Promising Ideas in Children's Health Insurance

Presumptive Eligibility for Children

April 2000

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This is the second in a series of issue briefs about innovative ways to offer affordable health care to more children. Letting health care providers and certain community-based organizations enroll children right away, while a regular application is pending, holds promise as a strategy for improved outreach, access to care, and enrollment. However, states have been slow to take advantage of this opportunity. This reluctance is based in part on uncertainty about how presumptive eligibility for children works. The purpose of this paper is to answer questions about presumptive eligibility that may stand in the way of more states adopting this approach. April 2000

PRESUMPTIVE ELIGIBILITY FOR CHILDREN-WHAT IS IT?

Presumptive eligibility for children is a way for states to empower health care providers and certain other organizations that serve low-income children to give temporary Medicaid cards to children. Children have access to all Medicaid-covered services. To be eligible, children generally must have a gross family income below Medicaid eligibility levels. To keep coverage, families must follow through on the regular application process by the end of the following month or the temporary coverage will expire. States have had such an option for pregnant women for more than ten years, but presumptive eligibility for children is still new. The presumptive eligibility option allows states to move enrollment into the community in a way that would not otherwise be possible under Medicaid rules.

There is no specific presumptive eligibility provision for separate child health programs under the Children's Health Insurance Program (CHIP) as there is in Medicaid. Nonetheless, states can implement presumptive eligibility in exactly the same way in separate child health programs as in Medicaid, in order to create a seamless system of children's health coverage.1

PRESUMPTIVE ELIGIBILITY FOR CHILDREN-HOW DOES IT WORK?

Medicaid providers and organizations that determine eligibility for Head Start, the Special Nutrition Program for Women, Infants, and Children (WIC), and the Child Care

and Development Block Grant (CCDBG) can participate in presumptive eligibility as "qualified entities." This is how it works: An employee of a "qualified entity," such as a Head Start program, asks a family coming to Head Start whether their children need health insurance. If so, the Head Start worker gives the family a simple form with questions about total family income. Often all the needed information may already be in the Head Start file. The Head Start worker compares the income information on the application to a chart showing income eligibility for children's health coverage. If family income is below the eligibility level, the worker determines that the family is "presumptively eligible."

The worker gives the family a notice that documents the children's eligibility for temporary health coverage and transmits the decision to the agency that administers Medicaid/CHIP within 5 working days.2 In some states the presumptive eligibility application is enough to start a "regular" application, while in other states a separate form is required. If a separate application is needed to start the "regular" application process, the Head Start worker informs the family and offers assistance to complete and file the full application. If the family then does not file the required application, eligibility expires at the end of the temporary coverage period.

If the child has an immediate unmet health need, the Head Start worker can help the family to schedule an appointment with any health care provider participating in the Medicaid/CHIP program. In Medicaid, the favorable presumptive eligibility determination entitles the child to all covered services. Once the state gets the presumptive eligibility determination from the "qualified entity," it enters the temporary eligibility decision into its system. In most states, health care providers can telephone into the Medicaid/CHIP system to verify that a person is covered. Some states issue a Medicaid/CHIP card during the temporary coverage period, while others rely on the notice the qualified entity originally gives the family to document eligibility.

Once an application for regular Medicaid/CHIP is filed, the Medicaid/CHIP eligibility worker processes it in the usual way. If the information is incomplete or verification is missing, the worker will communicate with the family to supply the necessary information. Sometimes the qualified entity that made the presumptive eligibility determination follows up to assure that the application is going smoothly. Meanwhile, the child has temporary health coverage until a final decision on the regular application is made. Even if the child is ultimately found ineligible, medical expenses will be covered during the presumptive period and the state will receive its federal matching funds for those expenses.

PRESUMPTIVE ELIGIBILITY FOR CHILDREN-WHY IS IT IMPORTANT?

Presumptive Eligibility can be an effective way to improve outreach, access to care, and enrollment in children's health coverage programs:

Outreach

Presumptive eligibility offers qualified entities an added incentive to engage in outreach to their patients and clients, many of whom are likely to be eligible for children's health coverage. Such qualified entities include:

- organizations already serving low-income children in early education, nutrition, and child care programs; and
- the clinics, health departments and other safety-net providers that serve uninsured children as well as other providers of children's health services, such as doctors, hospitals and, often, school systems.

Community settings provide a convenient and trusted site for families to learn about health coverage options for their children.

- In a recent national survey, more than half of low-income families of uninsured children reported that being able to enroll right away and provide the forms later, as well as having the opportunity to enroll at a doctor's office or clinic, would make them "much more likely" to enroll their children in Medicaid. 3

Access to Care

Presumptive eligibility can also be the quickest way to get access to health care services. Qualified entities make presumptive eligibility determinations on the same day that the family applies.

- Under Medicaid, a state may take up to 45 days from the date of application to determine eligibility.4 In separate child health plans, once eligibility is determined, coverage typically does not begin until the following month.

Without evidence of coverage, a child with a pending Medicaid/CHIP application may not be able to get care from non-emergency providers. A family may be reluctant to seek care without the certainty that a pending application will eventually be approved to cover the bill.

- Research documents that the lack of insurance coverage is a barrier to health care, and delayed care often means more serious and expensive intervention later.5
- A survey of families with children newly enrolled in the Florida KidCare program found that four out of ten families faced application processing times of more than two months. One-fifth of the families reportedly delayed seeking medical care for financial reasons while awaiting coverage. Almost half of the families who did get medical care for their children while awaiting coverage paid over $50.6

Immediate access enhances coordination of care.

