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Health Policy Brief

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Hospital Presumptive Eligibility. The ACA expands the policy that allows key entities to temporarily enroll people in Medicaid, creating a path to more stable coverage.

WHAT'S THE ISSUE?

Presumptive eligibility is a Medicaid policy option that permits states to authorize specific types of "qualified entities," such as federally qualified health centers, hospitals, and schools, to screen eligibility based on gross income and temporarily enroll eligible children, pregnant women, or both in Medicaid or the Children's Health Insurance Program (CHIP). Presumptive eligibility serves a dual purpose of providing immediate access to needed health care services while putting people on a path to ongoing coverage.

The Affordable Care Act (ACA) extends presumptive eligibility beyond children and pregnant women and expands the role of hospitals in determining eligibility presumptively. States that have adopted the policy for children or pregnant women now have flexibility to extend it to parents and adults. Moreover, the law gives hospitals the prerogative to make presumptive eligibility determinations for low-income people, regardless of whether the state has an established program. Given the current status of ACA implementation, presumptive eligibility may be an important tool to expedite access to coverage as states fine-tune their business processes and tweak new eligibility and enrollment systems.

WHAT'S THE BACKGROUND?

States have long had the option to allow qualified entities to enroll eligible children or pregnant women presumptively. As of January 1, 2013, two-thirds of the states (33) used presumptive eligibility for pregnant women, children, or both (see Exhibit 1). The policy is widely viewed as an effective way to move the enrollment process into the community where trusted organizations can identify and enroll eligible people. Once temporarily enrolled, families are often more encouraged to follow through with the regular application process. While there is strong anecdotal evidence that presumptive eligibility coupled with follow-up assistance does result in ongoing coverage, there is limited published data showing the impact of presumptive eligibility on enrollment. One 2004 study on simplifying children's coverage by Karl Kronebusch and Brian Elbel estimated that presumptive eligibility would increase the probability of enrollment by 6.4 percent.

Simply put, the qualified entity is trained to screen a person's household income and follow steps set up by the state to temporarily enroll people who meet the income standard in Medicaid or CHIP. Current state implementation of the policy ranges dramatically from a largely manual process relying on paper applications mailed or faxed to the state to more

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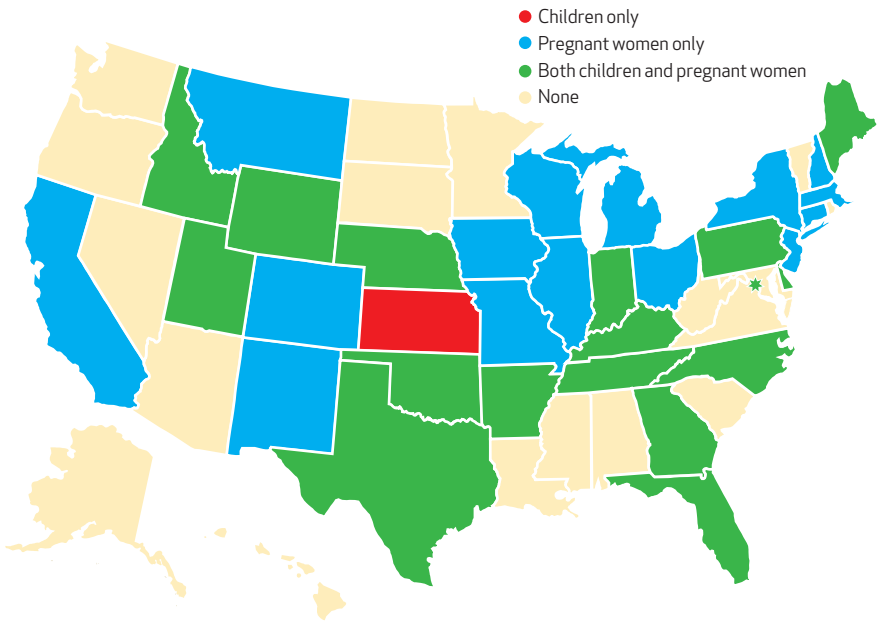
sophisticated web-based training and enrollment systems. States may be inclusive, allowing any qualified entity to participate, or may choose to be more strategic in targeting and recruiting specific types of qualified entities (see Exhibit 2).

