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IssueBrief

Presumptive Eligibility:
A Step Toward Streamlined Enrollment in Medicaid and CHIP

The Patient Protection and Affordable Care Act (also known as the Affordable Care Act) envisions a simple and streamlined enrollment process for Medicaid, the Children's Health Insurance Program (CHIP), Basic Health, and the premium credits that will help consumers purchase coverage through the exchanges. The Affordable Care Act allows—and in many cases requires—that states take steps to dramatically ease the enrollment process for consumers. Automated eligibility and enrollment systems will be an important part of that process, but there are other tools states can use. One that has not received much attention in the context of health reform implementation is presumptive eligibility. Presumptive eligibility is not a new idea; states have used it to some extent in the Medicaid program since the mid-1980s and in CHIP since its enactment in the late1990s. However, the Affordable Care Act significantly expands states' ability to use presumptive eligibility to streamline the enrollment process for Medicaid and CHIP. This issue brief provides an overview of presumptive eligibility, explores the changes in the new law that pertain to presumptive eligibility, and outlines how presumptive eligibility fits into the new enrollment paradigm.

Background on Presumptive Eligibility

In 1986, presumptive eligibility in Medicaid was established as a state option to improve access to timely care for uninsured pregnant women.[1] States that take up the option can provide immediate temporary Medicaid coverage to pregnant women who appear to be income eligible for the program. Rather than delaying care until a full eligibility determination is made or forgoing care all together, these previously uninsured women can get needed prenatal care. Research has shown that access to early prenatal care can lead to better birth outcomes, so using presumptive eligibility to give pregnant woman more immediate access to care is good for both the mother and the child.[2] It's a bridge to coverage, which, in turn, is a bridge to getting timely health services.[3]

With the creation of CHIP in 1997, presumptive eligibility for children was enacted as a state option.[4] Similar to presumptive eligibility for pregnant women, children who appear to be income eligible for Medicaid or CHIP are able to receive temporary coverage while a full determination is processed. This makes it easier for children to see a doctor and maintain continuity of care until a full eligibility determination is processed.

In addition, hospitals, doctors, and pharmacies are paid for the services they provide during this temporary coverage period.[5] Currently, 16 states have adopted presumptive eligibility for children, and 30 states and the District of Columbia have the option in place for pregnant women.[6]

How Presumptive Eligibility Works

Under current law, if a state decides to take up presumptive eligibility, the state can decide which populations (children, pregnant women, or both) can be determined presumptively eligible for coverage in Medicaid and/or CHIP. In addition, drawing from a list provided by the Center for Medicare and Medicaid Services (CMS), the state needs to authorize "qualified entities" to conduct presumptive eligibility determinations. The list of approved qualified entities includes, but is not limited to, hospitals, physicians, local health departments, primary and secondary schools, and community and rural health centers.[7] States have a great deal of flexibility in determining which types of qualified entities they will authorize to conduct presumptive eligibility and how many individual qualified entities they will certify.

Here is an example of how presumptive eligibility would work in a state that has it in place for pregnant women: An uninsured pregnant woman shows up to receive care, related to her pregnancy or not, at a hospital, doctor's office, or other qualified entity that the state has authorized to conduct presumptive eligibility. The staff can ask her a few simple questions about her income and family circumstances, and if her responses suggest that she is likely eligible for Medicaid, she can be deemed "presumptively eligible" for coverage for a temporary period of time.

In some states, the presumptive eligibility application is enough to start a "regular" application for full, on-going coverage, while in other states a separate form is required.[8] If a separate application is needed to start the regular application process, the individual or family will receive additional assistance to complete and file the full application. The individual or family then has until the end of the month following the month that they were presumed eligible to submit any additional information needed to process a full eligibility determination. During this temporary eligibility period, states receive federal Medicaid matching funds for the cost of covering individuals who are presumed eligible.[9] In addition, providers who treat these individuals during this period get reimbursed just as they would for a patient who is already fully enrolled in coverage.

Presumptive Eligibility Is a "Best Practice"

Presumptive eligibility has been recognized as an effective tool in connecting uninsured children and pregnant women to coverage. In fact, the Children's Health Insurance Program Reauthorization Act (CHIPRA) recognizes presumptive eligibility as one of eight enrollment and retention "best practices" that a state can implement in order to qualify for federally funded performance bonus payments (a state must implement at least five of the eight "best practices" in order to receive a performance bonus).[10] During the first two cycles that performance bonuses were awarded, eight states received credit for presumptive eligibility as one of their "five of eight" policies (four states in 2009 and four additional states in 2010).[11]

To read more about CHIPRA's performance bonuses, see *Covering More Children, Rewarding Success: State Performance Bonuses*, available online at http://www.familiesusa.org/assets/pdfs/chipra/state-performance-bonuses.pdf.

