State Health Reform Assistance Network
Charting the Road to Coverage

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# Implementation of the Affordable Care Act's Hospital Presumptive Eligibility Option: Considerations for States

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## Introduction

Beginning January 1, 2014, the Affordable Care Act (ACA) gives qualified hospitals the opportunity to determine presumptive eligibility (PE) for certain Medicaid-eligible populations. This will enable hospitals to temporarily enroll individuals in Medicaid, ensuring compensation for hospital-based services, while providing patients access to medical care and a pathway to longer-term Medicaid coverage. Today, 33 states have existing presumptive eligibility policies for pregnant women and/or children. This new ACA option allows hospitals to become PE providers regardless of whether their state has previously implemented PE, and expands the number of groups for which hospitals may determine presumptive eligibility. As many states prepare to expand Medicaid coverage under the ACA in 2014, this new hospital-based capability will help expedite access to coverage.

States have an important role in the implementation and oversight of hospital PE. The Centers for Medicare & Medicaid Services' (CMS) final rule on hospital PE (CMS-2334-F) provides states with flexibility in how to design their hospital PE programs. In particular, the final rule provides opportunities for states to train and certify hospital PE providers, track provider performance, and oversee program quality.

This brief provides guidance to aid state Medicaid programs in developing the policies and procedures for hospital PE implementation. An accompanying appendix details existing practices from select state PE programs. The information was obtained from the final CMS rule, related CMS guidance, expert sources, and interviews with states currently operating PE programs. The brief organizes information on hospital PE under four topics: (1) qualified provider requirements; (2) training and certification; (3) performance standards; and (4) plan enrollment and payment.

## Qualified Provider Requirements

To be eligible to make PE determinations, a qualified hospital must: (1) participate in the Medicaid program; (2) notify the state of its decision to make hospital PE determinations; and (3) agree to make PE determinations consistent with state policies and procedures (such as a state requirement to assist individuals with the full application). Below are details from the CMS final rule regarding hospital settings, workers, and worker requirements for hospital PE



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determinations.

***Eligible Hospital Settings:*** The final rule does not restrict the types of settings in which hospital PE can be conducted, but rather, makes clear that the individual making the determination must be an employee of the hospital. States are free to allow hospital PE determinations to occur in both outpatient and inpatient hospital settings and during the procedure scheduling process.

***Eligible Hospital Workers:*** According to the final rule, only hospital employees are authorized to conduct PE determinations and PE authority cannot be delegated to another entity.[1] As a result, hospital employees and trained hospital volunteers can make determinations, but staff at affiliated clinics not legally owned by the hospital cannot. New Jersey provides one example of restrictions on staff conducting PE determinations, requiring that PE staff only do PE processing for the facility under which they are registered.[2]

***Hospitals Assisting with Completion of the Full Application:*** States must ensure that an individual determined presumptively eligible is informed about how to apply for Medicaid and where to obtain an application. CMS' final rule gives states the option to require hospitals to assist individuals with completing and submitting the full application.[3]

***Hospitals Assisting Non-Patients:*** Hospital PE providers can provide PE determinations for patients as well as non-patients such as family members or other individuals. The final rule uses the word "individual," not "patient," when describing whom hospitals will conduct PE determinations for, confirming that non-patients are eligible.

***Hospitals Imposing Citizenship andlor Residency Requirements:*** CMS has indicated that a hospital provider may require an individual or third party to attest that the individual is a U.S. citizen/national or a state resident,[4] indicating that self-attestation is a permissible state option for PE applications (note that citizenship must be confirmed as part of the full eligibility determination process).

## Training and Certification

CMS does not require states to establish a formal training program for hospital PE providers, but the rules do require states to provide qualified hospitals with information on relevant state policies and procedures and information on how to appropriately make PE determinations. States must submit materials used to educate or train qualified hospitals about the PE process to CMS with their hospital PE Medicaid State Plan Amendment (S 21).

States currently use a range of strategies to train PE providers, including one-on-one meetings, in-person group sessions, web-based trainings, or some combination thereof. Iowa conducts web-based training, whereas Connecticut conducts on-site training and hosts regional trainings when the state introduces major program changes.[5] New Jersey provides webinar trainings and tests prospective PE providers, requiring a score of 85 percent or greater before an individual can qualify.[6] New Mexico also requires trainees to pass a test after in-person or web-based trainings.

