



Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage

by Tricia Brooks

Presumptive eligibility for parents and adults is now a state option and can help states move toward more coordinated family-based coverage.

Introduction

As a state policy option designed to expedite immediate access to needed health care services, presumptive eligibility does double duty in effectively connecting uninsured, eligible children and pregnant women to health coverage through Medicaid and the Children’s Health Insurance Program (CHIP). The policy gives states the option to train specific “qualified entities,” such as health care providers, schools, government agencies and community-based organizations, to screen for eligibility and temporarily enroll children and pregnant women in Medicaid or CHIP.¹ Individuals determined presumptively eligible can secure covered health care services without delay while they complete the regular application process for ongoing coverage.

Statutory Background

Presumptive eligibility in Medicaid was first established as a state option to accelerate access to ambulatory prenatal care services for pregnant women, but it now can be used more broadly for children and other adults.² In light of its success for pregnant women,³ Congress extended the option to children in Medicaid when CHIP was enacted in 1997.⁴ In 2010, the Affordable Care Act (ACA) added a new population to presumptive eligibility, giving states the flexibility to extend it to include parents and other adults eligible for Medicaid.⁵ This is an important step that can help states move to more coordinated family-based coverage.

Notably, the ACA will give hospitals that provide Medicaid services the prerogative to make presumptive eligibility decisions regardless of whether the state otherwise has adopted the option. This authority

goes into effect in 2014 along with the new national income eligibility floor for Medicaid of 133 percent of the federal poverty level (FPL). Given this new reality, states may want to consider implementing presumptive eligibility now to get their systems and processes in place in advance of 2014.

Financing

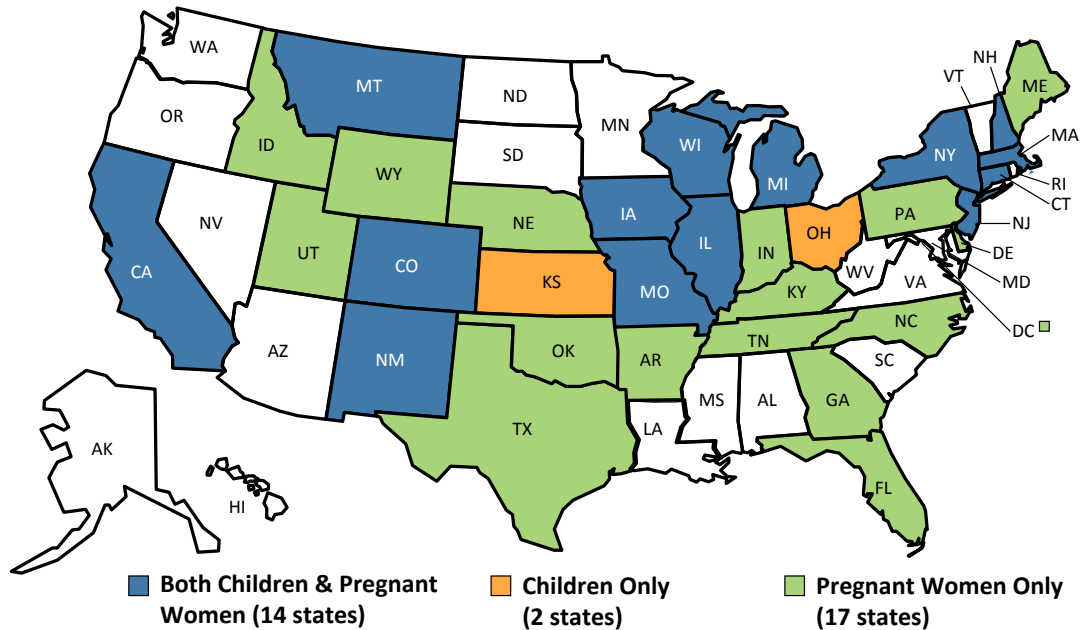
The financing of presumptive eligibility is relatively straightforward now but it hasn’t always been that way.⁶ During the presumptive eligibility period, states receive their regular federal medical assistance participation (FMAP) match for children determined presumptively eligible for Medicaid and the enhanced FMAP for children determined eligible for CHIP or a CHIP-financed Medicaid expansion group. Once a child is enrolled in coverage on an ongoing basis, the federal match is based on the child’s final eligibility determination.

