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Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs

January 2014

Overview

Q1: What is hospital presumptive eligibility and how is it different from presumptive eligibility (PE) for pregnant women and children?

A1: For years, states have had the option to use presumptive eligibility (PE) to connect pregnant women and children to Medicaid. Hospitals were often key to implementing PE for those populations. Starting in January 2014, the Affordable Care Act gives qualified hospitals a unique new opportunity to connect other populations to Medicaid coverage. Under this new PE authority, hospitals will be able to immediately enroll patients who are likely eligible under a state's Medicaid eligibility guidelines for a temporary period of time. An individual provides information about his or her income and household size, and (at state option) information regarding citizenship, immigration status, and residency, and if they appear to be eligible for Medicaid based on this information, a hospital shall determine that individual to be "presumptively eligible" for Medicaid. The individual is temporarily enrolled, and health care providers (not just hospitals) will receive payment for services provided during this interim period pending a final adjudication of Medicaid eligibility by the state Medicaid agency. Like other forms of PE, hospital PE aims to:

- Assure timely access to care while a final eligibility determination is made; and
- Promote enrollment (beyond the interim PE period) in ongoing Medicaid coverage by offering additional channels through which individuals can apply.

The choice to make PE determinations rests with each individual hospital (not with the state) and is not dependent on whether the hospital (or the state) operates PE for other populations.

Q2: Does my state have to implement hospital PE?

A2: Yes, under the law, all states must implement hospital PE to include all qualifying hospitals willing to abide by state policies and procedures. States have discretion in how they operate hospital PE to ensure that appropriate PE determinations are being made. In order to be considered a qualified entity, under the regulation at 42 CFR 435.1110(b)(1), the hospital must agree to make presumptive eligibility determinations consistent with state policies and procedures, and the state can and should exercise oversight to ensure proper administration of hospital PE. To fulfill this responsibility, states must provide qualified entities with information

on relevant state policies and procedures and information on how to fulfill their responsibilities in making presumptive eligibility determinations.

Q3: Given that hospital PE was effective January 1, 2014, what is the deadline for states to submit their Medicaid state plan amendment to implement this provision?

A3: The latest date by which the SPA must be filed in order to meet the required effective date of January 1, 2014 is March 31, 2014 (the end of the quarter in which the policy will take effect). However, the hospital PE provision took effect on January 1 and every state is expected to implement this provision in compliance with the law.

CMS has provided a series of guidance and tools designed to assist states in implementing hospital presumptive eligibility, including proposed and final regulations, several all-state SOTA calls and webinars, and a model set of training materials for states to use in educating hospitals about PE. In addition, CMS convened an "affinity group" of a dozen states designed to share questions and best practices in detail as states were designing their hospital PE policies. These discussions were informed by several internal and external subject matter experts in the field of PE who offered suggestions about developing training materials, simplifying applications, and considering standards for states to use in measuring hospital performance and ensuring accountability. CMS is available to provide ongoing technical assistance and to review preliminary SPA proposals to help ensure that states are implementing hospital PE properly. States that wish to discuss mitigation approaches for implementing hospital PE should reach out through the SOTA process.

Q4: How do states implement hospital PE?

A4: States have flexibility in establishing agreements with hospitals, structuring training programs and conducting oversight consistent with overall federal guidance and the goal of ensuring that hospital PE is available as a way for individuals to access coverage. Under the regulations, states must explain their PE policies and procedures to their qualified entities. To provide transparency into the states' approach to ensuring that qualified entities have information on state eligibility policies and procedures, states must describe their process as part of their state plan amendment (SPA) submission and include with their SPA copies of training materials, documents or other materials provided to qualified entities demonstrating that the state is fulfilling its responsibilities. To assist states, CMS has provided a model structure for training materials and examples from other states where hospital PE has been approved. CMS will review materials in draft form in order to facilitate the SPA review and approval process. Materials relating to hospital PE are available on Medicaid.gov at http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Learning-Collaborative-State-Toolbox/State-Toolbox-Expanding-Coverage.html

Q5: What is the timeline that applies to a hospital PE period? Is it different than other PE periods?