## Performance Standards

States have the option to establish standards for hospital PE providers based on either: (1) the proportion of individuals determined presumptively eligible by the hospital who submit a full application; or (2) the proportion of individuals who are determined eligible for Medicaid based on the full application. CMS has noted that oversight of qualified hospitals is a state responsibility, and has therefore decided not to impose a uniform federal standard for all participating hospitals across all states. Instead, CMS will monitor implementation of state hospital PE standards to determine whether further guidance is needed. Regardless of the standards a state chooses, hospitals may only be disqualified from conducting PE determinations after they have been provided additional training by the state or the state has taken other reasonable corrective action measures.

Current PE performance standards vary significantly by state, with some simply tracking submitted PE applications and intervening when errors or abnormalities are observed, while others use precise metrics to judge performance. New Jersey

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[1] See §435.1102(b)(2)(vi).

[2] Centers for Medicare & Medicaid Services. *Hospital Presumptive Affinity Group Webinar*, September 4, 2013.

[3] See §435.1110(b)(2).

[4] See §435.1102(d).

[5] T. Brooks. "Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage." Center for Children and Families, Georgetown University Health Policy Institute. May 2011.

[6] Centers for Medicare & Medicaid Services. *Hospital Presumptive Affinity Group Webinar*, September 4, 2013.

reviews all online applications and offers remedial training to providers or sites that repeatedly submit incorrect applications.[7] New Mexico may "terminate immediately for cause" a PE provider if less than 90 percent of determinations result in submission of a full Medicaid application, or if 10 percent or more of the full Medicaid applications submitted contain errors, are incomplete, or otherwise require the state's intervention in processing.[8]

## Plan Enrollment and Payment

***Selection of Managed Care Plans:*** Many states must decide whether individuals gaining Medicaid coverage through hospital PE will be enrolled in managed care or fee-for-service (FFS) plans during the PE period. If states choose the former, they may want to place limitations on hospitals' ability to "steer" individuals toward particular managed care organizations.

States tend to provide PE services via FFS arrangements, waiting until the full eligibility determination is made to enroll the individual in managed care, if available. This means that the eligible individual would only be enrolled into a managed care plan at the start of the plan's enrollment period (e.g., at the beginning of the month following a person's Medicaid determination). States can also work with managed care plans to expedite enrollment, pro-rating the cost of coverage during this period.[9] Alternatively, some states require PE providers to enroll applicants in a managed care program as part of the PE process (e.g., as required for pregnant women in New York).[10]

Currently, individuals in New Mexico are not enrolled in managed care during the PE period. This is to guard against PE workers steering individuals to a particular managed care plan in a follow-on eligibility period. PE workers are trained to avoid this steering and PE providers should have brochures available for all managed care organizations.[11] This training will become even more important in 2014 when New Mexico requires enrollment in managed care during the PE period. States could discourage selective enrollment by: (1) establishing performance measures for the proportion of enrollees assigned to health plans at a given hospital-based PE site, thus allowing the state to identify potential outliers; or (2) requiring attestation that the applicant was fully informed of the range of available health plan options.

***Federal Match Rate During and After PE Period:*** The increased Federal Medical Assistance Percentage (FMAP) for "newly eligible" adults will be available once the state has determined that the individual is actually (not presumptively) qualified for Medicaid. This retroactive adjustment may extend back to the first day of the month in which the regular application was filed, or up to three months prior to the month of application.

In order to make payment adjustments for individuals enrolled in Medicaid through PE, states may need to calibrate their eligibility and accounting systems with their Medicaid Management Information System to determine appropriate FMAP calculations. Though states with current PE programs may already have systems to handle payment adjustments, altering those accounting systems to include hospital PE may require significant effort. States that do not have PE will need to adjust accounting systems to claim the correct FMAP.

## Conclusion

With the recent guidance from CMS, states are now in the early phases of planning for hospital PE implementation. While current practices from states with existing PE programs offer a starting point (see the Appendix for a list of current and planned state PE policies), the development of hospital PE training, standards, and other requirements for all Medicaid-eligible populations will be slightly different than current PE programs for pregnant women and children. Given the tight timelines for establishing hospital PE requirements, states may choose to initially develop modest training and performance standards to launch hospital PE promptly. These policies can be modified after a state gains experience with the program. States will also want to carefully examine eligibility system programming and ensure that existing and proposed information systems will allow for enhanced FMAP once final eligibility determinations are made.

States and hospitals can now begin to prepare to launch hospital PE programs. With appropriate safeguards and standards in place, this new "door" to enrollment will benefit prospective beneficiaries, hospital providers, and state Medicaid agencies alike—offering a streamlined and expedited path to coverage for a broad population.