Where States Stand

As of January 1, 2011, 31 states use presumptive eligibility for pregnant women.⁷ Thirteen (13) states have implemented presumptive eligibility for children in both their Medicaid and CHIP programs and three states have adopted the option for children in Medicaid only. Connecticut, one of the three states offering presumptive eligibility in Medicaid only, recently announced plans to extend the policy to CHIP.⁸ In Wisconsin and Missouri, presumptive eligibility is limited to children with family income of less than 150 percent of the FPL, while California has an income cutoff of 200 percent of the FPL. Iowa, Ohio and Montana⁹ are among the most recent states to adopt presumptive eligibility for children.

States That Have Adopted Presumptive Eligibility For Children and Pregnant Women

As of January 1, 2011



Source: Based on the findings of a national survey conducted by the Georgetown Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, 2010. Note: includes states that have adopted PE in Medicaid, CHIP, or both programs. LA, MD, OH and SC have presumptive-eligibility like process for pregnant women. Note: CT, MO, NH only have Presumptive Eligibility for children in Medicaid.

Presumptive eligibility enables community-based organizations to enroll some of the hardest-to-reach, uninsured children.

The Benefits of Presumptive Eligibility

Provides Immediate Access to Health Care Services - With presumptive eligibility, qualified entities can make on-the-spot, temporary eligibility decisions so eligible children and pregnant women (and now adults) get immediate access to medical services. Otherwise, without insurance to cover the cost of services, families may delay care for conditions that, if left untreated, could result in more extensive and expensive services.¹⁰ For example, an uninsured child seeking treatment for asthma in an emergency room can be presumptively enrolled and obtain prescription drugs critical to controlling the illness and avoiding subsequent visits to the hospital. Pregnant women can also receive early prenatal care that has proven to lower health care expenditures by reducing premature and low-weight births.¹¹

Enrolls Eligible, Uninsured Children, Often Connecting the Hardest-to-Reach - Presumptive eligibility allows established community-based organizations, which often serve the lowest-income families, to enroll eligible children who have not been reached through other approaches. For example, a Head Start program can presumptively enroll an uninsured child who is overdue for a well-child checkup or immunizations and coordinate these needed services with-

out delay. For families who face literacy or cultural barriers, live in remote areas, or are wary of government, extra assistance from trusted community-based organizations can provide a vital link to Medicaid and CHIP.¹²

Encourages Families to Complete the Application Process - Temporary enrollment may encourage families to follow through with the complete application process in order to keep coverage after the initial presumptive period.¹³ In states that still rely heavily on paperwork to verify eligibility, PE sites often assist in gathering and submitting needed documents, easing the administrative burden on eligibility offices and ensuring that ongoing coverage is established.

Helps States Qualify for CHIPRA Performance Bonus - The adoption of presumptive eligibility in both Medicaid and CHIP can help states qualify for a performance bonus established by the Children's Health Insurance Program Reauthorization Act (CHIPRA).¹⁴ To earn a bonus, a state must meet certain enrollment targets for children in Medicaid and adopt at least five of eight program features, of which presumptive eligibility is one.¹⁵ In 2010, fifteen states received bonuses totaling \$206 million; up from ten states receiving \$75 million in bonuses in 2009.¹⁶

How Does It Work?

States use presumptive eligibility to certify specific entities to screen and temporarily enroll eligible children and pregnant women in Medicaid or CHIP so they have immediate access to needed health care services. The state selects or recruits and trains qualified entities to make presumptive eligibility decisions after obtaining sufficient information from the family to determine if their gross income is within the income guidelines for Medicaid or CHIP.¹⁷ The PE site provides the child (or other eligible individual) with a temporary card or form confirming eligibility. The applicant's information is transferred, either electronically or through paper documents, to the state agency to activate the temporary period of coverage.

