

State Health Reform Assistance Network

Charting the Road to Coverage

ISSUE BRIEF
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Establishing Performance Standards for Hospital-Based Presumptive Eligibility: Considerations for State Medicaid Agencies

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Introduction

The Affordable Care Act (ACA) allows hospitals to use preliminary information to enroll people who appear eligible for Medicaid into coverage on a temporary basis. The goal of this “presumptive eligibility (PE)” option for hospitals is to quickly and efficiently enroll eligible people into Medicaid. While presumptive eligibility is not a new concept in Medicaid, the ACA for the first time gives hospitals—rather than states—the authority to decide whether to participate in PE.

While states are obligated to allow hospitals that participate in Medicaid to conduct PE determinations, they have the authority to oversee the quality of hospitals’ PE determinations. States may require hospitals to participate in training before conducting PE determinations and to meet performance standards on an ongoing basis.¹ If a hospital fails to meet a state’s performance standards, it must be allowed to take corrective action, but if it continues to fall short a state may discontinue the hospital’s authority to conduct PE determinations. By authorizing states to develop performance standards, the Department of Health and Human Services (HHS) has provided states with a tool to ensure that PE connects eligible people to coverage as intended.

This issue brief describes the flexibility available to states to establish performance standards and discusses approaches states may want to consider as they develop standards. It is based on Manatt Health Solutions’ review of federal law and regulations, as well as interviews with several state officials and other experts from states that currently operate hospital-based presumptive eligibility programs.²

Background on presumptive eligibility

Beginning January 1, 2014, the ACA allowed qualified hospitals (i.e., those participating in Medicaid) to temporarily enroll Medicaid-eligible individuals into coverage based on preliminary information. Hospitals can use the new provision to enroll children, pregnant women, parents, and caretaker relatives, and if their state has expanded Medicaid, adults without children. It also may be used for people eligible for Medicaid through a breast or cervical cancer program or family planning initiative. The temporary coverage or “presumptive eligibility” period

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State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org.

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lasts until the last day of the month after the person applies or if earlier, the date on which they receive a determination of Medicaid eligibility. For example, if a person is found eligible for temporary coverage in January and never files a full Medicaid application, it will end on the last day of February.

During this temporary or “presumptive eligibility” period, hospitals can receive reimbursement for the cost of Medicaid-covered services, including both inpatient and outpatient care. Moreover, in general, people found presumptively eligible are covered for all Medicaid services, not just those provided by the hospital, for the duration of the PE period.³ Among other things, this allows people discharged from the hospital to fill prescriptions, attend follow-up visits, and receive any other needed services covered by Medicaid. If PE enrollees are determined to be ineligible for Medicaid or fail to file a complete application by the PE deadline, they lose coverage. However, neither they nor their providers are required to reimburse Medicaid for the cost of services provided during the PE period.⁴

When hospitals conduct PE determinations, they rely on the information an individual provides to conduct a simplified assessment of whether the applicant meets a state’s income requirements. When conducting simplified determinations, hospitals use gross income or a simplified measure of income developed by their state—not the more detailed measure of income known as “Modified Adjusted Gross Income (MAGI)” used for a full determination. Similarly, states may authorize hospitals to apply a simple definition of family (e.g., tell us about who is in your family), rather than the MAGI household composition rules. Also at state option, hospitals may be required to have applicants attest that they meet Medicaid’s citizenship, immigration, and residency requirements.

After a hospital conducts the PE determination, it must provide the applicant with a regular or “full” Medicaid application and at state option it may be expected to help the person fill it out, submit it, and provide any required documentation. Unlike a PE application, the full application will gather all of the data needed to determine Medicaid eligibility on an ongoing basis.⁵

