Presumptive Eligibility

Rachel Klein

When Congress established the State Children’s Health Insurance Program (SCHIP) in 1997, it also enacted presumptive eligibility, a new state option for expediting children’s enrollment in Medicaid. Presumptive eligibility helps states cover children more quickly by allowing them to provide immediate, but temporary, enrollment in Medicaid or SCHIP to children who appear to meet program eligibility standards. During a period of presumptive eligibility, children have access to the full range of Medicaid- or SCHIP-covered services (for whichever program they are presumed to be eligible), allowing them to receive needed health care immediately rather than waiting for completion of a full eligibility determination. This approach facilitates access to care for uninsured children and contributes to state efforts to increase participation in Medicaid and SCHIP.

This article provides an overview of presumptive eligibility as a strategy for increasing participation in Medicaid and SCHIP. In addition to describing the process of determining presumptive eligibility and its benefits for children, the article also examines some concerns that have slowed the widespread adoption of presumptive eligibility to date. Finally, the article discusses possible solutions that will enable presumptive eligibility to meet its potential to quickly cover eligible children and increase the continuity of their care.

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How Presumptive Eligibility Works

To expedite the process of enrolling eligible children in public health programs, presumptive eligibility uses two strategies: an expedited application process, and community-based outreach and enrollment.

With presumptive eligibility, states can provide immediate coverage to children in families with gross incomes below Medicaid or SCHIP eligibility levels, instead of waiting for a full determination of eligibility. To keep coverage, families must be found eligible through the regular application process by the end of the month following the initial application, or the temporary coverage will expire. States receive federal matching funds for the costs of covering children who are presumed eligible: If the child is presumed eligible for Medicaid, the state receives its regular federal match; if the child is presumed eligible for SCHIP, the state receives the higher SCHIP federal match. States receive the federal match even if the child is later found to be ineligible. In December 2000, Congress enacted legislation that changed these rules somewhat, giving states more incentive to adopt presumptive eligibility in separate SCHIP programs and making it easier for states to coordinate Medicaid and SCHIP presumptive eligibility. (See Box 1.)

Presumptive eligibility helps states move the enrollment process into the community in a way that Medicaid rules would not otherwise permit. By allowing states to empower health care providers, certain community-based organizations that serve low-income
increases in incentives for financing presumptive eligibility

The financing of presumptive eligibility for children depends on how states choose to implement the program: States can choose to operate presumptive eligibility in Medicaid, SCHIP, or in both programs. Prior to the passage of the Benefits Improvement and Protection Act of 2000 (BIPA) in December 2000, states had more incentive to adopt presumptive eligibility in Medicaid than in SCHIP. Now, however, that incentive may have shifted because the funding mechanisms for presumptive eligibility were revised under the Act.

Prior to passage of BIPA, states assumed somewhat more risk in adopting presumptive eligibility in SCHIP than in Medicaid. In Medicaid, federal financial participation at the regular Medicaid matching rate is guaranteed for children presumed eligible, even if they are ultimately determined ineligible for Medicaid. In addition, Medicaid eligibility can begin as many as three months prior to the date of an application for Medicaid if the child would have been eligible during that time and had incurred medical bills, so presumptive eligibility may not add to the cost of delivering care to children who are sick or have a chronic condition. In SCHIP, the federal government would pay the enhanced SCHIP matching rate if the child was ultimately determined eligible for SCHIP. However, if a child was presumed eligible for SCHIP but determined eligible for Medicaid, the state would receive only the regular Medicaid match rate for services delivered to that child. Moreover, if a child presumed eligible for SCHIP was ultimately determined ineligible for either Medicaid or SCHIP, expenses were considered “direct health services” and charged to states’ limited administrative and outreach funds. Thus, with SCHIP presumptive eligibility, states could not know how much to expect from the federal government until each eligibility determination was complete, and they were unable to judge what expenses were likely to be charged as a “direct service” under SCHIP, leaving fewer administrative and outreach funds than they had planned.