- A health clinic can schedule follow-up care; a Head Start program can arrange for immunizations; a nutrition program can arrange treatment for an infant with baby

bottle tooth decay; and a child care eligibility site can offer benefits to families on its waiting list.

Enrollment

Presumptive eligibility is designed to facilitate regular enrollment into Medicaid/CHIP.

- The qualified entity has a duty to inform the family of the importance of completing the application process and offer assistance.
- Knowing that their children have already been determined eligible, parents may have a stronger incentive to follow through with the application process.
- In most states, presumptive eligibility for children will not be available a second time in the same year to discourage families from relying on presumptive eligibility whenever the child needs care.

There is evidence from the Presumptive Eligibility for Pregnant Women program that presumptive eligibility is an effective enrollment strategy.

- A report looking at a range of reforms designed to facilitate Medicaid enrollment of pregnant women found that states that both dropped the asset test and adopted presumptive eligibility saw the largest growth in enrollment.7
- Studies of presumptive eligibility for pregnant women in Tennessee and Wisconsin have found high rates of completed enrollment and low rates of erroneous presumptive eligibility determinations.8

Proposed Amendments to Presumptive Eligibility for Children

The President has proposed amendments to the Presumptive Eligibility for Children law in his 2001 budget proposal. The proposed amendments would expand eligible sites to serve as qualified entities to include schools, child care centers, homeless shelters, agencies that determine eligibility for Medicaid, TANF (cash welfare for families), and CHIP, and other entities approved by the Secretary of the Department of Health and Human Services.

QUESTIONS & ANSWERS

Who Can Be a Qualified Entity?

The state selects qualified entities from among any of the health care providers participating in Medicaid, as well as organizations that make eligibility determinations for Head Start; the Special Nutrition Program for Women, Infants, and Children (WIC); and the Child Care and Development Block Grant program (CCDBG). The state can further limit who can be a qualified entity and must determine that a qualified entity is capable of making presumptive eligibility determinations.

Head Start, WIC, and agencies that determine CCDBG eligibility may be able to combine the needed information to make their own eligibility determinations with that needed to complete a Medicaid application. Most of the time, the income eligibility levels for these three programs will be below Medicaid/CHIP income levels. For more information about Head Start, WIC, and CCDBG, see the boxes below. Safety-net providers may also have information about the income of the uninsured children they serve that can be used in making presumptive eligibility determinations.

The definition of qualified entities does not specifically include schools, but many qualify as they are also Medicaid providers. Similarly Medicaid and CHIP eligibility workers cannot make presumptive eligibility determinations unless they also make eligibility determinations for CCDBG or otherwise meet the definition of a "qualified entity." The federal agency overseeing presumptive eligibility has said that it lacks discretion to allow states to expand the definition of qualified entities beyond the statute. However, there are legislative proposals to expand eligible entities.

Some states, such as New Mexico, Nebraska, and New Hampshire, authorize all types of federally permitted qualified entities. For example, New Mexico has trained and certified more than 1,100 individuals in agencies defined as qualified entities. Qualified entities in New Mexico include local health departments, the Indian Health Service, Head Start programs, several school systems (that are also Medicaid providers), and the Division of Children and Families (the lead agency on the Child Care and Development Block Grant). Taking a more gradual approach, New Jersey limits the definition of qualified entities to hospital-based clinics, federally qualified health centers, or local health departments delivering primary health care services.

Presumptive Eligibility for Pregnant Women

Presumptive eligibility began in 1987 as a Medicaid option for pregnant women only. By 1998, more than half the states had adopted presumptive eligibility for pregnant women. Presumptive eligibility for children was enacted in 1997, and is modeled after presumptive eligibility for pregnant women but differs from it in several important respects. A pregnant woman cannot obtain all Medicaid-covered services, but only "ambulatory prenatal care" during the presumptive eligibility period. Children, in contrast, are presumptively eligible for all Medicaid-covered services. The only entities that can determine presumptive eligibility for pregnant women are Medicaid providers that deliver prenatal care services and are called "qualified providers." In presumptive eligibility for children, any kind of Medicaid provider can be a qualified entity, as can the organizations that determine eligibility for Headstart; the Special Nutrition Program for Women, Infants, and Children (WIC); and the Child Care and Development Block Grant (CCDBG).

How Many States Have Adopted Presumptive Eligibility for Children?

Presumptive eligibility for children was enacted in 1997 as a state option in the Medicaid program.9 As of February 2000, only five states have actually implemented presumptive eligibility for children in their Medicaid programs: Massachusetts, Nebraska, New Mexico, New Hampshire, and New Jersey.10 New York, Kentucky, and Connecticut have legally authorized presumptive eligibility for children in Medicaid but have not yet implemented it. In addition, Massachusetts, New Jersey, and New York have adopted presumptive eligibility in separate child health programs under CHIP. Many more states are exploring the possibility of adopting presumptive eligibility for children in Medicaid and/or separate child health programs.

What Kinds of Medicaid Services Are Available During the Presumptive Period?

A child, who is determined to be presumptively eligible, is entitled to all Medicaid-covered services offered by a state, including the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT).11

What Basic Eligibility Information Is Needed by the Qualified Entity?

