pregnancy
- Prenatal lab work
- Transportation to prenatal visits

For a list of covered codes, see *Presumptive Eligibility for Pregnant Women Codes* on the [Code Sets](#) page at indianamedicaid.com.

Presumptive Eligibility Family Planning Services Only

The Presumptive Eligibility Family Planning Services Only benefit plan is limited to the services defined under the Family Planning Eligibility Program benefit plan, including the following:

- 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

For a list of covered codes, see *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com.

Managed Care PE Benefit Plan (PE Adult)

The Presumptive Eligibility – Adult benefit plan includes all covered services available under the *HIP Basic* benefit plan, including copayments for covered services. Copayments are:

- Outpatient services (physician/hospital): \$4 per visit
- Inpatient services: \$75 per admission
- Preferred drugs: \$4 per prescription
- Nonpreferred drugs: \$8 per prescription
- Nonemergency ER visit: \$8/\$25

Note: Copayments do not apply to pregnant members, American Indian/Alaskan Native, or members who have met their maximum cost sharing obligation for the quarter. Copayments will not apply to preventative services, maternity services, family planning services, or services provided for an emergency health condition.

PE Adult members are enrolled with an MCE. If the PE Adult member receives emergency services in a hospital that is not within 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.

For PE Adult members who do not submit an *Indiana Application for Health Coverage* by the last day of the month following the month PE was established, their PE coverage will end on that date.

PE Adult members who complete 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 may notice a lag between their PE eligibility and the time when their information is visible in all MCE vendor systems. The QP should advise these members that it will take between five to seven business days before their coverage is visible to MCE pharmacy systems. All IHCP providers should accept the PE acceptance letter as proof of coverage. Members who need a prescription filled immediately and experience difficulty using their PE acceptance letter as proof of coverage are advised to their MCE.

Member Identification and Eligibility Verification

Members who are found eligible through the PE process use the acceptance letter provided by the enrolling QP to 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.

Note: PE coverage is reflected in the IHCP EVS and FFS pharmacy systems within 24 hours of the initial determination. It may take a few days for the member's PE coverage to be visible in MCE systems, and up to seven business days for it to be visible in MCE pharmacy systems. For this reason, the original presumptive eligibility acceptance letter is sufficient to validate temporary coverage, even if the member is not yet listed in the appropriate system.

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 ID in place of the IHCP Member ID.

If the FSSA approves an individual for IHCP eligibility, his or her benefit plan changes from the PE package assigned during the PE process to the appropriate IHCP benefit plan. He or she also receives a member identification card with his or her Member ID number.

Inpatient Admission and PE Eligibility

For presumptive eligibility benefit plans that include inpatient hospital coverage, whether or not any portion of the inpatient stay will be covered when the admission date is before the PE start date depends on how the service is reimbursed:

- If the 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 the 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 on or after the member's PE start date will be covered. Dates of service 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. For PE Adult members, retroactive eligibility is possible if the member becomes HIP-eligible and makes a Fast Track payment.

Coordination with Presumptive Eligibility for Pregnant Women

Similar to PE, PEPW is a process through which qualified providers can determine presumptive eligible for temporary IHCP coverage. The PEPW process is limited to the Pregnant Women aid category. These women receive ambulatory prenatal services through a simplified application while their *Indiana Application for Health Coverage* is processed.

Unlike the PE process, pregnant women determined to be presumptively eligible through the PEPW process receive coverage through the managed care delivery system. Pregnant women found presumptively eligible through the PEPW process must contact the enrollment broker, MAXIMUS, to select an MCE and a primary medical provider (PMP) on the same day that they are determined presumptively eligible in order to initiate coverage.

The following provider types can be PEPW QPs:

- Advanced practice nurse practitioner (Type 09, Specialty 093)
- Certified nurse midwife (Type 09, Specialty 095)
- Family or general practitioner (Type 31, Specialty 316 or 318)
- Obstetrician or gynecologist (Type 31, Specialty 328)
- General internist (Type 31, Specialty 344)
- General pediatrician (Type 31, Specialty 345)
- FQHC (Type 08, Specialty 080)
- RHC (Type 08, Specialty 081)
- Medical clinic (Type 08, Specialty 082)
- Family planning clinic (Type 08, Specialty 083)
- County health department (Type 13, Specialty 130)
- Acute care hospital (Type 01, Specialty 010)*

**Note: Hospitals are no longer eligible to enroll in the PEPW process. Hospitals that are not currently enrolled as PEPW QPs are eligible to enroll as QPs only under the PE process. Hospitals currently enrolled as PEPW QPs retain their ability to determine presumptive eligibility for pregnant women under the PEPW process.*

Psychiatric hospitals and CMHCs are not eligible to become PEPW QPs.

FQHCs, RHCs, county health departments, and acute care hospitals that are enrolled as both PE QPs and PEPW QPs are able to enroll qualified pregnant women through either the PEPW or PE process, whichever the pregnant woman chooses. The following examples provide suggestions for 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 PE process.
 - If the pregnant woman is seeking 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 PE process.
 - If the pregnant woman is seeking prenatal care through an obstetrician's or gynecologist'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 PE process.
 - If the pregnant woman is seeking services during the hours of 8 a.m.–6 p.m., Monday–Friday, the 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.

Special Rules Regarding Presumptive Eligibility for Inmates

Certain incarcerated individuals can receive limited Medicaid coverage through the PE for Inmates process. This process allows hospitals that are 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.

Note: Only acute care hospital and freestanding psychiatric hospital (provider type 01, specialty 010 or 011) QPs are eligible to enroll members through the PE for Inmates process. This process is not available to the other PE qualified provider types.

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 (see the [General Requirements for All PE Applicants](#) section)

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 category based on their age would apply. However, all services for individuals enrolled through this process are paid on an FFS basis, so no inmates will be assigned to the Presumptive Eligibility – Adult benefit plan, even if they qualify through the PE Adult aid category.

Covered Services

Individuals enrolled through the PE for Inmates process are eligible only for inpatient hospitalization services, under the Medicaid Inpatient Hospital Services Only benefit plan. 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 use the standard 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, hospital PE 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, listing 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 according to normal procedures.

If the incarcerated individual meets all the eligibility requirements, he or she will be enrolled in the Medicaid Inpatient Hospital Services Only benefit plan.

Presumptive Eligibility Claim Submission

Providers serving individuals who have been determined presumptively eligible must verify the individual's eligibility on each date of service. 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.

Claims for PE services are submitted with the member's PE ID, which starts with a "6" (except in cases where an IHCP Member ID already existed for that individual due to previous coverage, and was assigned as the PE ID). If a PE member is later officially approved for coverage under the IHCP, QPs should then submit claims using the assigned Member ID.

QPs should submit claims compliant with applicable program standards.

Fee-for-Service PE Claims

Claims for FFS services rendered during the presumptive eligibility period should be submitted to DXC, as described in the [Claim Submission and Processing](#) module.

QPs are reimbursed at regular IHCP rates for FFS 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 PE Adult members should be submitted to the appropriate MCE. See the [IHCP Quick Reference Guide](#) for contact information.

A PE Adult member is eligible for a benefit plan that mirrors the *HIP Basic* benefit plan, and is subject to copays. Copay amounts will be applied. Providers will be reimbursed HIP program rates for PE Adult members.

PE Adult members may have up to a three-day delay before they are visible in the MCE systems and five to seven business days before it is visible in MCE pharmacy systems. If a member requires prior authorization or urgent medications before that time, the acceptance letter should serve as proof of eligibility. Providers should call the MCE if there are concerns.