PRESUMPTIVE ELIGIBILITY
PROVIDER GUIDANCE

H-100 OVERVIEW

Presumptive Eligibility (PE) allows qualified providers and hospitals to determine certain individuals "presumptively eligible" for Medicaid based on preliminary information obtained from the applicant. Individuals determined eligible for PE receive Medicaid benefits for a temporary period of time, provided all eligibility criteria is met.

The purpose of PE is to provide a streamlined process for individuals to obtain access to immediate coverage and to promote ongoing Medicaid enrollment by encouraging individuals to complete a full application for health insurance with DWSS.

Questions regarding all PE or Medicaid policy listed in this Medicaid Assistance Manual (MAM) should be directed to the DWSS Chief of Eligibility and Payments or the DWSS Medicaid Program Specialist.

H-101 QUALIFIED PROVIDERS / QUALIFIED HOSPITALS

A qualified provider or hospital participates as a provider under the State Medicaid Program and must agree that they will make PE determinations consistent with state policies and procedures outlined in both the Division of Health Care Financing and Policy (DHCFP) Medicaid Services Manual (MSM) and the Division of Welfare and Supportive Services (DWSS) Medicaid Assistance Manual (MAM).

Each provider or hospital electing to participate in the PE program must have a signed Presumptive Eligibility Medicaid provider contract amendment in place with DHCFP. Hospital staff making the PE determination must be trained and certified by the DWSS Learning and Development unit to obtain system access to the DWSS PE Portal.

Qualified Provider or Qualified Hospital Requirements

DHCFP and DWSS will determine the appropriate Medicaid provider types for each PE program. Selected providers must be publicly available and must allow any individual or family to request a PE application and determination be made for them regardless of whether the individual or family is a current patient of the provider or hospital.

There are differences in the PE program that a qualified Provider or a qualified Hospital may approve:

- qualified providers may approve Prenatal Pregnancy PE only.
- qualified hospitals may approve full Health Care Services (Hospital PE)

H-102 PRENATAL PREGNANCY PE

Prenatal Pregnancy PE can only be approved by a certified employee of a qualified provider. Pregnant individuals approved under this program are eligible to receive prenatal pregnancy care at outpatient clinics or other places in the community. PE for prenatal care provides limited services and will not cover the cost if you are admitted to a hospital. Questions on what specific services are or aren't covered under this program should be directed to the DHCFP Provider Services unit.

H-103 HOSPITAL PE

Hospital PE can only be approved by a certified employee of a qualified hospital. Individuals and families approved under this program are eligible to receive immediate Medicaid services such as doctor visits, hospital care, and prescription drugs. They can go to any health care provider who accepts Medicaid starting the day you are approved. Questions on what specific services are or aren't covered under this program should be directed to the DHCFP Provider Services unit.

H-105 ELIGIBLE GROUPS

Eligibility for medical assistance is categorized in groups based on the associated budget methodology used to determine eligibility.

An application for PE must contain the applicant's name, address, and signature. See MAM D-100 for more information on acceptable applications and signatures.

Individuals applying for PE may designate anyone to act on their behalf by providing a signed written statement. If circumstances exist that render the individual incapacitated and unable to make that designation, a responsible adult family member or facility staff completing the application may designate themselves. See MAM A-120 for more information and restrictions on designating an Authorized Representative.

Individuals are eligible for 1 presumptive eligibility period in a 24- month period. Pregnant individuals are eligible for 1 presumptive eligibility period for each separate pregnancy.

a. Children

- Under the age of 19; and
- Children with household income that is at or below the FPL for the child's age and applicable assistance unit.

  1. Children 0 through 5 up to 165% (CH aid code)
  2. Children 6 through 18 up to 122% (CH aid code)
  3. Children 6 through 18 above CH up to 138% (CH1 aid code)

- Children on CH1 aid code can have dental and vision insurance but cannot have other major medical insurance.

Note: This group only covers children approved for CH and/or CH1 categories. Pregnant children are evaluated under the Pregnant Women group for CHP or CHO. Qualified providers or hospitals do not make determinations for Nevada Check Up.

b. Parents and caretaker relatives

- A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

  1. the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;
  2. the spouse of such parent or relative, including same-sex marriage, even after the marriage is terminated by death or divorce; or
  3. another relative of the child based on blood (including those of half-blood), adoption, or marriage;
  4. the domestic partner of the parent or other caretaker relative; (domestic partnerships must be registered in Nevada.)

- Parents and caretakers with household income that is at or below 138% FPL for the applicable assistance unit. (AM aid code).

- Parents and caretakers with income between the AM income limit and 138% of FPL (AM1 aid code);

  - Are not eligible if they are entitled to or enrolled in Medicare.

Note: See MAM Appendix A, MAGI Income chart

c. Pregnant women

- Pregnant women with household income that is at or below 165% FPL for the applicable family size. (CHP aid code)
- Pregnant women approved for prenatal PE service only. (CHO aid code).