Federal law permits a qualified entity to find a child presumptively eligible based on preliminary information about age and gross family income alone, but states can choose to require additional information. A qualified entity does not have to inquire about such other eligibility criteria as citizenship status or asset ownership in those states with a resource test. Nor does a qualified entity need to obtain any third-party verification of the applicant's statements. However, the federal agency administering presumptive eligibility has determined that a state can ask a qualified entity to apply simple income adjustments. The state may also ask for other information as long as it is simple to obtain and requested in a fair and nondiscriminatory manner. For example, states can allow qualified entities to deduct a standardized amount from earnings before comparing a family's income to income eligibility levels.12 However, a presumptive eligibility determination does not consider all possible adjustments to income. A qualified entity must inform parents whose children are ineligible for presumptive eligibility how to apply for "regular" Medicaid.

Verification of Citizenship/Alien Status

Federal law does not require qualified entities to ask about citizenship/alien status in order to make a presumptive eligibility determination.13 However, the agency making final eligibility decisions will need to determine the child's citizenship/alien status. In addition, states can choose to require qualified entities to ask about citizenship/alien status of the child so long as the information is simple for the family to supply and asked in a fair and nondiscriminatory manner. Massachusetts, New Mexico, New Jersey, New Hampshire, and Nebraska all include a question about citizenship/alien status on the presumptive eligibility application/certification form, but the verification of qualified alien status is left to the state agency.

How Long Does the Temporary Eligibility Period Last?

If the family files a Medicaid application by the end of the month following the month in which the presumptive eligibility determination is made, presumptive eligibility lasts until a final determination is made. However, if the family does not apply by that deadline, presumptive eligibility will expire at the end of the month following the month in which the presumptive eligibility determination was made. If states combine the presumptive eligibility form with a Medicaid application form, as New Hampshire and Nebraska have done, the presumptive eligibility period will always continue until a final eligibility determination is made.

Do Families Have to Pay Back Benefits If They Are Not Approved for Medicaid After the Presumptive Period Ends?

No. Neither families nor providers have to repay the costs of services obtained during the presumptive eligibility period even if the family never completes a Medicaid application or completes the application and is denied coverage.

Will the State Receive Federal Reimbursement for a Child Who Is Not Approved For Medicaid after the Presumptive Eligibility Period Ends?

States will be reimbursed at the regular federal Medicaid matching rate for covering children during the presumptive eligibility period, even if the children are not ultimately found eligible for health coverage. Furthermore, such payments will not be considered errors for purposes of Medicaid Eligibility Quality Control reviews. However, if a child does not establish eligibility after the presumptive eligibility period expires, expenditures will be deducted from the state's CHIP allotment, as explained below (see Tables 1 and 2).

What Are the Risks of Fraud or Error?

Some states are wary of the presumptive eligibility option, fearing that families will misrepresent their income in order to obtain services for ineligible children. However, there is little reason for families to lie in order to get 30-60 days of health coverage for their children. States that have moved to self-declaration of income in Medicaid for children report low error rates. At least one study of presumptive eligibility for pregnant women in Wisconsin found an error rate of less than 1 percent.14 Head Start, WIC, and eligibility sites for CCDBG are likely to be accurate because they must also make income determinations for participation in their own programs and may often have first-hand knowledge of a family's financial circumstances. Also, the children applying at these sites are unlikely to need more than routine and preventive care during the presumptive eligibility period.

In addition, there are several options available to states to limit presumptive eligibility's potential for fraud or error. The state can narrow the range of agencies eligible to be qualified entities and, in any event, must determine that qualified entities are capable of making determinations. Qualified entities that submit a high proportion of erroneous

determinations can be decertified. In addition, states can impose reasonable limitations on the number of times a child can be found presumptively eligible. Most states require prior approval for unusually costly procedures. States can expedite the application process when a provider has requested prior approval during the presumptive eligibility period. In New Jersey, the state reviews all presumptive eligibility determinations to assure that the children are not already on Medicaid and that the determination is not erroneous.

Does Presumptive Eligibility Have to Be Available Statewide?

Yes.15 However, a state that wants to begin presumptive eligibility on a smaller scale can do so by limiting the types of qualified entities it recognizes. For example, New Jersey has limited the definition of qualified entities to certain types of health care providers.

How Is Presumptive Eligibility in Separate Child Health Programs Different from Medicaid?

In Medicaid, the presumptive eligibility statute specifies who can be a qualified entity, how long the temporary eligibility period lasts, which services are covered, and other details. Separate child health programs that adopt presumptive eligibility are not required to comply with any of the specific features of the Medicaid version of presumptive eligibility. For example, a state can adopt a system of presumptive eligibility in a separate child health program that does not include the use of qualified entities, as New York has done in its Child Health Plus program. In Child Health Plus, presumptive eligibility is used to temporarily enroll otherwise eligible children, pending receipt of verification. On the other hand, a state's separate child health program could choose to use all of the features of presumptive eligibility in Medicaid in order to create a unified system of children's health coverage as New Jersey has done in NJ Kid Care.

In both Medicaid and separate child health programs, states that choose to cover children before a final eligibility decision is made will receive federal matching funds for the costs of coverage. However, there are differences between Medicaid and separate child health programs in the matching rate for presumptive eligibility, whether costs are deducted from each state's allotment of federal CHIP funds, and whether costs are applied against a 10-percent cap on certain kinds of costs. These reimbursement issues are discussed more fully below.

Nebraska's PHONE Project Supports Presumptive Eligibility

Nebraska's Kids Connection provides Medicaid to children in families with income up to 185 percent of the poverty level. The state has entered into contracts with community action agencies and health departments to deliver outreach and case management services under Medicaid. The Nebraska initiative is called Public Health Outreach and Nursing Education (PHONE). The goal of PHONE is to increase children's access to coverage through Kids Connection and to increase access to providers. Central Nebraska Community Services runs a PHONE project and it also has about 15 employees at its Head Start, WIC, public health clinics, and

home visiting programs that are certified to do presumptive eligibility. This agency reports that about 70 percent of the presumptive eligibility determinations resulted in Medicaid approvals. Under the PHONE project, public health nurses follow up with the local office or the family after the presumptive eligibility determination to make sure the application process will be completed. The agency believes these follow-up calls are an important contributor to its enrollment rate. The PHONE project has also sponsored meetings with providers to encourage them to participate as qualified entities and Medicaid providers.

How Many Times Can a Child Be Found Eligible for Presumptive Eligibility?

States fear that, without limitations on presumptive eligibility, families will have little incentive to complete the application process. To address these fears, states can impose reasonable limitations on the number of times a child can be found presumptively eligible. Proposed regulations published in November 1999 solicited comments on what kinds of limitations would be reasonable. In the Presumptive Eligibility for Pregnant Women program, for example, presumptive eligibility is limited to one period per pregnancy. So far the states adopting presumptive eligibility for children have limited it to one period in any consecutive 12-month period (Massachusetts, New Jersey, New Mexico, Nebraska), or one period until a period of regular Medicaid eligibility has been established by the state agency (New Hampshire).

How Can States Delivering Services through Medicaid Managed Care Plans Use Presumptive Eligibility?

In Medicaid managed care, families typically have a certain period of time after an eligibility determination is made to choose a managed care plan. Once the family enrolls with a plan, the state pays the plan a fixed monthly fee. In most states, the family is covered by fee-for-service Medicaid, which pays participating providers for services provided, until enrollment with a managed care plan is complete. Because Medicaid coverage begins in the month of application and can be retroactive up to three months prior to the month of application, participating providers, who delivered services during the coverage period, but before the family received notice of eligibility, are also reimbursed on a fee-for-service basis. Presumptive eligibility can operate the same way: Providers are paid on a fee-for-service basis until a child is found eligible and enrolls in a managed care plan.

States where most children are enrolled in managed care may have cost concerns about using fee-for-service providers during the presumptive eligibility period. However, to the extent that presumptive eligibility helps expedite the regular application process, the state's fee-for-service exposure, pending enrollment in a managed care plan, may actually be shorter with presumptive eligibility.

How Can Separate Child Health Programs that Deliver Services through Managed Care Plans, or that Impose a Premium Charge on Families, Use Presumptive Eligibility?

Some separate child health programs charge families a monthly premium or enrollment fee or deliver services only through managed care plans. Unlike Medicaid, such programs have no network of providers paid on a fee-for-service basis. Nonetheless, the state can still use presumptive eligibility. Both New Jersey and Massachusetts use the same fee-for-service network during the presumptive eligibility period for children in their separate child health programs and in Medicaid. The family is only charged a premium in the separate child health program after a final eligibility determination and enrollment with a managed care plan. Another possibility is to negotiate with participating plans to offer immediate coverage in return for the fixed monthly payment or a pro rata payment.16

How Do States Claim Federal Matching Funds for the Costs of Presumptive Eligibility in Medicaid?

Federal matching payments to the state for costs incurred during the presumptive eligibility period will be paid regardless of whether or not a child is found eligible when the presumptive eligibility period ends. However, the rate at which payments are made and whether payments are deducted from the CHIP allotment depend on the child's final eligibility status. The CHIP allotment is the annual amount of federal funds available to pay the enhanced matching rate for child coverage expansions. However, certain federal matching costs associated with presumptive eligibility are also deducted from the state's CHIP allotment. In Medicaid, the costs of care during the presumptive eligibility period for an ineligible child will be federally reimbursed at the regular Medicaid rate (not the CHIP enhanced rate), but will be deducted from the state's CHIP allotment.17 The 10-percent cap on certain expenditures (see below) does not apply to presumptive eligibility in Medicaid, as explained further below (see Table 1).

How Do States Claim Federal Matching Funds for the Costs of Presumptive Eligibility in Separate Child Health Programs?

If a separate child health program provides for health coverage for children before an eligibility decision is made, then (as in Medicaid) reimbursement will be affected by the ultimate eligibility determination.

The costs of ineligible children will be considered the costs of a "child health initiative." Under the CHIP statute, "child health initiatives," combined with all administrative and outreach costs, cannot exceed 10 percent of expenditures on child health services. States do not need to create a "child health initiative" in Medicaid because presumptive eligibility is specifically authorized in the Medicaid law. Therefore, the 10-percent cap does not apply to Medicaid. Also, unlike Medicaid, children found ineligible will be reimbursed at the CHIP rate, not the Medicaid rate, and count against the 10-percent cap (see Table 2).

