CardinalCare
Virginia's Medicaid Program

Presumptive Eligibility for Pregnant Women

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Current Landscape:
Medicaid and Hospital Presumptive Eligibility

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Pregnancy Coverage Group: Medicaid Application Process

- As of November 1st, 38,778 individuals were enrolled in a pregnancy coverage group through the Virginia's Medicaid or CHIP (FAMIS) programs.
- Virginia's current income limit for pregnancy coverage is 205% of the federal poverty level (FPL) ($63,960 a year for a household of 4).
- Individuals may apply online, by phone through the state-wide call center, Cover Virginia, or in person. Application assisters are available throughout the state to assist individuals with the application process.
- Cover Virginia operates a specialty unit for pregnant women which provides a direct, dedicated line through the call center at (855) 242-8282 (option 2).

Pregnancy Coverage Group: Application Process

- Once a complete Medicaid application and any required information has been submitted:
  - 12VAC30-141-790 requires processing of a pregnancy application within ten business days.
  - Virginia Medicaid eligibility policy requires processing of a pregnancy application within seven calendar days.
  - DMAS requires the Cover Virginia vendor, Maximus, to process pregnancy applications within five calendar days.

- Managed care enrollment occurs four to six weeks after the applicant is approved for full-benefit Medicaid.

Hospital Presumptive Eligibility

- The Affordable Care Act requires states to implement hospital presumptive eligibility (HPE) for certain Medicaid eligibility groups including pregnant women, children under 19, low-income parents/caretakers and Expansion adults, effective 1/1/2014.
  - States have the option to expand HPE to additional eligibility groups, including CHIP (FAMIS) populations.

- Currently, 49 hospitals participate in the HPE program. An average of 43 HPE applications are received each month (less than one per hospital) of those:
  - 88% are approved for HPE coverage
  - 94% of HPE applicants file a full application for Medicaid

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Overview: Presumptive Eligibility

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Presumptive Eligibility: Overview

The Omnibus Budget Reconciliation Act of 1986 allows states the option to permit certain qualified providers to provide ambulatory prenatal care to pregnant women on the basis of preliminary eligibility information, even if they have not formally been determined eligible; otherwise known as presumptive eligibility (PE).

Presumptive Eligibility: Qualified Entities

- A qualified entity is an entity that is determined by the Medicaid state agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements. 42 CFR 435.1101 provides a full list of allowable entity types, including:
  - Medicaid enrolled provider/entity
  - Head Start enrollment entity
  - WIC entity
  - Elementary or secondary school
  - Public or assisted housing entity
- Qualified entities may not delegate or contract the presumptive eligibility determinations to a third party (ex: a billing contractor).
- Once the state has determined which entities to certify as qualified entities, it must update the Medicaid State Plan and develop training and oversight protocols.

Presumptive Eligibility: Qualified Entity Responsibilities

All entities deemed qualified by the state are responsible for:

- Completing state training prior to making any determinations and on a regular basis as required by the state.
- Submitting the presumptive eligibility enrollment forms to DMAS within five days of determination.
- Collecting and record keeping of information used to make the determination.
- Submitting to periodic auditing of determinations to ensure program integrity.
- Providing the individual with a full Medicaid application as well as information about how to complete the application.

Presumptive Eligibility: Application and Determination Process

- To be determined presumptively eligible, an individual must meet the categorical requirements of an eligibility group. For pregnancy coverage, this includes:
  - Being pregnant or within the 12-month post-partum period as defined in 42 CFR 435.4.
  - Having household income that does not exceed the state's income eligibility level.

- The qualified entity may accept an individual's attestation that they meet eligibility requirements, such as income, household size, and citizenship and residency, to make a PE determination.

- A PE period begins on the date in which the qualified entity makes the determination and can last until the end of the following month.
  - Example: PE determined is on 10/5, the PE period will be 10/5 – 11/30/2024.
  - Coverage is provided through fee-for-service during this period.

Presumptive Eligibility: Application and Determination Process

- An application for Medicaid must be filed prior to the end of the PE period and a full determination must be completed for coverage to continue.

- If an application for Medicaid is submitted and approved, the full-benefit pregnancy coverage will begin the first of the month that the application was submitted.
  - Eligible individuals may also be eligible for up to 3 months of retroactive coverage.

- If the individual is determined ineligible for Medicaid, PE ends the day the adverse determination is made.
  - If a pregnant woman is presumptively eligible and subsequently determined ineligible for Medicaid, the pregnant woman is entitled to a fair hearing, or appeal, on the Medicaid application but is not entitled to extended PE.

Presumptive Eligibility: Coverage Limitations

- Per federal restrictions, PE coverage for pregnant women includes only ambulatory prenatal care.
  - Coverage includes prescription drugs and doctor visits related to the pregnancy.
  - Ambulatory prenatal care is not equivalent to coverage provided under pregnancy Medicaid.
  - Labor and delivery are not covered.

- Individuals enrolled through PE are not enrolled in a managed care plan but remain in fee-for-service (FFS). Managed care provides pregnant members additional services and supports:
  - Care management
  - Plan specific enhanced benefits
  - Assistance finding a provider

- Only one period of PE per pregnancy may be approved (and one every 12 months for other populations).

Summary: Full-benefit Pregnancy Medicaid & FAMIS v. Presumptive Eligibility

Full-benefit Coverage

- Continuous coverage through 12 months postpartum
- Comprehensive coverage
- Application processing timelines and verification procedures apply
- Managed care delivery system
- Medicaid and FAMIS populations (up to 205% FPL)
- Newborns are automatically enrolled, aka ‘deemed newborn’

Presumptive Eligibility Coverage

- Time limited to the month of enrollment and the following month.
- Limited coverage
- Near immediate determination, no additional verification processes
- Fee-for-Service delivery system
- Medicaid only (up to 148% FPL)
- Application must be submitted for newborn and mother if enrolled in HPE at the time of delivery.

Operational Considerations Outside of Policy Implications

- System changes: A portal or platform will be required for qualified entities to access and input presumptive eligibility application information and determination.

- Training and certification: A state training unit or vendor will be required to provide initial ongoing training and maintain an up-to-date of certified qualified entities.

- Auditing/Oversight: Additional state funds/staffing will be needed to perform auditing functions of qualified entity determinations.

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Appendix

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Additional Eligibility Policy Options

- Expand current HPE to FAMIS pregnant women and children.
  - HPE currently only applies to Medicaid populations.
  - Medicaid for Pregnant Women income limit is 143% FPL.
  - FAMIS income limit is 205% FPL.
- Enhance monitoring of pregnancy-related application processing time.
- Enhance community-based application and enrollment assistance support.
- Increase income limit for pregnancy-related coverage
- Create a specialized pregnant woman unit at Cover VA to handle all aspects of pregnancy application, case maintenance, and provide support/resources throughout pregnancy and post-partum period.

Income Limits Outside of Virginia

- The income limit in Virginia for the pregnancy coverage group is 205% FPL.
- 23 states and DC have higher income limits than VA, ranging from 210 - 380% FPL
- Income limits of Virginia's bordering states:
  - DC: 324% FPL
  - MD: 264% FPL
  - TN: 255% FPL
  - WV: 305% FPL
  - NC: 201% FPL