

Implementation Guide: Medicaid State Plan Eligibility Presumptive Eligibility Presumptive Eligibility by Hospitals

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Presumptive Eligibility by Hospitals

POLICY CITATION

Statute: 1902(a)(47)(B) of the Act

Regulation: 42 CFR 435.1110

BACKGROUND

Overview

This reviewable unit (RU) describes the provisions under which hospitals determine presumptive eligibility (PE) for various groups of individuals, as described at 42 CFR 435.1110. Qualified hospitals may determine PE for groups of individuals described in the state plan, subject to the same requirements that apply to PE determinations made under the authority of 42 CFR 435.1102 and 435.1103, but regardless of whether the state elected to allow PE determinations under such sections. This option allows an individual to be determined presumptively eligible by a qualified hospital and to access Medicaid-covered services while his or her full application is being processed. A full eligibility determination is not immediately needed and cannot be required in order for PE to be approved. An individual may attest to information needed to make a PE determination, such as income, household size, and, at state option, citizenship and residency, but verification of such information is not required.

NOTE: This provision is an option for qualified hospitals in the state. It is not an option elected by the Medicaid agency. States must complete this RU in order to accommodate any hospitals that may seek to become qualified entities, regardless of whether any hospitals are currently participating.

Eligibility Groups or Populations

If a qualified hospital elects to make PE determinations, it must determine eligibility presumptively for the following eligibility groups:

- Pregnant Women
- Infants and Children under Age 19
- Parents and Other Caretaker Relatives
- Former Foster Care Children
- Adult Group (if covered by the state)
- Individuals above 133% FPL under Age 65 (if covered by the state)
- Individuals eligible for Family Planning Services (if covered by the state)
- Certain Individuals Needing Treatment for Breast or Cervical Cancer (if covered by the state)
 - The state may limit PE for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

Option: Other Groups or Populations: The state may identify additional eligibility groups and/or 1115 demonstration populations for which hospitals may make PE determinations.

Presumptive Eligibility Determination

To be determined presumptively eligible, an individual must meet the categorical requirements of the eligibility group or population for which PE is being determined (e.g., age, pregnancy status, status as a parent/caretaker relative, disability). An individual cannot be required to provide a Social Security Number in order to receive a PE determination.

Options: Household Income. As described at 42 CFR 435.1102(a), in determining household income for the required eligibility groups listed above (MAGI-based eligibility groups), the state may elect to use either gross income or a reasonable estimate of MAGI. A full MAGI-based eligibility determination cannot be required to determine PE. To arrive at a reasonable estimate of MAGI, states may utilize a simplified methodology such as determining household composition following the rules for non-filers described at 42 CFR 435.603(f). For other eligibility groups or populations, the state may specify other income methodologies to be used in determining household income for PE.

Option: Additional PE Determination Factors of Residency and Citizenship. In addition to the categorical and income requirements, states may elect to permit hospitals to consider state residency and U.S. citizenship or eligible immigration status when making a PE determination. Verification of such information is not required. If a state does not elect these options in the state plan, then attestation of residency, citizenship and immigration status cannot be required as part of the PE application process.

Qualified Hospitals

As described at 42 CFR 435.1110(b), a qualified hospital is one that meets the following criteria:

- Participates as a provider under the Medicaid state plan or a section 1115 demonstration;
- Notifies the Medicaid agency of its election to make PE determinations;
- Agrees to make PE determinations consistent with state policies and procedures; and
- Has not been disqualified by the Medicaid agency for failure to:
 - Make PE determinations in accordance with applicable state policies and procedures, or
 - Meet any standards established by the Medicaid agency.

Option: Application Assistance: States may require qualified hospitals to assist individuals who want to submit a full application. If the state elects this option, a qualified hospital would need to make assistance available for completing and submitting a full application and for understanding any documentation requirements. Individuals cannot be required to submit a full application as a condition of PE.