HHS suggested performance standards

Hospital-based PE is a powerful new tool that allows hospitals to initiate Medicaid coverage for beneficiaries and secure reimbursement for services. To take advantage of it, hospitals must be enrolled in the state’s Medicaid program, inform the state of their intention to conduct PE determinations, participate in training, and agree to follow state policies and procedures for PE determinations. In addition, states may establish performance standards that hospitals must meet to continue to participate. If a hospital fails to meet a state’s performance standard, the state may bar it from participating in hospital-based PE, but only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue. In general, HHS has given states broad flexibility to develop appropriate standards, including the measures of hospital performance and target performance levels (see discussion about targets below). However, in light of emerging discussions about whether hospital PE standards can be too harsh, it is possible that the agency will establish some limits on this flexibility to prevent standards from being used to undercut the requirement that hospitals be allowed to conduct PE determinations.⁶

Along with giving states the authority to establish performance standards for hospital-based PE, HHS has provided two examples of standards they might want to adopt.⁷ Both of the recommended standards are intended to encourage hospitals to connect people to Medicaid on an ongoing basis, not just for a short presumptive eligibility period.

1. **Percent of PE enrollees who file a regular application:** HHS suggests that states evaluate hospitals based on the percent of people enrolled in Medicaid on a PE basis who ultimately submit a full Medicaid application. For example, a hospital might be expected to ensure that at least 70 percent of PE enrollees submit a regular Medicaid application. By using this measure, a state could assess the extent to which hospitals are appropriately encouraging PE enrollees to submit applications for ongoing Medicaid coverage.
2. **Percent of PE enrollees who enroll in Medicaid on an ongoing basis:** HHS’s second suggested performance standard examines the extent to which hospitals actually enroll eligible people in Medicaid on an ongoing basis. Specifically, HHS recommends monitoring the percent of people enrolled in Medicaid on a PE basis who eventually file a regular Medicaid application and are found eligible for the program. For example, a state might expect that 50 percent of PE enrollees are eventually enrolled in regular Medicaid coverage.

While HHS has identified these measures as ones that states may want to use, it has not yet established any parameters as to an appropriate target for each measure, leaving the decision up to states. The 70 percent and 50 percent figures used in the examples above are only hypothetical targets. As discussed below, it will be important for states to develop appropriate, realistic targets tailored to their specific circumstances.

Additional performance measures

Along with the HHS recommended measures, the state officials and experts interviewed for this issue brief identified additional measures that states may want to consider for hospital-based PE programs. Some measures are similar to those recommended by HHS to broadly seek to ensure that hospital-based PE is used to increase ongoing enrollment in coverage and use of health care services. Others are aimed at reducing the potential administrative complexity created for the state's eligibility and enrollment system by hospital-based PE programs. For example, state officials are concerned about the risk of duplicate applications when someone who already is enrolled in Medicaid arrives at a hospital and asks for a PE determination perhaps due to confusion over their insurance status.

Some of the additional and alternative measures identified by interviewees are described below.

MEASURES AIMED AT STRENGTHENING ONGOING COVERAGE

- **Percent of PE applicants identified through outpatient clinics:** States may want to consider measures that assess the extent to which a hospital's outpatient departments participate in PE determinations to ensure that the hospital focuses beyond inpatient care.

For example: A state could require hospitals to report on the percent of their uninsured patients who receive services in outpatient versus inpatient settings, and require that their share of PE applications be proportionate.

- **Percent of PE enrollees that use services after enrollment in regular coverage:** Some interviewees recommended measures that evaluate the extent to which PE applicants access services after enrollment. Such a measure would capture whether hospitals are effectively educating people about how to use their Medicaid coverage once they are enrolled in regular Medicaid.

For example: A state could establish a standard that identifies those hospitals whose PE applicants are using their Medicaid coverage at a markedly lower rate than other applicants (or PE applicants at other hospitals).

MEASURES INTENDED TO REDUCE ADMINISTRATIVE COMPLEXITY

- **Percent of applicants checked for existing Medicaid enrollment:** To prevent PE from generating duplicate enrollments, states could require that hospitals verify a person is not already enrolled in Medicaid prior to submitting a PE application on his or her behalf. Such a measure is viable only if hospitals have a means to identify if someone already is enrolled in Medicaid, such as electronic access to a state system that identifies current enrollees.

For example: Hospitals could be required to ensure that 95 percent or even all potential applicants are checked for existing enrollment in Medicaid before a PE determination is conducted.

- **Percent of applicants checked for prior PE enrollment:** Under federal PE regulations, states must establish reasonable standards regarding the number of periods of presumptive eligibility available to an individual in a given time frame (e.g., a person might be allowed to enroll in Medicaid on a PE basis no more than once a year). In addition, pregnant women are limited to only one PE period per pregnancy. States could consider a performance measure that evaluates whether hospitals are taking the steps necessary to prevent people from presumptively enrolling in coverage too frequently. Such a measure is viable only if hospitals have access to information about whether someone has recently enrolled in Medicaid on a PE basis.

For example: Hospitals could be required to ensure that 95 to 100 percent of potential applicants are checked for recent PE determinations (e.g., not enrolled in prior 12 months or whatever time period is specified by the state) before a new PE determination is conducted on their behalf.

- **Percent of PE determinations conducted accurately:** States may want to consider a measure that assesses whether hospitals are conducting PE determinations in accordance with Medicaid eligibility rules. For example, are hospitals correctly identifying whether an applicant has gross family income below a state's eligibility threshold? Under such a measure, hospitals are evaluated based on the information that is given to them by families, but are not held responsible if families provided erroneous or outdated information.

For example: A state could require that 90 percent of a hospital's PE determinations be done correctly based on the data that an applicant has provided. If an applicant provides misinformation, his or her circumstances change, or his or her data cannot be verified, it would not affect a hospital's performance on the accuracy measure.

Along with the measures described above, states have broad flexibility to identify alternative or additional measures. States also have the flexibility to use a combination of measures, as well as to modify their measures over time.

Establishing appropriate targets for selected measures

Along with selecting measures, states must determine appropriate targets for their measures. For example, if a state elects to adopt the HHS recommended measure of the percent of PE applicants who eventually enroll in regular Medicaid, it must decide on a reasonable outcome measure. Should 30 percent of PE enrollees eventually be enrolled in full coverage? Fifty percent? Ninety percent? Unfortunately, as discussed in Figure 1, little data are available from states that already operate PE programs to help identify appropriate targets.⁸

In light of the dearth of existing, useful benchmarks, states may want to consider the following strategies when establishing targets:

- Base targets on data gathered during initial implementation:** States may want to consider gathering data from hospitals on their experiences with presumptive eligibility for a period of time in 2014 prior to establishing firm targets. By gathering data first, states are positioned to establish targets that reflect the expectations they set for hospitals in their PE programs and the reality of how their eligibility and enrollment systems are operating. Given the complexity associated with implementing the ACA, states may want to disregard the data from the first quarter or more of 2014 before settling on an appropriate benchmark period.

For example: A state could look at the share of PE applicants who file a full application and are found eligible for regular Medicaid in the third quarter of 2014, identify the average or median outcome on this measure, and use it to set the target for hospitals in 2015.

- Consider increasing benchmarks over time:** States may want to consider targets that increase over time, reflecting that hospitals and states still will be learning how to implement the hospital-based PE option for a number of months or even years.

For example: A state could start with a modest target, but then increase it by five percentage points (or more) in future years. Alternatively, it could “re-base” its target each year based on hospital performance in the prior year.

- Use an outlier approach:** Some states may find themselves particularly concerned about “outliers,” those few hospitals that are making significant errors or falling short of expectations. In such circumstances, a state may want to consider a measure that identifies those hospitals whose outcomes are one or two standard deviations or more away from the mean or median for the state as a whole.

For example: A state could use its hospital-specific data to identify facilities with outcomes that are two standard deviations away from the mean. Alternatively, it could require corrective action for hospitals in the bottom decile, quintile, or quartile of hospitals.

FIGURE 1 – LESSONS FROM EXISTING PE PROGRAMS ABOUT PERFORMANCE STANDARDS

Thirty-three states already operated presumptive eligibility programs for pregnant women and/or children prior to January 1, 2014,⁹ raising the possibility that their experiences could inform state efforts to establish performance standards for hospital-based PE programs. In talking with state officials and experts however, Manatt Health Solutions found that they reported dramatically different experiences depending on how they have implemented PE. As a result, the primary lesson from existing PE programs appears to be that each state will need to develop performance standards for its hospitals tailored to its own circumstances.