Table 1. Medicaid Presumptive Eligibility

Status After Presumptive Period Ends	Federal Matching Rate	Deduction from CHIP Allotment	Applies Against 10% CHIP Cap
Child Eligible for Medicaid (pre-CHIP level)	Regular Medicaid Rate	No	No
Child Eligible for CHIP (Medicaid or Separate Program)	Enhanced CHIP Rate	Yes	No
Child Ineligible	Regular Medicaid Rate	Yes	No

Table 2. Separate Child Health Program Presumptive Eligibility

Status After Presumptive Period Ends	Federal Matching Rate	Deduction from CHIP Allotment	Applies Against 10% CHIP Cap
Child Eligible for Medicaid (pre-CHIP level)	Regular Medicaid Rate	No	No
Child Eligible for CHIP (Medicaid or Separate Program)	Enhanced CHIP Rate	Yes	No
Child Ineligible	Enhanced CHIP Rate	Yes	No

How Can a Separate Child Health Program Comply with "Screen And Enroll" and Implement Presumptive Eligibility?

Separate child health programs must screen applicant children to identify those eligible for Medicaid. Such programs must have procedures to assure that these children are enrolled in Medicaid. This "screen and enroll" requirement can be combined with presumptive eligibility in several ways. New Jersey and Massachusetts have adopted presumptive eligibility for children in both the Medicaid program and the separate child health program, and both use the same network of fee-for-service providers during the presumptive eligibility period. The required screening for Medicaid eligibility takes place as part of the "regular" application process prior to a final determination.

QUALIFIED ENTITIES: MORE ABOUT WIC, HEAD START, AND CCDBG

Which families are eligible for WIC?

The Special Nutrition Program for Women, Infants, and Children (WIC) provides supplemental food, as well as education and referral services, to children under the age of 5 and pregnant and post-partum women in families with incomes at or below 185 percent of poverty, who are nutritionally at risk. Also, families receiving Medicaid, Food Stamps, or TANF (cash welfare for families) are automatically deemed income-eligible for WIC. State WIC agencies also have the option of recognizing automatic income eligibility for participants in other state-administered programs (with income limits at or under 185 percent of poverty). All but 10 states offer Medicaid/CHIP coverage to children in families with incomes equal to or higher than the WIC threshold of 185 percent of poverty. Estimates are that 1.5 million children in families receiving services from WIC are uninsured.18

Who determines eligibility for WIC?

WIC is administered by 88 WIC state agencies and 2,000 local WIC agencies in 10,000 sites. Eligibility is determined by the local WIC agencies. Local WIC agencies are required to provide information and referral services about other health services, such as Medicaid, to their uninsured clients. In a policy memorandum, the federal agency that oversees WIC has encouraged WIC agencies to participate in Medicaid/CHIP outreach and referral activities. However, in order to participate in presumptive eligibility, local offices must have the authorization of the state WIC agency, a written agreement with the Medicaid agency, and a source of payment for presumptive eligibility activities other than the WIC program.19

Which families are eligible for Head Start?

Head Start and Early Head Start provide services to children from birth to age 5. In order to be income eligible, family income must be below the poverty level or derived from a public benefit program like TANF; however, up to 10 percent of Head Start children can have higher incomes. Within 90 days of Head Start enrollment, the agency must determine whether the child has a usual source of health care and, if not, assist the family in obtaining one. In all state Medicaid programs, children under age 6 are eligible if family income is at or under 133 percent of poverty. Therefore, almost all Head Start children should be income-eligible for Medicaid.

Who determines eligibility for Head Start?

The Administration of Children and Families regional offices make Head Start grants to over 1,500 local agencies that administer Head Start and Early Head Start programs to over 850,000 children nationally (1998). The local Head Start grantees make the eligibility determinations for the program.

Which families are eligible for CCDBG?

The 1996 Welfare Reform Act consolidated four programs to subsidize child care services for lower-income working families into the Child Care and Development Block

Grant (CCDBG). Income limits vary among the states but cannot exceed 85 percent of the state's median income. Services are generally limited to children under age 13 and older children under 19 in protective services or with special needs. In 1997, the upper-income limits for a family of three ranged from $3,413 per month in New Hampshire to $1,249 per month in West Virginia. A comparison of each state's 1997 CCDBG upper-income level to 1998 Medicaid/CHIP upper-incomes levels for children found that Medicaid/CHIP levels exceeded CCDBG levels in two-thirds of the states.20 Children in these states who qualify for CCDBG are likely to be eligible for children's health coverage.

Who determines CCDBG eligibility?

Each state has a lead agency that administers the CCDBG. In most states, the lead agency is a social service or human service agency. Eligibility determinations are made by state and local staff of the lead agency, by other contracted agencies, or a combination of the two. In the period from 1997-1999, in over half the states, only the lead agency determined eligibility. Contracted agencies also made eligibility determinations in the remaining states.21

LESSONS DRAWN FROM EARLY STATE EXPERIENCE

Recruitment

The states that have implemented presumptive eligibility for children began by drawing on organizations that previously participated as qualified providers in presumptive eligibility for pregnant women or outstation sites. Most have been successful in encouraging additional organizations to participate as qualified entities. So far, the states implementing presumptive eligibility for children do not offer specific financial incentives for presumptive eligibility determinations. However, New Jersey and New Hampshire offer financial incentives for application assistance at outstation sites. Nebraska contracts with health departments and community action agencies for activities that support presumptive eligibility.

