



# **Presumptive Eligibility:** Creating a Pathway to Ongoing Medi-Cal Coverage

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## About the Foundation

The **California Health Care Foundation** (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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## Executive Summary

Presumptive eligibility (PE) is an important tool for states to enroll people with low incomes into temporary Medicaid coverage. As California continues to expand eligibility for Medi-Cal, its Medicaid program, there is growing interest in understanding options for enrolling all eligible people. This report presents findings from two related studies that examined PE and a type of PE called hospital presumptive eligibility (HPE), with the goal of understanding opportunities for enhancing the ability of these processes in California to serve as a pathway to ongoing coverage. The first study focused on HPE in Medi-Cal and assessed the processes that hospitals use to help their patients who receive HPE submit applications for ongoing coverage through Medi-Cal or the Covered California marketplace; this study also assessed what is helpful and challenging about providing this assistance. The second study focused on how other states have implemented HPE for adults and PE for children. This study assessed promising practices in using HPE and PE as an on-ramp to longer-term Medicaid coverage that might be feasible in California.

The California hospitals that participated in the study invest considerable resources to help patients apply for HPE and regular Medi-Cal. They described several external and internal factors that facilitate the process, such as good communication with Medi-Cal eligibility workers and efforts to monitor patients' transitions from HPE to regular Medi-Cal. The study on hospitals' experiences also points to some ways the state — and, in some cases, counties — could make it easier to help people who receive PE apply for ongoing Medi-Cal coverage.

- ▶ Provide clear guidance to hospitals and applicants about Medi-Cal eligibility for undocumented immigrants, since children and young adult immigrants are eligible regardless of their immigration status, and the state plans to make immigrants of all ages eligible in 2024.

- ▶ Make the Medi-Cal application less daunting to complete by shortening the paper and online applications and making them more user-friendly and understandable.
- ▶ Facilitate opportunities for people to demonstrate eligibility for regular Medi-Cal (e.g., by using portals to easily transfer documents and expanding access to live telephone assistance).
- ▶ Foster connections between hospitals and county eligibility staff to ensure applications for ongoing Medi-Cal are complete and eligibility determinations can be made promptly.
- ▶ Provide more guidance on policy changes to hospital staff supporting HPE and Medi-Cal applications to ensure that they do not miss new ways for patients to gain coverage, such as allowing applicants to provide verbal signatures on their applications.

Findings on the HPE and PE implementation choices in other states, and study respondents' views of their effectiveness, suggest additional options for California. These are policy and programmatic choices not currently in place in Medi-Cal but that might be feasible in California's county-based eligibility determination structure.

- ▶ Expand the range of entities qualified to conduct PE determinations to include community organizations, which could help to increase PE determinations by reaching people in communities that Medi-Cal may otherwise fail to reach, such as immigrants or people who speak languages other than English.
- ▶ Explore application design options to facilitate transitions to regular Medi-Cal, such as whether California's PE portal could support automatically generating Medi-Cal applications using PE application data.

- ▶ Require hospitals to help HPE and PE enrollees complete their applications for ongoing Medi-Cal, instead of only requiring the entities qualified to conduct PE determinations to provide the application.
- ▶ Ensure quality monitoring includes regular communication and is consistent across counties to facilitate transitions from temporary coverage to regular Medicaid.
- ▶ Enhance HPE and PE data collection to understand how many HPE and PE enrollees subsequently apply for Medi-Cal and the potential disparities in these application rates among HPE and PE enrollees.

The two related studies were designed to identify promising practices and significant challenges using a modest number of in-depth interviews. These studies were qualitative and did not assess data linking implementation choices and enrollment outcomes. Future studies could consider examining the relationship between enrollment assistance practices and enrollment outcomes or could survey a larger number of hospitals in California or respondents in other states. Future studies also could examine the perspectives of PE enrollees, or the role of Medicaid managed care plans in facilitating transitions from PE to ongoing Medicaid.

## Introduction

Presumptive eligibility (PE) is an important tool for enrolling people with low incomes into temporary Medicaid coverage. PE allows qualified entities (QEs), such as hospitals and clinics, to quickly enroll eligible people in temporary coverage, often using abbreviated applications and real-time eligibility determination systems. PE helps to ensure that people can access needed care immediately and acts as an on-ramp to ongoing Medicaid or other coverage through state health insurance marketplaces.

As California continues to expand eligibility for Medi-Cal, its Medicaid program, there is growing interest in understanding options for enrolling all eligible people. This report presents findings from two related studies that examined the implementation of PE and a type of PE called hospital presumptive eligibility (HPE), with the goal of understanding opportunities for enhancing these processes in California.

- ▶ The first study focused on HPE in Medi-Cal. The study assessed the processes that California hospitals use to help patients who receive HPE also apply for ongoing Medi-Cal coverage.<sup>1</sup> It also assessed what is helpful and challenging about providing this assistance.
- ▶ The second study focused on how other states have implemented HPE as well as PE for children. This study assessed promising practices for using HPE and PE as on-ramps to longer-term coverage.

These studies were qualitative and did not assess the relationship between implementation choices and enrollment outcomes. The studies were designed to identify promising practices and significant challenges using a modest number of in-depth interviews. The California study focused on high-volume HPE providers, and, therefore, the findings may not be representative of all HPE providers.

Likewise, the study of state practices included several respondents per state in each of five states, and the findings may not generalize to all states.

Mathematica conducted these studies with guidance from the California Health Care Foundation and an advisory group of national and state-level experts in Medicaid policy. The advisory group provided feedback on all aspects of the research, including design, methodology, data collection instruments, findings, and recommendations. Advisors also assisted with reaching out to states and hospitals to help gain their participation in this research.

The advisory group included representatives from the California Hospital Association, the California Association of Public Hospitals and Health Systems, the County Welfare Directors Association of California, the Western Center on Law & Poverty, and the Georgetown University McCourt School of Public Policy's Center for Children and Families.

## Overview of Presumptive Eligibility and Hospital Presumptive Eligibility

PE is a process that allows QEs to screen and enroll likely eligible people in immediate temporary Medicaid coverage based on the individual's self-attested preliminary information. PE thus provides immediate access to Medicaid benefits, such as payment for emergency services and prenatal care, while individuals apply for ongoing Medicaid coverage or other health coverage. PE for pregnant individuals has been an option for states since 1986, and PE for children was authorized along with the Children's Health Insurance Program (CHIP) in 1997. The Affordable Care Act of 2010 (ACA) expanded PE as a state option for eligibility groups other than pregnant individuals and children and instituted HPE as a mandatory policy in any state in

which hospitals wish to conduct PE determinations. These policies were the focus of considerable policy attention in the first few years after the passage of the ACA<sup>2</sup> and continue to be discussed as potential solutions to challenges, such as coverage for transition-age youth,<sup>3</sup> access to mental health care for youth,<sup>4</sup> and access to care during the COVID-19 pandemic.<sup>5</sup>

PE and HPE can reach their potential as seamless pathways to ongoing coverage only if QEs actively use them and if people determined presumptively eligible receive the assistance they need to submit an application for ongoing coverage before their temporary coverage ends. States and QEs have implemented policies and practices in a range of ways that affect the ease and rates of use of connections between PE and ongoing Medicaid coverage. In California, some implementation choices for submitting and processing applications for ongoing Medi-Cal coverage also vary across counties given the state's county-based administration of Medi-Cal eligibility.

The basic process for PE and HPE is the same: (1) states qualify providers and other entities to make PE determinations; (2) individual workers within the QEs undergo state-provided training; (3) QE workers collect basic information on consumers — usually health care patients — and enter it into PE applications; and (4) in many states, QE workers assist consumers who are determined presumptively eligible with regular applications for Medicaid. PE and HPE also differ in several ways. States have more discretion in implementing PE than HPE. For example, in contrast to HPE, states can limit PE to certain eligibility groups or not offer it at all.

California uses PE to enroll likely eligible people into immediate temporary Medi-Cal coverage through multiple programs, including the Breast and Cervical Cancer Treatment Program, the Child Health and Disability Prevention Program, and

Every Woman Counts, a public health program that connects women to cancer screenings and follow-up services. The state also operates a Presumptive Eligibility for Pregnant Women program and, like all states, an HPE program.

