IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201528 MAY 12, 2015

Important information about Presumptive Eligibility

This bulletin clarifies certain procedures and policies pertaining to the Indiana Health Coverage Programs (IHCP) Presumptive Eligibility (PE) process, including hospital-based presumptive eligibility. The IHCP recently expanded the PE process, to include additional eligibility groups and additional provider types to perform PE determinations. More about these expansions can be found in *IHCP Bulletins* BT201505, BT201513, and BT201514.

In general, the PE process allows individuals to be determined eligible for IHCP coverage on a temporary basis. **PE is intended to quickly assess the eligibility of individuals who are facing acute healthcare issues. It is not intended to be the primary method of enrollment in the Healthy Indiana Plan (HIP) or other IHCP programs.**

An individual may be determined presumptively eligible when he or she visits a provider that is enrolled as a qualified provider (QP) and the member answers a short list of eligibility questions including age, income, pregnancy status, and residency status. This information is quickly evaluated and a PE eligibility determination made. Individuals who are found presumptively eligible have coverage starting that same day. They are given a PE acceptance letter that serves as their proof of coverage. Because this coverage is temporary, they do not get a membership card. The letter includes critical information for providers:

- Name
- Date PE coverage begins and ends
- PE ID number that starts with "600"
- The benefit package for the member
- The managed care entity (MCE) and telephone number – if they are in the PE Adult eligibility category

After a member is found presumptively eligible – he or she is fully eligible for all services covered for their PE aid category. Their coverage is temporary and they are directed to apply for full coverage before the end of the following month. An individual may only get PE coverage once per year or per pregnancy.

Eligibility verification and providing service to PE members

The PE determination is a real-time, immediate process. However, it may take several days for the member's information to be fully visible in all provider eligibility systems. This is especially true for members in the PE Adult category who are being served via MCEs. Eligibility should be visible in the different systems as follows:

- **Within one business day of PE eligibility**: A member's eligibility will be verifiable through the IHCP Eligibility Verification System options – the Automated Voice Response (AVR) system and Web interChange – and visible through the Catamaran Pharmacy Benefit Manager (PBM) system processing fee-for-service (FFS) pharmacy claims.
- **Within three business days of PE eligibility**: A member's eligibility will be visible through the MCE's system.
- **Within five to seven business days of PE eligibility**: A member's eligibility will be visible through the MCE's PBM system.

Regardless, members are fully eligible for coverage at the point of PE determination. Some providers hesitate to accept the PE letter as proof of coverage and are declining services until the person's eligibility is fully visible through the various systems. The State continues to stress to providers, including pharmacies, that the acceptance letter is proof of coverage. If possible, members should wait to seek pharmacy services; however, if a member needs prescription coverage before the five-to-seven-day window, they should call their MCE for assistance.

As long as the member has his or her PE acceptance letter, providers can be assured that covered services rendered during the indicated PE period will be paid.

Billing

Providers should check eligibility prior to rendering services as they would for any IHCP member. When using the AVR or Web interChange systems, please use the member Social Security number (SSN) for eligibility verification. If the member shows a "600" PE ID and a "100" member identification number (RID) for a particular date of service, the "100" RID should be used for billing purposes.

Covered Services by Benefit Package

Members found eligible for PE are assigned to the benefit packages listed in Table 1. The members are able to seek any covered service within their benefit package from any IHCP provider under the FFS delivery system or from a provider enrolled in their MCE's provider network under the risk-based managed care delivery system (RBMC).

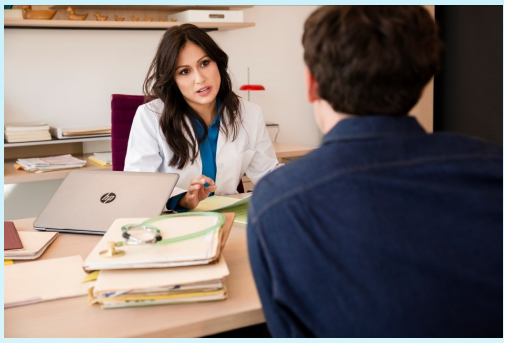
Table 1 – PE benefit packages

Aid Category	Description	Benefits	Delivery System
HI	PE Infants	Package A	FFS
HK	PE Children	Package A	FFS
HA	PE Adult	HIP Basic	RBMC
HP	PE Parent/Caretaker	Package A	FFS
HW	PE Pregnant Women	Package P	FFS
H1	PE Former Foster Care Children	Package A	FFS
HF	PE Family Planning	Family Planning Only	FFS

If a member seeks a service that requires prior authorization (PA) (or precertification), providers should follow the FFS or RBMC process, as appropriate, for obtaining PA. Questions regarding FFS PA should be directed to ADVANTAGE Health Solutions at 1-800-269-5720. Questions regarding RBMC PA should be directed to the MCE under which the member is enrolled. The benefits covered under the designated packages are as follows:

- Package A – Standard Plan: This package encompasses the full array of IHCP benefits. Members on this plan are able to receive any services covered by Traditional Medicaid.
- Package P – Pregnancy Only: The coverage under this package is limited to ambulatory prenatal care services only. These services include prenatal doctor visits, prescription drugs related to pregnancy, prenatal lab work, and transportation to prenatal visits. This package *does not* cover any services related to labor and delivery.

- *HIP Basic* – This package covers a wide range of ambulatory patient services, hospitalization, emergency room (ER), mental health and substance abuse, prescription drugs, labs, preventive care, and rehabilitative care. *HIP Basic does not* cover dental, vision, nonemergency transportation or Medicaid Rehabilitation Option (MRO) services. Most members in this category will have copays for most services.
- Family Planning – This package provides very limited coverage for family planning services only. The following services are covered:
  - Family planning visits
  - Laboratory tests (if medically indicated as part of the decision-making process regarding contraceptive methods)
  - Limited health history and physical exams
  - Pap smears
  - Initial diagnosis of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs)
  - Follow-up care for complications associated with contraceptive methods



  - 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

Frequently Asked Questions (FAQs)

When I check the member's presumptive eligibility/hospital-based presumptive eligibility, I cannot find his or her PE ID in Web interChange. How can I confirm that I will be reimbursed for a service?

The PE acceptance letter clearly indicates the date a member's coverage begins and ends and the managed care plan to which the member belongs, if applicable. If the member is eligible under the PE Adult aid category, providers should contact the MCE listed on the letter for services that require PA (or precertification). Although it may take up to three days from the PE coverage start date for a member to be visible in the MCE's system, each MCE has a process in place to provide PA (or precertification) for PE Adult members.

Where can a PE member receive services?

The member is not limited to receiving services only from the provider location or hospital where he or she was determined presumptively eligible. Most PE members can receive covered services from any IHCP-enrolled provider. PE Adult members should seek nonemergency care through providers in their MCE network.

What if a member's eligibility for services is denied via a pharmacy's point-of-sale system?

It may take several days for a member's eligibility status to be visible in all eligibility systems, particularly in the eligibility systems of the MCE pharmacy benefit managers. During that time, the member is eligible to receive services. The eligibility verification letter clearly indicates the date a member's coverage begins and ends and serves as a member's proof of eligibility. If a member is enrolled with an MCE and the pharmacy provider is unsure of the member's status, the provider can contact the MCE listed on the eligibility verification letter for guidance.

If an individual is admitted to the hospital and a PE determination is made during his or her stay, is that stay covered?

Member PE 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 eligibility also applies to hospital admission dates that pre-date 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.

QUESTIONS?

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