

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Health Care Policy

(Amendment)

907 KAR 20:050. Presumptive eligibility.

RELATES TO: KRS 205.520(3), ~~205.5375(7)~~, 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) Complete the paper or electronic application approved by the department pursuant to Section 8 of this administrative regulation;

(b) Enter the data into the department's Integrated Eligibility and Enrollment System (IEES) self-service portal for a real-time eligibility determination;

(c)

1. [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 or via the IEES self-service portal; and

2. Inform the individual of any other requirements pursuant to KRS 205.5375(2)(b);
~~(d) [(e)]~~ Inform the individual of the location of the individual's local DCBS office;
~~(e) [(d)]~~ Issue presumptive eligibility identification to the presumed eligible individual;
~~[(and)]~~
~~(f) [(e)]~~ Maintain a record of the presumptive eligibility screening for each applicant
for at least five (5) years; and
~~(g) Complete and securely submit the form described in Section 8(3) of this~~
administrative regulation to the department or the department's designee.
- (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.
- (3) A qualified provider shall, as appropriate, assist the patient with a full Medicaid application pursuant to KRS 205.5375(2)(e).

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 218~~[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) and as consistent with 907 KAR 4:030;
 - (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. 218 ~~[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, as consistent with 907 KAR 4:020;
 - (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 loses presumptive eligibility at the end of the presumptive eligibility period~~[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.

(1) 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.

(2) A hospital's determination that an individual does not meet criteria for presumptive eligibility shall be consistent with KRS 205.5375 and Section 2 of this administrative regulation.

Section 8. Department Established Training and Presumptive Eligibility Form.

(1)

(a) As required by KRS 205.5375, and in collaboration with the Kentucky Hospital Association and each academic medical center, the department shall institute and conduct a training at least once every twelve (12) months that addresses current state and federal laws related to presumptive eligibility for all qualified hospitals.

(b) The training may include a component that demonstrates and clarifies use of the most current presumptive eligibility application form that is designated by the department for use by the qualified hospitals.

(c)

1. The training required pursuant to this subsection shall be available in an on-demand format for review by all interested qualified hospital staff.

2. At the request of the department, the Kentucky Hospital Association, or any of the academic medical centers the training may also be conducted virtually or in-person.

3. The most current on-demand version of the training shall be hosted on the department's Web site at: <https://chfs.ky.gov/agencies/dms/Pages/training.aspx>.

(2) The department, in consultation with the Kentucky Hospital Association and any academic medical center, shall establish a comprehensive and thorough presumptive eligibility application form for use by each qualified hospital when making presumptive eligibility determinations.

(a) The form shall be:

1. Updated within thirty (30) days of a relevant or substantial change in applicable state and federal law relating to presumptive eligibility;

2. A current and comprehensive document that assists a hospital contractor, employee, or volunteer in completing and making an accurate determination relating to the presumptive eligibility status of an individual; and

3. Available on the department's Web site at: <https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/hospital.aspx>

(b) The form may be utilized by a qualified hospital as a paper application or within an eligibility application as allowable pursuant to current state and federal law.

(3)

(a) In accordance with KRS 205.5375(2)(a), the department, in consultation with the Kentucky Hospital Association and any academic medical center, shall establish a notification form for a qualified hospital to use to notify the department, or designee, of a determination that an individual is presumptively eligible for Medicaid.

(b) The form shall be:

1. Updated within thirty (30) days of a relevant or substantial change in applicable state and federal law relating to notifications of presumptive eligibility; and

2. Available on the department's Web site at: <https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/hospital.aspx>

(4) The department and a qualified hospital shall observe appropriate privacy and confidentiality standards of state and federal law, including 45 C.F.R. Part 164, in

transmitting a completed form that is determined to contain protected health information.
This may include:

- (a) Use of encrypted email;
- (b) Use of other encrypted electronic file transfer systems; or
- (c) Any other department approved secure method of sharing personally identifiable health information that is allowable pursuant to state and federal law.

LISA D. LEE, Commissioner

ERIC C. FRIEDLANDER, Secretary

APPROVED BY AGENCY: October 6, 2022

FILED WITH LRC: October 11, 2022 at 3 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on December 21, 2022, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by December 14, 2022, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until December 31, 2022. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Specialist, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-6746; fax 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Jonathan Scott

(1) Provide a brief summary of:

(a) What this administrative regulation does:

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.