## Organization of This Report

The next section in this report discusses findings from the HPE in Medi-Cal study, and the following section discusses findings from the study on other states' implementation choices for HPE and PE. The report then offers options for enhancing HPE and PE in California and suggests avenues for further research.

# Hospital Presumptive Eligibility in California Medi-Cal

To gain insight into how to improve California HPE as an on-ramp to ongoing coverage, we examined how state and county Medi-Cal policies and processes, as well as hospitals' internal strategies, affect hospitals' ability to help HPE enrollees submit

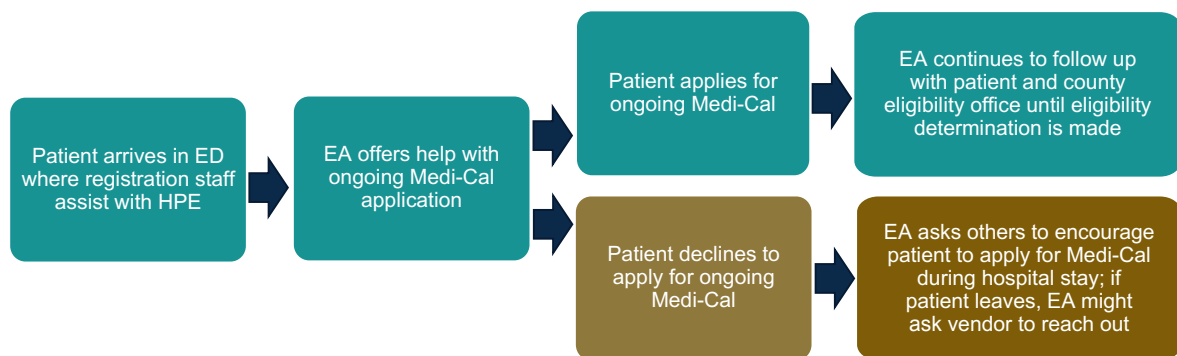
applications for ongoing Medi-Cal coverage. The study did not focus on the HPE determination process itself, nor on whether applicants ultimately enrolled in ongoing coverage, because those eligibility determinations are outside of the purview of hospitals. The study addressed the following research questions:

- ▶ *What factors facilitate and impede HPE enrollees' submission of applications for ongoing Medi-Cal coverage?*
- ▶ *What policies and practices might increase the application rate?*

## Key Findings on Application Assistance Staffing and Processes

All seven hospitals we interviewed take a proactive approach to HPE and Medi-Cal enrollment assistance to ensure that their patients have coverage and to obtain reimbursement for the care they provide. Figure 1 shows an overview of the common types of staff and processes hospitals use to assist patients from the time they enter the hospital until they receive Medi-Cal or leave the hospital, at which point further follow-up by hospital staff or enrollment vendors may be successful or unsuccessful.

**Figure 1. Generalized HPE and Medi-Cal Application Assistance Process at California Hospitals**



Notes: EA is enrollment assister; ED is emergency department; HPE is hospital presumptive eligibility.

Source: Author interviews with staff members of seven California hospitals, January through May 2022.

**Types of staff involved.** Most of the study hospitals have different groups of staff assisting patients with HPE applications and applications for ongoing Medi-Cal coverage. Interviewed hospital staff typically reported that registration staff who work around the clock in the emergency department (ED) help uninsured patients complete the HPE application when they arrive at the hospital. It is important to help ED patients quickly because HPE coverage begins on the day that the patient's HPE application is approved and is not retroactive to prior days.<sup>6</sup> Next, separate enrollment assister (EA) staff reach out to HPE enrollees to encourage them to apply for ongoing coverage and offer assistance with completing the application and compiling

needed documentation. The submission of the application for ongoing Medi-Cal coverage is not as time sensitive as the HPE application; so long as the application for ongoing coverage is submitted prior to the last day of the month following the one in which the individual was determined eligible for HPE, the HPE enrollment period will continue until the day a determination on the application for ongoing coverage is made.

As a result, EAs do not necessarily need to provide ongoing Medi-Cal enrollment assistance 24/7, but they often work extended shifts that include evenings and weekends to help as many patients as possible before they leave the hospital to ensure

## Methods and Data Sources

**Hospital sample.** We identified 24 California hospitals with the highest numbers of patients determined presumptively eligible for Medi-Cal from 2014 to 2021. Among these, we selected an initial sample of hospitals that varied on several characteristics, including the HPE-to-Medi-Cal conversion rate (which we used as a proxy for the rate of applications for ongoing Medi-Cal coverage submitted among the hospital's patients determined presumptively eligible), ownership, patient demographics (e.g., race, ethnicity, and housing status), and region. We also added one hospital with a lower HPE volume to ensure that we captured the perspective of a critical access hospital. The final sample of seven study hospitals represented a mix of public and private hospitals and most regions of the state.

**Key informants.** To obtain a range of perspectives from each hospital, we requested interviews with: (1) an enrollment assister (EA), (2) a manager of EAs, and (3) a leader knowledgeable about HPE and regular Medi-Cal enrollment assistance. To help identify the most appropriate staff members to interview for each category, we provided our initial contact at each hospital (usually the chief financial officer) with details on the desired characteristics and responsibilities of staff in each category and the types of topics we would cover with them.

**Interviews.** From January to May 2022, we interviewed 20 people across the seven hospitals (two to four people at each). We gathered a range of perspectives on the staff and processes that providers use for HPE and regular Medi-Cal enrollment assistance, the factors that help hospitals assist patients determined presumptively eligible to apply for ongoing coverage, and the challenges that hospitals face providing that assistance.

**Study limitations.** The sample size for this study was small, and the findings might not be generalizable to all California hospitals. For example, hospitals in the study had relatively high HPE volumes, so their experiences might not represent those of hospitals with a different patient mix or with fewer enrollment assistance resources.

they apply. Two of the study hospitals use a different staffing and application process in which EAs assist patients with both HPE applications and applications for ongoing Medi-Cal coverage close to or at the same time.

**Use of vendors.** Some hospitals also contract with vendors to help extend the reach of their EA staff. Sometimes known as enrollment brokers, these vendors are typically private regional or national companies that specialize in helping people obtain coverage of various types and help hospitals with financial management and maximizing revenues. Hospitals typically use vendors to reach out to patients whom the EA staff were unable to assist (e.g., because of patients' conditions or the EAs' workload) while they were in the hospital or soon after their discharge.

## Factors That Help Hospitals Assist Hospital Presumptive Eligibility Enrollees with Applications for Ongoing Medi-Cal Coverage

Six factors helped hospitals with their efforts to encourage and assist HPE enrollees with applications for ongoing Medi-Cal coverage. One of these factors is related to county decisions to assign eligibility workers to hospitals, and another is related to state decisions that enable hospitals to accept nonphysical forms of information and signatures. The other four factors fall under the hospitals' purview based on funding and regulatory considerations: closely linking assistance for both the HPE application and the application for ongoing Medi-Cal coverage, capacity to provide personalized assistance, strategies to communicate more with patients virtually, and tools to monitor the status of applications.

**Having a dedicated county Medi-Cal eligibility worker.** Some counties assign eligibility workers to hospitals that treat relatively large numbers of uninsured patients who are likely eligible for Medi-Cal — usually larger safety-net hospitals. Hospital staff reported that having a specific person from the county eligibility office with whom they can readily communicate about the regular Medi-Cal application (whether in person or via telephone or email) helps expedite the application process in several ways. Some EAs reported that they lacked access to state and county eligibility systems and therefore relied on county workers to help keep them apprised of application status and any documents the patient might be missing. Having a county eligibility worker physically located at the hospital can be particularly helpful in building a trusting relationship with the EAs and the patients; county workers often serve as informal trainers to the EAs on changes in eligibility and enrollment policies and can work directly with the patients to answer their questions, collect documentation, and process applications quickly.