The PE site also must provide the family with the regular application or instructions on steps necessary to secure ongoing coverage. If the individual applies for Medicaid or CHIP, their temporary coverage runs until a final eligibility decision is reached. If the individual does not apply for ongoing coverage, the temporary coverage period expires at the end of the month following the presumptive eligibility decision.

States must provide the full array of Medicaid benefits, including all Early Periodic Screening Diagnosis and Treatment (EPSDT) services, to children determined presumptively eligible for Medicaid. In CHIP, states have the option to provide the CHIP benefit package, but many provide Medicaid benefits through their Medicaid fee-for-service delivery systems during the presumptive eligibility period. Under presumptive eligibility for pregnant women, services are limited to ambulatory prenatal care such as prenatal check-ups and outpatient hospital laboratory or radiology services.¹⁹

Implementation Considerations

States have ample flexibility in how they implement presumptive eligibility including determining which

coverage groups can be enrolled presumptively and which qualified entities to use (as long as they are allowed to make presumptive eligibility decisions on a statewide basis).²⁰ States vary significantly in how they implement presumptive eligibility, including whether they use automated systems or paper processes, what reasonable limits they set on how often someone can be enrolled presumptively,²¹ and how quickly eligibility information can be verified by providers in the state's claims payment system.

Ensuring Ongoing Enrollment - While presumptive eligibility accelerates access to needed services, a critical objective in designing the presumptive eligibility

process is to ensure ongoing coverage. States accomplish this in different ways from partnering with qualified entities to facilitate the regular application process to using the PE application to initiate a review for ongoing eligibility. In New Hampshire, qualified entities receive a fee for assisting the family in completing and submitting

the regular application; the fee is doubled if all documents needed to verify eligibility are submitted with the application. In Iowa, a web-based enrollment site automatically transfers information on PE enrollees to initiate a new application in the state eligibility system, which is then assigned to a state eligibility worker to process. A good starting point for states is to simplify the application process and reduce the amount of paperwork that families, PE sites, and eligibility workers have to process by using technology to verify eligibility data through other sources such as wage databases.

Choosing Qualified Entities - One of the most important decisions for states in implementing presumptive eligibility is determining which qualified entities will be authorized as PE sites. The list of possible entities is broad and includes health care providers, elementary and secondary schools, and organizations that administer other assistance such as the special supplemental nutrition program for women and children (WIC), Head Start, or housing assistance.²² Although states must be mindful of the federal requirement for

Ensuring ongoing enrollment following the temporary coverage period is key to maximizing the potential of presumptive eligibility.

State Experience: Iowa
Iowa, one of the most recent adopters of presumptive eligibility, is making the most of technology to administer its policy. The state has created an online training program, which PE staff at qualified entities must complete before they are certified to make presumptive eligibility decisions. Individuals must renew their certification annually to retain access to the Iowa Medicaid Portal Application (IMPA), a web-based enrollment site through which they enter information on persons determined presumptively eligible. This action not only starts the temporary period of coverage, but it also automatically initiates a regular application for Medicaid or CHIP by transmitting data to the state's eligibility system. Iowa uses its existing Medicaid FFS delivery system to provide benefits during the temporary period of coverage, as well as after the final eligibility decision is made until enrollment in managed care begins.¹⁸

statewide access to presumptive eligibility, they may limit the types or numbers of qualified entities. For example, California limits presumptive determinations to the Child Health & Disability Program (CHDP) providers that deliver preventive and screening services to children. On the other hand, Wisconsin allows any federally qualified entity to become certified. A number of states, including New Mexico, New Hampshire, New York, and Connecticut, rely heavily on federally-qualified and other community health centers as presumptive eligibility partners. These sites serve as a health care safety net for low-income, uninsured children, many of whom are eligible for Medicaid or CHIP.

Some states have phased in the number or type of organizations authorized as PE sites when first implementing the policy. This gives the state time to refine its processes and work out any issues that arise. Iowa first trained its CHIP outreach coordinators in the public health department as PE assistants and then extended PE authority to school nurses. The state is now in the process of expanding presumptive eligibility to more sites.

Certifying Presumptive Eligibility Sites - States often have a formal process for authorizing an agency to conduct presumptive eligibility and may require signed agreements that address the responsibilities of both parties and other critical issues such as confidentiality. States may have separate processes

Qualified Entities

States have flexibility in selecting presumptive eligibility agencies from among these types of organizations, known as qualified entities:

- Medicaid or CHIP health care providers;
- Head Start programs;
- Subsidized child care agencies;
- WIC (Special nutrition program for women, infants and children);
- Medicaid and CHIP eligibility agencies;
- Elementary or secondary schools, including those operated by the Bureau of Indian Affairs;
- State or Tribal child support agencies;
- Organizations that provide emergency food and shelter;
- State or Tribal offices or entities involved in Medicaid or CHIP enrollment activities; or
- Organizations that determine eligibility for public housing assistance; and
- Any other entity the State deems capable of making a presumptive eligibility decision (subject to federal approval).

for enrolling the organization as a PE agency while certifying specific individuals within the organization to make presumptive eligibility decisions. For example, Iowa requires the organization to submit an application and sign a Memorandum of Understanding, while individuals within the organization must complete an online training course to be certified to make presumptive eligibility decisions.

State Experience: Connecticut

Connecticut, at one time, used a special presumptive eligibility form but later determined that use of the regular Medicaid-only application would result in a greater likelihood of ongoing eligibility. Given that the state verifies income administratively for many families and confirms citizenship through an electronic match with the Social Security Administration, generally no additional information or documents are needed to establish ongoing eligibility. The state processes presumptive eligibility applications at regional centers, which also have the responsibility for evaluating eligibility for ongoing Medicaid coverage. If additional information is needed, the regional center follows up directly with the family. Onsite training is provided for new sites or new staff within a site and regional trainings are hosted when the state introduces significant policy or process changes.

Providing Training and Ongoing Support -

For presumptive eligibility to work as intended, PE sites need to be well trained on the basics of eligibility and the application process. States use a range of training strategies including one-on-one, in-person group sessions, web-based trainings, or some combination. Iowa relies solely on web-based training, while Connecticut conducts onsite training for new PE sites or new staff within an agency and hosts regional trainings when the state introduces major program changes. In determining the number of PE sites to qualify, states may want to assess their capacity to provide appropriate training and ongoing technical assistance and consider the volume of applications that PE sites might submit. New Hampshire initially authorized all qualified entities to do presumptive eligibility but scaled back authorized sites to hospitals and community health centers after determining that the program would work better if it were concentrated among the most active and, therefore, knowledgeable organizations.

Dedicating Staff to Support PE Sites - Some states centralize at least some, if not all, presumptive eligibility functions and designate specific staff to provide customer service and technical assistance to PE sites. Staff dedicated to administering presumptive eligibility can focus on ensuring that the process works well and

Selecting the right presumptive eligibility partners is one of the most important decisions in implementing the policy.

take responsibility for a range of tasks, from providing training and technical assistance to conducting outreach and coordinating urgently needed services. In Colorado and New Hampshire, a centralized office provides support to PE sites. Connecticut has set up regional centers to process PE applications and uses a central unit to conduct trainings.

Encouraging Networking and Sharing Best Practices

- Some states find it useful to convene their PE partners on a routine basis to update training and promote networking and sharing of best practices among agencies. To encourage PE sites to share their experiences and learn from one another, New Mexico partners with the state's Primary Care Association to bring together PE assistors from community health centers. In Connecticut, state officials participate in quarterly meetings of the Covering Kids and Families coalition during which presumptive eligibility and other enrollment issues are often discussed.

Harnessing Technology for PE Enrollment - States administer presumptive eligibility in a range of ways from paper-driven processes to electronic applications. The most expeditious process is to develop a web-based enrollment site or allow PE assistors limited access to the state eligibility system to directly enroll an individual determined presumptively eligible. Wisconsin has created a portal in its ACCESS eligibility system for qualified entities to enter presumptive eligibility applications and print temporary coverage cards. Colorado provides restricted access to specific functions within the state eligibility system in order for PE sites to enroll an individual presumptively after checking for pending applications or current eligibility.

