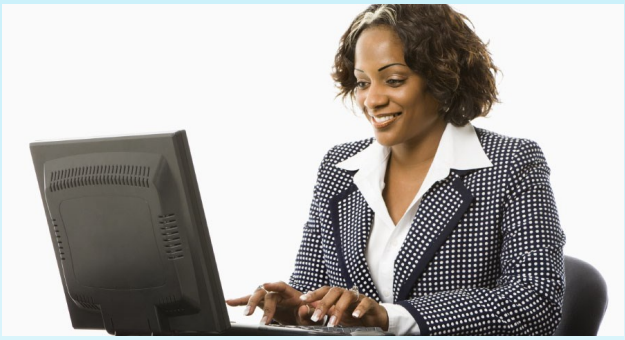
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202192 OCTOBER 14, 2021

IHCP Presumptive Eligibility benefits, coverage categories and effective dates

As described in *Code of Federal Regulations 42 CFR 435.1103*, Presumptive Eligibility (PE) allows individuals to be determined presumptively eligible by a qualified entity and have access to Medicaid-covered services while their full Indiana Health Coverage Programs (IHCP) application is being processed.



A qualified provider (QP) can make a PE determination by completing a short application on the IHCP Provider Healthcare Portal (Portal), accessible from the home page at in.gov/medicaid/providers. Individual self-attestation is acceptable for this PE application process, and documentation is not required.

For a list of IHCP provider specialties eligible to become QPs for PE, as well as QP enrollment instructions and qualifying criteria for PE coverage under the various PE aid categories, see the Presumptive Eligibility provider reference module available at in.gov/medicaid/providers.

The PE determination is a real-time, immediate process. Individuals who are found presumptively eligible have coverage starting that same day. Services delivered prior to the PE determination date are not covered. PE coverage is not retroactive.

PE benefit plans

The IHCP offers the following benefit plans for presumptively eligible individuals.

Presumptive Eligibility – Package A Standard Plan

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

Presumptive Eligibility Adult

The Presumptive Eligibility Adult (PE Adult) benefit plan includes all covered services available under the Healthy Indiana Plan (HIP) Basic benefit plan. (For more information on *HIP Basic* coverage, see the *Healthy Indiana Plan* provider reference module located at in.gov/medicaid/providers.) However, PE Adult benefits are delivered on a fee-for-service (FFS) basis rather than through a managed care entity (MCE).

The copayment requirements for PE Adult are also the same as those for *HIP Basic*:

- Professional claims (medical/physician): $4 per rendering provider, per date of service
- Outpatient claims (hospital/facility): $4 per date of service
- Inpatient claims: $75 per admission
- Preferred drugs: $4 per prescription
- Nonpreferred drugs: $8 per prescription
- Nonemergency emergency department visit: $8

All cost-sharing is temporarily suspended for the duration of the COVID-19 public health emergency. Members who typically had copayments will not have any copayments applied. This applies to all IHCP programs.

Copayments do not apply to pregnant members, American Indian/Alaskan Native members or members who have met their maximum cost-sharing obligation for the quarter. See the *Member Eligibility and Benefit Coverage* provider reference module for details. In addition, the following services are exempt from PE Adult/HIP Basic copayment requirements:

- Preventive care services
  (For applicable codes, see *Preventive Care Services Excluded from Copayment for Healthy Indiana Plan and Presumptive Eligibility – Adult Members*, accessible from the *Code Sets* page at in.gov/medicaid/providers.)
- Tobacco cessation drugs
- Family planning services
  (For applicable codes, see the table of covered procedure codes in Family Planning Eligibility Program Codes, accessible from the *Code Sets* page at in.gov/medicaid/providers.)
- Nonpharmacy services provided for an emergency health condition
  (Professional claims must include an emergency indicator at the detail level, outpatient claims must include an emergency diagnosis code, and inpatient claims must have admission type 1 or 5, or be a transfer with an admission source of 4.)