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[7] Centers for Medicare & Medicaid Services. *Hospital Presumptive Affinity Group Webinar*, September 4, 2013.

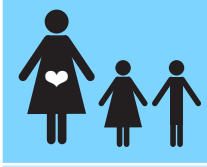
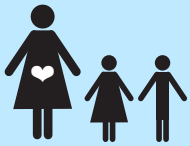
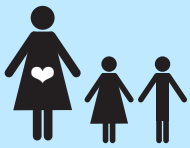
[8] Centers for Medicare & Medicaid Services. *Hospital Presumptive Eligibility Group Webinar*, September 26, 2013.

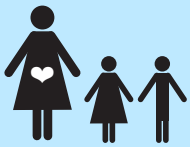
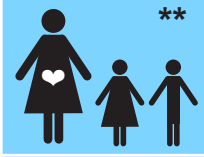
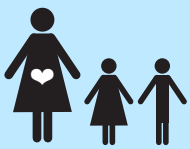
[9] Ibid.

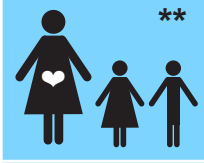
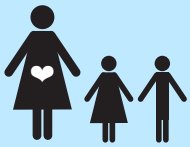
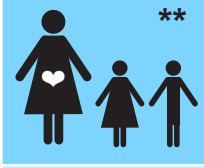
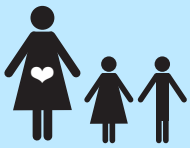
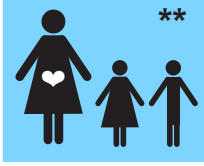
[10] New York State Medicaid Update, June 2011, Volume 27, Number 8.
Available at: http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-06.htm#fee.

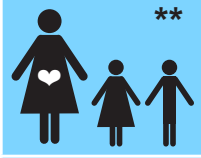
[11] Centers for Medicare & Medicaid Services. *Hospital Presumptive Eligibility Group Webinar*, September 26, 2013.

# Appendix A – Current Medicaid Presumptive Eligibility Practices in Select States

| State or Framework | Setting and Workers | Performance Standards | Training and Certification | Eligibility System Tracking and FMAP Determination<br><br>Plan Enrollment (if applicable) |
|---|---|---|---|---|
| **California**  | Providers must be enrolled as Medi-Cal providers in good standing and provide prenatal or perinatal services to become a qualified PE provider. | The provider must record each patient's enrollment on the Weekly Presumptive Eligibility (PE) Enrollment Summary (MC 283) and within five days of patient enrollment, mail, email, or fax the summary to Department of Health Care Services. | To become a qualified PE provider for pregnant women, providers must submit an application to the Department of Health Care Services, attend a PE training (webinar posted on Medi-Cal Learning Portal webpage), and sign a form agreeing to cooperate with qualified provider responsibilities. | The PE for Pregnant Women program currently does not allow for electronic claims submission. Providers must complete the manual paper claim forms for reimbursement for all services rendered. |
| **Connecticut**  | Outpatient hospitals are included in the list of qualified PE providers. | A qualified provider shall agree to:<br>1. Accurately determine PE;<br>2. Process applications in a timely manner;<br>3. Not participate in unfair, unequal, or discriminatory treatment of applicants or recipients.<br><br>The Department may revoke, suspend, or deny a qualified provider's authorization to make PE determinations at any time for any reason deemed sufficient (including failing to meet above requirements). | Connecticut conducts on-site training for new PE sites or new staff and hosts regional trainings when the state introduces major program changes. Over the past year, Medicaid Regional Processing Unit supervisors have been overseeing the training for new PE providers.<br><br>Qualified providers must also execute a Statement of Agreement. | No managed care. |
| **Idaho**  | Hospitals are qualified providers for PE for pregnant women in Idaho. | | Approved providers must be trained and certified by Medicaid. Providers must sign Provider Agreement form. | |
| **Illinois**  | MPE providers must be enrolled in the Illinois Medicaid program and deliver outpatient hospital services, clinic services, or rural health care as defined by Title XIX of the Social Security Act. | The state does not currently have performance standards. | The Illinois Department of Health and Family Services certifies PE providers and provides instructions and training. All providers must attend a department training and have an agreement with the Department to become certified. | Illinois uses a client enrollment broker, so the hospitals will not be able to control assignments for managed care, though they can make suggestions. |
| **Indiana**  | The state requires that qualified providers must:<br>1. Be able to verify pregnancy via a professionally administered pregnancy test;<br>2. Have Internet, telephone, printer, and fax access that is available to facilitate the PE and Medicaid application process; and<br>3. Have access to EDS Web interChange. | The state's Qualified Provider PE manual does not list any performance standards. | Providers must be trained by the Family and Social Services Administration (FSSA) or designee (such as fiscal agent) and complete a qualified provider enrollment application. | Providers must give the applicant a managed care entity (MCE) side-by-side comparison and have her contact the enrollment broker, MAXIMUS, to select her MCE and primary medical provider (PMP). The selection of an MCE and PMP activates the PE eligibility. Providers are encouraged to enroll with an MCE as a PMP to continue providing services for the pregnant woman. |

| State or Framework | Setting and Workers | Performance Standards | Training and Certification | Eligibility System Tracking and FMAP Determination<br><br>Plan Enrollment (if applicable) |
|---|---|---|---|---|
| **Kansas**  | PE may be performed in hospitals.<br><br>No restrictions on workers, however all staff currently performing PE are financial counselors, outreach workers, or reception staff. | Current performance standards:<br>• 95% of PE determinations completed accurately<br>• 98% of PE determinations and complete applications submitted to the eligibility clearinghouse within 2 days of the PE determination<br>• 60% of PE applicants ultimately achieve eligibility through the clearinghouse process<br><br>Qualified entities may be disqualified for failure to meet standards if performance does not improve after 90-day plan for improvement and/or retraining. | Currently provide in-person training with new sites.<br><br>For the future, contemplating 9 to 10 hours of training utilizing a combination of web-based system training and an interactive webinar on PE policies. | There are no rules built into the eligibility system to determine PE—an eligibility segment is created when the system receives the PE determination data from a qualified entity. Federal match for all PE is at the Medicaid rate, with no retroactive adjustment to take advantage of the higher CHIP match.<br><br>Preliminary enrollment in a managed care plan conducted during PE determination; members have the option to change plans after receiving further information. Steerage is avoided through a report to monitor plan assignments and proactive communication with qualified entities that steerage is not permitted. |
| **Kentucky**  | Hospitals are not currently qualified entities.<br><br>Providers must apply to participate, and must go through state-mandated training. | No performance standards are in place for existing PE; performance standards are under development for HPE providers. Providers are encouraged to have applicants complete full Medicaid application. | State mandated training provided by Medicaid agency. All PE providers must be trained by the state and receive a certificate. | Providers enter client information and once accepted, a PE card is generated.<br><br>Presumptive period is provided through managed care. Patients have no restrictions on plan selection; enrollees are auto-assigned using an extensive MCO assignment algorithm if they do not make affirmative plan selection. |
| **Michigan**  | PE may be performed in hospitals.<br><br>Qualified workers include state employees, public health department employees, and eligibility counselors at health clinics designated by the State. | | Providers must be trained and approved by the Department of Community Health. | Hospitals and other entities can help individuals submit a full application via a “Virtual Gateway” that also allows providers to verify eligibility. |
| **Missouri** **  | PE may be performed in hospitals; PE for children is limited to children’s hospitals. | | | The children active under PE for Children are not enrolled in managed care. Once deemed eligible for PE, they can obtain covered services from any enrolled MO HealthNet fee-for-service provider. |
| **Montana**  | PE may be performed in hospitals.<br><br>There are no restrictions on the types of employees who can qualify as PE providers. | None currently in place. | | No managed care. |

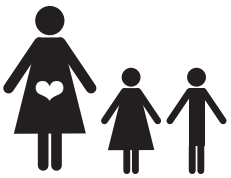
| State or Framework | Setting and Workers | Performance Standards | Training and Certification | Eligibility System Tracking and FMAP Determination<br><br>Plan Enrollment (if applicable) |
|---|---|---|---|---|
| **New Hampshire**<br>  | Hospitals are listed as qualified PE entities, but the state is unsure if any hospitals actually conduct PE determinations.<br><br>There are no restrictions on the types of employees who can qualify as PE providers. | No metrics or standards in place; the state monitors the agencies conducting PE and learns what kind of issues they're having. Then they meet with the agency head, review the issues, and determine whether the agency should come back for a refresher training. | The family planning training (which is simpler than the children's Medicaid training) consists of a half day of policy and procedures training in a classroom. State employees from the Training Unit conduct the training. The training consists of a lecture via PPT; they also get a training manual with policies and procedures. There is no test at the end. | No managed care. |
| **New Jersey**<br>  | Acute care hospitals conduct PE in NJ.<br><br>PE providers must be employed at only one facility and trained in the PE process in order to become certified. Third party agencies are allowed to do PE processing but must be overseen by the PE coordinator (for hospital presumptive eligibility (HPE), third parties may not complete the determination). However, the state is not authorized to provide third parties any client information; the PE coordinator must request all client information. | The Division of Medical Assistance and Health Services shall monitor the PE determinations made by approved PE determination entities. If the review discloses a pattern of incorrect PE determinations or failure to adhere to requirements, the Division shall initiate corrective action, including, but not limited to, consultation and training. Continued incorrect PE determinations or failure to adhere to procedural requirements shall result in the Division revoking approval for that entity to make PE determinations. | New Jersey does not currently have set performance standards for PE providers, though it is planning to enforce the two performance standards noted by CMS (the "completion rate" and "error rate" measures) for hospital PE providers. Currently, New Jersey tracks all incoming online applications for mistakes. If it notices a particular provider is making repeated mistakes, it will contact the PE coordinator at the provider's site and suggest appropriate action to address this issue, such as additional training from the state. | No managed care for PE. |
| **New Mexico**<br>  | Qualified providers are called PE/Medicaid On-Site Application Assistance Determiners; they can be school or community organization employees or employees at doctors' offices, hospitals, or clinics. | The state may disqualify a PE provider if less than 90% of PE submissions result in a full Medicaid application or if more than 10% of PE submissions contain errors. | New Mexico conducts in-person and web-based training, with the intention to move to all web-based training in the future. Trainees must pass a test to receive a certificate, which along with a signed agreement are prerequisites for doing PE activities. | Enrollees will need to select a managed care plan beginning January 1, 2014. |
| **New York**<br>  | | | The PE provider must complete online training through an e-learning portal. The state encourages providers to retake the training course periodically. | New York requires PE providers to enroll applicants in a managed care program as part of the PE process. |
| **Ohio**<br>  | PE enrollment is accomplished through a web portal, so in theory can be performed in any physical location. Hospitals, FQHCs, and FQHC lookalikes are considered qualified entities.<br><br>There are no specific restrictions on workers providing PE services; qualified entities are responsible for assigning access to the system. | PE enrollment privileges are terminated if more than 15% of PE cases have no follow-on application for full coverage, or if more than 15% of completed applications are found to be ineligible for coverage. | For HPE, there will be mandatory training and a requirement for a signed acknowledgement of administrative responsibilities. | No managed care for PE. |

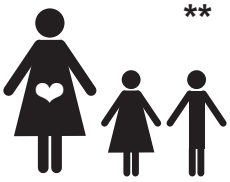
| State or Framework | Setting and Workers | Performance Standards | Training and Certification | Eligibility System Tracking and FMAP Determination<br><br>Plan Enrollment (if applicable) |
|---|---|---|---|---|
| **Pennsylvania**  | Hospitals, along with other qualified entities, can perform PE determinations. | No formal performance metrics. | None currently. Instructions are provided to PE Qualified Providers, but there is no formal training currently provided. | Applications are submitted through an online eligibility application/COMPASS.<br><br>PA had a pilot program whereby it allowed one county to enroll their pregnant PE women into managed care. For most of the state, women cannot enroll in MC during the PE period. At the point that the woman is determined eligible by the state, she is sent information about MCOs operating in the county in which she resides. The woman has the ability to select the plan of her choice, but if she does not make a selection within 30 to 45 days, she is auto-assigned to one of the plans operating in her county. |
| **Wisconsin**  | Outpatient hospitals permitted to make PE determinations. | | Providers are required to be Medicaid-certified or have submitted an application for Medicaid certification. | When Wisconsin Medicaid receives the application, a woman who meets the requirements for the PE for Pregnant Women Benefit is established on the Medicaid Eligibility Verification System (EVS). |
| **Wyoming**  | Hospitals are not currently qualified entities.<br><br>There are no restrictions on workers. | Do not have performance standards for the current program. In process of developing for inclusion in Administrative Rules. | Online training provided. | State is still determining eligibility process for HPE program.<br><br>No managed care. |

## Legend: Current Populations Served


Pregnant Women


Children


Pregnant Women and Children


Pregnant Women and Children; Children served by Medicaid only