Using a Single Application to Evaluate PE and Ongoing Eligibility - States that rely on paper processes are not required to use their regular Medicaid application for presumptive eligibility, but many do. By using a streamlined Medicaid application (which most states have rather than an application that screens for multiple public assistance programs and entails more information), the family is one step closer to completing the process to maintain ongoing coverage. States that have yet to simplify the regular application may opt to use a shortened form that requires only the minimal information needed for presumptive eligibility in order to expedite presumptive coverage.

Confirming Eligibility Promptly - If presumptive eligibility is a paper-based process, it is important that the state take prompt action to issue a Medicaid identification number and open an active enrollment status in the state's eligibility and claims payment systems. Even in states that support electronic enrollment, there can be a lag before eligibility data is transferred to the state's claims payment system, which often is the source for providers to confirm coverage electronically or by phone. Although individuals enrolled presumptively are eligible for immediate coverage of services, the systems lag can result in problems in obtaining services if providers cannot confirm eligibility.

Educating Providers - To help ensure access to needed services, a number of states actively work to inform providers they will receive payment for services rendered to children (and others) enrolled on a presumptive basis. This is particularly important in states where there is a delay before providers can verify coverage. States often include information in provider manuals, including showing samples of the temporary coverage card or form authorizing the temporary coverage period. States choosing a more proactive route also use their outreach workers, presumptive eligibility staff, or provider representatives to reach out directly to providers and promote their acceptance of the temporary authorization of eligibility.

State Experience: New Hampshire
New Hampshire relies largely on a paper-driven presumptive eligibility process but dedicates customer service staff to support PE sites and ensure that presumptive applications are expedited. New Hampshire Healthy Kids (NHHK), the state's nonprofit CHIP administrator, convenes statewide and regional meetings to provide training and facilitate networking between PE sites. NHHK also hosts community forums to promote referrals from schools and community-based organizations to the community health centers and hospitals that serve as PE sites. To encourage ongoing coverage, New Hampshire pays PE sites a fee for helping the family complete the regular application process; the fee is doubled if all documents needed to verify eligibility are submitted with the application. As a result, PE applications in New Hampshire almost always result in ongoing coverage. NHHK sends quarterly reports to presumptive eligibility agencies on the number and disposition of applications, as well as other data.

Technology aids the administration of presumptive eligibility but states have found ways to make the policy work without automated processes.

Facilitating Access to Care - Despite outreach to providers, states still often need to facilitate access to urgently needed services, especially when the authorizing PE agency is not a health care provider. States and stakeholders report that access to prescription drugs tends to be a particular issue given the retail nature of the service and that pharmacies typically require immediate payment or they will not dispense a medication. Staff responsible for presumptive eligibility can triage this needed access to care by coordinating referrals to providers and assuring payment for services.

Providing Services in States with Managed Care - Generally, states provide presumptive eligibility services through a fee-for-service (FFS) arrangement. Once a final eligibility decision is made, states that rely mostly on managed care for Medicaid and CHIP often continue using their FFS programs until managed care enrollment starts (e.g., at the beginning of the month following a person's Medicaid determination). Iowa uses their Medicaid fee-for-service delivery system to provide services for both Medicaid and CHIP beneficiaries during the presumptive period as well as after the final eligibility decision is made until managed care enrollment begins. Alternatively, states may work with their managed care plans to expedite enrollment and pro-rate the cost of coverage during this period.

Establishing a Communications Loopback - To be maximally effective, there should be two-way communication with the state agency so that PE assistors are able to get timely information on the status of an application. States that automate the PE function may provide electronic reports as Wisconsin does or give PE sites the ability to check the status online like Colorado. States relying on paper forms may exchange information over the phone as is done in New Hampshire. Some states require an "authorization to release information" from the family before sharing

information with the PE site. Ideally, this authorization is embedded in the application or PE form as is done in California's certified application assistance program. (See page A4 of the California Healthy Families application at <http://www.healthyfamilies.ca.gov/Downloads/Applications.aspx>.)