*"[Patients] get discharged and then they're going to have to get all the paperwork and take it to the agency. As it is, they're not feeling well yet. They're still trying to recover. So, it's just more steps for the patient to have to do all that. When we had a Medi-Cal worker here, [the worker] did everything for [the patients], as long as the family members would bring the information."*

— Enrollment assister



**Ability to accept nonphysical signatures and information.** In response to the COVID-19 pandemic, the state allowed EAs at hospitals to accept verbal patient signatures over the phone for HPE applications. For the regular application for ongoing Medi-Cal coverage, the state also has allowed self-attestation of information when individuals cannot readily produce documents. Although most hospital staff reported this flexibility has been helpful for obtaining necessary information to advance patients' Medi-Cal applications, one EA noted that she and some of her colleagues felt uncomfortable when they could not verify that the information provided was "true and correct." Since before the pandemic, county eligibility workers have been authorized to accept signatures electronically or via telephone for the applications for ongoing Medi-Cal coverage.<sup>7</sup> However, hospital staff reported that some county workers indicated to EAs that they were uncomfortable accepting signatures this way, suggesting there may be some confusion among county workers on their authority.

*"Since the pandemic, we [have been primarily providing remote assistance], but what has been helpful, and I believe will continue past the pandemic, is allowing for telephonic signatures of clients for programs like HPE."*

— Enrollment assister manager

**Closely linking assistance for the HPE application and applications for ongoing Medi-Cal coverage.**

The hospitals with the highest HPE-to-Medi-Cal conversion rates among our sample had EAs assisting patients with both the HPE application and applications for ongoing Medi-Cal coverage. They found it more efficient and effective to complete both applications close to or at the same time because the applications inform each other, and it is easier to

capture all needed information from patients in one sitting. Although most hospitals in our study had separate staff to assist patients with HPE and with ongoing Medi-Cal — in part, to help maximize the number of patients who receive HPE by assisting them at the time of registration — they noted the importance of creating processes to minimize the gap between the two steps and thus reduce the risk that patients leave the hospital without completing the application for ongoing Medi-Cal coverage. For example, EAs at one hospital are notified immediately when a patient receives HPE and they quickly go to the ED to assist with the application for ongoing Medi-Cal. At another hospital, the EAs receive a daily list of the patients that the registration staff have enrolled in HPE. The EAs reach out to those patients to encourage them to apply for ongoing Medi-Cal coverage and to offer assistance.

*"Doing [the HPE and ongoing Medi-Cal applications] at the same time, it's actually a lot better for us... because we don't have to go back and forth between floors. We can use that time to go see another patient instead of going back to the patient we just completed."*

— Enrollment assister

**Capacity to provide personalized assistance.** Staff at several hospitals noted the importance of having enough EAs at the hospital to assist patients one on one, preferably in person.<sup>8</sup> They found this vital for giving patients adequate attention and time to build rapport and address questions about sharing personal information. Hospitals also need adequate staff to follow up with patients throughout the Medi-Cal application process. In some cases, hospitals have needed more EAs because of growing patient volumes or because they trained more registration staff in HPE, which increased the

number of patients determined presumptively eligible. Several hospitals increased their EA staff over the last few years and/or increased their reliance on vendors when their EA staff have been unable to reach all patients needing application assistance either in person or by phone. Vendors have the flexibility to visit patients at home, which helps build rapport and trust with patients who have been discharged from the hospital and makes gathering needed documentation for the application easier. Some hospitals also find that requesting assistance from other staff, such as financial counselors and social workers who have relationships with patients, can be effective in encouraging reluctant patients to apply for ongoing Medi-Cal coverage. Staff at a couple of hospitals reported that they also identify HPE enrollees who have not yet applied for Medi-Cal when they seek follow-up care in hospital outpatient clinics; clinic staff either offer direct assistance with applications for ongoing Medi-Cal coverage or offer to connect the HPE enrollees to a hospital EA.

*“When the patients are seeing you and you’re talking to them, they’re understanding more than just over the phone. Because when over the phone, they’re like, ‘Oh, okay, okay,’ but they’re not physically seeing what you’re looking at.”*

— Enrollment assister

*“It’s very effective [to have vendors conduct patient follow-up] actually, because they have the resources to go to the patients’ houses and try to get more information from them, rather than us, which [we] can only do here at the hospital. So, having that capability of going to the patient’s home and try to obtain more information, I think it makes it easier for them to go ahead and help those patients like that.”*

— Enrollment assister manager

#### **Ability to communicate with patients virtually.**

Hospitals have traditionally sent letters to HPE enrollees who leave the hospital before completing the application for ongoing Medi-Cal coverage to remind them to apply, but are increasingly using technology for this purpose, such as robocalls, emails, and texts. EAs described how much easier it is for patients to text them photos of documents, such as pay stubs and ID cards, than to fax those documents or present them in person. To further expedite the submission process, one hospital recently implemented a patient portal in its electronic health record that allows patients to upload these images for their application. Staff at two hospitals reported an increase in patients and EAs completing applications online in the past several years, attributing this to patients’ increasing access to and comfort with submitting information over the internet and to reduced direct patient contact during the COVID-19 pandemic.

*“We’ve already been using cell phones: Patients send us pictures of their pay slips, [and] then we’re able to upload them. Because of COVID, we had to make these changes, and so technology has been helpful for us, especially for those that do have the technology to do these things.”*

— Enrollment assister manager

**Processes to monitor HPE-to-Medi-Cal transitions.** Hospitals in the study reported using mostly manual processes to track their patients who have received HPE and whether they have applied for ongoing Medi-Cal coverage. These processes help hospitals determine which patients EAs should follow up with, why some patients decline to submit an application, and the status of submitted applications. In some cases, EA managers print out the daily patient census from the hospital to identify patients for EAs to contact, and they maintain spreadsheets for the EAs to document their interactions with those patients. EAs rely on their connections with county eligibility workers to help update the status of the applications. One manager described keeping track of demographic information to help identify potential trends and issues on which patients might need more attention. In a more advanced example, one hospital uses its electronic health record to aid in this process; EAs enter information directly into the patient record and can generate lists of patients based on their application status to help identify who still requires attention.

### **Challenges with Assisting HPE Enrollees with Applications for Ongoing Medi-Cal Coverage**

Hospitals faced four common types of challenges in assisting patients with submitting applications for ongoing Medi-Cal coverage after gaining HPE: (1) patients’ misconceptions about the utility of ongoing Medi-Cal coverage and the ability to obtain it, (2) the overwhelming length and requirements of the full Medi-Cal application, (3) challenges with sharing needed information, and (4) the effects of COVID-19 restrictions and other impacts. The first three relate mostly to challenges that patients face, while the fourth is related to hospital staffing and processes.

#### **Misconceptions about the utility of ongoing Medi-Cal coverage and the ability to obtain it.**

EAs reported struggling to relay to some patients the importance of applying for ongoing Medi-Cal coverage. This stemmed from three main issues. First, some patients confuse HPE for limited scope Medi-Cal or otherwise do not understand that HPE is temporary and will last at most two months (less if they apply for ongoing Medi-Cal coverage and are determined ineligible). Second, some patients receive HPE because they went to the ED for an acute issue that they do not perceive to be an ongoing problem and do not see the need for ongoing coverage for primary care. And third, some patients think they would be found ineligible for ongoing coverage, perhaps because of immigration status (even though the state offers some level of coverage regardless of immigration status if otherwise eligible for Medi-Cal), their assets (even though they likely are not counted), or other factors.

### Common Patient Misconceptions Regarding HPE and Ongoing Medi-Cal Coverage

1. Patients do not understand that HPE is temporary; sometimes this is because they confuse HPE for limited-scope Medi-Cal.
2. Patients think ongoing Medi-Cal is unnecessary because they only need acute care.
3. Patients assume they will not be eligible for ongoing Medi-Cal.

*“With most of our clients, they are afraid of filling out the application because they say, our home is going to be taken away, and I’m not going to qualify because I have too much this, and I have this... So it’s just that fear that they have with the application, to fill it out.”*

— Enrollment assister

**Overwhelming length and requirements of the regular Medi-Cal application.** EAs reported that some patients find the Medi-Cal application daunting, requiring the EAs to spend time convincing them that it is worth completing. When patients are very sick — or even unresponsive — it is difficult and insensitive to ask them and their family members for necessary information and documents for the application, so this might not occur while the patient is in the hospital. EAs described how the application is particularly challenging for patients with limited English language skills. Although hospitals employ bilingual EAs and California has made the Medi-Cal application available in Spanish, among other languages, not all common dialects are represented. Even when translated, many of the concepts and terms used in the applications are difficult to convey in a way that patients fully understand.