A5: The timeline is the same for all types of PE, including hospital PE. The hospital PE period begins on the day that the qualified hospital approves PE. The end date, if a Medicaid application

is filed by the last day of the month after the month that PE is determined, is the date full Medicaid eligibility is approved or denied. If a Medicaid application is not filed by the last day of the month after the month that hospital PE is determined, the PE period ends on that day. The statute (§§1920(b)(1), 1920A(b)(2), and §1920B(b)(1)), codified at §435.1101 (definitions), discusses the beginning and end dates for coverage based on presumptive eligibility.

Application Processing

Q6: Does a Medicaid application have to be to approved and processed in order for a PE eligibility determination to be made?

A6: The purpose of hospital PE and PE more broadly is to provide a streamlined option for people who appear to be eligible to get access to immediate coverage. The statute makes it clear that a full eligibility determination is not immediately needed and cannot be required in order for hospital PE to be approved.

While states may not require an individual to fill out a full Medicaid application in order to receive a hospital PE determination or before a PE period begins, individuals should be informed that filing a full Medicaid application is necessary for coverage to continue, and states may require that qualified entities assist individuals determined presumptively eligible in completing a full Medicaid application during the PE period.

A state may use the full application for enrollment into hospital PE as long as the application clearly notes which questions need not be answered for PE purposes. An applicant can decide whether to answer those questions at the same time they are enrolling in PE, or to finish the application at a later time. Alternatively, a state could use a separate, short-form hospital PE application and then direct the qualified entity to help the applicant complete the full application by the end of the hospital PE period.

Q7: Can states require citizenship and residency attestations on hospital PE applications?

A7: Yes, this is a state option. Consistent with 42 CFR §435.1102(d)(i), the individual or another person completing the application on the individual's behalf (who has reasonable knowledge of the individual's status) may be asked to attest that the individual is a citizen or in satisfactory immigration status, and is a resident of the state. It is important to note that while questions regarding attestation for citizenship, immigration status, and state residency are allowed, hospital PE determinations cannot be held up pending verification of such status. Verification of citizenship and immigration status is, however, required before a final eligibility determination can be made.

Q8: Which components of the single, streamlined application are relevant for hospital PE and can or should be required for hospital PE determinations?

A8: As noted above, states have many different options for developing and administering the presumptive eligibility application. States are not required to use a written application for hospital PE; they can permit qualified entities to ask the applicant for the information needed to

make a PE determination and be accountable for accurately recording the information provided. States can also choose to use a written application for hospital PE. If a state requires the use of the single, streamlined application for hospital PE, it must denote which fields must be filled out in order for PE to be determined, meaning that the PE determination will be denied or delayed if this information is not provided by the applicant. The state cannot require the full Medicaid application be filled out in order to receive a PE determination. Questions that are not related to making a PE determination cannot be required (e.g. race and ethnicity).

If the state intends to use a separate application designed specifically for hospital PE, the questions must be limited to those needed by the qualified hospital to make a PE determination. CMS is available to provide technical assistance on the application questions that are necessary and that cannot be required for hospital PE purposes.

Q9: Do application policies and procedures have to be consistent between hospital PE and PE for children, pregnant women, and the Breast and Cervical Cancer Program?

A9: No, policies and procedures may differ between each type of PE, or the state can choose to align its policies. All policies must be consistent with applicable federal law.

Q10: Can and should states require their hospitals to assist individuals in filling out the full Medicaid application?

