Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

September 22, 2014

John McCarthy, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 14-0013

Dear Mr. McCarthy:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #14-0013 -Presumptive Eligibility for Former Foster Care Children
-Effective April 1, 2014

Please contact Christine Davidson, of my staff, at (312) 886-3642 or christine.davidson@cms.hhs.gov if you have any questions.

Sincerely,

/s/

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Debbie Saxe, ODM
Andy Jones, ODM
Sarah Curtin, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

Table of Contents

State/Territory Name: Ohio

State Plan Amendment (SPA) #: 14-0013

This file contains the following documents in the order listed:

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Ohio**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

OH-14-0013

Proposed Effective Date

04/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435.150, 1902(a)(10)(A)(i)(IX)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Eligibility: Presumptive Eligibility for Former Foster Care Children
This SPA supersedes S33 approved in TN 13-0025-MM1.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  The State Medicaid Director is the Governor's designee.

Signature of State Agency Official

Submitted By:	**John Mccarthy**
Last Revision Date:	**Sep 19, 2014**
Submit Date:	**Jun 25, 2014**

DATE RECEIVED:	**DATE APPROVED:**
6/25/14	9/22/14
PLAN APPROVED – ONE COPY ATTACHED	
EFFECTIVE DATE OF APPROVED MATERIAL:	**SIGNATURE OF REGIONAL OFFICIAL:**
4/1/14	/s/
TYPED NAME	**TITLE**
Verlon Johnson	Associate Regional Administrator

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Former Foster Care Children S33

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

■ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☑ The state attests that it operates this eligibility group under the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under age 26.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

■ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

◉ Yes ○ No

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

○ Yes ◉ No

■ The presumptive eligibility determination is based on the following factors:

- ■ The individual must meet the categorical requirements of 42 CFR 435.150.
- ☒ State residency
- ☒ Citizenship, status as a national, or satisfactory immigration status

■ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☒ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- ☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- ☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

Medicaid Eligibility

	Name of entity	Description	
+	CDJFS	County Departments of Job and Family Services	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Hospital Presumptive Eligibility

Training Template for Qualified Hospitals

Agenda

- HPE as part of the Continuum of Coverage
- HPE Overview
- How Hospitals Can Participate in HPE
- Who is Eligible to Enroll in Medicaid through HPE? What are the Benefits?
- How the HPE Process Works
- Contact Information

HPE as part of the Continuum of Coverage

ACA Coverage Changes

- The Affordable Care Act (ACA) was signed into law in March 2010; it makes major changes to how people secure health coverage in the U.S. Coverage changes include:
  - Medicaid and CHIP expansion and improvements
  - Health insurance marketplaces for individuals and small businesses
  - Private insurance market reforms

The New Vision for Medicaid and CHIP

- **Medicaid Coverage Expansion**
  - Covers adults 19-64 with incomes up to 133% FPL who are not eligible and enrolled in a mandatory group
- **Single Streamlined Application**
  - Individuals can apply for Marketplace coverage and all insurance affordability programs (Medicaid, CHIP, premium tax credits) on one application
- **Simplified Eligibility and Enrollment Rules**
  - Modified Adjusted Gross Income (MAGI) is the new income methodology based on IRS-defined concepts of income and household to determine Medicaid and CHIP eligibility for children, pregnant women, parents and caretaker relatives, and adults 19-64
- **Modernized Eligibility Systems**
  - Increases use of automated rules engines to enable real-time eligibility determinations; individuals can apply for coverage online
- **Children's Coverage Improvements**
  - All children up to age 19 with family incomes up to 133% FPL are now Medicaid-eligible
- **Hospital Presumptive Eligibility**
  - Hospitals can now determine individuals to be presumptively eligible for Medicaid

Additional Information on Coverage Changes

- There are a variety of changes to eligibility for Medicaid programs. More information regarding those changes can be found at the following link: **Affordable Care Act Overview: A Primer for Medicaid/CHIP Eligibility Workers**

HPE Overview

What Is Hospital Presumptive Eligibility (HPE)?