Identifying Opportunities for Program Improvements - Open channels of communication benefit not only the PE site assisting the family but also the state agency.

Organizations engaged in presumptive eligibility have deep experience in helping families obtain coverage and access needed services through Medicaid and CHIP. They know what works well within the system and can readily identify areas in need of attention. States can gain valuable insight if they solicit input from PE sites on ways to improve how Medicaid and CHIP work on the ground for families.

State Experience: New Mexico

New Mexico works with a broad list of qualified entities including hospitals, federally qualified health centers, its Children, Youth and Families Department, Department of Health clinics, schools, providers, Head Starts agencies and Boys and Girls Clubs. Individuals must attend a one-day training session and be certified before determining eligibility presumptively. PE agencies also are required to provide "Medicaid On-Site Application Assistance" (MOSAA). As a MOSAA site, they assist the individual in completing the application for on-going Medicaid or CHIP, gather documents needed to verify eligibility, and submit the application. The state provides qualified entities with the option to submit PE applications via fax or to enter presumptive approvals through a web portal directly into the Medicaid system in "real time." Slightly more than half of presumptive applications are entered directly into the system, reducing paperwork and allowing for immediate verification of eligibility for claims submission.

Offering Financial Support to PE Agencies - There is no requirement for states to financially support PE sites, and many don't, citing the fact that health care providers comprise the majority of PE sites and already have a financial incentive to see children and pregnant women enrolled in coverage. However, some states do support PE sites through outreach grants or application processing fees. As modest as these funds generally are, they help extend the limited resources of these organizations and can be used to incentivize agencies to help families successfully complete the regular application process.

Conclusion

Presumptive eligibility is a useful tool to reach uninsured children and pregnant women who are eligible for Medicaid and CHIP and provide them with access to urgently needed health care services. This policy option can be used in conjunction with targeted efforts at the community level to find and enroll the hardest-to-reach, uninsured children. It effectively combines proven strategies of conducting outreach through community partners and simplifying the enrollment process through direct, one-on-one assistance.

States gain valuable insight on ways to improve Medicaid and CHIP by soliciting input from presumptive eligibility partners.

States may want to ready their systems and processes to administer presumptive eligibility in advance of 2014 when hospitals are given the prerogative to make PE decisions.

Presumptive eligibility can also ease the administrative burden on state eligibility agencies by working with providers or community agencies dedicated to helping families complete the regular application process, including submitting all documents needed to verify eligibility. Given that the ACA expands the populations on whose behalf presumptive eligibility can be used and allows hospitals to elect to make presumptive eligibility decisions, states may want to get a jumpstart on readying their systems and processes by implementing this key policy for children and pregnant women now.

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CCF is an independent, nonpartisan research and policy center based at Georgetown University's Health Policy Institute whose mission is to expand and improve health coverage for America's children and families.