A10: States have the option to require hospitals to assist individuals in submitting the full application, which can help connect more people to longer-term coverage. While we encourage states to do so, to promote ongoing coverage, as noted above, a full application cannot be required as a condition of receiving a hospital PE determination, as the purpose of PE is to promote quick access to care on an interim basis while the full application process is underway. States can strike a reasonable balance by using the full application for hospital PE determinations, but clearly delineating which questions are necessary for PE purposes. States and hospitals can also use inserts or additional language to differentiate between the hospital PE application and the full application.

Q11: What if my state is implementing a real-time eligibility system?

A11: Real-time eligibility determinations make the role of PE different than it has been in the past. In situations in which the individual files a full application right away, the PE period would likely be considerably shorter—and eliminated altogether, as a practical matter, if a real-time determination is made. However, even with the most modernized systems, there invariably will be individuals for whom a real-time eligibility determination will not be possible. There also will be individuals who will not be comfortable with the online application, or ready with the information needed to complete a full online application and will instead opt to apply later or use a paper application. In such situations and for such individuals, PE remains a useful tool to facilitate prompt coverage and enrollment in the program. States have flexibility to in effect minimize the length of the PE periods by requiring that hospitals and other qualified entities assist individuals in submitting the single streamlined application online, as long as the individual is not required to submit the full application online as a condition of qualifying for PE.

Q12: Can states use a simplified method for income counting as an option for all groups eligible for PE, including hospital PE, or is this option limited to children and pregnant women? Are hospitals expected to be trained to calculate MAGI rules?

A12: Yes. A simplified method of determining income (e.g., using use of gross income rather than or other simplified approximation of MAGI) per 42 CFR 435.1102(a) is permitted for all types of PE. Our regulations at 42 CFR 435.1102(a) discuss the use of simplified income methods and clearly state that full MAGI-based eligibility determinations cannot be used to determine PE. This requirement applies to all forms of PE, including hospital PE, per 42 CFR 435.1103(a) and 435.1110(a).

Q13: Can states allow providers to use "non-filer" tax rules to determine household composition for hospital PE?

A13: Yes. A reasonable and simplified way of determining household composition for purposes of determining presumptive eligibility, including under hospital PE, would be to apply the rules for individuals who do not file taxes (i.e. the non-filer rules) as described at 42 CFR 435.603(f).

Eligible Populations

Q14: For which populations must hospitals be able to determine PE?

A14: At a minimum, states must implement hospital PE to ensure that hospitals are able to make PE determinations for all of the populations included in §435.1102 and §435.1103 (that is, all MAGI-eligible groups: pregnant women, infants, and children, parents and caretaker relatives, the adult group, if covered by the state, individuals above 133 percent of the Federal Poverty Level under age 65, if covered by the state, individuals eligible for family planning services, if covered by the state, former foster care children, and certain individuals needing treatment for breast or cervical cancer, if covered by the state). States may allow hospitals to determine PE for other groups, such as the aged, blind, and disabled, and those whose eligibility is established by section 1115 waiver authority. States permitting hospital PE for other groups are responsible for providing information on relevant state policies and procedures and information on how hospitals should fulfill their responsibilities in making presumptive eligibility determinations for such individuals

Q15: Does hospital PE apply to the Children's Health Insurance Program (CHIP)?

A15: The hospital PE provision in the Affordable Care Act is just for Medicaid state plan and 1115 groups and does not apply to separate CHIP state plan or CHIP 1115 groups. However, hospitals can determine PE for CHIP if a state designates a hospital as a qualified entity under CHIP authorities. A state that covers children and pregnant women in a separate CHIP may elect to have certain qualified entities determine PE for them, and the state determines what types of entities may be qualified entities, which may include hospitals.

Q16: Can a hospital make hospital PE determinations for non-patients?

A16: Yes, hospital PE is not limited to patients of the hospital. Hospitals can assist with PE determinations for family members and may also enroll eligible individuals from the broader community.

Q17: Do states have to limit PE periods for pregnant women to one period per pregnancy? Or, can they limit them to one PE period per calendar year?