- As of the later of January 20, 2014, or formal federal approval of any necessary state plan amendment, hospitals can immediately determine Medicaid eligibility for certain individuals who are likely to be eligible
- Eligibility under PE is temporary but allows immediate access to coverage for eligible individuals; this is discussed in more detail later in the presentation
- HPE policies and procedures for MAGI covered groups differ slightly from those in Ohio's Medicaid PE programs for children and pregnant women

How HPE Works to Get People Connected to Coverage and Care

- HPE improves individuals' access to Medicaid and necessary services by providing another channel to apply for coverage
- It ensures the hospital will be reimbursed for services provided, just as if the individual was enrolled in standard Medicaid
- HPE is not about short-term coverage; it provides individuals with an opportunity to get connected to longer-term coverage options

How Hospitals Can Participate in HPE

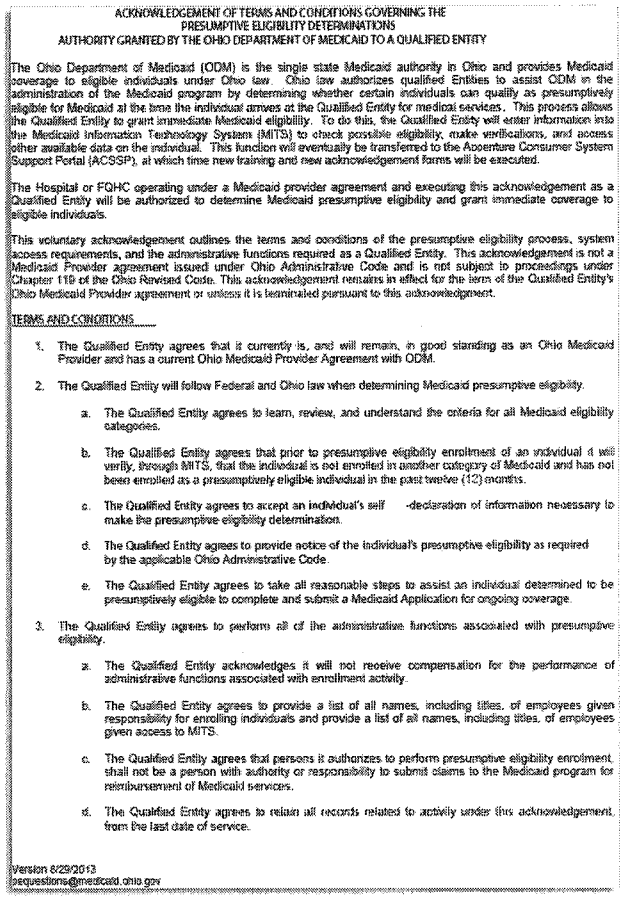
How Hospitals Can Participate in HPE

- Hospital participation in HPE is optional, but states must provide a mechanism for a hospital to become qualified entity to conduct PE
- To make HPE determinations, a hospital must:
  - Participate in the Medicaid program
  - Notify the state of its election to make HPE determinations by completing this training, and executing an acknowledgement form and return that form to Pequestions@medicaid.ohio.gov.
  - Agree to make HPE determinations consistent with policies and procedures of the state by signing the Acknowledgement of Terms and Conditions
  - Agree to provide the consumer with 36 hours' worth of needed medications

Acknowledgement of Terms and Conditions

Acknowledgement of Terms and Conditions

Full PDF version located here:
http://medicaid.ohio.gov/Portals/0/Providers/Training/PE_Acknowledgement_Form.pdf



ACKNOWLEDGEMENT OF TERMS AND CONDITIONS GOVERNING THE
PRESUMPTIVE ELIGIBILITY DETERMINATIONS
AUTHORITY GRANTED BY THE OHIO DEPARTMENT OF MEDICAID TO A QUALIFIED ENTITY

The Ohio Department of Medicaid (ODM) is the single state Medicaid authority in Ohio and provides Medicaid coverage to eligible individuals under Ohio law. Ohio law authorizes qualified Entities to assist ODM in the administration of the Medicaid program by determining whether certain individuals can qualify as presumptively eligible for Medicaid at the time the individual arrives at the Qualified Entity for medical services. This process allows the Qualified Entity to grant immediate Medicaid eligibility. To do this, the Qualified Entity will enter information into the Medicaid Information Technology System (MITS) to check possible eligibility, make verifications, and access other available data on the individual. This function will eventually be transferred to the Accenture Consumer System Support Portal (ACSSP), at which time new training and new acknowledgement forms will be executed.

The Hospital or FQHC operating under a Medicaid provider agreement and executing this acknowledgement as a Qualified Entity will be authorized to determine Medicaid presumptive eligibility and grant immediate coverage to eligible individuals.

This voluntary acknowledgement outlines the terms and conditions of the presumptive eligibility process, system access requirements, and the administrative functions required as a Qualified Entity. This acknowledgement is not a Medicaid Provider agreement issued under Ohio Administrative Code and is not subject to proceedings under Chapter 119 of the Ohio Revised Code. This acknowledgement remains in effect for the term of the Qualified Entity's Ohio Medicaid Provider agreement or unless it is terminated pursuant to this acknowledgment.

TERMS AND CONDITIONS

1. The Qualified Entity agrees that it currently is, and will remain, in good standing as an Ohio Medicaid Provider and has a current Ohio Medicaid Provider Agreement with ODM.
2. The Qualified Entity will follow Federal and Ohio law when determining Medicaid presumptive eligibility.
   a. The Qualified Entity agrees to learn, review, and understand the criteria for all Medicaid eligibility categories.
   b. The Qualified Entity agrees that prior to presumptive eligibility enrollment of an individual it will verify, through MITS, that the individual is not enrolled in another category of Medicaid and has not been enrolled as a presumptively eligible individual in the past twelve (12) months.
   c. The Qualified Entity agrees to accept an individual's self -declaration of information necessary to make the presumptive eligibility determination.
   d. The Qualified Entity agrees to provide notice of the individual's presumptive eligibility as required by the applicable Ohio Administrative Code.
   e. The Qualified Entity agrees to take all reasonable steps to assist an individual determined to be presumptively eligible to complete and submit a Medicaid Application for ongoing coverage.
3. The Qualified Entity agrees to perform all of the administrative functions associated with presumptive eligibility.
   a. The Qualified Entity acknowledges it will not receive compensation for the performance of administrative functions associated with enrollment activity.
   b. The Qualified Entity agrees to provide a list of all names, including titles, of employees given responsibility for enrolling individuals and provide a list of all names, including titles, of employees given access to MITS.
   c. The Qualified Entity agrees that persons it authorizes to perform presumptive eligibility enrollment shall not be a person with authority or responsibility to submit claims to the Medicaid program for reimbursement of Medicaid services.
   d. The Qualified Entity agrees to retain all records related to activity under this acknowledgement, from the last date of service.

Version 6/29/2013
pequestions@medicaid.ohio.gov

Hospital Staff Eligible to Make HPE Determinations

- Once a hospital is a qualified entity:
  - Any hospital employee who is properly trained and certified can make HPE determinations
    - This includes employees in hospital-owned physician practices or clinics, including those in off-site locations
  - Participating hospitals may not delegate HPE determinations to non-hospital staff
    - Third party vendors or contractors may not make PE determinations

Staff Training and Certification

- Hospital staff will view this training, and will have access to job aids detailing how to enter requests into the system
- *http://medicaid.ohio.gov/PROVIDERS/Training.aspx*
- This training will be available online for training new staff or for refresher training

HPE Performance Standards

- Performance standards for hospitals are listed in the Acknowledgement of Terms and Conditions
- ODM staff will monitor PE enrollments monthly, quarterly and annually to determine if the following standards are being met by any single QE. First, for all persons enrolled presumptively by a QE, at least 85% must have had an application for full Medicaid benefits submitted. Second, for all persons who had an application for full benefits filed, at least 85% of those must result in an awarding of Medicaid eligibility.
- The state has the authority to take corrective action against hospitals, including termination from the HPE program, if the hospital does not follow state policies or does not meet established standards.

Who is Eligible to Enroll in Medicaid through HPE? What are the Benefits?

Populations Eligible for Medicaid via HPE Determinations

- Not currently receiving Medicaid benefits and have not had a PE span in the past twelve months (pregnant women are limited to one PE span per pregnancy)

  and
- Ohio resident

  and
- US citizen or has satisfactory immigration status

  and
- Meets eligibility criteria for one of the following groups:
  - Insured Child up to 156% FPL
  - Uninsured Child up to 206% FPL
  - Parent/Caretaker Relative up to 90% FPL
  - Pregnant Women up to 200% FPL
  - Adult Expansion up to 133% FPL
  - Former Foster Care: Individuals at least eighteen years old and younger than twenty-six years old who were in foster care on their 18th birthday – no income test