With the passage of BIPA, the financing issues that dissuaded states from adopting presumptive eligibility in SCHIP have been addressed. States may now have more incentive to implement presumptive eligibility in SCHIP than in Medicaid: Provisions adopted in BIPA clarified that services delivered during a presumptive eligibility period will be charged to the states’ regular SCHIP funds and not the restricted administration and outreach portion of the block grant. Further, federal regulations clarify that states will be reimbursed at the enhanced SCHIP match rate for services delivered to children who are presumed eligible for SCHIP, regardless of the outcome of the full eligibility determination. Likewise, states will receive the regular Medicaid match for children presumed eligible for Medicaid regardless of the outcome of the full eligibility determination. Presumptive eligibility now can save the states money by increasing the federal government’s contribution toward its cost: The government will reimburse states at the higher SCHIP rate for children who are initially presumed eligible for SCHIP but later found eligible for Medicaid.


a States may spend up to 10% of their total annual SCHIP expenditures on administration, outreach, and “direct services” to children.
b States that expanded Medicaid instead of establishing a separate SCHIP program will receive the enhanced match for children determined eligible as part of the expansion group and not “regular” Medicaid.
c The “enhanced match” for SCHIP is the lower of 70% of the regular Medicaid match rate plus 30 percentage points or 85%. The federal government pays from 65% to 83% of the cost of providing coverage to children in FY 2002, while the Medicaid match rate is 50% to 75%.

Box 2 provides an overview of entities that states can authorize to determine presumptive eligibility. Many of these entities are already engaged in efforts to find and help eligible children enroll in Medicaid and SCHIP. Presumptive eligibility allows them to take the next step of actually enrolling children on an immediate but temporary basis.
States have discretion to decide which of the approved entities they will authorize to make presumptive eligibility determinations and how many individual qualified entities will be certified. New Mexico, for example, has trained and certified more than 1,100 individuals in local health departments, the Indian Health Service, Head Start programs, several school systems, and the Division of Children and Families (which approves child care subsidy applications). New Jersey, by contrast, limits the definition of qualified entities to hospital-based clinics, federally qualified health centers, and local health departments delivering primary health care services.

In order for presumptive eligibility to work efficiently, the state should ensure that qualified entities have the capacity to handle presumptive eligibility determinations and that the individuals making presumptive eligibility decisions are knowledgeable about Medicaid and SCHIP eligibility rules and the application process. In addition to training, ongoing coordination between the state Medicaid/SCHIP agency and qualified entities is key to ensuring that staff at qualified entity organizations are kept abreast of eligibility policy changes and that new staff joining a qualified entity undergo training. The capacity of a qualified entity to conduct presumptive eligibility determinations is important because the most successful presumptive eligibility programs are those that conduct intensive follow-up with families to gather the documentation that the Medicaid or SCHIP agency requires to complete the application process. If a state has streamlined the application process by eliminating documentation requirements, however, it may not need to conduct as much follow-up with families. For a description of the process for presumptively enrolling children in Medicaid and SCHIP, see Figure 1.

### Box 2

**Entities Qualified to Determine Presumptive Eligibility**

- Medicaid providers
- Primary or secondary schools
- Agencies administering Medicaid, SCHIP, or Temporary Assistance for Needy Families (TANF)
- Agencies that determine eligibility for Head Start
- Agencies that determine eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Agencies that determine eligibility for the Child Care and Development Fund
- Child support enforcement agencies
- Agencies that determine eligibility for federal housing assistance programs
- Organizations that provide emergency food and shelter under a grant from the Stewart B. McKinney Homeless Assistance Act
- Any other entity a state chooses, if approved by the Secretary of Health and Human Services

**Presumptive Eligibility Enrollment Process**

**STEP 1.** A family seeks assistance from a “qualified entity.” (See Box 2.)

- Do the children in the family need health insurance?
  - Yes: Go to next step.
  - No: The children are designated as “presumed eligible” and receive immediate, temporary coverage. The children may obtain health services immediately, as needed. The state pays medical expenses during the temporary coverage period and receives federal matching funds for services covered. Even if the child is ultimately found ineligible, medical expenses incurred during the presumptive eligibility period will be covered, and the state will receive its federal matching funds for those expenses.

- Is the family’s income below the eligibility level for coverage?
  - Yes: The children are designated as “presumed eligible” and receive immediate, temporary coverage. The children may obtain health services immediately, as needed. The state pays medical expenses during the temporary coverage period and receives federal matching funds for services covered. Even if the child is ultimately found ineligible, medical expenses incurred during the presumptive eligibility period will be covered, and the state will receive its federal matching funds for those expenses.
  - No: No further action is taken.

**STEP 2.** The state determines whether the family meets the eligibility criteria.

- Did the family complete the application, if required?
  - Yes: Did the family meet the eligibility criteria?
    - Yes: The children are enrolled in Medicaid or SCHIP.
    - No: Eligibility ends at the end of the temporary coverage period.
  - No: No further action is taken.

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*Children may be presumed eligible for a period of up to 60 days or until a “regular” eligibility determination is made by the state.*

*When children who are presumed eligible have an immediate health need, workers can help their families schedule an appointment with any Medicaid/SCHIP health care provider. If the entity making the presumptive eligibility determination is a health care provider, that provider can immediately deliver care and the state will reimburse for the services provided.*

*Even if the child is ultimately found ineligible, medical expenses incurred during the presumptive eligibility period will be covered, and the state will receive its federal matching funds for those expenses.*

*Source: Adapted from federal law and regulations (Section 1920A of the Social Security Act).*
Benefits of Presumptive Eligibility for Children

Presumptive eligibility offers several benefits for children and for states administering the program. It can be an effective way to improve outreach, access to care, and enrollment in children’s health coverage programs, whether through Medicaid or SCHIP.

Outreach
Presumptive eligibility bridges the gap between outreach and enrollment. It allows states to bring the enrollment process into the community, where qualified entities can engage in outreach, and families can both learn about children’s health insurance and receive coverage from a known and accessible source.

Community settings may provide convenient and familiar sites for families to learn about health coverage options for their children. In a 1999 national survey, more than one-half of low-income families of uninsured children reported that the ability to enroll immediately and provide forms later, combined with the opportunity to enroll at a doctor’s office or clinic, would make them “much more likely” to enroll their children in Medicaid.7 Besides being convenient to families, 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. Entities that are providers know they will be paid for their services and have the opportunity to provide follow-up care to children who need it. Other entities, such as schools, Head Start agencies, and Child Care and Development Funds can use the presumptive eligibility process to help children receive immunizations, eyeglasses, dental care, or physicals, improving the health of the children they already serve.

Access to Care
Presumptive eligibility can make health care services available much more quickly than is possible under the regular eligibility determination process. For example, qualified entities can make presumptive eligibility determinations on the same day a family applies and provide forms later, combined with the opportunity to enroll at a doctor’s office or clinic, would make them “much more likely” to enroll their children in Medicaid.7 Besides being convenient to families, 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. Entities that are providers know they will be paid for their services and have the opportunity to provide follow-up care to children who need it. Other entities, such as schools, Head Start agencies, and Child Care and Development Funds can use the presumptive eligibility process to help children receive immunizations, eyeglasses, dental care, or physicals, improving the health of the children they already serve.
Ensuring quick access to services prevents health problems from worsening and enhances continuity and coordination of care.

soon as the determination is made, in separate children’s health plans, coverage typically does not begin until the first of the following month. Therefore, a child found eligible on March 10, for example, will likely have to wait until April 1 for coverage to begin. A 2000 survey of families with children newly enrolled in the Florida KidCare program found that 3 out of 10 families faced application-processing times of more than two months. One-fifth of the families reported a delay in seeking medical care for financial reasons while awaiting coverage. Almost one-half of the families who did get medical care for their children while awaiting coverage paid more than $50.