Even without a specific reimbursement for presumptive eligibility determinations, Medicaid providers have an obvious financial incentive to help self-pay patients obtain coverage to pay for services. WIC and Head Start agencies include health coverage referrals as part of their current work and may want to enhance their ability to facilitate enrollment. Organizations offering CCDBG subsidies often turn eligible families away because of the shortage of child care funds, and may welcome the opportunity to offer families an immediate benefit. However, in the long run, resource constraints may limit local agencies' ability to participate as qualified entities without reimbursement for the costs of making the presumptive eligibility determination. In New Mexico, for example, the district health offices express frustration with the additional responsibility for overburdened local health officers.22 New Hampshire is planning a survey to determine why some qualified entities have not participated in making presumptive eligibility determinations.

The following activities may assist state recruitment efforts:

- offer reasonable reimbursement to qualified entities for the administrative costs of making presumptive eligibility determinations;
- recruit from safety-net providers (among Medicaid providers) that serve the uninsured as well as from hospitals, clinics, county health departments, and large group practices that are most likely to have the patient volume to make presumptive eligibility for children feasible; and
- determine what kind of interagency agreements the agencies that oversee Head Start, WIC, and CCDBG require, and coordinate efforts to recruit local organizations with the agencies that oversee them. (See the websites listed below for the name and location of these agencies in each state.)

Training

States must determine that qualified entities are capable of making the presumptive eligibility determination. All the states with presumptive eligibility for children offer training and certification of qualified entities. Sometimes the organization receives the certification and can train its own workers (New Jersey), and sometimes each individual worker must be trained and certified (New Mexico). Each state also provides a package of written materials to qualified entities. This package includes at least the sample forms used in the presumptive eligibility process and may include a more detailed account of eligibility policies. Several qualified entities reported attending the basic training more than once in order to keep their knowledge current. New Jersey initially offered special training for staff members who determine presumptive eligibility for pregnant women. Such agency personnel are now seeking to do presumptive eligibility for children. New Jersey also offers ongoing trainings at a central site to accommodate the turnover in staff making presumptive eligibility determinations for pregnant women and children.

States setting up training for qualified entities should consider the following steps:

- provide an ongoing opportunity for training and retraining (this not only gives qualified entities a chance to keep up their knowledge and skills, it creates a forum to identify implementation problems);
- include the local offices that enter presumptive eligibility determinations into the Medicaid/CHIP system and follow up on "regular" applications as part of the ongoing training, particularly when the state first implements presumptive eligibility; and
- designate a staff person at the Medicaid/CHIP agency central office who can troubleshoot implementation problems and answer eligibility questions.

Access to Providers

Children are temporarily eligible for Medicaid from the date of the presumptive eligibility determination. However, to get services from any provider other than one who determined eligibility, the family must have evidence of coverage. If the evidence is

something other than a standard Medicaid card, the state must inform providers how to verify eligibility and bill for services during the presumptive eligibility period. In all four states using qualified entities, the qualified entity gives the family a copy of the signed presumptive eligibility certification as evidence of coverage. In New Jersey and New Hampshire, once the agency enters the presumptive eligibility status into the system, the family is later mailed a regular Medicaid card to use during the presumptive eligibility period. In Nebraska and New Mexico, the certification form is the family's only evidence of coverage until a final determination is made.

All four states have automated verification response systems that providers can use to verify eligibility. Providers can also telephone the qualified entity or the local agency office to verify eligibility. Several of the states reported problems, as pharmacists refused a presumptive eligibility notice as insufficient evidence of coverage. Generally, providers appear to be willing to deliver services based on the notice.

The states also vary in the time it takes for the presumptive eligibility determination to be entered into the computer system. Until presumptive eligibility is entered into the system, providers cannot easily verify eligibility. In New Mexico and New Jersey the determination is entered into the system at a central location within one to three days. In Nebraska and New Hampshire, the qualified entity has five working days to mail the presumptive eligibility certification to the local office, which then has additional time to enter the information into the system.

Managed care can also raise access and continuity of care challenges when fee-for-service rates have not been updated or when children are assigned to health plans that do not include the providers they saw during the fee-for-service period. Also, the slower a state's eligibility determination and enrollment process, the greater is the state's financial exposure to the potentially higher costs of fee-for-service. These problems should be addressed, not just for those with presumptive eligibility, but for all new Medicaid beneficiaries.

States planning to implement presumptive eligibility should consider the following steps to improve provider access:

- develop an automated verification response system that providers can use, with information found on the presumptive eligibility certification form;
- enter the presumptive eligibility determination into the system from a central site;
- issue a regular Medicaid card for use during the presumptive eligibility period in addition to the notice of presumptive eligibility;
- offer public education to providers about presumptive eligibility, particularly to pharmacists and other who typically bill as soon as services are delivered, and
- update fee-for-service rates and assure that families are not automatically assigned to plans in which the children's providers do not participate.

Completed Enrollment

Ultimately the success of presumptive eligibility will be measured by how many presumptive eligibility determinations result in completed enrollment. All the application simplification reforms that generally facilitate Medicaid enrollment apply to completed enrollment after presumptive eligibility. In addition, states must decide whether to require a separate Medicaid application or combine the presumptive eligibility certification with the Medicaid application. The five states vary in their approach to these issues.

All five states use short application forms, have eliminated asset tests, and do not require a separate face-to-face interview with the local office of the state agency after the presumptive eligibility determination. New Mexico still requires face-to-face determinations for applications that do not originate with qualified entities. None of the five states has reduced third-party documentation to the federally required minimum verification of qualified alien status. Several states require third-party documentation for as many as five to seven separate items. Several states have developed forms that list types of verification. The qualified entity checks off the types of verification needed and gives the form to the family.