HPE Income Eligibility Chart

Medicaid HH Size	Parents/ Caretaker Relatives 90%	Expansion Adults 133%	Children with Insurance 156%	Pregnant Women 200%	Children without Insurance 206%
1	$862	$1,274	$1,494	$1,915	$1,973
2	$1,164	$1,720	$2,017	$2,585	$2,663
3	$1,465	$2,165	$2,539	$3,255	$3,353
4	$1,767	$2,611	$3,062	$3,925	$4,043
5	$2,068	$3,056	$3,585	$4,595	$4,733
6	$2,370	$3,502	$4,107	$5,265	$5,423
7	$2,671	$3,947	$4,630	$5,935	$6,114
8	$2,973	$4,393	$5,152	$6,605	$6,804
9	$3,274	$4,838	$5,675	$7,275	$7,494
10	$3,576	$5,284	$6,198	$7,945	$8,184
11	$3,877	$5,729	$6,720	$8,615	$8,874
12	$4,179	$6,175	$7,243	$9,285	$9,564

There is no income test for the Former Foster Care group

Duration of Eligibility under HPE

- HPE period begins with, and includes, the day on which the hospital makes the HPE determination
- HPE period ends with:
  - The day on which the state makes the eligibility determination for full Medicaid, or
  - The last day of the month following the month in which the hospital makes the HPE determination, if the individual does not file a full application by that time
- The HPE period is limited to one every 12 months or once per pregnancy for pregnant women

Determining Household Size

- *Factors to consider when determining household size can be found at the following link:*
- **Household Composition and Income Eligibility Rules: Detailed Rules for Medicaid/CHIP Eligibility Workers**

Determining Financial Eligibility
Income Sources

- *Factors to consider when determining income can be found at the following link:*
- **Household Composition and Income Eligibility Rules: Detailed Rules for Medicaid/CHIP Eligibility Workers**

Covered Services Under PE

- Benefits are the same as those provided under the Medicaid group for which the individual is determined presumptively eligible
- Exceptions
  - Pregnant women - benefits limited to ambulatory prenatal care (birthing expenses are not covered)

How The HPE Process Works

The HPE Determination Process

At individual's initial visit, PE worker should take the following steps:

1. Assist individual with completing HPE application using the PE and Deemed portal if not already enrolled in Medicaid
   - Enter individual's personal data
   - Assist individual in completing required questions *(See Presumptive Eligibility Provider Portal Job Aid)*
   - Assist individual with calculating monthly family income and household size
2. Determine if individual meets HPE criteria; if so, confirm eligibility
3. Print/provide eligibility notice
4. Summarize benefits and answer any questions
5. Take all reasonable steps to assist the individual to complete and submit a Medicaid application for ongoing coverage

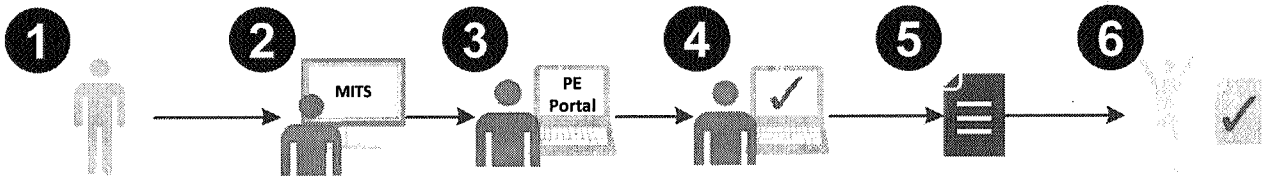
PE and Deemed Portal

The PE and Deemed Portal is the application tool that Qualified Entities will use to make eligibility determinations for Presumptive Eligibility and Deemed Newborn requests. This Portal is a single streamlined application that is linked directly to the Ohio Integrated Eligibility System for eligibility and record keeping purposes.

How to Use PE and Deemed Portal

Uninsured Resident at a Qualified Provider

This intake process allows prospective Medicaid beneficiaries to receive immediate, time-limited access to medical services.