Presumptive Eligibility Working on the Ground: Experiences from Two States

Iowa

Iowa started implementing presumptive eligibility for children in Medicaid and CHIP in March 2010. This effort began by training 16 state-employed outreach workers to conduct presumptive eligibility determinations. Since then, the Iowa Department of Education and the Iowa Department of Public Health have trained more qualified entities, such as school nurses, in an effort to expand presumptive eligibility. As of May 2011, Iowa has approximately 159 qualified entities that have successfully enrolled approximately 1,000 children using presumptive eligibility.[12]

Presumptive eligibility is the fastest way for those who are eligible for coverage to get care. In Iowa, a family whose kids are without care can go to a Women, Infants, and Children (WIC) office, and an outreach worker will help them apply for coverage. Presumptive eligibility determinations are done electronically through Iowa's Medicaid Portal Application (IMPA). The outreach worker can enter the applicant's information into the online system, and within seconds of submitting the application, the worker will receive a determination stating whether the applicant is presumed eligible for coverage. If the child is presumed eligible, the family can go directly to a doctor's office or pharmacy and get the care or medicine that the child needs as though they had received a full eligibility determination.[13]

Connecticut

Connecticut implemented presumptive eligibility for children in Medicaid in 2005, and has since expanded it to include additional populations. In 2009, the state implemented presumptive eligibility for pregnant women, and in April 2011, it extended presumptive eligibility to children in CHIP. Through presumptive eligibility, the state successfully enrolls approximately 195 children in Medicaid and 40 children in CHIP per month.[14]

Connecticut has also made great strides in simplifying the enrollment process by using the same application for presumptive eligibility, Medicaid, and CHIP. Furthermore, since Connecticut verifies citizenship and identity through electronic data matching with the Social Security Administration and also verifies income electronically through other databases, there are many cases where the applicant or family does not need to provide additional information or paper documentation to receive a full determination. In these cases, qualified entities can grant an individual presumptive eligibility, and from there, Connecticut's Department of Social Services can process that presumptive eligibility application for full Medicaid or CHIP eligibility.[15]

The Role of Presumptive Eligibility in 2014 and Beyond

The Affordable Care Act gives states options to expand the use of presumptive eligibility in two new ways:

1. States that use presumptive eligibility for children or pregnant women can now use presumptive eligibility for parents and other adults who appear to be eligible for Medicaid.[16]
2. Beginning January 1, 2014, states can allow Medicaid-participating hospitals to conduct presumptive eligibility determinations for any Medicaid-eligible populations regardless of whether the state is using presumptive eligibility in any other setting or for any other populations in the state.[17]

The Affordable Care Act ushers in a new way of thinking about Medicaid and CHIP: as one important piece of an overall system of coverage, with "everybody in." Beginning in 2014, the Affordable Care Act envisions that individuals who lack affordable health insurance will apply for *coverage*, rather than applying separately for Medicaid, CHIP, Basic Health, or premium credits. To achieve this, the law issues requirements to streamline the application process, eliminate unnecessary paperwork and documentation requirements when information can be supplied and verified electronically, and connect people to the most generous form of assistance that they are eligible for. But what role, if any, will presumptive eligibility play in 2014 and in following years?

At the fullest stage of implementation, it is possible that presumptive eligibility may not be necessary. Ideally, online applications will be sufficiently linked to state and federal databases so that individuals or families will no longer need to document their income, citizenship, and other information; the eligibility system would do that for them. If an individual can apply for coverage by supplying basic information—potentially no more than is currently required for presumptive eligibility—and obtain an instant eligibility determination, there may no longer be a need for a temporary eligibility period. However, the following are situations in which having presumptive eligibility in place may be helpful:

- **When more recent eligibility-related information is needed:** Even the best data systems will not be effective for 100 percent of applicants. The system may not be able to reflect recent changes in income if, for example, an individual loses his or her job or adds a family member to his or her household. If an applicant's income appears higher in the system than it actually is at the time the individual applies, he or she may not be determined eligible in real time for the full amount of assistance that he or she is qualified for. States can only require individuals to document their income if this information is unavailable electronically or if the income information obtained electronically is incompatible with the income

information the applicant provides.[18] In these cases, presumptive eligibility may provide a useful backstop to ensure that applicants get needed health services through Medicaid and CHIP and that providers be reimbursed for their services while a full determination is being processed.