Presumptive Eligibility For Pregnant Women

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

- Doctor visits for prenatal care
- Prescriptions related to pregnancy
- Prenatal lab work
- Transportation for prenatal or emergency-related care

PEPW does not cover the following:

- Hospice
- Long-term care
- Inpatient care
- Labor and delivery services
- Abortion services
- Sterilization and hysterectomy services
- Postpartum services
- Services unrelated to pregnancy or birth

Although the preceding services are not covered under PEPW, these services may be covered retroactively if the individual is later determined to be fully eligible for IHCP benefits. After submitting a full *Indiana Application for Health Coverage* (IHCP application), pregnant individuals who are approved for enrollment in HIP or Hoosier Healthwise may also be determined eligible for retroactive coverage for up to three months prior to their IHCP application date. This retroactive coverage, provided through the FFS delivery system, will override the existing PE coverage and includes benefits beyond the pregnancy-related services covered under the PEPW benefit plan.

Individuals are eligible for PEPW coverage once per pregnancy. If a PEPW member miscarries and becomes pregnant again during the nine months following her original pregnancy, the QP should email PresumptiveEligibility@fssa.in.gov to request a new PEPW period.

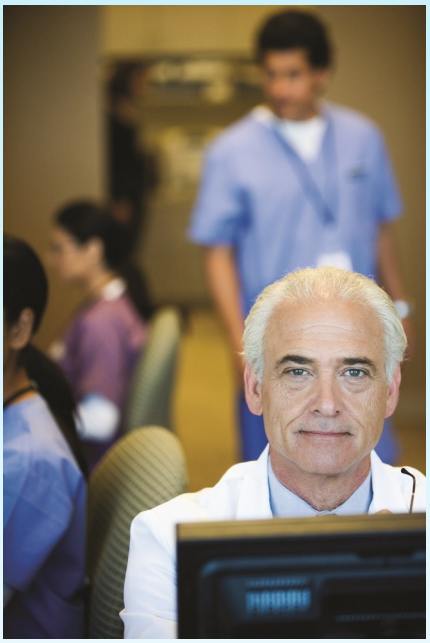
If a PE member's pregnancy ends at any time during the presumptive eligibility coverage period, the PEPW coverage continues until it would normally end.

Presumptive Eligibility Family Planning Services Only

The PE Family Planning Services Only benefit plan is limited to the services defined under that plan including the following:

- Family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods
- Limited health history and physical exams
- Laboratory tests (if medically indicated as part of the decision-making process regarding contraceptive methods)
- Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, within the parameters described in the *Obstetrical and Gynecological Services* provider reference module
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Food and Drug Administration (FDA)-approved contraceptive drugs, devices and supplies, including emergency contraceptives

- Initial diagnosis of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs), if medically indicated, including the provision of FDA-approved anti-infective agents
- Screening, testing, counseling and referral of members at risk for human immunodeficiency virus (HIV) within the parameters described in the *Laboratory Services* provider reference module
- Tubal ligations
- Hysteroscopy sterilization with an implant device (Essure)
- Vasectomies



For a list of covered codes, see *Family Planning Eligibility Program Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Medicaid Inpatient Hospital Services Only (PE for Inmates)

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 Family and Social Service Administration (FSSA)
- Not be on house arrest
- Not be pregnant or admitted for labor and delivery
- Be under the age of 65
- Be admitted for inpatient hospitalization
- Meet all standard PE requirements, except requirements pertaining to incarceration, current IHCP coverage and current or past PE coverage

Individuals from various aid categories may be found presumptively eligible under the PE for Inmates process. All requirements specific to the aid category – including income requirements – continue to apply under PE for Inmates.

PE effective dates and end dates

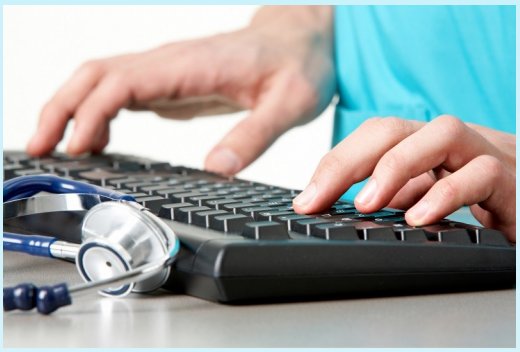
The PE period begins the day a QP determines an individual to be presumptively eligible. The end date varies, depending upon whether the individual submits an IHCP application:

- If the individual submits an IHCP application by the last day of the month following the month in which PE was determined, the PE period will continue until full Medicaid eligibility is either approved or denied.
- If the individual does not submit an IHCP application, the PE period ends on the last day of the month following the month in which PE was determined.