### Challenges with obtaining needed information.

EAs reported having difficulty gathering the necessary information for the applications for ongoing Medi-Cal coverage from certain groups, including people who are undocumented or experiencing homelessness and people who became newly eligible for HPE during the COVID-19 pandemic (i.e., those who are over age 65, who are blind, and who have other disabilities). EAs were not always able to establish and maintain communication with these individuals, in part, due to a lack of consistent access to smartphones and email. Lack of access to and comfort with technology has been a particular issue for the new HPE group because they are required under current rules to provide more documentation related to assets than other eligibility groups and face more challenges obtaining and submitting it.<sup>9</sup>

EAs also reported that people they perceive as undocumented immigrants have particular concerns about sharing personal information. California provides full-scope Medi-Cal to undocumented people up to age 25 and age 50 and older, and people age 26 through 49 will become eligible on January 1, 2024. Even when EAs assure these patients that receiving Medi-Cal would not categorize them as a “public charge” or otherwise harm their immigration status,<sup>10</sup> these individuals often fear that applying could affect their or a family member’s ability to obtain permanent resident status or could lead to deportation. In these cases, connecting patients with legal assistance can help ease their concerns.

*“We also are very well aware that not all of our patients are equipped with the smart devices that you would need to be able to [submit documentation virtually] or [are] not necessarily technologically savvy enough to be able to go through and do that.”*

— Enrollment assister manager

*“A lot of our patients are afraid to apply for programs due to their immigration status.... Sometimes for example, a patient comes to us and says, ‘Oh, no, I don’t want to apply because of my [documentation status].’ And so we have been provided by our upper management some phone numbers where they can contact some lawyers that can assist them and answer questions, and walk them through the process.”*

— Enrollment assister manager

**COVID-19 restrictions and effects.** The pandemic created challenges in assisting HPE enrollees with their applications for ongoing Medi-Cal coverage in a few ways. First, at most hospitals, EAs no longer go to patients’ beds to provide application assistance, and they reported that having to assist patients over the phone is difficult, takes more time, and is not as effective. Also, counties removed eligibility staff from hospitals at the start of the pandemic, and hospital staff typically miss the extra support and guidance these workers had provided, although some were able to maintain a relationship with those staff remotely. Second, the pandemic created workforce shortages, as many EAs either contracted COVID-19 or were afraid to come to work because of the risk of acquiring it. Hospitals are working to rebuild their EA staff, but many still have fewer EAs than they had before the pandemic. Staff at a couple of hospitals reported that the pandemic ended regular meetings that they had with the county Medi-Cal agency or their local hospital association that they found helpful for communicating updates and best practices about HPE and Medi-Cal eligibility and enrollment.

*“It was very hard for a lot of our clients, very difficult, who are so used to in-person, face-to-face [assistance]. Having them send their personal information through an email that they didn’t know it was a secure document, that was very hard, or sending it through our work phone and then us sending it to our email because they weren’t able to do email or didn’t have email. A lot of that.”*

— Enrollment assister manager

## States’ Implementation Choices for Hospital Presumptive Eligibility and Presumptive Eligibility

In addition to studying HPE in Medi-Cal, we assessed HPE and PE in other states to identify promising practices for encouraging PE determinations and subsequent applications for ongoing Medicaid. Specifically, this study addressed these research questions:

- ▶ What are promising HPE and PE practices in other states? Which of those practices might be replicable in California?
- ▶ What are the views of Medicaid administrators, QEs (including hospitals), EAs, and consumer advocates on how HPE and PE can maximize enrollments and minimize enrollment disparities?

## Methods and Data Sources

**Environmental scan.** We conducted a scan of states' publicly available HPE and PE program documents. We also consulted gray literature on HPE and PE.<sup>11</sup> We used information from a [list on Medicaid.gov](#) (dated August 2021) to determine whether states have PE for children.

**Study states.** We identified six study states that have promising HPE and PE practices, characteristics in common with California (such as population size or county-based eligibility determination), or both, based on data collected from our environmental scan. (Publicly available data across all states is not available on the percentage of HPE and PE enrollees who convert to Medicaid.) We selected four states with both HPE and PE for children (Indiana, Iowa, New Hampshire, and Oregon) and two states with HPE but not PE for children (Texas, which does have PE for other groups, and Virginia, which does not have PE for any groups).

**Interviews.** We conducted 15 interviews across the six study states from March to May 2022. We interviewed a Medicaid official responsible for HPE and PE in all six states. We also interviewed hospital representatives, consumer advocates, and EAs in five of the states. We identified these respondents using suggestions from Medicaid officials, state hospital associations, and a group of experts on Medicaid and California's health policy that advised the project. (We dropped New Hampshire from the sample because we learned that the state had discontinued the PE practices that led us to include it in the sample and because we were unable to obtain a response from a hospital or advocate.)

**Study limitations.** The sample size for this study was small, and the findings might not generalize to all QEs within the study states or to all states. During our environmental scan, we also found that information on HPE and PE on states' websites was often outdated. In addition, the implementation choices presented are based solely on qualitative findings and do not assess the relationship between implementation choices and enrollment data.

## Key Findings on States’ Hospital Presumptive Eligibility and Presumptive Eligibility Implementation Choices

Even though HPE is mandatory, and PE is a state option, states have implementation flexibilities for both policies (see Table 1). These implementation choices matter for the number and timeliness of PE determinations, and for how many presumptively eligible people subsequently apply for ongoing Medicaid.

Here, we describe key implementation choices for HPE and PE, trade-offs involved with these choices, and examples from our study states. Appendix A summarizes these implementation choices by the respective study state and for California.

**Eligibility groups.** The most fundamental implementation choice available to states — other than whether to implement PE in addition to HPE — is what eligibility groups to include. States have more control over which eligibility groups they include in PE: They can include only children, pregnant individuals, or both, or they can also include parents

and caretaker relatives, other adults, former foster children, and people who need breast and cervical cancer treatment or family planning services.<sup>12</sup> States with a separate CHIP can also choose to include children in that program in addition to or instead of children eligible for Medicaid. For HPE, in contrast, states must allow QEs to make PE determinations for all these groups, but they also can choose to include the aged, blind, and disabled Medicaid eligibility category and those eligible under a Section 1115 demonstration.<sup>13</sup> In California, in addition to HPE, the state has PE for children, pregnant individuals, and people who need breast and cervical cancer treatment or family planning services. Other study states (Iowa, Indiana, Oregon, and Texas) also include PE for parents, caretaker relatives, and former foster care youth. In addition, Iowa, Indiana, and Oregon also include childless adults, and Indiana also includes inmates who are hospitalized.

**Types of qualified entities.** For PE, states can include a wide variety of QEs. This gives states the option to enroll people who are uninsured but eligible for Medicaid and to help enroll people before they are sick. Oregon took a more

**Table 1. Comparison of Implementation Flexibilities in HPE and PE, by Program Design Element**

	FLEXIBILITY IN HPE?	FLEXIBILITY IN PE?
<b>State option</b>	No — HPE is mandatory	Yes
<b>Eligibility groups</b>	Limited — Many groups are required	Yes
<b>Organization types that can be qualified entities</b>	No — They must be hospitals or hospital-owned clinics	Yes
<b>Application procedures</b>	Yes	Yes
<b>Performance standards</b>	Not required, although federal guidance encourages standards	Not required

Notes: HPE is hospital presumptive eligibility; PE is presumptive eligibility.

Source: Author analysis of federal regulations and guidance. See endnotes.

expansive approach during the COVID-19 public health emergency and temporarily added certified community organizations as QEs during the COVID-19 public health emergency. Although Oregon’s Medicaid officials noted that this expansion involved increased administrative oversight and training, they agreed that the change helps to address disparities by reaching under-resourced or marginalized communities that many programs and policies otherwise fail to reach. This was one of the few practices that respondents described as specifically helpful for addressing disparities in HPE determinations.<sup>14</sup> In California, QEs for PE for children include pediatricians, family practitioners, internists, and independent certified family or pediatric nurse practitioners. (QEs for HPE include Medi-Cal hospitals and hospital-owned clinics that participate under the hospital license.) California has proposed to expand the list of QEs that can conduct PE determinations for children to all Medi-Cal providers, including federally qualified health centers, family centers, and community clinics, which have historically been eligible to conduct PE for pregnant women.

*“We did [find] recently in some data that the applications that our partners have touched 80 different preferred languages. They are in some of the most rural places in the state where other options really aren’t there. We have people who are embedded in state office provider offices, tribes, public health departments, health affairs, [and] COVID-19 testing and vaccination sites. We try very hard to be where people are and to represent the people who we are serving.”*

— Oregon Medicaid official

### Spotlight on Oregon

In response to the COVID-19 pandemic, Oregon temporarily added certified community partners as QEs. The state offered the opportunity to make PE determinations to its community partner network of about 300 organizations and 1,500 application assisters. Of these partners, 62 opted to participate, including physical care and mental health providers, faith-based organizations, nonprofits, schools, and more.

### HPE and PE application design and processes.

States have the flexibility to determine the length and detail of their HPE and PE applications, as well as the application process.<sup>15</sup> Many states, including California, have made their HPE and PE applications short and easy to complete as a way to encourage enrollment. Other states have created HPE and PE application processes that minimize the application burden for consumers and QE staff and facilitate the use of HPE and PE as an on-ramp to Medicaid. For example, in Iowa, a question on the HPE and PE application asks if applicants would also like to apply for ongoing Medicaid. If checked, the HPE and PE application automatically triggers an application for ongoing Medicaid coverage that state eligibility staff take responsibility for completing, rather than QE staff. In those cases, Iowa residents only fill out a single application. In Texas, the state’s PE portal automatically links HPE and PE applications to applications for ongoing Medicaid coverage and pre-populates certain questions on that application to improve accuracy and reduce processing time.



### Spotlight on Iowa

HPE and PE determinations require only a subset of the application fields required for a regular Medicaid application. But if the applicant wants to apply for ongoing Medicaid coverage, the QE worker makes a selection in the online portal that will display additional questions and allow the QE worker to upload any available documentation. The QE worker submits the additional application data into the online PE portal, and the data are forwarded to the state's eligibility system in a nightly batch for ongoing Medicaid determination. If additional information or verifications are required, a state eligibility worker follows up with the applicant.

*"I also think that the decision to make the ongoing Medicaid application part of the presumptive application, and automate that to the extent that we have, is a pretty efficient process. ... [T]he integration of the two really ensures that as many people as possible are not only getting presumptive, but [also] have the opportunity in the simplest way possible to go on and get ongoing Medicaid as well."*

— Iowa Medicaid official

**Online portals and communication between QEs and states.** Online portals that facilitate real-time PE determinations allow QE workers to give presumptively eligible people a Medicaid ID number and immediate coverage that helps them obtain care from multiple provider types. Some states' portals also offer additional functionality. For example, in Virginia and Iowa, applications submitted with potential errors generate error codes that give

QE workers an opportunity to make corrections. Respondents viewed enhanced portal functionality as an effective way to support PE processes. California's HPE portal provides real-time determination and the opportunity for QE workers to fix errors quickly as they finalize HPE applications, as well as a beneficiary identification number that the patient can use immediately to receive covered services from any Medi-Cal provider.

*"We already have limited uptake in the [Medicaid] program. We would have no participants if it wasn't real-time, same-day eligibility. When a person has made the decision through years of substance use that they are going into detox, we don't have the luxury to wait until Monday morning to do the application."*

— Advocate in Indiana

**QE performance standards and requirements.** Study states take a wide range of approaches to performance monitoring for HPE. Federal regulations do not require particular standards or define the way states must monitor them, although states must take action if hospitals are not meeting the standards they do establish.<sup>16</sup> (States are not required to have performance standards for PE.) Many states monitor the percentage of HPE applications that results in a regular Medicaid application and the percentage of people determined presumptively eligible through HPE who are subsequently determined eligible for ongoing Medicaid. California does not include these metrics. Its performance metrics are: (1) HPE providers must provide at least 95% of the beneficiaries with a copy of the insurance affordability application prior to release from the hospital, (2) HPE providers must provide 100% of the HPE applicants a paper copy of their HPE eligibility determination, and (3) HPE providers

must meet all HPE determination performance standards, as specified in California Department of Health Care Services provider instructions or regulations.

States also can define performance metrics or requirements that drive whether and how QEs facilitate regular Medicaid applications. In California, QEs are only required to assist if requested. Two study states, Oregon and Indiana, have a formal standard requiring QEs to facilitate regular Medicaid applications. In Oregon, the state requires that 90% of people approved for temporary coverage must receive a full application and help or resources to complete the application. Indiana requires QEs to have a process for helping applicants with the regular Medicaid application but does not require a specific process.

**Approach to quality monitoring.** In addition to tracking and monitoring performance standards, some states also regularly communicate with QEs about their performance against defined metrics and about the status of ongoing Medicaid applications for people who the QEs determined to be presumptively eligible. Several study states use high-touch, relationship-based quality assurance strategies to facilitate high conversion rates to ongoing Medicaid. For example, in Virginia, the Medicaid agency sends hospital workers reminders and emails to make sure workers help with regular applications, and it attributes the state's high conversion rates to the personal relationship between the HPE manager and the hospital workers. In Iowa, instead of requiring and monitoring performance standards, the state follows up with QEs on issues with individual PE applications, such as missing information. One hospital representative we spoke with felt the state's approach is useful and supportive. In California, because of the state's county-based eligibility system, quality monitoring and communication with QEs vary by county.

*"We haven't had to enforce [corrective action plans]. Building relationships with the hospitals makes a big difference. They have their own HPE inbox they can send questions to. They get a response from me within 24 hours."*

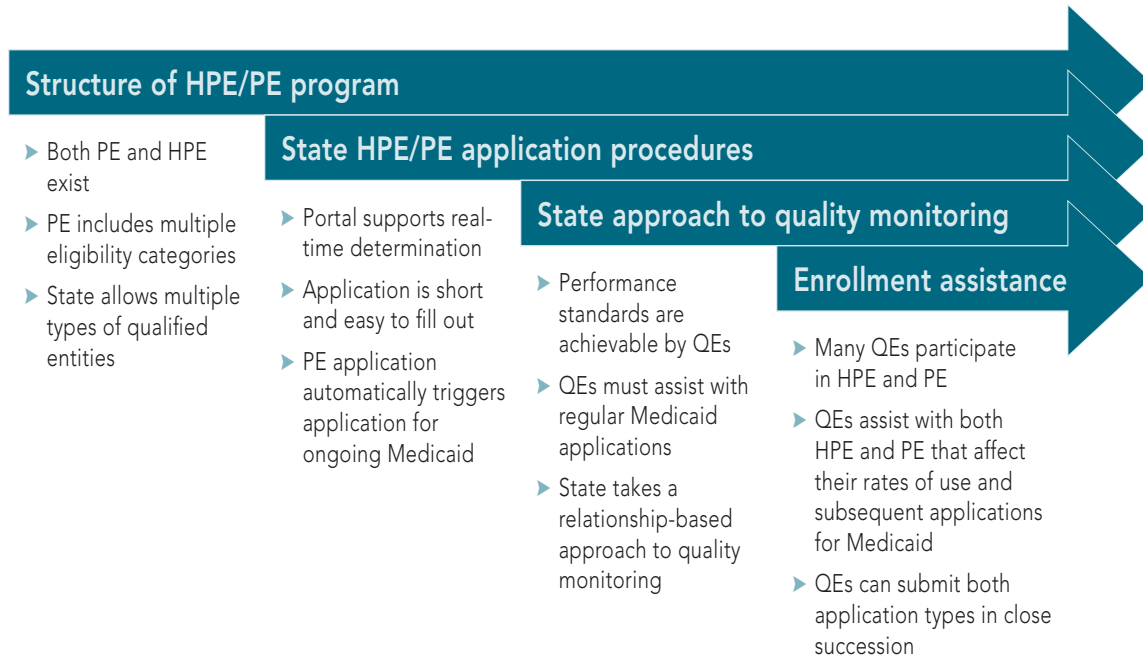
— Virginia Medicaid official

## Implementation Choices Associated with Greater Use of Hospital Presumptive Eligibility and Presumptive Eligibility as an On-Ramp to Medicaid

States and QEs have implemented PE and HPE in a range of ways that affect their rates of use and subsequent applications for ongoing Medicaid coverage. States' implementation choices drive QE participation in HPE and PE as well as the ways in which QEs assist consumers with low incomes with both HPE and PE and applications for ongoing Medicaid coverage. In turn, both state implementation choices and QE behavior affect the way people with low incomes enroll in Medicaid, the support they receive, the length of their coverage, and, ultimately, their access to care.