(b) The necessity of this administrative regulation:

This administrative regulation is necessary to establish requirements for the determination of presumptive eligibility and the provision of services to individuals deemed presumptively eligible for Medicaid-covered services.

(c) How this administrative regulation conforms to the content of the authorizing statutes:

This administrative regulation conforms to the content of the authorizing statutes by establishing requirements for the determination of presumptive eligibility and the provision of services to individuals deemed presumptively eligible for Medicaid-covered services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes:

This administrative regulation assists in the effective administration of the statutes by establishing requirements for the determination of presumptive eligibility and the provision of services to individuals deemed presumptively eligible for Medicaid-covered services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation:

The amendment changes the administrative regulation by incorporating changes made by 2022's HB 7. The administrative regulation requires DMS to collaborate with the KHA and academic medical centers to institute an annual training process, and to establish a comprehensive form to assist with the use of presumptive eligibility within the qualified hospital setting. In addition a form and process for informing DMS of a presumptive eligibility decision within 5 days is being created. The administrative regulation also clarifies expected privacy standards for transfer of documents by qualified hospitals and DMS.

(b) The necessity of the amendment to this administrative regulation:

The amendment is required to reflect changes made to presumptive eligibility by 2022's HB 7.

(c) How the amendment conforms to the content of the authorizing statutes:

The amendment complies with 2022's HB 7's changes to the department's presumptive eligibility procedures.

(d) How the amendment will assist in the effective administration of the statutes:

The amendment incorporates changes made by 2022's HB 7.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:

This administrative regulation impacts the department and more than 70 public and private hospitals who may provide presumptive eligibility services as qualified hospitals.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment:

. Regulated entities will need to comply with HB 7, and utilize the application forms implemented by the administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3):

. DMS will be developing training and application forms as a part of this legislative implementation. DMS expects that costs to regulated entities to comply will be minimal, if any.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3):

. The regulated entities will be able to continue providing presumptive eligibility determinations. (5) Provide an estimate of how much it will cost to implement this administrative regulation:

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially:

DMS will absorb any costs to implement this administrative regulation on an initial basis consistent with requirements established in the state executive branch budget pursuant to HB 1 of the 2022 Regular Session.

(b) On a continuing basis:

DMS will absorb any costs to implement this administrative regulation on a continuing basis consistent with requirements established in the state executive branch budget pursuant to HB 1 of the 2022 Regular Session.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation:

Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and restricted appropriation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment:

Neither an increase in fees nor funding will be necessary to implement the amendments.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees:

The amendment does not establish or increase any fees.

(9) TIERING: Is tiering applied?

is not applied in this administrative regulation as it applies equally to all entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

(1) Federal statute or regulation constituting the federal mandate.

42 U.S.C. 1315, 42 U.S.C. 1396a(e)(14)(C) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

(2) State compliance standards.

KRS 205.520(3) authorizes the cabinet to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

(3) Minimum or uniform standards contained in the federal mandate.

The federal law prohibits the application of a resource test to the MAGI population or to the former foster care population.

(4) Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

No.

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

N/A

FISCAL NOTE

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation?

The Department for Medicaid Services

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation.

KRS 194A.030(2), 194A.050(1), 205.520(3), 205.5375

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year?

The amendment is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years?

The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year?

DMS will absorb any costs to implement this administrative regulation on an initial basis consistent with requirements established in the state executive branch budget pursuant to HB 1 of the 2022 Regular Session.

(d) How much will it cost to administer this program for subsequent years?

DMS will absorb any costs to implement this administrative regulation on an initial basis consistent with requirements established in the state executive branch budget pursuant to HB 1 of the 2022 Regular Session.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year?

DMS does not anticipate that cost savings will be generated for regulated entities as a result of the amendments to this administrative regulation in the first year. This administrative regulation may result in higher reimbursement for regulated entities.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years?

DMS does not anticipate that cost savings will be generated for regulated entities as a result of the amendments to this administrative regulation in subsequent years. This administrative regulation may result in higher reimbursement for regulated entities.

(c) How much will it cost the regulated entities for the first year?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in the first year.

(d) How much will it cost the regulated entities for subsequent years?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Cost Savings (+/-):

Expenditures (+/-):

Other Explanation:

(5) Explain whether this administrative regulation will have a major economic impact, as defined below.

"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars (\$500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)] The administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities.