907 KAR 20:050. Presumptive eligibility.

RELATES TO: KRS 205.520(3), 205.592, 42 U.S.C. 1396a(a)(47), r-1
STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050(1), 205.520(3)
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. KRS 205.592 establishes Medicaid eligibility requirements for pregnant women and children up to age one (1). This administrative regulation establishes requirements for the determination of presumptive eligibility and the provision of services to individuals deemed presumptively eligible for Medicaid-covered services.

Section 1. Providers Eligible to Grant Presumptive Eligibility. (1) A determination of presumptive eligibility regarding:
(a) A pregnant woman shall be made by a qualified provider who is:
1. A family or general practitioner;
2. A pediatrician;
3. An internist;
4. An obstetrician or gynecologist;
5. A physician assistant;
6. A certified nurse midwife;
7. An advanced practice registered nurse;
8. A federally-qualified health care center;
9. A primary care center;
10. A rural health clinic; or
11. A local health department; or
(b) An individual whose income standard for Medicaid eligibility purposes is a modified adjusted gross income shall be made by an inpatient hospital participating in the Medicaid Program.
(2) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be an individual identified in 907 KAR 20:100 as having a modified adjusted gross income as the Medicaid income eligibility standard.

Section 2. Provider Responsibilities. (1) A qualified provider who determines that an individual is presumptively eligible for Medicaid based on criteria established in Section 3 of this administrative regulation shall:
(a) Notify the department and obtain an authorization number;
(b) Inform the individual at the time the determination is made that the individual is required to make an application for Medicaid benefits through the individual’s local DCBS office;
(c) Inform the individual of the location of the individual’s local DCBS office;
(d) Issue presumptive eligibility identification to the presumed eligible individual; and
(e) Maintain a record of the presumptive eligibility screening for each applicant.
(2) If an individual is determined not to be presumptively eligible, the qualified provider shall inform the individual of the following in writing:
(a) The reason for the determination;
(b) That the individual may file an application for Medicaid if the individual wishes to have a formal determination made; and
(c) The location of the individual’s local DCBS office.

Section 3. Eligibility Criteria. Presumptive eligibility shall be granted to:
(1) A woman if she:
(a) Is pregnant;
(b) Is a Kentucky resident;
(c) Does not have income exceeding 195 percent of the federal poverty level established annually by the United States Department of Health and Human Services pursuant to 42 U.S.C. 9902(2);
(d) Does not currently have a pending Medicaid application on file with the DCBS;
(e) Is not currently enrolled in Medicaid;
(f) Has not been previously granted presumptive eligibility for the current pregnancy; and
(g) Is not an inmate of a public institution, except as established in 907 KAR 20:005, Section 7(2); or
(2) An individual whose Medicaid income eligibility standard is a modified adjusted gross income if the individual:
(a) Is a Kentucky resident;
(b) Does not have income exceeding:
1. 133 percent of the federal poverty level established annually by the United States Department of Health and Human Services pursuant to 42 U.S.C. 9902(2); or
2. 150 percent of the federal poverty level established annually by the United States Department of Health and Human Services pursuant to 42 U.S.C. 9902(2), if the individual is a targeted low-income child;
(c) Does not currently have a pending Medicaid application on file with the DCBS;
(d) Is not currently enrolled in Medicaid; and
(e) Is not an inmate of a public institution except as established in 907 KAR 20:005, Section 7(2).

Section 4. Presumptive Eligibility Period. (1) Presumptive eligibility for an individual shall begin on the date on which a qualified provider:
(a) Determines that the individual is presumptively eligible based on the criteria specified in Section 3 of this administrative regulation if the qualified provider obtains an authorization number from the department on:
1. That day; or
2. If the department is closed, the next business day the department is open; or
(b) Obtains an authorization number from the department if it is not the day specified in paragraph (a) of this subsection.
(2) The presumptive eligibility period shall end on:
(a) The day preceding the date the presumptively-eligible individual is granted full eligibility in the Medicaid Program by the DCBS; or
(b) The last day of the month following the month in which a qualified provider made the presumptive eligibility determination if the presumed eligible individual:
1. Does not apply for the full Medicaid benefit package; or
2. Applies for and is found ineligible for the full Medicaid benefit package.
(3) To illustrate the presumptive eligibility period, if an individual became presumptively eligible on July 7, 2014, the individual shall remain presumptively eligible through August 31, 2014.
(4) For a woman who gains presumptive eligibility by being pregnant, only one (1) presumptive eligibility period shall be granted for each episode of pregnancy.

Section 5. Covered Services. (1)(a) Payment for a covered service provided to a presumptively-eligible individual shall be in accordance with the current Medicaid reimbursement policy for the service unless the service is provided to an individual who is enrolled with a managed care organization.

(b) A managed care organization:

1. Shall not be required to reimburse in the same manner or amount as the department reimburses for a Medicaid-covered service provided to a presumptively eligible individual; or

2. May elect to reimburse in the same manner or amount as the department reimburses for a Medicaid-covered service provided to a presumptively eligible individual.

(2) Covered services for a presumptively-eligible:

(a) Pregnant woman shall be limited to ambulatory prenatal care services delivered in an outpatient setting and shall include:

1. Services furnished by a primary care provider, including:

a. A family or general practitioner;

b. A pediatrician;

c. An internist;

d. An obstetrician or gynecologist;

e. A physician assistant;

f. A certified nurse midwife; or

g. An advanced practice registered nurse;

2. Laboratory services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

3. Radiological services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

4. Dental services provided in accordance with 907 KAR 1:026;

5. Emergency room services provided in accordance with 907 KAR 10:014;

6. Emergency and nonemergency transportation provided in accordance with 907 KAR 1:060;

7. Pharmacy services provided in accordance with 907 KAR 23:010;

8. Services delivered by rural health clinics provided in accordance with 907 KAR 1:082;

9. Services delivered by primary care centers, federally-qualified health centers, and federally-qualified health center look-alikes provided in accordance with 907 KAR 1:054; or

10. Primary care services delivered by local health departments provided in accordance with 907 KAR 1:360; or

(b) Individual who is not a pregnant woman shall include:

1. Services furnished by a primary care provider, including:

a. A family or general practitioner;

b. A pediatrician;

c. An internist;

d. An obstetrician or gynecologist;

e. A physician assistant;

f. A certified nurse midwife; or

g. An advanced practice registered nurse;

2. Laboratory services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

3. Radiological services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

4. Dental services provided in accordance with 907 KAR 1:026;

5. Emergency room services provided in accordance with 907 KAR 10:014;

6. Emergency and nonemergency transportation provided in accordance with 907 KAR 1:060;

7. Pharmacy services provided in accordance with 907 KAR 23:010;

8. Services delivered by rural health clinics provided in accordance with 907 KAR 1:082;

9. Services delivered by primary care centers, federally-qualified health centers, and federally-qualified health center look-alikes provided in accordance with 907 KAR 1:054;

10. Primary care services delivered by local health departments provided in accordance with 907 KAR 1:360; or

11. Inpatient or outpatient hospital services provided by a hospital.

Section 6. Appeal Rights. (1) The appeal rights of the Medicaid Program shall not apply if an individual is:

(a) Determined not to be presumptively eligible; or

(b) Determined to be presumptively eligible but fails to file an application for Medicaid with the DCBS before the individual's presumptive eligibility ends and therefore is determined to be ineligible for Medicaid benefits.

(2) The appeal rights of the Medicaid Program shall apply if an individual is:

(a) Determined to be presumptively eligible; and

(b) Files an application with the DCBS but is determined ineligible for Medicaid benefits.

(3) Except as specified in subsection (1) of this section, an appeal of a negative action taken by the department regarding a Medicaid recipient shall be in accordance with:

(a) 907 KAR 1:563 if the individual is:

1. Not enrolled with a managed care organization; or

2. Enrolled with a managed care organization and the individual has exhausted the MCO internal appeal process in accordance with 907 KAR 17:010 and requests an appeal of an adverse decision by the MCO; or

(b) 907 KAR 17:010 if the individual is enrolled with a managed care organization.

(4) Except as specified in subsection (1) of this section, an appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(5) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.

Section 7. Quality Assurance and Utilization Review. The cabinet shall evaluate, on a continuing basis, access, continuity of care, health outcomes, and services arranged or provided by a Medicaid provider to a presumptively eligible individual in accordance with accepted standards of practice for medical service. (28 Ky.R. 2133; 2355; eff. 4-30-2002; TAm eff. 5-3-11; Recodified from 907 KAR 1:810, 9-30-2013; 40 Ky.R. 1189; 1793; 2174; eff. 4-4-2014; TAm eff. 10-6-2017; Crt eff. 12-6-2019.)