Figure 2 shows a collection of state choices that encourage the use of HPE and PE as an on-ramp to longer-term Medicaid coverage. The arrows denote progress toward ongoing Medicaid enrollment using HPE and PE as an initial enrollment pathway. States use different combinations of these choices. Implementing more of them, or adding those that do not currently exist in a state, might help to encourage both initial HPE/PE applications and subsequent Medicaid applications for HPE/PE enrollees.

**Figure 2. State and Qualified Entity Choices Associated with Greater Use of HPE and PE as an On-Ramp to Regular Medicaid Coverage**



Notes: HPE is hospital presumptive eligibility; PE is presumptive eligibility; QEs is qualified entities.

Source: Author interviews with 15 Medicaid officials and stakeholders across six states, March through May 2022.

## Implications for California

California has already made changes designed to help more people obtain HPE and transition to ongoing Medi-Cal. To the extent that these efforts help populations that face challenges completing the regular Medi-Cal application, they could help the Medi-Cal program foster equity in health care access and outcomes. One significant change that the state plans to make permanent is an expansion of HPE to include people age 65 and older, people who are blind, and people who have other disabilities. The state recently allowed adults to have two HPE periods per year instead of one but plans to return to a one-period limit. This could adversely affect people who face challenges with the regular Medi-Cal application, such as unhoused individuals and undocumented immigrants.

As it prepares to resume redetermining eligibility for Medi-Cal beneficiaries after the public health emergency ends (known as the 12-month “unwinding” period),<sup>17</sup> California is also adopting temporary flexibilities related to documentation requirements for regular Medi-Cal. First, the state will expand the use of asset verification reports for people age 65 and older, or who are blind or have other disabilities. These reports compile information on an individual’s liquid and nonliquid assets held in US financial institutions. In cases where these reports have complete information that can be electronically verified, applicants need not provide paper documentation. California is also raising upper limits on assets and eventually will eliminate the asset test altogether, which also will eliminate the need to verify assets.<sup>18</sup>

In addition, for groups evaluated for Modified Adjusted Gross Income (MAGI) Medi-Cal, the state will start using a reasonable compatibility threshold to compare self-reported income with federal data. Throughout the public health emergency unwinding period in 2023 and possibly later, the state will consider an applicant's self-reported income as "reasonably compatible" with federal data if there is no discrepancy or the discrepancy is no greater than 20%. Within this threshold, applicants do not have to submit separate income documentation, making the application process less burdensome. For all applicants, the state will allow the county Medi-Cal eligibility agencies to accept applicants' explanations about why their self-attested information does not align with electronic sources. The state plans to make this an automated process after the unwinding period.

Our study findings on California hospitals' experiences with HPE also point to several additional ways the state (and in some cases, counties) could further reduce the barriers that many people who receive PE face in subsequently applying for ongoing Medi-Cal coverage, including:

- ▶ **Provide clear guidance to QEs and applicants about Medi-Cal eligibility for undocumented immigrants.** This includes communicating the recent expansions of full-scope Medi-Cal eligibility regardless of immigration status. As of May 2016, all children under age 19 qualify for full-scope Medi-Cal regardless of immigration status. As of January 2020, young adult immigrants age 19 to 26 are eligible, and, as of May 2022, immigrants age 50 and older became eligible. Starting in 2024, immigrants of all ages will become eligible for full-scope Medi-Cal. Equally important, immigrants need reassurance that applying for Medi-Cal will not impact their immigration status.
- ▶ **Make the Medi-Cal application less daunting to complete.** This includes finding ways to further simplify the Single Streamlined Application, both

on paper and online. The state could consider shortening the application and making it more user friendly and understandable, such as by describing terms more clearly and ensuring that questions are asked using plain language. The state also could consider translating the application into common dialects, such as Indigenous languages spoken by people from Mexico and Guatemala.

- ▶ **Facilitate opportunities for people to demonstrate eligibility for ongoing Medi-Cal.** While continuing to support ways to make it easier for applicants to submit necessary documents and information — such as using customer portals that allow applicants to submit documents and text messages and email communications — the state could maintain and potentially expand live telephone assistance. This might be particularly helpful for people experiencing homelessness and new immigrants who might lack access to or comfort with technology or who might need assistance given language or other barriers.
- ▶ **Foster connections between QEs, county eligibility staff, and state systems to ensure applications for ongoing Medi-Cal coverage are complete and eligibility determinations can be made promptly.** Finding new ways for hospital and county workers to maintain close communications on applications for ongoing Medi-Cal will be important as county workers become busier with eligibility redeterminations after the public health emergency ends. Counties unable to place staff in hospitals that serve many uninsured and Medi-Cal patients could explore other ways to establish such connections. For example, they could match county workers to individual hospitals so that hospital staff have a clear point of contact and establish more ways to connect EAs with county workers virtually. The state could also consider allowing QEs some level of access to the eligibility system so that they can check an application's status instead

of having to contact the county for this information. For example, encouraging more EAs at QEs to become state-certified application assisters (with access to information through BenefitsCal and Covered California) would foster access to basic information on the status of applications they assisted with, as well as connect them to the latest trainings and resources those programs provide to better assist applicants.

- ▶ **Provide more guidance on policy changes to QEs and county eligibility workers to ensure they do not miss new ways to facilitate applications.** The state could more regularly and proactively share written updates on policy changes with QEs to keep EAs apprised of changes and how to implement them. Providing regular virtual training sessions, especially on more complex changes, also could help EAs interpret the changes, ask questions, and engage in example scenarios that they might encounter with the patients they assist. County eligibility offices could provide additional support and training to QEs in person or virtually. The state also could consider providing more guidance and training to county eligibility workers to ensure consistency and compliance across counties on what they request and accept to determine eligibility. For example, the state could clarify the requirement that the county eligibility workers accept verbal signatures from Medi-Cal applicants to ensure consistency in this practice.

Our findings on HPE and PE implementation choices in other states and on respondents' views of their effectiveness suggest additional options for California. These are policy and programmatic choices not currently in place in Medi-Cal but that might be feasible in California's county-based eligibility determination structure, including:

- ▶ **Expand the range of QEs for PE.** California allows ambulatory care providers but not community organizations to serve as QEs. Expanding

the range of QEs to include community organizations, such as community centers or schools, could help to increase PE determinations by reaching people in communities that Medi-Cal may otherwise fail to reach, such as immigrants or people who speak languages other than English.

- ▶ **Explore application design options to facilitate transitions to ongoing Medi-Cal coverage.** California does have a purposely short and easy-to-use HPE and PE application, but it does not use that application to pre-populate or trigger an application for ongoing Medi-Cal coverage. The state could review questions that overlap across the two applications and explore possibilities for pre-populating and triggering the Medi-Cal application. For example, with the applicant's consent, the HPE portal could push data to CalHEERS (California Healthcare Eligibility, Enrollment, and Retention System) to generate an application for ongoing coverage automatically and potentially enable the applicant to receive accelerated enrollment into ongoing Medi-Cal. To make the most of a change like this, California also could consider strategies to establish more warm handoffs between the hospital staff and county eligibility workers, as well as other ways to support and expand county eligibility workers' capacity to help complete partially pre-populated regular Medicaid applications, similar to eligibility workers' responsibilities in Iowa.
- ▶ **Require and provide support for QEs to assist HPE enrollees with applications for ongoing Medi-Cal coverage.** QEs in California are not required to assist with applications for ongoing Medi-Cal coverage unless consumers request support. Although the state requires QEs to give HPE enrollees an application, without a requirement to help them apply, many HPE enrollees could be unaware of the importance of applying or struggle to complete the application. The state also could revisit and invite input on the communications that PE enrollees receive

about the need to apply for ongoing coverage, to ensure that the messaging and language are clear and delivered in a proactive manner (i.e., hospitals could avoid simply distributing applications among the papers that a patient receives after receiving care).

- ▶ **Ensure quality monitoring is relationship based and consistent across counties.** California does conduct some high-touch, relationship-based communications with QEs to ensure applications for ongoing Medi-Cal coverage are completed, but the state could increase consistency across counties. The experiences of the study states suggest this approach can help QEs support consumers, whereas strict performance standards for the percentage of completed regular Medicaid applications present more of a burden for QEs and may decrease their interest in assisting with HPE.
- ▶ **Enhance HPE and PE data collection to understand how many HPE/PE enrollees subsequently apply for Medi-Cal and the potential disparities in HPE/PE applications.** California regularly collects and reports the percentage of people gaining PE who ultimately enroll in Medi-Cal, but does not currently collect data on rates of Medi-Cal applications among HPE/PE enrollees.<sup>19</sup> This would be a useful metric for understanding the use of HPE/PE as an on-ramp to longer-term coverage, whether through Medi-Cal or other options. California could collect and analyze demographic data on HPE and PE applicants to understand whether this enrollment pathway is equally accessible to different communities and which HPE enrollees are able to complete subsequent Medi-Cal applications.

## Avenues for Further Research

These two studies examining HPE and PE have limitations that point to the potential usefulness of further research. The sample size for both studies was small, and the findings might not generalize to all California hospitals, to all QEs within the study states, or to all states. Neither study included the perspectives of individuals applying for Medicaid, nonhospital PE entities, nor Medicaid managed care plans. To gain a more comprehensive picture of the potential for using HPE and PE as an on-ramp to ongoing coverage through Medi-Cal or Covered California, the following potential studies could be fruitful:

- ▶ A survey of a large number of hospitals in California or other states could generate systematic findings on the relative prevalence of application assistance strategies.
- ▶ A larger mixed-methods study within California or among more states could examine the relationship between the ways that QEs assist people with applications and who and how many people ultimately apply for and enroll in Medi-Cal or Covered California.
- ▶ Surveys or interviews with applicants could generate useful findings on their perspectives about what works well and what is challenging in applying to Medi-Cal after receiving PE.
- ▶ Interviews with Medicaid managed care plans in California and other states could increase our understanding of the role plans play, or could potentially play, in helping individuals transition from PE to ongoing Medicaid. In California, a high and growing percentage of Medi-Cal enrollees are enrolled in managed care plans. Plans have an incentive to ensure eligible individuals in their service areas gain and retain coverage.

## Conclusion

Presumptive eligibility (PE) is an important tool for states to enroll people with low incomes into temporary Medicaid coverage. As California continues to expand eligibility for Medi-Cal, its Medicaid program, policymakers can learn from the experience of hospitals in California and the PE implementation choices of other states to ensure PE is an effective on-ramp for ongoing coverage. Findings from these studies suggest several improvements that would make it easier and more likely for PE enrollees, including individuals who are undocumented, experiencing homelessness, or otherwise likely to be eligible but not enrolled in Medi-Cal, to get the help they need to submit an application for ongoing coverage before their temporary Medi-Cal coverage ends. These improvements thus have the potential to avoid unnecessary coverage gaps and remove barriers to care, moving California toward a more just and equitable health care system.

## Endnotes

1. In California, individuals generally apply for ongoing Medi-Cal coverage by completing a Single Streamlined Application. This application is used to determine whether they are eligible for Medi-Cal, including both full-scope Medi-Cal and limited or restricted-scope Medi-Cal that covers emergency services and pregnancy-related services for people who otherwise meet the eligibility criteria for Medi-Cal but do not have a satisfactory immigration status. In addition, the Single Streamlined Application is used to determine whether they are eligible for subsidized or unsubsidized private insurance through the state's marketplace, Covered California. Throughout this document, references to an application for ongoing Medi-Cal coverage thus generally also mean an application for coverage through Covered California.
2. See, for example, *Implementation of the Affordable Care Act's Hospital Presumptive Eligibility Option: Considerations for States* (PDF), Medicaid.gov, November 2013; "Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage," Center for Children and Families, Georgetown University Health Policy Institute, May 5, 2011; and *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (PDF), Centers for Medicare & Medicaid Services, January 2014.
3. Nia West-Bey and Kayla Tawa, "Unlocking Transformation and Healing: Community-Based Care Policy Options for Youth and Young Adults," Center for Law and Social Policy, June 16, 2020.
4. "Memorandum from PATH Team at CLASP to Renee Ensor-Pope, Jaqueline Duval-Harvey, Eugenia Greenhood Regarding: Presumptive Eligibility and Hospital Presumptive Eligibility," Center for Law and Social Policy, March 3, 2020.
5. Jessica Schubel and Jennifer Wagner, "State Medicaid Changes Can Improve Access to Coverage and Care During and After COVID-19 Crisis," Center on Budget and Policy Priorities, September 9, 2020.
6. It is a federal requirement that the presumptive eligibility (PE) period begins with and includes the day the hospital makes the determination. See *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (PDF), page 2, Centers for Medicare & Medicaid Services, January 2014.
7. Sandra Williams (chief, Medi-Cal Eligibility Div., California Department of Health Care Services) to all county welfare directors, *Medi-Cal Eligibility Division Information Letter No.: I 19-1720-12* (PDF), June 21, 2019.
8. The enrollment assisters (EAs) are employed by the hospitals. The funding source(s) used to support their salaries are unknown.

9. California is in the process of raising upper limits on assets and eventually will eliminate the asset test altogether, which will also eliminate the need to verify assets. **"Asset Limit Changes for Non-MAGI Medi-Cal,"** California Department of Health Care Services (DHCS), accessed July 21, 2022.
10. **Public Charge Guide** (PDF), California Health and Human Services Agency, updated October 2021.
11. Gray literature sources include the following:
  - West-Bey and Tawa, "Unlocking Transformation and Healing."
  - Tricia Brooks, **Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage** (PDF), Georgetown University, Health Policy Institute, May 2011.
  - "Memorandum from PATH Team," CLASP.
  - Hospital Presumptive Eligibility** (PDF), Centers for Disease Control and Prevention, Office for State, Tribal, Local, and Territorial Support, n.d.
  - Shannon McMahon, Maia Crawford, and Christian Heiss, **"Implementation of the Affordable Care Act's Hospital Presumptive Eligibility Option: Considerations for States,"** Center for Health Care Strategies, November 2013.
  - Schubel and Wagner, "State Medicaid Changes."
12. See 42 C.F.R. § 435.1103 (2013). The option to include populations other than children and pregnant individuals was created by the Affordable Care Act of 2010.
13. **Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs** (PDF), Centers for Medicare & Medicaid Services, January 2014.
14. No study state reported tracking or analyzing disparities in hospital presumptive eligibility (HPE) determinations by race, ethnicity, or other characteristics. Respondents described lack of data on applicants' race and ethnicity and language barriers as challenges to addressing disparities that might exist. For example, a Medicaid official in Iowa noted that although the state tried to simplify the language in its Medicaid applications, people in immigrant communities might not understand the terminology or how the program works. At the same time, as an Indiana Medicaid official noted, the relative simplicity of the HPE application might make HPE determinations more equitable than regular applications, which are difficult for people to complete, especially if they do not have a fixed address or telephone number.
15. According to guidance from the Centers for Medicare & Medicaid Services, states can ask applicants to attest to citizenship, immigration status, and residency status, but they cannot hold up HPE determinations to verify these statuses. Verification is required, however, for regular non-temporary Medicaid eligibility determinations. Respondents in our study states described challenges with assisting HPE/PE enrollees with regular applications when there are differences between HPE/PE applications and regular applications because they have incomplete information on citizenship, immigration, and residency status when determining PE. See endnote 6.
16. See 42 C.F.R. § 435.1110 (2013).
17. "Medi-Cal COVID-19 Public Health Emergency Operational Unwinding Plan," DHCS, May 17, 2022.
18. "Asset Limit Changes," DHCS.
19. **Medi-Cal Enrollment Update** (PDF), DHCS, May 24, 2022.