There are certain federal requirements that states and qualified entities must meet. The state must provide Medicaid application forms to qualified entities and inform them how to assist applicants in completing the forms. The state must also establish procedures to ensure that the qualified entity is fulfilling its responsibilities. In turn, qualified entities must provide written notification of the eligibility determination or denial, furnish the individual with the regular application, inform the individual when temporary coverage will end if the regular application is not filed, and notify the state within five days of the presumptive eligibility determination.

Presumptive eligibility denials cannot be appealed, but people who are denied may file a regular Medicaid application and need to be informed of this option. During the presumptive eligibility period, children are eligible for the full spectrum of Medicaid services including early and periodic screening, diagnostic, and treatment (EPSDT) services. On the other hand, pregnant women are eligible only for ambulatory prenatal care. Presumptive eligibility ends the day the individual is enrolled in full Medicaid or on the last day of the month following the month in which the presumptive determination was made, whichever comes first. The state may set reasonable limits on the number of presumptive eligibility periods within a given period of time that an individual may be enrolled presumptively (for example, once per calendar year) with the exception of pregnant women, who are limited to one presumptive eligibility period per pregnancy.

EXHIBIT 1

States That Have Adopted Presumptive Eligibility for Children and Pregnant Women (as of January 1, 2013)



SOURCE Based on the findings of a national survey conducted by the Georgetown Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, 2013. **NOTES** Includes states that have adopted presumptive eligibility in Medicaid, the Children's Health Insurance Program (CHIP), or both. LA, MD, OH, and SC have presumptive eligibility–like processes for pregnant women. CT, MO, and NH have presumptive eligibility for children in Medicaid only.

WHAT'S NEW?

The ACA updates current regulations and expands presumptive eligibility to adults. Regulations released in July 2013 update current presumptive eligibility rules and provide a consistent basis for operationalizing the policy across the different eligibility groups that may be served. New or revised presumptive eligibility provisions include the following:

- States are required to establish an oversight mechanism to ensure that presumptive eligibility determinations are being made in accordance with federal and state requirements.

- If a state has adopted presumptive eligibility for children or pregnant women, it may also allow authorized entities to enroll parents and adults covered by the state Medicaid program. Additionally, states may use presumptive eligibility to temporarily enroll former foster youth and people seeking family planning services. These people will be eligible for all benefits under the group for which they are determined presumptively eligible, with the exception of pregnant women, whose services are limited to prenatal care as noted above.

Qualified entities may not delegate their presumptive eligibility authority to another entity. For example, a hospital may not assign its authority to a third-party recovery firm that is contracted to assist with medical assistance applications. States have the flexibility to require that individuals attest to their state residency and citizenship or satisfactory immigration status; however, they may not require verification or documentation as a condition of presumptive eligibility.

Hospitals that are Medicaid providers have the option to make presumptive eligibility determinations, regardless of whether the state has otherwise adopted the policy. A hospital may participate if it is a Medicaid provider (either under the state plan or a section 1115 Medicaid waiver program) and notifies the state of its election. It must also agree to adhere to state policies and procedures. In establishing a hospital presumptive eligibility program, the state:

- Must set up procedures for the hospital to follow in enrolling a person presumptively. The regulations do not require a formal training program, but the state must provide qualified hospitals with information on relevant state policies and procedures and instruct them how to fulfill their responsibilities in making presumptive eligibility determinations.

- May establish standards, such as requiring hospitals to assist people with completing regular applications or achieving a high proportion of people who are determined eligible for ongoing Medicaid coverage. For states expanding Medicaid, this is particularly important because the 100 percent federal match for health care services provided to newly eligible people is available only if a full Medicaid determination is made.

- Must take remedial action, such as providing additional training, before disqualifying a hospital that fails to meet state standards.

- May limit hospital presumptive eligibility determinations to children, pregnant women, parents and caretaker relatives, and other adults whose eligibility is based on income, including those eligible for family planning services and women eligible for the Breast and Cervical Cancer Early Detection Program (BCCEDP). However, states may also permit hospitals to enroll people presumptively in other eligibility groups for which income is not the only factor of eligibility (for example, those who are eligible based on disability).