Option: Performance Standards: States may establish reasonable performance standards for qualified hospitals that elect to make PE determinations. If a state establishes such a standard, the standard may be related to:

- The percentage of individuals who receive a PE determination and follow-up to file a full Medicaid application before the end of the PE period, or
- The percentage of individuals who are determined eligible for ongoing Medicaid coverage after submitting a full application.

A state may establish standards related to one or both options.

Qualified hospitals determining PE must be appropriately trained on the state's PE screening process and the requirements for PE. A copy of the state's training materials is submitted with this RU for CMS review.

Application for Presumptive Eligibility

States have different options for developing and administering the PE application process used by hospitals, but they must establish a standardized screening process for determining PE. States are not required to use a written application for PE; they may utilize verbal screening questions, a written application, or an online portal. Whichever process is used, the qualified hospital is responsible for collecting and recording all information necessary to make a PE determination.

If the state requires hospitals to use a written application, either the single, streamlined application or a PE-specific application may be used. When the single, streamlined application is used, it must denote those fields that are required for a PE determination. A PE-specific application may not include questions that are not relevant to a PE determination. If an online portal or electronic screening tool is used for PE, it must meet the same guidelines. Both written and electronic applications are submitted with the **Presumptive Eligibility by Hospitals** RU for approval.

Presumptive Eligibility Period

Individuals may be covered under a PE determination only for a limited period of time. Section 1920A(b)(2) of the Act, codified at 42 CFR 435.1101, discusses the beginning and end dates for coverage based on PE, as follows.

- **Beginning:** The PE period begins on the day that a qualified entity determines the individual to be presumptively eligible.
- **End:** The end date varies depending on whether or not the individual submits a Medicaid application.
 - If the individual submits a Medicaid 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 a Medicaid application, the PE period ends on the last day of the month following the month in which PE was determined.

Example: PE is determined on the 5th of February. If a full Medicaid application is not submitted by March 30th, coverage will end on that date. If a full Medicaid application is filed by March 30th, PE coverage ends on the day the full Medicaid application is either approved or denied.

States must establish reasonable standards limiting the number of PE periods that will be authorized. These standards may be based on the calendar year – no more than one PE period per calendar year – or they may be based on a specific timeframe, such as no more than one PE period every 12 months. States may establish other reasonable limitations that reflect the needs of the population.

INSTRUCTIONS

Introductory Assurances

- Indicate that the state has policies and procedures in place to enable qualified hospitals to determine PE and that the state provides coverage to individuals determined presumptively eligible by hospitals under the cited federal regulation. To do this, check the box next to the assurance.
- Indicate that hospital PE is administered in accordance with the provisions in the RU. To do this, check the box next to the assurance.

A. Qualification of Hospitals

- At **A.3.** select *Yes* or *No* to indicate if the requirements for a qualified hospital include assisting individuals in completing and submitting the full application and understanding any documentation requirements.

B. Eligibility Groups or Populations Included

- At **B.8.** select *Yes* or *No* to indicate if the state limits the qualified hospitals making PE determinations for the Breast and Cervical Cancer group to those that conduct breast and cervical cancer screening under the state's CDC National Breast and Cervical Cancer Early Detection Program.
- At **B.9.**, check the box if there are other Medicaid state plan eligibility groups for which PE determinations are made by hospitals. This election is optional. If selected,
 - Select the **+Add Eligibility Group** link.
 - Enter the name and a description of the eligibility group.
 - Use the name for the group that is used in the **Mandatory Eligibility Group** or **Optional Eligibility Group** RUs.
 - Include the statutory or regulatory citation in the **Description** text box.
 - If there is more than one other eligibility group, select the **+Add Eligibility Group** link again and repeat the steps above.
 - To delete a previously added eligibility group, select the **X** next its name and description.
- At **B.10.** check the box if qualified hospitals may make PE determinations for populations who qualify under a section 1115 demonstration. This is optional.
 - If selected, indicate the name and number of the section 1115 demonstration and provide a description of the population(s) in the text box provided.

C. Standards for Participating Hospitals

- At **C.1.**, select *Yes* or *No* to indicate if the state has elected one or more reasonable standard(s) for qualified hospitals making PE determinations.
 - If *Yes*, select one or more of the options that are displayed.
 - If option C.1. or C.2 is selected, enter the appropriate percentage in the text box provided.
 - If option C.3. is selected,
 - Select the state has elected one or more other reasonable standard(s)
 - Enter the description(s) if State has one or more other reasonable standard.

D. Presumptive Eligibility Period

- **D.1.** has a general rule that the PE period begins on the date the determination is made.
- **D.2.** has rules for the end date of the PE period.
- At **D.3.**, select one of the five options to indicate how the periods of PE are limited.
 - If **D.3.e. *Other reasonable limitation*** is selected:
 - Select the **+Add Limitation** link.
 - Provide the name of the limitation and a description in the text boxes provided.
 - If there is more than one other limitation, select the **+Add Limitation** link again and repeat the above step.
 - To delete a previously added limitation, select the **X** next to its name and description.

E. Application for Presumptive Eligibility

- At **E.1.**, indicate that a standardized screening process is used for determining PE. To do this, check the box next to the assurance.
- Select one or more of the three options at **E.2.** through **E.4.**
- If **E.2** is selected, select either **E.2.a.** or **E.2.b.**, or both.
- Upload at least one document (application form or screen shot) for each option that is selected. (If both **E.2.a.** and **E.2.b.** are selected, upload copies of both the paper and online PE applications.) Once approved, the uploaded documents will become part of the state plan.
- At **E.5.**, describe the PE screening process in the text box provided.

F. Presumptive Eligibility Determination

- **F.1.** has a statement that the individual must meet the categorical or non-financial eligibility requirements of the specific eligibility group for which PE is being determined.
- At **F.2.**, select one of the options regarding the income counting methodology. An additional income counting option is available if you selected additional groups or populations at **B. *Eligibility Groups or Populations Included*** for inclusion in hospital PE.
 - If your state includes only the mandatory groups (i.e., you did not select option **B.9.** or **B.10.**), at **F.2.**, select one of two options regarding the income counting methodology.
 - If your state includes additional groups or populations in hospital PE (i.e., you selected either option **B.9.** or **B.10.**), at **F.2.**, select one of three options regarding the income counting methodology.
 - If you do not use the same methodology for all the groups for which hospitals determine PE, select **F.2.c. *Other income methodology***.
 - If **F.2.c.** is selected, describe the other methodology in the text box provided, including the groups for which it is used. If more than one

methodology is used, describe each one and indicate which groups or populations use which methodology.

- Select **F.3.** and/or **F.4.** only if applicable in your state.

G. Qualified Entity Requirements

- At **G.1.**, indicate that the requirements for qualified hospitals have been communicated and adequate training has been provided to the hospitals. To do this, check the box next to the assurance.
- At **G.2.**, upload a copy of the training materials for review (e.g., PowerPoint or webinar training slides, written instructions or manual for PE determinations). These uploaded documents are submitted for reference only and will not become part of the state plan.

H. Additional Information (optional)

Except in limited circumstances, this field remains blank. Please consult with CMS before adding any additional information concerning this RU.

REVIEW CRITERIA

The description of the Other Medicaid state plan eligibility groups at B.9. and/or the 1115 Demonstration population at B.10 must be sufficiently clear, detailed and complete to permit the reviewer to determine that it meets applicable federal statutory, regulatory and policy requirements. The description at B.9. must include specific names of eligibility groups (preferably as they are named in the Optional Eligibility Group and Mandatory Eligibility Group RUs) and their statutory or regulatory citation. The description at B.10. must include the name of the population used in the 1115 Demonstration and the name and identifying number of the Demonstration project.

If the state selects the “Other reasonable limitation” option at D.3.e., it must name any such limitation and provide a description. The description must be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

The description of an Other income methodology at F.2.c. must be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements. If the state varies income methodologies among the groups and populations for which hospitals determine PE, the description must clearly indicate which groups or populations use which methodology.