For example, PE is determined on Feb. 5. PE coverage begins Feb. 5. If a full IHCP application is not submitted by March 31, coverage will end on March 31. However, if a full IHCP application is submitted by March 31, PE coverage ends on the day the full IHCP application is either approved or denied.

There are two situations in which PE coverage start dates can be adjusted:

- When a system outage of the IHCP Portal makes the web-based application unavailable on the date of service In this instance, the PE application must be submitted within one day of the date of service. After the PE application is submitted and PE is established, a QP can submit a request to have the established PE effective date changed to the date of service.
- When a QP located in the Central time zone submits a PE application between 11 p.m. and 11:59 p.m. Central Time and is provided a PE start date based on Eastern Time, which pushes the eligibility date to one day after the date of service. In this instance, the QP can submit a request to have the PE effective date changed to the date of service, which is the date the PE application was submitted from the perspective of the provider.



No additional exceptions will be made to backdate PE coverage, including for patients receiving behavioral health services and patients that are medically unable to be screened by a QP on the date of service.

Requests for adjusted start dates can be submitted to the Office of Medicaid Policy and Planning (OMPP) through email at PresumptiveEligibility@fssa.in.gov. Requests that do not meet the above criteria will be declined.

IHCP coverage

The best pathway through which an individual can gain coverage is by submitting an IHCP application. If approved, a member's coverage could start as early as the first day of the month during which the application was submitted.

For HIP coverage, a Fast Track prepayment must be submitted for a member to start coverage on the first day of the month in which the IHCP application was submitted. If an individual is determined by the FSSA to be eligible for HIP, the individual's PE coverage will be retained for up to 60 days from when they were approved, provided application timelines are met. This time frame allows these individuals to make a POWER Account contribution and gain full HIP eligibility without a gap in coverage. HIP-approved individuals with an income less than 100% of the FPL who fail to make a POWER Account contribution will be enrolled in *HIP Basic* coverage. PE Adult members with an income greater than 100% of the FPL who fail to make a POWER Account contribution within 60 days of being approved for HIP will lose coverage.

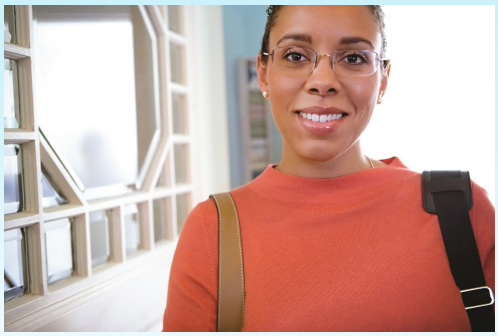
Fast Track is temporarily suspended for the duration of the COVID-19 public health emergency.

IHCP application

It is the QP's responsibility to have a process in place to assist the PE member in completing and submitting a full IHCP application for continued coverage. Individuals that do not submit this application will lose coverage when the PE period ends, and only one PE coverage period is allowed per rolling 12-month period or per pregnancy. Therefore, it is imperative that the QP inform all PE members of the need to complete the full application before the temporary eligibility period ends and provide them with information about how to do so.

As explained in the PE acceptance letter (which is autogenerated in the Portal when a PE application is approved), the individual may complete the IHCP application using any of the following methods:

- In person, at the location where the individual was determined presumptively eligible
- Online through the *FSSA Benefits Portal* at fssabenefits.in.gov/bp
- Over the telephone at 800-403-0864
- In person at an FSSA Division of Family Resources (DFR) local office



Paper applications can be requested online, over the phone or at a DFR office. Paper applications must be returned to the DFR in person or by mail or fax.

The DFR makes all final eligibility determinations.

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