- **While data-driven eligibility systems are refined:** In an ideal world, data-driven eligibility systems will allow applicants to receive full eligibility determinations for Medicaid and CHIP in real time. However, it may take time to refine how these systems function, and their success will likely vary widely from state to state and for different populations. Presumptive eligibility ensures that people who are likely eligible will not be denied coverage or be forced to delay care even if the system is not functioning properly or cannot find the data to support an individual's eligibility determination.
- **When uninsured individuals seek care in a hospital:** Hospitals already play a critical role in connecting people to existing sources of coverage, and this role will only grow as eligibility for Medicaid and premium credits is expanded in 2014. While hospitals can receive retroactive reimbursement for services they provide to patients who are ultimately determined eligible for Medicaid, presumptive eligibility may still be helpful in connecting people to immediate, temporary coverage if they are unable to complete the application process while they are at the hospital. For example, if an individual seeks care at the hospital and is discharged with a prescription for antibiotics or needs to start physical therapy to recover from the condition he or she was treated for in the hospital, presumptive eligibility can mean immediate access to these services while he or she is completing the enrollment process or awaiting determination.
- **When outreach is tough during lean times:** With economic recovery coming very slowly, most states are facing vast revenue shortfalls and are forced to make serious decisions that affect Medicaid coverage for low-income people. Unfortunately, outreach is often one of the first things on the budget chopping block. Even as state economies bounce back over the next few years, restoring outreach funding may be a tough sell. This is another area where presumptive eligibility can be useful. In a sense, it is another form of outreach; health care providers and other organizations that already have existing, trusting relationships with community members can operate as qualified entities and connect people to coverage.
- **During emergency situations and disasters:** In case of a natural disaster or an epidemic, it is important to have a system in place to connect people to coverage immediately. Historically, the federal government has intervened in emergency situations to allow more people to get Medicaid coverage through nontraditional pathways. One example is during the immediate aftermath of Hurricane Katrina,

which struck Louisiana in the fall of 2005. The catastrophic effects of the hurricane left many survivors in need of immediate medical attention, and the federal government took numerous actions to ensure that Medicaid and CHIP could respond to the victims and their acute health care needs.[19] In the future, if states already have presumptive eligibility in place, eligible people can enroll to get the immediate treatment they need. This may prove especially important when system failures caused by natural disasters make data-matching impossible.

In short, presumptive eligibility will help assure that low-income people who are uninsured and appear to be income eligible for coverage get immediate access to needed health services in 2014 and beyond. The Affordable Care Act's requirement that people obtain health coverage is likely to increase awareness of Medicaid and CHIP, which will, in turn, increase interest in enrollment. In addition, millions of people who will be newly eligible for Medicaid as a result of the expansion and people who were eligible but not enrolled prior to the enactment of the Affordable Care Act may seek coverage too. It is hard to predict the exact number of people who will enroll in coverage, but having a system like presumptive eligibility already in place will make the implementation process go more smoothly, both for eligible individuals and for states.

Next Steps for States and Advocates

Policy makers and advocates will play a key role in ensuring that the provisions in the Affordable Care Act are implemented effectively in their states. Here are some important next steps that states can take now to ensure that presumptive eligibility is a part of the enrollment picture in 2014.

- **Consider how presumptive eligibility will fit into your state's enrollment system in 2014.** What will the application process for Medicaid, CHIP, and exchange coverage entail in your state? If the application(s) for Medicaid and CHIP do not require more information than is captured on the presumptive eligibility form, there may be no need for separate applications. In this case, a presumptive eligibility determination and full determination could be processed from the same application; presumptive eligibility would provide access to health services while a full, more complicated determination is being processed. This could be especially important in cases where third-party data are unavailable or not "reasonably compatible" with what an individual reports and the state requests that the individual provide paper documentation.[20]

- **Make the presumptive eligibility-enrollment connection.** While presumptive eligibility is a good option for states to get children and families who appear to be eligible for Medicaid and CHIP in the door, it is equally important to focus on making sure that they *actually get enrolled* beyond their temporary eligibility period. Is the presumptive eligibility application different from a full application for Medicaid, CHIP, and exchange? If so, what steps are being taken to ensure people complete a full application within the allotted time? What role can call centers, outreach workers, or navigators play in following up with the presumptively eligible population to ensure they ultimately enrolled in coverage?
- **Adopt presumptive eligibility for children and pregnant women early.** States that have not adopted presumptive eligibility for children or pregnant women should consider adopting this policy early. By doing this, states will have the option to extend presumptive eligibility to parents and other adults who are eligible for Medicaid. This will also lay the groundwork for 2014, when states can use presumptive eligibility to temporarily enroll to adults with incomes up to 133 percent of poverty.
- **Conduct presumptive eligibility determinations for everyone in the family.** Qualified entities should check to see if other immediate family members may qualify for temporary, immediate coverage when they conduct a presumptive eligibility determination for one family member.
- **Consider authorizing additional qualified entities.** As Medicaid is expanded, new groups of people who have not historically been eligible will qualify (for example, homeless adults without dependent children or young adults who are newly on their own and do not have job-based coverage). States may want to consider adding qualified entities in places where these individuals may already be seeking other services, like emergency food and shelter programs, free clinics, or faith-based outreach programs.