## Appendix A. Hospital Presumptive Eligibility and Presumptive Eligibility Implementation Choices in Study States and in California

IOWA	INDIANA	OREGON*	TEXAS	VIRGINIA	CALIFORNIA
<b>Eligibility groups</b>					
<p>In addition to HPE, PE for:</p> <ul style="list-style-type: none"> <li>▶ Children in Medicaid and CHIP</li> <li>▶ Pregnant individuals</li> <li>▶ Parents and caretaker relatives</li> <li>▶ Childless adults</li> <li>▶ People eligible for BCCT</li> <li>▶ Former foster care youth</li> </ul>	<p>In addition to HPE, PE for:</p> <ul style="list-style-type: none"> <li>▶ Children in Medicaid (but not in CHIP)</li> <li>▶ Pregnant individuals</li> <li>▶ Parents and caretaker relatives</li> <li>▶ Childless adults</li> <li>▶ Former foster care youth</li> <li>▶ Inmates who are hospitalized</li> </ul>	<p>In addition to HPE, PE for:</p> <ul style="list-style-type: none"> <li>▶ Children in Medicaid and CHIP</li> <li>▶ Pregnant individuals</li> <li>▶ Parents and caretaker relatives</li> <li>▶ Childless adults</li> <li>▶ People eligible for BCCT</li> <li>▶ Former foster care youth</li> </ul>	<p>In addition to HPE, PE for:</p> <ul style="list-style-type: none"> <li>▶ Pregnant individuals</li> <li>▶ Parents and caretaker relatives</li> <li>▶ Former foster care youth</li> <li>▶ People eligible for Medicaid for BCCT</li> </ul>	<p>HPE only</p>	<p>In addition to HPE, the state also has PE for:</p> <ul style="list-style-type: none"> <li>▶ Children in Medicaid (no separate CHIP)</li> <li>▶ Pregnant individuals</li> <li>▶ People eligible for BCCT</li> </ul>
<b>Qualified entities for PE</b> (For HPE, QEs are hospitals and hospital-owned clinics.)					
<p>Medicaid and CHIP providers, including FQHCs and health departments</p>	<p>Acute care hospitals, freestanding psychiatric hospitals, FQHCs, RHCs, community mental health centers, and county health departments. QEs exclusively for PE for pregnant women in Indiana include family practitioners, general practitioners, ob/gyns, internists, pediatricians, family planning clinics, nurse practitioners, and nurse midwives.</p>	<p>In response to the COVID-19 pandemic, Oregon temporarily added certified community partners as QEs. When the PHE ends, certified community partners will no longer qualify as QEs (only hospitals).</p>	<p>For HPE, hospitals or hospital-owned clinics that are Medicaid providers. QEs for PE are Medicaid providers and other organizations, such as schools, clinics, and tribal entities.</p>	<p>N/A (HPE only)</p>	<p>Medi-Cal hospitals and hospital-owned clinics that participate under the hospital license. For PE for children, the state has proposed to expand the list of QEs for PE for children to all Medi-Cal providers.</p>

IOWA	INDIANA	OREGON*	TEXAS	VIRGINIA	CALIFORNIA
<b>Application design</b>					
HPE and PE application triggers full Medicaid application if the consumer requests this (in which case consumers only complete one application).	Short-form application	Short-form application	Short-form application that pre-populates some information in the regular Medicaid application	Short-form application	Short-form application
<b>Functions of online HPE and PE portals</b>					
Real-time determination Identify the PE category and eligibility group that the patient fits in Applications with errors generate error codes so workers can double-check and possibly fix them.	Real-time determination	No portal. QEs fax HPE and regular applications.	Real-time determination	Real-time determination Applications with errors generate error codes so workers can double-check and possibly fix them.	Real-time determination Applications with errors generate error codes so workers can double-check and possibly fix them.
<b>Performance standards</b>					
State does not collect performance data.	<ul style="list-style-type: none"> <li>▶ Of PE eligible members, 95% complete a regular Medicaid application.</li> <li>▶ Of regular Medicaid applications, 90% are completed correctly.</li> <li>▶ Of PE members who submitted a regular Medicaid application, 95% are determined eligible for regular Medicaid.</li> </ul>	<p>90% of the time, the provider's determinations must be correct about the applicant not having current Medicaid coverage or HPE coverage within the past 12 months.</p> <p>Of people approved for temporary coverage:</p> <ul style="list-style-type: none"> <li>▶ 90% must receive a full application and help or resources completing the application.</li> <li>▶ Who complete a full application, 90% must turn out to be eligible for full Oregon Health Plan coverage.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Of people who are determined eligible for HPE, 95% submit a regular application.</li> <li>▶ Of HPE determinations by hospital and corresponding regular application, 95% are electronically submitted within one workday and 100% within five working days.</li> <li>▶ Of people determined HPE, 97% are determined eligible for Medicaid based upon submission of a regular application.</li> </ul>	<p>Of HPE determinations:</p> <ul style="list-style-type: none"> <li>▶ 85% will result in the submission of a full Medicaid application for continued coverage.</li> <li>▶ At least 70% will result in people being determined eligible for Medicaid based on submission of a full application.</li> </ul>	<p>HPE providers must:</p> <ul style="list-style-type: none"> <li>▶ Provide at least 95% of the beneficiaries with a copy of the insurance affordability application prior to release from the hospital.</li> <li>▶ Provide 100% of HPE applicants with a paper copy of their HPE eligibility determination.</li> <li>▶ Meet all HPE determination performance standards, as specified in California Department of Health Care Services' provider instructions or regulations.</li> </ul>

IOWA	INDIANA	OREGON*	TEXAS	VIRGINIA	CALIFORNIA
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**Requirements for QEs to assist consumers with completing regular Medicaid applications**

N/A. An HPE/PE application automatically triggers a regular Medicaid application if requested by the consumer, which state eligibility workers complete.	QEs must have a process, but the process can vary.	QEs are required to help people approved for temporary coverage with a full application and help or resources in completing the application; in practice, this sometimes consists of referring applicants to a community partner.	QEs are required to help consumers with regular Medicaid applications but are not expected to ensure documentation is complete.	The state encourages QEs to direct consumers to Cover Virginia, a centralized enrollment hub, or to county workers to complete regular Medicaid applications.	QEs must help complete applications for ongoing Medi-Cal coverage if consumers request it.
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**Quality assurance**

State follows up with QEs on issues with individual applications.	N/A. Indiana does not routinely communicate with QEs on individual applications.	Outside of the PHE, the state conducts regular site visits for on-site QE support.	Medicaid agency meets with QEs monthly and communicates with some daily.	Medicaid agency sends hospital workers reminders and emails to make sure workers help with regular applications.	Varies by county
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**Training for QEs**

Self-directed online training; required annually	Fiscal agent provides one-time training to QEs. Training is once per entity, not once per individual. People are trained by other providers in the hospital.	Self-directed online training; required annually	Online training	Self-directed online training	Self-directed online training
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\* In Oregon, certified community partners include physical care and mental health providers, faith-based organizations, nonprofits, and schools.

Notes: *BCCT* is breast and cervical cancer treatment; *CHIP* is Children’s Health Insurance Program; *FQHC* is Federally Qualified Health Center; *HPE* is hospital presumptive eligibility; *N/A* is not applicable; *QE* is qualified entity; *PE* is presumptive eligibility; *PHE* is COVID-19 public health emergency; *RHC* is Rural Health Clinic.

Sources: Publicly available policy and program guidelines on all study states’ websites and information collected in interviews with state Medicaid officials in the five study states (besides California). Information on whether states have PE for children (in Medicaid, CHIP, or both) is from Medicaid.gov and is current as of August 2021.