Endnotes

1. Additional qualified entities allowed to presumptively determine eligibility for children were added when the Benefits Improvement and Protection Act (BIPA) of 2000 was enacted (see Appendix F of the Consolidated Appropriations Act of 2001). The 2009 CHIP Reauthorization Act established that all qualified entities for children's presumptive eligibility could be used for presumptive eligibility for pregnant women.
2. Presumptive eligibility for pregnant women was adopted as part of the Omnibus Budget Reconciliation Act (OBRA) in 1986. Information on presumptive eligibility for pregnant women can be found in the Social Security Act §1920. In 2000, the Breast and Cervical Cancer Prevention and Treatment Act was enacted and includes the option to presumptively enroll women eligible for breast and cervical cancer prevention and treatment services.
3. General Accounting Office, "Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions" (February 1991).
4. When presumptive eligibility was first enacted through the Children's Health Insurance Program (CHIP), the law did not explicitly extend presumptive eligibility to children eligible for CHIP. However, in a State Medicaid Director Letter dated October 10, 1997, CMS issued guidance indicating that a state could craft an equivalent procedure in CHIP as a health services initiative. However, by doing presumptive eligibility as a health services initiative, CHIP PE expenditures counted against the state's 10 percent cap on administrative and outreach costs. In the 2000 enactment of BIPA, presumptive eligibility was fully extended to CHIP. This ended the requirement that presumptive eligibility expenditures in CHIP be counted toward the 10 percent cap.
5. The ACA also gives states the option to apply presumptive eligibility to women in need of family planning services.
6. Initially all presumptive eligibility expenditures were based on the child's ultimate eligibility determination. Prior to the 2000 enactment of the BIPA, expenditures for children found ineligible, as well as those eligible for CHIP, were considered direct services and charged against the state's 10% CHIP cap on administrative and outreach costs. R. Klein, "Presumptive Eligibility," *The Future of Children*, Volume 13, Number 1, (Spring 2003).
7. M. Heberlein, Tricia Brooks, Jocelyn Guyer, Samatha Artiga & Jessica Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011," Kaiser Commission on Medicaid and the Uninsured (January 2011).
8. As part of an initiative to streamline administration of health care services in the state, Connecticut's Governor announced that as of April 1, 2011, the state would implement presumptive eligibility for CHIP (HUSKY B). Connecticut Office of the Governor, "Malloy/Wyman Streamline Administration of Health Care Services for Nearly 600,000 Residents," Press Release (February 8, 2011).
9. According to a report in the Billings Gazette on March 28, 2011, presumptive eligibility, which was approved by voters in a statewide ballot initiative that expanded Montana's Healthy Kids program in 2008, is being targeted for elimination by the Montana legislature as part of the budget process.
10. A. Russo, J. Jiang, & M. Barrett, "Trends in Potentially Preventable Hospitalizations Among Adults and Children 1997-2004," *Agency for Healthcare Research and Quality* (August 2007).
11. R. Gorsky & J. Colby, Jr., "The Cost-Effectiveness of Pre-natal Care in Reducing Low Birth Weight in New Hampshire," *Health Services Research*, 24(5): 583-598 (December 1989).
12. V. Wachino & A. Weiss, "Maximizing Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children," *National Academy of State Health Policy* (February 2009).
13. K. Kronebusch & B. Elbel, "Simplifying Children's Medicaid and SCHIP: What helps? What hurts? What's next for States," *Health Affairs*, 23(3): 233-246 (May/June 2004); and R. Klein, "Presumptive Eligibility," *The Future of Children*, 13(1): 230-237 (Spring 2003).
14. Georgetown University Center for Children and Families & Kaiser Commission on Medicaid and the Uninsured, "CHIP Tips: Medicaid Performance Bonus" (April 2009).

15. Georgetown University Center for Children and Families & Kaiser Commission on Medicaid and the Uninsured, "CHIP Tips: Medicaid Performance Bonus "5 out of 8" Requirements" (April 2009).
16. Department of Health and Human Services, "States Get Bonuses for Boosting Enrollment of Uninsured Children in Medicaid," Press Release (December 27, 2010).
17. 42 CFR 435.1102(a) allows a presumptive eligibility determination to be made based on the child's estimated gross family income or, at the state's option, the child's estimated family income, after applying simple disregards.
18. Iowa provides all Medicaid services through Medicaid fee-for-service delivery system to children transitioning between their presumptive eligibility period and CHIP managed care enrollment. Any services that are not covered by CHIP are considered a CHIP Health Services Initiative and count against the state's administrative costs, which are capped at 10 percent in CHIP.
19. For further statutory and regulatory information on presumptive eligibility for children, see the Social Security Act §1920A; 42 CFR 435.1101-1102 (June 2001); and 42 CFR 457.355 (June 2001).
20. 42 CFR 435.1102(b)(4) establishes that states must allow determinations of presumptive eligibility to be made by qualified entities on a statewide basis.
21. States must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame. Most frequently, states establish that a person can be enrolled presumptively only once during a 12-month period.
22. 42 CFR 435.1101 provides the list of qualified entities for presumptive eligibility for children.