Note: Each unborn is counted as an additional member when determining assistance unit size for the pregnant woman's assistance unit.

d. Childless adults age 19-64

- age 19 and under age 65; and
- not pregnant; and
- not entitled to or enrolled in Medicare benefits under Part A or B; and
- not otherwise eligible for medical coverage in any other group; and
- member of a household that has income that is at or below 138% FPL for the applicable family size. (CA aid code)

e. Aged Out of Foster Care

- under 26 years of age; and
- were in foster care in Nevada, under the responsibility of the state at the time they turned 18 years of age; and
- were enrolled in Medicaid while in foster care;
- were in foster care under the responsibility of any state and turned 18 years of age on or after January 1, 2023.

OR

- under 21 years of age; and
- were in foster care under the responsibility of a state at the time they turned 18 years of age.

Note: Aged out of foster care is aid code AO regardless of which category. Individuals who qualify as AO should be referred to the Division of Child & Family Services (DCFS) website for more information at http://dcfs.nv.gov/Programs/CWS/IL/ where they can obtain a copy of the full Medicaid application for AO individuals.

MAGI Exception: Individuals who receive Supplemental Security Income (SSI) from social security may qualify for PE under any eligibility group identified above. SSI individuals must meet all other factors of eligibility to qualify. SSI income is not countable under the PE program.

H-110 FACTORS OF ELIGIBILITY

To be eligible for PE, potential recipients must meet certain citizenship, residency, and income criteria.

Citizenship – Individuals must attest to U.S. Citizenship or indicate they are a Lawful Permanent Resident and have been continuously residing in the U.S. for 5 years.

Residency – Individuals must be living in Nevada with the intention of making Nevada their home permanently OR must be living in Nevada with a job commitment or seeking employment. Individuals are not required to have a fixed place of residence to meet this requirement.

Income – Individuals must meet income eligibility criteria for the appropriate eligibility group. MAGI specific Federal Poverty Levels (FPL) and their effective dates are listed in MAM Appendix A.

Budget the current taxable gross income received, or anticipated to be received, for every individual included in the assistance unit, with the following exceptions:

a. Income of a child in the parent's assistance unit determination unless the child is required to file a tax return.

b. Income deemed non-taxable.

c. Allowable pre-tax deductions.

Note: See MAM E-300 for types of earned and unearned income, E-110.1 for who must file a tax return and E135.1 for allowable deductions.

Assistance Unit – Must apply non-filer rules to all cases.

The non-filer household consists of the individual **and, if living with the individual**;

a. the individual's spouse/domestic partner; **and**

b. the individual's natural, adopted and step children under age 19; **and**

c. in the case of children under age 19:

    1. the child's natural, adopted and step parents; and
    2. natural, adoptive and step siblings under age 19

H-115 VERIFICATION

Qualified providers and hospitals are prohibited from requiring individuals to provide verification of any eligibility factors used in a PE determination. Hospitals must accept client attestation.

Note: If the individual provides any type of verification, a copy of the verification needs to be retained with the application.

H-120 PE COVERAGE PERIOD

The PE period begins the day of application and ends the last day of the month following the first month of the eligibility determination, **if a** full application for health insurance is not received by DWSS for the individual. If a full application for health insurance is received during the PE period, PE ends the day DWSS approves or denies the full application.

Example: A PE determination is made on January 10th and no health insurance application is received. Medicaid eligibility begins January 10th and ends February 28th. The system will automatically terminate eligibility, requiring no action by DWSS staff.

Example: A PE determination is made on February 10th and a full DWSS application for health insurance application is received on March 2nd. DWSS processes the application on April 10th. PE ends April 10th.

Individuals approved for Hospital PE are eligible for one (1) PE period every 24 months.

Pregnant individuals and individuals approved under the Prenatal Pregnancy PE program may receive one (1) PE period for each separate pregnancy.

Both PE programs, Prenatal and Hospital, will count against the other program's restricted time limit.

Note: Adverse action notification is not required when ending a PE period after the denial of the DWSS application for full health insurance.

H-125 NOTIFICATION OF PE DETERMINATION

Qualified providers and hospitals are required to provide a written notification of the PE eligibility determination through a Notice of Decision (NOD) to individuals and families applying for PE. The NOD must advise the applicant of the eligibility determination, the appropriate PE period and the option for individuals or families to submit a complete health insurance application to DWSS. The PE Notice of Decision (Form 2991) will be provided to the qualified providers and hospitals by DWSS.

The requirement to provide a notice and fair hearing regulations and appeal rights does not apply to the PE determination.

H-130 TIME FRAMES

The hospital must enter the presumptive eligibility determination into the DWSS PE system within five (5) days of the application date. This process serves as notification of the eligibility decision.