33 states

As of January 1, 2013, two-thirds of the states used presumptive eligibility for pregnant women, children, or both.

WHAT'S THE DEBATE?

As states prepare to support hospital presumptive eligibility, there are several questions that have surfaced and are being discussed among states or debated in the media. Some of the key questions that have emerged include the following:

Can hospitals enroll adults with income up to 138 percent of the poverty level, regardless of whether a state has opted to expand Medicaid? The short answer is no. A state's current eligibility levels are used as the basis for enrolling people presumptively. In states that have not expanded Medicaid, the existing eligibility levels in the state will apply to all presumptive eligibility determinations. So in a state that does not expand Medicaid and does not cover adults without dependent children, such adults could not be enrolled presumptively.

Why can't qualified entities delegate their presumptive eligibility authority to another entity? This change to the presumptive eligibility regulations, which applies to all qualified entities and not just hospitals, has been met with mixed reaction. On one hand, there are concerns about program integrity if delegated entities that have no direct relationship with the Medicaid agency have authority to enroll someone presumptively. On the other hand, qualified entities, and particularly hospitals, have established relationships with third-party vendors that they rely on to assist uninsured patients. It remains to be seen if the Centers for Medicare and Medicaid Services (CMS) will revisit this provision.

EXHIBIT 2

What Organizations—Aside from Hospitals—Can Serve as Presumptive Eligibility–Qualified Entities?

States have flexibility in selecting presumptive eligibility agencies from among these types of organizations, known as qualified entities:
Medicaid and Children's Health Insurance Program (CHIP) health care providers
Head Start programs
Subsidized child care agencies
WIC (Special Supplemental Nutrition Program for Women, Infants, and Children)
Medicaid and CHIP eligibility agencies
Elementary and secondary schools, including those operated by the Bureau of Indian Affairs
State and tribal child support agencies
Organizations that provide emergency food and shelter
State and tribal offices and entities involved in Medicaid and CHIP enrollment activities
Organizations that determine eligibility for public housing assistance
Any other entity the state deems capable of making a presumptive eligibility decision (subject to federal approval)

SOURCE Code of Federal Regulations; Title 42 Public Health; Part 435—Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa; Subpart L—Options for Coverage of Special Groups under Presumptive Eligibility, 2013.

"States have a number of decisions to make, and even states with current presumptive eligibility programs have changes to incorporate."

Will a state be responsible for 100 percent of the cost of services for someone enrolled presumptively but determined ineligible when they apply for ongoing coverage? All covered services provided during the presumptive eligibility period receive federal matching funds, even if the person is later determined ineligible. The regulations also clarify that a state may not hold a qualified hospital or entity liable when a person is enrolled presumptively but later denied Medicaid eligibility. It's important to note that people may have a change in circumstances (for example, securing a new job) after they are enrolled presumptively but before a final Medicaid application is reviewed. However, state monitoring and oversight will help ensure that presumptive eligibility is effectively deployed.

How can states protect against bad actors that could misuse presumptive eligibility? States are required to have oversight and may set performance standards as noted above. Several states already set such standards. For example, New Mexico may disqualify a presumptive eligibility provider if fewer than 90 percent of its presumptive eligibility determinations result in the submission of a full Medicaid application or if more than 10 percent of submitted applications contain errors. In Ohio, qualified entities may lose their privileges if more than 15 percent of presumptive eligibility cases have no full application submitted or more than 15 percent of completed applications are found to be ineligible. However, because presumptive eligibility can be an important tool for connecting people to coverage, states may want to start with monitoring and data collection to establish a baseline before setting unrealistically high standards, as discussed below.

How does presumptive eligibility add value when high-performing eligibility and enrollment systems can determine eligibility in real time? Some states question the necessity of hospital presumptive eligibility when people can apply for coverage and be immediately determined eligible for ongoing coverage. This is a valid question, but as yet state systems are not fully tested, and there will always be people with changes in circumstances or whose eligibility cannot be immediately determined through electronic verification.

