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This is an update about information in the provider manual. For access to the latest manual, go online to www.anthem.com/inmedicaidoc.

Hospital presumptive eligibility reference guide

Overview

Individuals determined by a hospital qualified provider (QP) to be presumptively eligible will be enrolled with a managed care entity (MCE) for a **presumptively eligible period, which begins on the day a QP determines that the individual is presumptively eligible** and ends on the earlier of:

- The day that a denial decision is made on the member's complete Indiana Health Coverage Program (IHCP) application.
- The last day of the month following the month in which a QP determined the individual to be eligible when the IHCP application has not been filed.

If the IHCP application is approved, a member's presumptively eligible period will end on the last day of the month the member is determined by the state to be conditionally eligible for Healthy Indiana Plan (HIP), with full HIP coverage starting the first day of the following month. The presumptively eligible applicant must select an MCE (i.e., Anthem Blue Cross and Blue Shield [Anthem]), MDwise or MHS) at the time of the hospital presumptive eligibility (HPE) determination. If an applicant fails to select an MCE at the time of the HPE determination, the state will auto-assign the applicant to an MCE on a rotating basis.

Hospital presumptive eligibility effective date

The coverage period for HPE begins on the date the qualified provider makes the determination that an individual is presumptively eligible for coverage under an IHCP program. The effective date is **not** the date an individual receives care. For example, if an individual accesses services on the first of the month, and the eligibility determination process is conducted on the third, HPE coverage will begin on the third of the month. Providers are therefore highly encouraged to conduct eligibility determinations on the same date an individual presents seeking care.

During the member's presumptively eligible period, Anthem will provide health benefits equivalent to the HIP Basic plan benefits as described below.

- Provide minimum essential coverage and include all required essential health benefits (Note: No chiropractic or nonemergent transportation)
- Provider services
- Inpatient and outpatient services
- Prescription drugs
- No routine vision or dental coverage
- Pregnancy services covered
- Copays apply to outpatient, inpatient, preferred and nonpreferred drugs and nonemergent ER visits

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Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

The member will not be provided a POWER Account during the presumptively eligible period; however, the member will be subject to copayments for some services as described below.

- Inpatient: \$75 per admission
- Outpatient services (physicians/hospitals): \$4 per visit
- Outpatient services (dental): \$4 per service
- Preferred drugs: \$4 per prescription
- Nonpreferred drugs: \$8 per prescription
- For the member's first nonemergent ER visit, the member will incur an \$8 copayment, while any subsequent nonemergent ER utilization would require a \$25 copayment

Please note: No copayment is required for preventive care or family planning services. Pregnant or Native American members are exempt from cost-sharing responsibilities, including the copayments listed above and nonemergent use of the ER. Additionally, members ages 19 and 20 on HPE will be eligible for vision and dental services under early and periodic screening, diagnosis and treatment.

Anthem must reduce reimbursement to providers for covered services rendered to HPE eligible members by the amount of the individual's required copayment. Providers must collect copayments at the time services are rendered. Some members enrolled in HIP may have other insurance coverage that may be found after Anthem has paid a claim that Anthem and/or the state were not aware existed at the time of service. In these situations, Anthem will notify the provider of the existence of the other insurance coverage. Anthem must recoup the claim and the provider must file a claim with the other insurance carrier according to that carrier's billing rules. Per federal rules, the provider has six months from the date of Anthem's recoupment notification to file with the other insurance carrier. Providers cannot pursue reimbursement from members per federal rules under any circumstance.

Enrolling as a qualified provider

Acute care hospitals and psychiatric hospitals are eligible to enroll as HPE QPs. To be eligible, an acute care or psychiatric hospital must meet certain enrollment criteria and complete the HPE QP enrollment using Web interChange. HPE QPs must also complete HPE training. Anthem encourages all acute care and psychiatric hospitals to enroll as an HPE QP through Web interChange. For additional information on enrolling as an HPE QP, please refer to provider bulletin BT201357 and BT201513 located at: provider.indianamedicaid.com.

Once the acute care or psychiatric hospital has completed enrollment and training, it can determine eligibility for the following IHCP aid categories:

- Infants
- Children
- Adults
- Parents/caretakers
- Family planning
- Former foster children enrolled in Medicaid as of their 18th birthday
- Pregnant women

Individual eligibility requirements

Individuals are allowed only one presumptive eligibility coverage period per rolling 12 months or per pregnancy. HPE QPs must check eligibility using Web interChange to ensure the prospective member is not currently eligible under IHCP. To be determined presumptively eligible, an individual must meet the following eligibility requirements:

- Be a U.S. citizen or qualified noncitizen

- Be an Indiana resident
- Not currently incarcerated
- Not currently covered under presumptive eligibility plan or enrolled in IHCP
- Meet income level requirements specific to certain aid categories in the IHCP
- Meet any additional requirements specific to certain aid categories

HPE application process

Once an individual has applied and is enrolled in the HPE program, he or she must complete the Indiana Application for Health Coverage application and submit it to their local Division of Family Resources office. A determination of eligibility will be made for continued health coverage. HPE QPs must remind HPE members to include their unique HPE recipient identification number obtained during the HPE application process on their Family and Social Services Administration enrollment application for medical coverage.

HPE benefits overview

Individuals qualifying for HPE coverage receive HIP Basic benefits (a more limited set of benefits that does not include vision or dental coverage) except for those in the HPE pregnant women aid category. Members will generally be charged a copayment for health care services they receive. These payments will range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital visit. Members can avoid these copayments by becoming fully eligible under the HIP Plus program.

After members are enrolled, Anthem will educate HPE members regarding the difference between HIP Plus and HIP Basic covered benefits and notify the member that HIP Plus is the preferred plan. HIP Plus provides the best value coverage and includes vision and dental services. With HIP Plus, there are no other costs or copayments unless an individual visits the ER when they don't have an emergency health condition.

In order to participate in HIP Plus or HIP State Plus plan, individuals are required to help fund the \$2,500 deductible by contributing to their POWER Account on a monthly basis. The state funds the difference between the required monthly POWER Account contributions and the \$2,500 POWER Account. For the monthly contribution, the individual is liable for 2% of their income, up to a maximum of \$100 a month (\$1,200 per year).

Questions

Providers with questions can contact the Provider Helpline at **1-800-345-4344** or their Anthem Network Relations representative. Members who select Anthem can be referred to the Anthem Customer Care Center at **1-866-408-6131**.