Note: The PE system will update the DHCFP Medicaid Eligibility Verification System (EVS). This process takes a minimum of two business days after case entry.

H-135 "PRUDENT PERSON" PRINCIPLE

The policies included in the manual are rules for determining eligibility. It is impossible to foresee and give examples for all situations; therefore, the qualified provider and hospital staff certified to make PE determinations are encouraged to use reason and apply good judgment in making eligibility decisions when rare and unusual situations are encountered.

Reasonable decisions made by PE certified staff based on the best information available, using good judgment, program knowledge, experience and expertise in a particular situation is referred to as the Prudent Person Principle. The "Prudent Person Principle" may be applied when rare and unusual situations are encountered, and guidance is not clearly stated in this Medicaid Assistance Manual (MAM). Any decision made that is determined to be incompatible with current DWSS or DHCFP policy will be cited in accordance with the established DWSS PRE PE Review Guide.

H-140 WITHDRAWAL OF APPLICATION

An individual may voluntarily withdraw an application any time before PE determination is made. The qualified provider or hospital must allow the request to be made electronically, telephonically recorded, or handwritten.

H-145 CASE DOCUMENTATION

All PE decisions are reviewed by the DWSS Program, Review, and Evaluation (PRE) unit. The PE certified staff must include in an individual's case record any facts used to support the decision on the application. A case narrative is required, and documentation must be clear and concise to allow the DWSS PRE unit reviewing the case to determine the reason, logic and accuracy of the PE certified staff's decision and actions.

Any decision made that is determined to be incompatible with current DWSS or DHCFP policy will be cited in accordance with the established DWSS PRE PE Review Guide.

Supporting documentation, voluntarily provided by the individual, must be maintained in the case record.

The PE application must be complete and signed by the individual or the individual's authorized representative.

The PE certified staff completing the eligibility determination is required to sign and issue the PE Notice of Decision (Form 2991).

H-150 PRESUMPTIVE ELIGIBILITY STANDARDS

All qualified providers and hospitals must maintain the following eligibility standards in order to remain a certified PE facility provider.

1. Ninety-four percent (94%) of all PE decisions must be correctly determined based on the State's PE policies and must be entered into the PE system correctly from the information gathered at application.

2. Ninety percent (90%) of individuals determined presumptively eligible by a hospital must submit a full health insurance application to DWSS prior to the end of the presumptive eligibility period.

3. Qualified providers processing Prenatal pregnancy PE are encouraged to stress the importance of applying for full health insurance from DWSS to continue to receive Medicaid services beyond the PE period.

When entering information into the PE system, PE certified staff must ensure the accuracy of the information being entered. The use of slang or nicknames is not permitted. Individual names, dates of birth, and social security numbers must be accurate upon entry into the PE system to ensure a proper data match can occur and identity confirmed.

H-151 DWSS PROGRAM, REVIEW, AND EVALUATION (PRE) AUDIT

DWSS Program, Review, and Evaluation (PRE) staff will monitor monthly reports as well as conduct audits to ensure policy, procedures and standards are being met. All qualified providers and hospitals are required to cooperate with PRE by providing case records and any supporting documentation as requested to complete a PRE audit.

When a qualified provider or hospital is determined to have fallen below standards based on the PRE audit review period, a corrective action plan (CAP) will be developed for the qualified provider or hospital by the DWSS PRE staff. If PRE staff determine, after implementation of the CAP, the qualified provider or hospital remains below the standards, the hospital will:

- be disqualified by DWSS; and
- no longer be authorized to conduct PE determinations; and
- be required to serve a 1 year sit out period from making PE determinations.

Note: Non-cooperation with a PRE audit request without good cause (as determined by PRE) may result in the immediate assessment of the qualified provider or hospital being placed in a CAP.

Qualified providers and hospitals may not delegate the authority to determine PE to another entity. Trained and certified staff must make the PE eligibility determinations. Third parties may assist in gathering information from applicants and assist in completion of the application paperwork, but they may not make the PE determination. Only PE certified staff will have access to the DWSS PE portal system.

H-155 CONDITIONS OF PARTICIPATION

Participating qualified providers and hospitals must meet all conditions of participation as set forth in the Division of Health Care Financing and Policy (DHCFP), Medicaid Services Manual, Chapter 100 all inclusive.

H-160 CASE RECORDS AND RETENTION (NRS 239.080, NRS 230.125)

The qualified provider or hospital must maintain case files in accordance with the State's record retention schedule. Records must be maintained for 37 months after the PE period end date.

Note: The qualified provider or hospital is required to maintain documentation regarding the PE eligibility determination and can be maintained as paper or electronic files.

H-165 AUTHORITY

42 CFR 435.1110, 42 CFR 435.907, 42 CFR 435.1102, 42 CFR 435.1103, NRS 422.306, SSA 1915(f)(2), SSA 1915(f).