WHAT'S NEXT?

States must file a Medicaid State Plan Amendment (SPA) for hospital presumptive eligibility. CMS has created a number of SPA templates for states to use in order to be in compliance with changes brought about by the ACA. The hospital presumptive eligibility SPA (S21) details how the state plans to implement the provision, such as identifying the eligibility groups that will be enrolled presumptively, listing the eligibility factors (such as citizenship attestation) to be used as the basis for the presumptive decision, and describing standards the state is establishing for hospitals. Additionally, states must provide CMS with copies of the training or materials used to educate hospitals on relevant state policies and procedures and information on how to appropriately make presumptive determinations.

States have tight time frames for operationalizing hospital presumptive eligibility. A snapshot of state implementation of ACA-related Medicaid provisions released in September 2013 by the National Association of Medicaid Directors noted that states were still in the design phase of developing hospital presumptive eligibility programs. States with current programs can build on their existing practices, which will also help guide states without programs. Nonetheless, states have a number of decisions to make, and even states with current presumptive eligibility programs have changes to incorporate. Some decisions are fairly straightforward administrative choices, such as what training will be provided, what application will be used, whether the state will use a gross income standard or simplified method of estimating household income, what eligibility factors will be considered, and how the hospital will transmit the information to the state. But others, such as incorporating presumptive eligibility in managed care contracts and assuring immediate access to the full spectrum of health care services, may be more challenging.

States are weighing the use of standards. States have limited experience in setting specific benchmarks for presumptive eligibility with some simply tracking presumptive applications and intervening when errors or omissions are discovered, while a few set specific performance metrics. Clearly, presumptive eligibility is not meeting its goals if ineligible people are enrolled (albeit temporarily) or if eligible people are enrolled only temporarily and the potential to connect them to ongoing coverage is not realized. Thus, two obvious standards emerge that CMS has articulated in its guidance but is leaving to state discretion: (1) the proportion of people for whom full applications are submitted, and

(2) the proportion of complete applications for which ongoing Medicaid eligibility is verified.

The bigger question is, Where should states set the bar? Setting standards too high may discourage participation, while setting them too low could detract from the potential of presumptive eligibility to connect people with ongoing coverage. States may want to start with more modest standards or by collecting performance metrics data to establish a baseline before setting more aggressive expectations. Additionally, states may want to consider what tools they have to help qualified entities meet a standard for completion of the regular application process. For example, a state could create a web-based presumptive enrollment process that also populates the regular application to facilitate ongoing enrollment. Having such tools would support setting higher standards.

States may want to consider partnering with navigator groups or health care associations in developing training. One of the bigger concerns facing states is having the staff resources to develop and deliver training. Some states already use partners such as the state primary care association to oversee training programs. Additionally, in states with state-based exchanges, navigator and assister training may already include reliable information on Medicaid that could be easily adapted for presumptive eligibility. Current presumptive entities or navigators could also be tapped in a "train the trainer" model.

Technology-based enrollment solutions are needed to maximize the effectiveness of presumptive eligibility programs. Even in states with existing programs, the presumptive eligibility process may not be automated, or, if it is, linkages to new eligibility and enrollment systems may need to be established. Technology solutions can overcome many of the challenges in optimizing presumptive eligibility and establishing effective oversight mechanisms. For example, if qualified entities are able to print a temporary Medicaid card that can be immediately verified by providers, access problems will be minimized. However, it is likely that technology-based presumptive enrollment solutions will have to wait in line for limited technology resources as the debut and refinement of new eligibility and enrollment systems take priority.

Despite the dwindling timeline and ACA implementation challenges, presumptive eligibility offers a streamlined and expedited path to coverage for people. Various studies have shown that uninsured people prefer getting enrollment assistance in health care settings, where they have a trusted, community connection and at a time they are more likely to be thinking about health insurance. In states where Medicaid system development and testing remains under way and the system is not quite ready to make real-time eligibility determinations, hospital presumptive eligibility can be an important tool to help states manage the initial volume of applications and achieve high levels of consumer satisfaction. ■

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