For example, Manatt asked interviewees to provide any available data on the percent of PE enrollees who eventually are found eligible for regular Medicaid. While the number of states interviewed was limited, the vastness of the range of responses remains striking. One state reported that 23 percent of PE enrollees eventually enrolled in Medicaid while another said the percent was “in the high 90s.” Among other things, the broad range reflects differences in how states have implemented their PE programs. For example, the state in which nearly everyone eventually is enrolled in Medicaid requires its hospitals to play an active role in helping families complete, mail, and document their application. Other states require only that their hospitals alert families to where to find a regular Medicaid application. Additional factors that might affect hospital performance on such a measure include: how difficult it is for applicants to be found eligible for regular Medicaid (e.g., how much documentation is required?); the effectiveness of a state’s training; the way in which the state gathers data for the measure; and hospital-specific efforts to enroll people in coverage.

Conclusion

Both states and hospitals have a strong interest in facilitating the enrollment of eligible individuals into coverage and generally ensuring that presumptive eligibility is working as intended. HHS allows states to establish and apply performance standards in implementing hospital-based PE. Since little existing data is available to inform expectations for hospital PE, states may want to rely initially on more modest performance standards aimed primarily at ensuring the integrity of PE programs. Over time, states could set higher standards by which to assess hospitals' effectiveness in connecting people to ongoing coverage. For example, a state might initially want to adopt performance standards aimed at preventing duplicate enrollments and ensuring hospitals are conducting PE determinations accurately in a high share of cases—but then adopt more robust measures aimed at connecting people to Medicaid on an ongoing basis in future years.

Endnotes

¹ 45 CFR 435.1110(d).

² Manatt interviewed officials and experts from five different states representing a geographically diverse cross-section of the country. At the request of a number of the interviewees—many of whom were in the midst of developing performance standards for their states—this issue brief does not identify the states by name. The interviewees included state officials, the head of a primary care association in a state that currently offers it to children and pregnant women, and a national expert on eligibility and enrollment issues who previously operated a CHIP program.

³ One exception, however, is that women who are found presumptively eligible for Medicaid on the basis of pregnancy can only receive ambulatory services.

⁴ See 45 CFR 435.1102, 45 CFR 435.1103, and 45 CFR 435.1110.

⁵ HHS's PE regulations use the phrase "regular" or "full" Medicaid application to refer to a form that people can fill out to be evaluated for Medicaid coverage on an ongoing basis, rather than for a temporary PE period. Although not specified in the regulations, the full Medicaid application presumably now is the single, unified application that the Affordable Care Act requires states to use when evaluating people for all insurance affordability programs (i.e., Medicaid, CHIP, premium tax credits, and cost-sharing reductions) or an alternative form approved by HHS. In contrast, a PE application requires people to provide only the data needed for a PE determination. States can design and use a special PE application or they can have hospitals give people a full application that clearly indicates the minimum application fields that must be filled out for a PE determination.

⁶ See Tricia Brooks, "Unreasonable Standards Will Likely Discourage Hospitals from Doing Presumptive Eligibility," January 10, 2014, Say Ahhh, accessed January 15, 2014 at <http://ccf.georgetown.edu/all/unreasonable-standards-will-likely-discourage-hospitals-from-doing-presumptive-eligibility>.

⁷ 78 Fed. Reg. 135. 42 CFR 435.1110. Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premium and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule. July 15, 2013.

⁸ See Appendix of "Implementation of the Affordable Care Act's Hospital Presumptive Eligibility Option: Considerations for States," Issue Brief, November 2013, Shannon M. McMahon, Maia Crawford, and Christian Heiss, Center for Health Care Strategies, prepared for the State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation.

⁹ Tricia Brooks, "Health Policy Brief: Presumptive Eligibility," *Health Affairs*, January 9, 2014.