PRESUMPTIVE ELIGIBILITY
PROVIDER GUIDANCE

H-100 OVERVIEW

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

A Qualified Hospital participates as a provider under the State Medicaid Program and agrees to make presumptive eligibility 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 hospital electing to participate in the PE program must have a Presumptive Eligibility (PE) contract amendment in place with DHCFP. Hospital staff making the presumptive eligibility determination must be trained and certified by DWSS Professional Development staff in order to obtain PE system access.

The purpose of PE is to provide a streamlined process for individuals to get 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 PE or Medicaid policy listed in this MAM should be directed to the DWSS Medicaid Program Specialist.

H-105 ELIGIBLE GROUPS

Hospitals participating in the PE program may make presumptive eligibility determinations for the following eligibility groups. Eligibility for medical assistance is categorized in groups based on the associated budget methodology.

Hospitals are not limited to hospital patients; they may assist with presumptive determinations for family members and other non-patients.

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)

Note: This group only covers children approved for CH and/or CH1 categories. Pregnant children are evaluated under the Pregnant Women group for CHP. 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.

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

  Note: See MAM Appendix A, MAGI Income chart

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

c. Pregnant women

- Pregnant women with household income that is at or below 165% FPL for the applicable family size. (CHP 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;

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 presumptive eligibility 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

Hospitals are prohibited from requiring individuals to provide verification of any of the eligibility factors used in a Medicaid determination. Hospitals must accept client attestation for all factors of eligibility.

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

Note: Adverse action is not required when ending a presumptive eligibility period by denying the full health insurance application.

H-125 NOTIFICATION

Hospitals are required to provide written notification of the eligibility determination (Notice of Decision) to individuals applying for PE. The notice must advise the applicant of the eligibility determination, the PE period and the requirement to submit a complete health insurance application.

Notice and fair hearing regulations do not apply to the PE determination. The Notice of Decision (Form 2991) will be provided to hospitals by DWSS.

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 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, PE case managers are encouraged to use reason and apply good judgment in making eligibility decisions when rare and unusual situations are encountered.

Reasonable decisions made by hospital PE 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 stated in the Medicaid Assistance Manual (MAM). All PE decisions are reviewed by the DWSS Program, Review, and Evaluation (PRE) unit. 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 Review Guide.

H-140 WITHDRAWAL OF APPLICATION

An individual may voluntarily withdraw an application any time before a case decision is made. The request can be made electronically, telephonically recorded or handwritten.

H-145 CASE DOCUMENTATION

The PE case manager must include in each applicant's case record facts to support the decision on the application. A case narrative is required and documentation must be clear and concise so anyone reviewing the case can determine the reason, logic and accuracy of the PE case manager's decision and actions.

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

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

The PE case manager completing the eligibility determination is required to sign and issue the Notice of Decision.

H-150 PRESUMPTIVE ELIGIBILITY STANDARDS

Hospitals must maintain the following eligibility standards in order to remain a PE provider.

1. 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.

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

Note: When entering information into the PE system, hospital 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.

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. Hospitals are required to cooperate with PRE by providing case records and any supporting documentation as requested to complete a PRE audit.

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

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

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

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

H-155 HOSPITAL CONDITIONS OF PARTICIPATION

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

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

The hospital must maintain case files in accordance with the State's record retention schedule. Records must be maintained for 37 months after the closure date.

Note: The hospital is required to maintain documentation regarding the eligibility determination and can decide if they will maintain 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).