Uninsured Individual/ Household | **Check for Coverage** | **Enter in PE Portal** | **Accept Result** | **Provide Documentation** | **Insured**

1. Uninsured Resident goes to QP for care
2. QP checks MITS to verify if Resident has preexisting coverage
3. If no preexisting coverage exists, QP will process a PE request through the PE Provider and Deemed Portal
4. The QP will provide a real time eligibility decision to the resident using the PE Provider and Deemed Portal
5. QP provides documentation of PE coverage to the resident
6. If the Resident is eligible, they will receive PE coverage for a 60-day period

For detailed information about processing PE requests in the PE and Deemed Portal, please refer to the *PE Provider Portal Job Aid*

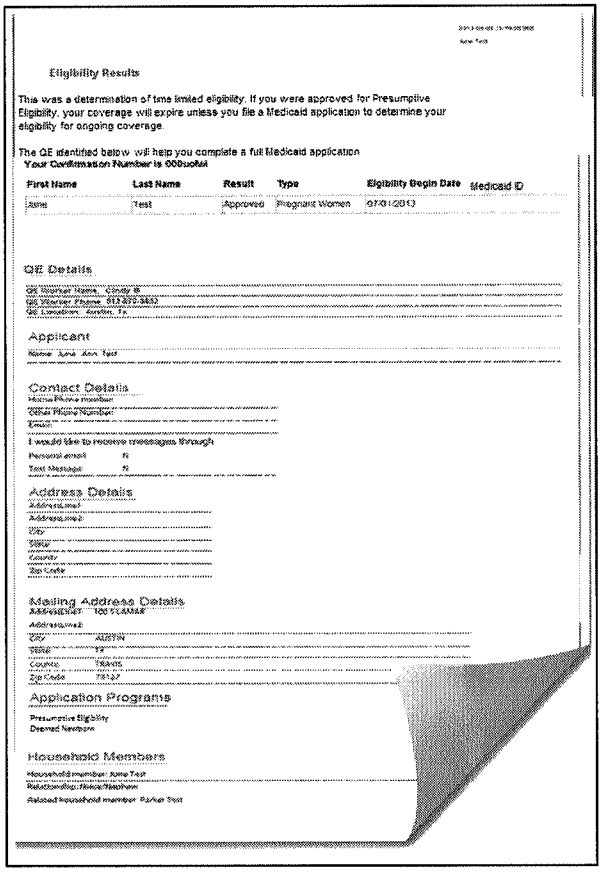
Verification of Eligibility Criteria for HPE

- Individual cannot be required to provide proof/documentation of any PE eligibility criteria
  - (e.g., can't require medical verification of pregnancy)
- Hospital must accept self-attestation of all eligibility factors

Approval and Denial Notices

- Hospitals must provide individuals with a written notice after the HPE determination is made, which includes:
  - Whether HPE was approved or denied
  - If approved, beginning and ending dates of the HPE period, which will be extended if the individuals files a Medicaid application and eligibility is not determined by then
  - If denied, the option to submit a regular Medicaid application
- Hospitals must notify the state agency of PE approvals, including date range for the HPE period, within five days. This notification is done by the system when the hospital uses the PE Portal to process PE requests

Approval/Denial Notices Example



Eligibility Results

This was a determination of tme limited eligibility. If you were approved for Presumptive Eligibility, your coverage will expire unless you file a Medicaid application to determine your eligibility for ongoing coverage.

The QE identified below will help you complete a full Medicaid application

Your Confirmation Number is 000uoNM

First Name	Last Name	Result	Type	Eligibility Begin Date	Medicaid ID
Jane	Test	Approved	Pregnant Women	07/01/2013	

QE Details

Applicant

Contact Details

I would like to receive messages through

Address Details

Mailing Address Details

Address1 100 FLAMM

City AUSTIN

Zip Code 78737

Application Programs

Presumptive Eligibility
Deemed Newborn

Household Members

Connecting to Full Medicaid Coverage Outside the Hospital

- Individuals can apply for full Medicaid coverage:
  - Online at www.Benefits.Ohio.gov
  - In-person at the local County Department of Job and Family Services (CDJFS)
  - By mailing or faxing the paper application to the local CDJFS
  - By calling the Ohio Medicaid Consumer Hotline at (800) 324-8680
- Individuals can find help completing the single streamlined application by contacting the hotline listed above or by using the Online Help tool provided on the Ohio Benefits portal.

Contact Information

Contact Info and Additional Resources

- PE Provider Help Mailbox: PEQuestions@Medicaid.ohio.gov
- PE Provider Help Desk: 1-800-686-1516
- Qualified Provider Enrollment Site: http://www.medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx
- Qualified Provider PE Training: http://www.medicaid.ohio.gov/PROVIDERS/Training/PresumptiveEligibilityTraining.aspx