When documentation is missing, local offices within a state have different practices. Some local offices allow only 10 days after receipt of the application for a family to supply missing information. This time frame seems particularly severe, since a family that never submits an application can be presumptively eligible for at least 30-60 days. Also, some computer-generated notices requesting missing information are worded in a confusing way that informs families that they are ineligible, but may be able to avoid an interruption in coverage if the missing information is supplied within 10 days.

Qualified entities vary in the extent to which they help the family assemble documentation and follow up the application process with the Medicaid/CHIP agency. Initiatives like Nebraska's PHONE project support follow-up assistance with good results in approved applications.

Three states require one form for both the presumptive eligibility application and the Medicaid application. The remaining two states, New Mexico and New Jersey, use two forms, one for presumptive eligibility applications and one for Medicaid/CHIP applications. Both New Mexico and New Jersey have short application forms that do not differ greatly from the presumptive eligibility form, but requiring a second form will be a barrier for some families. For example, in New Mexico, some qualified entities were unable to complete both forms in the same visit and required families to return to complete the Medicaid application. Also some local offices still required families to come in for a face-to-face interview to complete the application after a presumptive eligibility determination despite state policy that this was no longer necessary.23

Steps that states should consider in order to facilitate completion include:

- use a single simplified mail-in form as both a presumptive eligibility and a Medicaid application;

- offer incentives for qualified entities to assist with applications, and/or outstation state workers to assist with applications, if the state uses a presumptive eligibility form that does not serve as a Medicaid application;
- reduce third-party documentation to the federally required minimum;
- provide a check-off form listing the required documentation;
- adopt policies to permit sufficient time to submit documentation and write notices clearly;
- keep the qualified entity informed about the status of the child's application to facilitate follow-up assistance; and
- provide support for qualified entities to follow up with families that have incomplete applications, like Nebraska's PHONE project.

Evaluation

Few states had yet worked out the data systems needed to track applications. Several states had asked, or were planning to ask, local offices and/or qualified entities to manually record determinations and outcomes when possible. Massachusetts is in the process of conducting an evaluation of the first year of presumptive eligibility implementation (see box). The evaluation will analyze administrative data and conduct field studies in order to determine (1) how many children entering MassHealth, under presumptive eligibility, move to another type of coverage; (2) the reasons that children did not provide verification; and (3) the number of children who lose eligibility as the presumptive eligibility period expires, but reestablish eligibility within 12 months. A report on findings from the study is expected in the spring of 2000.

Massachusetts: Presumptive Eligibility with a Medicaid Waiver

Massachusetts Medicaid operates under an 1115 waiver that permits it to vary Medicaid rules, including rules relating to presumptive eligibility. The state agency, not qualified entities, decides that a child is presumptively eligible. The family has 60 days to supply missing documentation in order to continue coverage under MassHealth.

In all five states, applications resulting from a presumptive eligibility determination are processed at local offices and not at a central site. States such as Illinois have found that central processing of mail-in applications reduced procedural denial rates and expedited processing. However, New Mexico experimented with central processing of applications and found it slower than local processing. Central processing might facilitate better data gathering but will only be feasible if the central office has the capability to handle the application processing tasks.

While resources for data gathering and evaluation are always in short supply, all state Medicaid programs have the option of using resources already earmarked for Medicaid eligibility quality control to custom design quality control pilot projects.24 Wisconsin used this flexibility in September 1998 to assess its Presumptive Eligibility for Pregnant

Women program. Wisconsin analyzed more than 1,000 case files and surveyed hundreds of recipients and qualified providers. The resulting report not only quantified completion rates that documented the program's success, but also provided specific recommendations for improving the program.25

Steps states should take to gather data on presumptive eligibility include:

- adapt computer systems that can provide longitudinal data on the number of presumptive eligibility determinations received, how many determinations result in a Medicaid application before the presumptive eligibility period expires (or within a fixed period of time thereafter); and the outcome of the application, including reasons for denial;
- design pilot projects or undertake other evaluations to assess the effectiveness of presumptive eligibility for children, as well as to identify improvements; and
- in the absence of adequate computer system capability to track presumptive eligibility determinations, require local offices to (1) manually record the number of presumptive eligibility determinations received; (2) the application outcomes, and (3) encourage qualified entities to record and report on the number of presumptive eligibility determinations in order to cross-check with state data.

Websites with More Information on Presumptive Eligibility

From the Health Care Financing Administration [www.hcfa.gov/init/q&aintro.html]:

State Child Health; Implementing Regulations for the State Children's Health Insurance Program; Proposed Rule, 64 Fed. Reg. 60882, 60935 and 60945 (Nov. 8, 1999), online at 222.hcfa.gov/init/chnprm.htm

State Child Health; State Children's Health Insurance Program Allotments and Payments to States; Proposed Rule, 64 Federal Register 10412, 10423-25 (March 4, 1999), online at www.hcfa.gov/init/chipnprm.pdf

Administration Answers to Frequently Asked Questions

- Second Set, Released October 3, 1997 Q&A #32(a)
- Third Set, Released October 10, 1997 Q&A #42 - 49
- Fifth Set, Released July 29, 1998 Q&A #85

