

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility for Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

Package ID	TN2019MS0003O	SPA ID	TN-19-0003
Submission Type	Official	Initial Submission Date	3/29/2019
Approval Date	12/19/2019	Effective Date	3/18/2019
Superseded SPA ID	TN 16-0002		
	System-Derived		

The state covers ambulatory prenatal care for individuals qualifying as pregnant women under 42 CFR 435.116 when determined presumptively eligible by a qualified entity.

A. Presumptive Eligibility Period

- The presumptive period begins on the date the determination is made.
- The end date of the presumptive period is the earlier of:
 - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
 - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
- There may be no more than one period of presumptive eligibility per pregnancy.

B. Application for Presumptive Eligibility

1. The state uses a standardized screening process for determining presumptive eligibility.
2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.
3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.
4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Name	Date Created	
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C. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

- The woman must be pregnant.
- Household income must not exceed the applicable income standard at 42 CFR 435.116.
 - a. A reasonable estimate of MAGI-based income is used to determine household income.
 - b. Gross income is used to determine household size.
3. State residency
4. Citizenship, status as a national, or satisfactory immigration status

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D. Qualified Entities

1. The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group. A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.

2. The following qualified entities are used to determine presumptive eligibility for this eligibility group:

- Other entity the agency determines is capable of making presumptive eligibility determinations

Name of entity	Description
Selected FQHCs	Selected FQHCs in high volume areas
County health departments	Offices of the Department of Health located in each of Tennessee's 95 counties

3. The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved.

4. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
PE Desk Guide 121719	12/17/2019 12:56 PM EST	

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E. Additional Information (optional)

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Presumptive Eligibility by Hospitals

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The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A. Qualifications of Hospitals

A qualified hospital is a hospital that:

1. Participates as a provider under the state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.
2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.
3. Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

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B. Eligibility Groups or Populations Included

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

Yes No

9. Other Medicaid state plan eligibility groups:

10. Demonstration populations covered under section 1115

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C. Standards for Participating Hospitals

The state establishes reasonable standards for qualified hospitals making presumptive eligibility determinations.

Yes No

The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Percentage of individuals submitting a regular application:

99.00%

The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Percentage of individuals found eligible for Medicaid

97.00%

D. Presumptive Eligibility Period

- The presumptive period begins on the date the determination is made.
- The end date of the presumptive period is the earlier of:
 - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
 - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
- Periods of presumptive eligibility are limited as follows:
 - a. No more than one period within a calendar year.
 - b. No more than one period within two calendar years.
 - c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.
 - d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
 - e. Other reasonable limitation:

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E. Application for Presumptive Eligibility

1. The state uses a standardized screening process for determining presumptive eligibility.
2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.
3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.
4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

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F. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

- The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
- Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.
 - A reasonable estimate of MAGI-based income is used to determine household income.
 - Gross income is used to determine household size.
 - Other income methodology
- State residency
- Citizenship, status as a national, or satisfactory immigration status

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G. Qualified Entity Requirements

1. The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.
2. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
Hospital PE Training Presentation 12.13.19	12/17/2019 12:47 PM EST	
HPE Step-By-Step Instructional Guide v13	12/17/2019 12:48 PM EST	
HPE FAQ v.16	12/17/2019 12:48 PM EST	
Hospital PE Worksheet v06	12/17/2019 12:50 PM EST	

H. Additional Information (optional)

Participating hospitals shall ensure no less than 99% of individuals approved for PE actually completed and submitted the full application for ongoing TennCare eligibility. Applicants who choose not to apply for full coverage will not count against the 99% application standard.

No less than 93% of all applicants made presumptively eligible shall be found eligible for full Medicaid benefits in year 1, with the required approval proportion increasing to 95% and 97% in years 2 and 3, respectively. Thus, a hospital faces termination of HPE privileges if greater than 7% of the applicants they made presumptively eligible in year 1 were not in fact Medicaid eligible after determination based on a regular Medicaid application.

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