Ensuring quick access to services prevents health problems from worsening and enhances continuity and coordination of care. For instance, families may be reluctant to seek care without knowing that a pending application will eventually be approved to cover the bill, even though delayed care can sometimes mean more serious and expensive intervention later. If a family does seek care, a child with a pending Medicaid/SCHIP application may be unable to find a provider who will deliver care, except in an emergency. Finally, immediate access can enhance coordination of care. For example, a health clinic can schedule follow-up care, a Head Start program or school 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 incorporates lessons learned from other efforts to increase children’s enrollment in Medicaid and SCHIP. One lesson is that families are more likely to enroll if the process is simple and easy. Another is that families are more likely to complete the enrollment process if they receive assurance that they are eligible and help in understanding the benefits of health coverage. In addition, more families enroll when they can do so at a convenient location. Presumptive eligibility can take advantage of these lessons by adding entry points and streamlining the process of applying for health coverage by piggybacking Medicaid or SCHIP applications with assistance from other social service programs. For instance, presumptive eligibility could be used in conjunction with express lane eligibility (ELE), allowing a determination to be based on information provided on an application for another assistance program, such as the National School Lunch Program. (See the article by Horner, Lazarus, and Morrow on ELE in this journal issue.)

Presumptive eligibility can also help streamline the enrollment process in states that have separate eligibility determinations for Medicaid and SCHIP. If a child applies for SCHIP but is found during the “screen and enroll” process to be eligible for Medicaid, the state agency could presume the child eligible for Medicaid while the application is reviewed. Likewise, a family that applies for Medicaid but is found to have too much income could be presumed eligible for SCHIP while the application is pending. A state could also use this mechanism at renewal to help children maintain coverage through changes in circumstances that shift their eligibility from SCHIP to Medicaid or vice versa. (See the article by Cohen Ross and Hill in this journal issue for a more complete discussion of outreach and enrollment.)

Concerns Regarding Presumptive Eligibility
Despite its benefits, presumptive eligibility has not been widely adopted. Table 1 shows that, as of May 2002, only nine states have authorized presumptive eligibility for children in their Medicaid programs, and only five states have authorized it in their SCHIP programs. Reasons for states’ reluctance to adopt presumptive eligibility include concerns about cost implications and questions about whether presumptive eligibility is necessary when states have simplified the application and enrollment process.

Cost Implications
In this era of budget shortfalls, states may be wary of proposals that carry new cost implications. Presumptive eligibility, like any outreach and enrollment innovation, carries both administrative costs (for example, training qualified entities and processing applications) and programmatic costs (such as delivering health services during a presumptive eligibility period). In addition, some state officials have expressed concern that presumptive eligibility would put states at risk of providing expensive health
Anecdotal evidence suggests that states that have implemented presumptive eligibility have found that, with proper follow-up on the part of qualified entities, most families are successfully enrolled in Medicaid or SCHIP following a presumptive eligibility determination. For example, in Fiscal Year 2001, Nebraska had a 76% approval rate for ongoing coverage of children presumed eligible for Kids Connection, the state’s Medicaid expansion program for children. One of the largest qualified entities in the state reported an approval rate of 86%. To encourage families to follow through with the enrollment process, states have generally limited the number of times a child can be presumed eligible to once every 12 months. A high approval and enrollment rate for presumptive eligibility applications indicates that states are generally providing care only to children who are, in fact, eligible for Medicaid or SCHIP.

In addition, available evidence appears to indicate that children who are presumptively enrolled do not have significantly more expensive health care needs than children who are enrolled through the regular application process. For example, in an average month in Fiscal Year 2001, Nebraska served 315 children through presumptive eligibility at a cost of $172.23 each, which was nearly identical to the cost of coverage for a child enrolled regularly in Kids Connection. Furthermore, preventive care or treatment provided to a child during the presumptive eligibility period may save a state the cost of more expensive treatment later on, for a condition left untreated during the wait for enrollment in ongoing coverage. States that have adopted presumptive eligibility tend to agree that the benefits and cost savings achieved through addressing health care needs up front have outweighed the administrative burden of establishing a presumptive eligibility program.

The Need for Presumptive Eligibility

Another concern is that simplified application processes and retroactive Medicaid coverage for children make presumptive eligibility unnecessary. In fact, states have made it significantly easier to apply for children’s coverage under Medicaid and SCHIP. But presumptive eligibility is still useful for increasing access to coverage. Despite simplified applications, application-processing times may vary considerably, between Medicaid and SCHIP programs across counties, or at times when demand increases, such as when children go back to school in the fall. Presumptive eligibility could help ease those disparities. Moreover, although Medicaid has retroactive coverage, states generally have no comparable provision for retroactive SCHIP coverage, and families may have difficulty getting health care services without proof of insurance. Even if an application is processed very quickly, there may still be a lag time before a child is covered and able to receive services.

Conclusion

Presumptive eligibility for children has the potential to offer affordable health care to more children and to increase continuity of care and follow-up services. Enabling health care providers and certain community-based organizations to enroll children immediately, while a regular application is pending, holds promise as a strategy for improved outreach, access to care, and enrollment.

Table 1

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<th>States That Have Adopted Presumptive Eligibility for Children as of August 2002</th>
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*These states have adopted but not implemented presumptive eligibility as of August 2002.


2. See note 1, Social Security Act. A period of presumptive eligibility lasts from the date the child is presumed eligible to the end of the following month (thus, up to 60 days). However, if the family submits an application for ongoing Medicaid or SCHIP coverage, or if the presumptive eligibility application is the same as the regular Medicaid or SCHIP application, the temporary coverage continues until a full eligibility determination is made.

3. The federal government shares the cost of Medicaid and SCHIP with the states. The federal government pays 50% to 75% of Medicaid costs. To give states incentive to expand coverage to children under SCHIP, the SCHIP statute authorizes the federal government to pay a higher percentage of SCHIP costs. In Fiscal Year 2002, the federal government paid 65% to 83% of SCHIP costs. Social Security Act, 42 USC § 1397ec (1997).

4. States that adopt presumptive eligibility in a Medicaid expansion will receive the regular federal match for children determined to be eligible for regular Medicaid and the enhanced SCHIP match for children made eligible through the expansion.


8. Once Medicaid eligibility is determined, eligibility begins on the date of application. Medicaid rules allow families to receive coverage for up to three months prior to the date of application if they were eligible during that time and incurred medical expenses for qualifying services. This rule enables providers who have delivered services but not been paid to bill Medicaid, and it enables families to be reimbursed (at the Medicaid rate) for out-of-pocket payment for covered services.


10. Telephone survey of state SCHIP administrators, conducted by Families USA staff, June–August, 2000.


13. See note 6, Families USA.

14. See note 7, Lake, Snell, Perry, and Associates.


16. See note 7, Lake, Snell, Perry, and Associates.

17. Personal communications with state presumptive eligibility staff: Sue Fiero, Medicaid program specialist, Nebraska Department of Health and Human Services, May 2002; Kate Frye, Policy and Program Planning, New Hampshire Health Care Services Division, Department of Health and Human Services, May 2002; Fran Smith, director of Medicaid in the Schools, School Health Unit, New Mexico Department of Education, December 2000.

18. See note 17, Personal communications with state presumptive eligibility staff.


20. The average cost per child per month for children enrolled in Kids Connection is $172.31. Personal communication with Rob Stevenson, program analyst, Nebraska Department of Health and Human Services Office of Finance and Support, June 5, 2002.

21. See note 17, Personal communications with state presumptive eligibility staff.

22. Retroactive eligibility allows individuals to receive coverage for services they received prior to enrollment in Medicaid, and it allows providers to be paid for those services, but only if the individual is determined to have been eligible during that time. In contrast, presumptive eligibility allows a child to receive services, and the provider to be paid for those services, even if the child is ultimately found ineligible for Medicaid or SCHIP.


24. See note 17, Personal communications with state presumptive eligibility staff.

25. See note 10, Telephone survey of state SCHIP administrators.