A17: Per our regulations at 42 CFR 435.1103(a), pregnant women may have one PE period per pregnancy. If a woman is pregnant more than once in a calendar year, they may have more than one PE period in a calendar year due to the multiple pregnancies.

Q18: Can states limit the scope of benefits for particular groups of individuals in the PE period?

A18: In general, for individuals determined eligible under hospital PE, the benefits provided are the same as those provided under the eligibility group for which PE is determined. See 42 CFR 435.1103(a) and (c)(1)(ii), which specifies that covered benefits for pregnant women during a PE period are limited to ambulatory prenatal care, and benefits covered under family planning PE are limited to family planning services.

Qualified Entities

Q19: Can states limit the number or type of hospitals eligible to conduct PE determinations for the Breast and Cervical Cancer Program to hospitals that are affiliated with the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (BCCEDP))?

A19: If a state has elected to provide PE for individuals with breast or cervical cancer under §435.1103(c)(2), it can limit qualified entities under that section to providers who conduct screenings for breast and cervical cancer under the state's CDC BCCEDP, and if it has done so, the state may limit hospitals that may determine PE for individuals with breast or cervical cancer on that basis to hospitals that conduct screenings under the state's BCCEDP. In states that do not opt to provide PE for individuals with breast or cervical cancer under §435.1103(c), states similarly may limit hospitals' ability to determine PE for individuals with breast or cervical cancer under §435.1110 to those that conduct screenings under the state's BCCEDP.

Q20: Can hospitals rely on third party contractors to provide support in administering presumptive eligibility (PE)?

A20: When hospitals determine PE, they are subject to the same general rules set out for other qualified entities that may determine PE, including that they cannot "delegate the authority to determine presumptive eligibility to another entity." (See 42 CFR 435.1102(b)(2)(vi). However, they may implement PE with the support of third party contractors. For example, hospitals can rely on third party contractors to help staff their in-hospital PE operations, by staffing welcome

desks, meeting with consumers, and helping them fill out PE applications as long as the hospital takes responsibility for the PE determinations that result. In addition, the regulations at 42 CFR 435.1102(b)(2)(vi) do not limit the ability of third party contractors to assist individuals in completing and submitting the full application.

Hospitals that conduct off-site, targeted outreach may also employ third party contractors to reach out to individuals who may be Medicaid eligible and assist them with a presumptive application and the single streamlined application at the individual's request. Hospitals must oversee such off-site outreach to ensure hospital accountability for the PE determinations, including hospital review and approval of the PE recommendations made by non-hospital employees. States should not unduly limit a hospital's ability to rely on third-party contractors as long as the hospital is not delegating its authority to determine presumptive eligibility to a third party and is meeting appropriate state-established performance standards.

Q21: How can states keep track of all active PE providers?

A21: Keeping track of all eligible providers is important to ensure ongoing training and that the providers have regular updates in policy as well as to review performance, implement performance standards and develop quality assurance measures. Some states maintain a centralized list of all providers who have completed the process for learning the state's policies and procedures; the state may wish, for example, to periodically review the list by calling all identified providers or settings and asking whether or not listed individuals are currently conducting PE determinations. It is important for states to ensure, over time, that hospital PE is functioning throughout the state.

Q22: How can states engage hospitals on the issue of hospital PE – either to encourage participation or simply to gauge interest?

A22: States have used a number of strategies to engage hospitals, such as reaching out to the state hospital association or local hospital groups, sending hospitals a letter of interest to get feedback on their plans to participate in the program, and inviting hospital representatives to teleconferences and webinars about the policy. CMS has also reached out to various hospital associations to advise them of this new provision and the federal guidance supporting it.

<u>Qualification Standards</u>

Q23: Can states require hospital employees to take and pass knowledge tests in order to make PE determinations?