Conclusion

The Affordable Care Act provides many tools and principles to encourage streamlined, simplified enrollment into health coverage. Expanded presumptive eligibility is just one small part of this new approach to enrollment. Although it is not a magic bullet when it comes to connecting all of the newly eligible to coverage, it is one important strategy that should not be overlooked during the implementation of the Affordable Care Act.

Endnotes

[1] Section 1920 of the Social Security Act, 42 U.S.C. 1396r-1.

[2] Cathy Taylor, Greg Alexander, and Joseph Hepworth, "Clustering of U.S. Women Receiving No Prenatal Care; Difference in Pregnancy Outcomes and Implications for Targeting Interventions," *Maternal and Child Health Journal* 9, no. 2 (June 2005): 125-133.

[3] Amy Finkelstein, et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, July 7, 2011, available online at http://econ-www.mit.edu/files/6796.

[4] Section 1920A of the Social Security Act, 42 U.S.C. 1396r-1a.

[5] Presumptive eligibility guarantees that providers receive payment for the services they provide even if an individual does not complete the full application.

[6] Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samatha Artiga, and Jessica Stephens, *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2011), available online at http://www.kff.org/medicaid/upload/8130.pdf.

[7] Section 1920A of the Social Security Act, 42 U.S.C. 1396r-1a.

[8] Telephone conversation between Christine Sebastian, Families USA, and Melissa Ellis, Iowa Department of Public Health, on May 3, 2011; Telephone conversation between Christine Sebastian, Families USA, and Heidi Smith, New Jersey FamilyCare, on April 27, 2011.

[9] Likewise, if a state has taken up presumptive eligibility in CHIP, the state will receive its CHIP matching rate for children covered during this temporary eligibility period.

[10] As an extra incentive for states to simplify their application and renewal procedures and to encourage states to focus on getting the lowest-income children covered, the Children's Health Insurance Reauthorization Act (CHIPRA) of 2009 requires states to implement at least five of the following eight specific policies in order to qualify for a performance bonus: continuous eligibility, elimination of asset tests or administrative verification of assets, elimination of in-person interview requirements, use of a joint Medicaid-CHIP application, presumptive eligibility, express lane eligibility, and premium assistance.

[11] The eight states that qualified for a performance bonus and received credit for presumptive eligibility are CO, IL, IA, KS, MI, NJ, NM, and OH. CMS State Health Official Letter, *Performance Bonus Payment Attachment* (Washington: Centers for Medicare and Medicaid Services, December 16, 2009), available online at http://www.cms.gov/SMDL/downloads/SHO09015ATT.pdf; 2010 CHIPRA Annual Report, *Connecting Kids to Coverage: Continuing the Progress* (Washington: Department of Health and Human Services, February 4, 2012), available online at http://www.insurekidsnow.gov/professionals/reports/chipra/2010_annual.pdf.

[12] Telephone conversation between Christine Sebastian, Families USA, and Melissa Ellis, Iowa Department of Public Health, on May 3, 2011.

[13] Ibid.; Insurekidsnow.org video, *Iowa Connects Kids to Coverage*, available online at http://www.insurekidsnow.gov/professionals/campaigns/connectingkids/organizations.html.

[14] Telephone conversation between Christine Sebastian, Families USA, Kristin Dowty, Connecticut Department of Social Services, and Amanda Saunders Brock, Connecticut Department of Social Services, on August 25, 2011.

[15] Ibid.

[16] Technically, states will be able to use presumptive eligibility for the adults with income up to 133 of poverty level, including new and existing eligibles; *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 2, Subtitle C, Section 2202.

[17] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 2, Subtitle A, Section 2201(a)(4)(B).

[18] Centers for Medicare and Medicaid Services, *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010, Proposed Rule* (Baltimore: Department of Health and Human Services, August 2011).

[19] *Health Coverage for Individuals Affected by Hurricane Katrina: A Comparison of Different Approaches to Extend Medicaid Coverage* (Washington: Kaiser Commission on Medicaid and the Uninsured, October 10, 2005), available online at www.kff.org/medicaid/upload/7417.pdf.

[20] Centers for Medicare and Medicaid Services, op. cit.

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