State Medicaid Manual Section 3570, Optional Presumptive Eligibility Period for Pregnant Women (June 1991), online at www.hcfa.gov/pubforms/pub45pdf/smmtoc.htm

From the Center on Budget and Policy Priorities [www.cbpp.org]:

Presumptive Eligibility for Children: A Promising New Strategy for Enrolling Uninsured Children in Medicaid Ross, Donna Cohen, November 1, 1998: www.cbpp.org/pubs/order.htm

Free & Low Cost Health Insurance: Children You Know are Missing Out Ross, Donna Cohen; Jacobson, Wendy, 1998: www.cbpp.org/shsh/kit.htm

List of WIC state agencies: fns.usda.gov/wic/menu/contacts/statre/statealpha.htm

List of CCDBG lead agencies:
www.acf.dhhs.gov/programs/ccb/programs/plan/part1.htm

List of federal regional offices administering Head Start grants:
www.ach.dhhs.gov/orgs/regions.htm

CREDITS: Written by Vicky Pulos with research assistance from Joseph Choi.

Supported by project MCJ from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

Endnotes

1 See "How Is Presumptive Eligibility in Separate Child Health Programs Different from Medicaid?" above for more on how presumptive eligibility in separate child health programs can differ from Medicaid.

2 42 U.S.C. 1396r-1a(c)(2).

3 Lake, Snell, Perry & Associates, Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey, Kaiser Commission on Medicaid and the Uninsured: Washington, D.C., January 2000.

4 Once Medicaid eligibility is determined, it will date back to the month of application. Retroactive eligibility can go back up to three months from the month of application. This enables providers who have delivered services, but not been paid, to now bill Medicaid, and the family to be reimbursed (at the Medicaid rate) for out of pocket payment for covered services.

5 Edmunds, Margaret and Coye, Molly Joel, editors, America's Children: Health Insurance and Access to Care, National Academy Press, Washington, D.C., 1998.

6 Institute for Child Health Policy, Florida KidCare Program Evaluation Report, January 2000 (www.healthykids.org/html/reports.html).

7 General Accounting Office, Early Success in Enrolling Women Made Eligible by Medicaid Expansions, GAO/PEMD-91-10, February 1, 1991.

8 Phillippi, Raymond H., Ph.D., Presumptive Eligibility under the TennCare Program, Bureau of TennCare, Nashville, TN, 1998, and Medicaid Management Evaluation

Review: Presumptive Eligibility for Pregnant Women, State of Wisconsin, Dept. of Workforce Development, Division of Economic Support, Office of Quality Assurance, Madison, WI, September 1, 1998.

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

10 American Samoa and the Northern Mariana Islands are also reported to have presumptive eligibility for children.

11 Administration Answers to Frequently Asked Questions, Third Set: Q&A #42, HCFA, October 10, 1997.

12 Notice of Proposed Rule-Making, 64 Fed. Reg. 60882, 60935, November 8, 1999.

13 Personal communication with HCFA official. See also, 42 USC 1320b-7 (d)(4): a State may not delay or deny eligibility until a beneficiary has had a reasonable opportunity to submit evidence of satisfactory immigration status.

14 Medicaid Management Evaluation Review: Presumptive Eligibility for Pregnant Women, State of Wisconsin, Dept. of Workforce Development, Division of Economic Support, Office of Quality Assurance, Madison, WI: September 1, 1998.

15 Administration Answers to Frequently Asked Questions, Third Set: Q&A #47, HCFA, October 10, 1997.

16 The Michigan child health plan authorized a presumptive eligibility system in which participating plans could enroll children pending a final determination, but to date none of the participating plans have been interested in pursuing this option.

17 Notice of Proposed Rule-Making, 64 Fed. Reg. 10412,10423-10425, March 4, 1999 and Second Set of Frequently Asked Questions and Answers, HCFA: October 12, 1997, Q & A 32a.

18 Kenney, Genevieve M., et al., Most Uninsured Children Are in Families Served by Government Programs, Urban Institute: Washington D.C., December 1999.

19 WIC Policy Memorandum #99-05, from Patricia N. Daniels, Director, Supplemental Food Program Division, USDA, to Regional Directors, Strategies for Outreach to Children Eligible for the New Children's Health Insurance Program (CHIP) or the Medicaid Program and Cost Issues, March 30, 1999.

20 Ross, Donna Cohen and Jacobson, Wendy, Free and Low Cost Health Insurance: Children You Know Are Missing Out, Appendix D, Center on Budget and Policy Priorities, Washington, D.C. ,1998.

21 Child Care and Development Block Grant Report of the State Plans for the period from October 1, 1997 to September 30, 1999, (Child Care Bureau: Washington DC, March 1998).

22 Schwalberg, Renee et al., Making Child Health Coverage a Reality: Case Studies of Medicaid and CHIP Outreach and Enrollment Strategies, Kaiser Commission of Medicaid and the Uninsured: September 1999, (Chapter IV, New Mexico).

23 Schwalberg, Renee et al., op.cit. NM still requires face-to-face interviews for applications that have not come from qualified entities.

24 Guidelines for Developing State Medicaid Eligibility Quality Control Pilot Projects: www.hcfa.gov/medicaid/regions/mqcguide.htm

25 Medicaid Management Evaluation Review: Presumptive Eligibility for Pregnant Women, State of Wisconsin, Department of Workforce Development, Division of Economic Support, Office of Quality Assurance, Madison, WI: September 1, 1998

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