A23: Yes, in order to ensure that hospitals comply with the agreement to make presumptive eligibility determinations consistent with state policies and procedures, states have the flexibility to require hospitals to have the staff that will do PE determinations take and pass knowledge tests in order to make PE determinations. Since the PE enrollment process does not require detailed knowledge of Medicaid eligibility policy, the test should be appropriately geared to the information needed to make an appropriate decision and comply with state procedures.

Q24: Is there a requirement that states use the two performance metrics CMS described in the final rule?

A24: The use of the two performance metrics CMS described in the final rule at section 435.1110 (the proportion of individuals determined PE who submit a full application and the proportion of those who submit an application who are deemed to be Medicaid eligible) is optional for states. States may choose to use other or additional metrics in their hospital PE programs. All states should collect data on hospital performance to fulfill their oversight responsibilities.

Q25: What types of performance standards are states considering beyond the two options CMS presents in the final rule?

A25: States are considering a number of different types of performance standards, including the proportion of hospital PE determinations made in an outpatient setting (given that a strong incentive exists for determinations in inpatient settings but it is desirable to also implement PE for outpatients to ensure reaching as broad a population as possible) and the number of hospital PE applications completed in one month. Other states are collecting baseline data in order to measure hospital performance and plan to establish specific standards at a later point.

Federal Matching Funds

Q26: What federal matching rate applies for individuals found presumptively eligible by hospitals? Is the newly eligible federal medical assistance percentage (FMAP) available for populations found presumptively eligible for the new adult group?

A26: While individuals may be determined "presumptively eligible" for coverage under the new adult group by a qualified hospital or qualified entity, the newly eligible FMAP is only available once the full eligibility determination has been completed. In these circumstances, the newly eligible FMAP is only authorized with respect to individuals determined eligible for the new adult group by the state agency or other public entity authorized to make final Medicaid eligibility determinations. The regular FMAP applies until such time as the state (or other authorized entity) determines an individual to be eligible for the new adult group and the state confirms that they also meet the definition of a "newly eligible individual."

As noted in our August 2013 FAQs, in appropriate circumstances, a state may retroactively adjust claiming for services provided during a presumptive eligibility period. Specifically, newly eligible status is available based on the effective date of eligibility for the new adult group, which may be as early as the third month prior to the month that the individual applied for Medicaid in accordance with 42 CFR §435.914 (resdesignated at §435.915 under the March 2012 final eligibility rule), provided that the individual would have been eligible for Medicaid had he or she applied as of the earlier date. To the extent to which the presumptive eligibility period is encompassed within such retroactive eligibility period and the state determines that the individual meets the criteria for newly eligible status, the state may retroactively adjust claiming for services provided during a presumptive eligibility period. The state is not required to make

such a retroactive adjustment if the state determines that an adjustment would be administratively burdensome.

Q27: Are federal matching funds available for services provided during a PE period when the individual is subsequently found to not be eligible after the completion of a full Medicaid application?

A27: Yes, services covered under the state plan rendered during the PE period will qualify for federal match regardless of the ultimate Medicaid eligibility decision. The standards that states can set for hospitals and the findings from reviews of hospital performance relative to those standards are intended to ensure that hospitals are making appropriate PE determinations and following state hospital PE procedures. When problems are identified, states should take corrective action to ensure future compliance with state policies and procedures.

Q28: Can a state make a qualified hospital liable when a PE determination results in a denial of Medicaid eligibility?

A28: There is no recoupment for Medicaid services provided during a PE period resulting from erroneous determinations made by qualified entities. Payment for services covered under the state plan (as well as federal financial participation) is guaranteed during a PE period; without such a guarantee, providers could not rely on the PE determination. As noted, states have various ways to ensure that hospitals are making appropriate PE determinations and must fulfill their oversight responsibilities.

Q29: Must the hospital complete the PE application and determination process before services can be covered by Medicaid?

A29: Yes, an individual has to be found presumptively eligible (the PE application is submitted and a determination made) for services to be covered during the hospital PE period.