

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: North Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

All Survey Agency staff are trained in accordance with, and individually issued, Appendix P, Survey Procedures for Long Term Care Facilities, which states "Do not announce SNF/NF survey. The Life Safety Code survey must not precede the survey of resident care requirements."

Survey schedules are developed, documented and distributed within the agency as "confidential" and "nondisclosable." All surveyor agency staff are informed in their orientation that any form of disclosure of survey schedules will subject the employee to monetary fine and termination of employment. Staff is furthermore instructed to report immediately to the Section Chief any suspected discrepancies. The policy for "unannounced" surveys is reviewed periodically in staff meetings. Life Safety Code surveys are conducted after the standard survey has been completed. Surveyors do not divulge the nature of their business when making logging/travel arrangements nor are families of surveyors allowed to contact surveyors on-site. All calls are routed through the State Agency.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The Certification Section of Division of Facility Services is in the process of:

- a. Developing and implementing a Q.A. program targeting LTC that is managed by the Q.A. Officer

is based on the HCFA On-Site Performance and Training Survey (OSPATS) module to include on-site process and end line review

receives input from QLI - QIT 4; members of the team and/or designees in Q.A. surveillance

provides Q.A. findings and consultation to Section Management

incorporates Q.A. findings into Training needs assessment

provides Technical Assistance to managers and surveyors as on request or as directed by Section Chief
- b. Developing retrieval system from existing Quality Control units to collecting and utilize Q.C. data in the Q.A. program.

TN No. 92-25

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

(See attached.)

OPERATIONAL POLICIES AND PROCEDURES
FOR PROCESSING AND INVESTIGATING COMPLAINTS

PURPOSE:

To establish a quality control policy to assure that all complaints are appropriately investigated and reported in accordance with approved procedures; thus assuring uniform handling of complaints regarding licensed and certified facilities.

Policy:

The Branch Head or her designee is responsible for assuring that all complaints are properly recorded and investigated, within forty-five (45) days and a response sent to the complainant and all involved parties within sixty (60) days from the receipt of the complaint.

Complaints concerning care, treatment, or services at licensed health care facilities and which are within the jurisdiction of the Division of Facility Services (DFS) Licensure Section will be accepted for investigation. Each complaint will be assessed to determine the type investigation required. Allegations which are not within the jurisdiction of the Licensure Section will be referred to the proper agency/office.

When complainants indicate that they have not attempted to resolve concerns with facility management, they will be encouraged

TN No. 92-25
Supersedes
TN No. New

Approval Date AUG 27 1992

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do so. If complaints are unable to achieve a satisfactory resolution with facility management, a complaint will be accepted for investigation by the Complaints Investigation Branch (CIB).

Anonymous complaints will be accepted.

Confidentiality will be maintained of all known complainants and all medical records inspected. When complaint files are reviewed by the public, all confidential information will be removed from the file prior to the review in accordance with G.S. 131E-105 and G.S. 131E-124(C).

PROCEDURE:

Complaints will be accepted by telephone, mail, or office visits by the complainant or by referral from other agencies.

- A. Telephone complaint will be taken by CIB Staff.

Complaints will be entered on a complaint information form (attached).

- B. Appointments will be scheduled for complainants who wish to lodge their complaint in person. These complaints will be entered on a complaint information form.

- C. When complainants have not attempted to resolve their concerns with facility management but indicate willingness to do so, a report for record will be completed following the initial contact; and arrangements made for recontact with the complainant within one week to determine the facility's response to concerns. When facility's

response has been unsatisfactory to the complainant, a complaint will be recorded for investigation by the CIB during the second contact. If complainants have any hesitancy in talking with facility management, a complaint will always be taken during the initial contact.

II. Upon receipt, complaints are directed to the Branch Head or her designee who will:

- A. Review the complaint.
- B. Label the complaint with the complaint category (ies).
- C. Write a letter to the complainant acknowledging receipt of the complaint.
- D. Decide whether all or portions of the complaint should be referred to other agencies/groups, etc.
 1. Complaints alleging abuse, neglect, or exploitation of a specifically named patient are immediately referred to the County Department of Social Services, Adult Protective Services, in accordance with the agreement between Division of Facility Services and Division of Social Services. In accordance with G.S. 108A-103 the Division of Social Services (DSS) will make "a prompt and thorough evaluation to determine whether the individual is in need of protective services." When in the course of the DSS investigation it becomes apparent that the abuse, neglect, or exploitation will be substantiated, the county DSS director will be immediately notify DFS by phone. The CIB will assess data from the DSS to determine

whether there is an on-going and current threat to the patient's health and safety, and if so, the CIB will investigate the situation within two working days.

2. Assistance may be requested from Nursing Home Community Advisory Committees (NHCAC) when allegations are of a general nature and do not require special, professional expertise for investigation. The Branch Head will contact the Division of Aging Regional Ombudsman to determine if the NHCAC is capable of investigating the specific complaint and able to provide the requested assistance.
3. If referrals are made, a note to this effect is made on the complaint form indicating the date of referral and to whom it was referred.

III. Following initial review, the Branch Head will send complaints to the branch Administrative Assistant who will:

- A. Assign a complaint number.
- B. Enter the complaint on the complaint log.
- C. Prepare a folder and large envelope labeled with the facility name and location and the complaint number, and the date of 45th day following receipt.
- D. Type and mail the acknowledgement letter to the complainant.
- E. Make a copy of the complaint and place it in the large envelope for the investigator to use as a working copy.
- F. Place the original complaint and a copy of the letter to

TN No. 92-25
Supersedes
TN No. New

Approval Date AUG 27 1992

Effective Date 04-01-92

the complainant in the file folder for filing in the complaint file, which is to maintained separately form the licensure files and certification files.

- IV. the Branch Head or her designee will assign complaints to staff for investigation. During periods of heavy work load, the Branch Head may request assistance from Health Care Facilities Branch (HCFB) staff to assure the 45 day deadline is met.
- A. Routinely, complaints will be scheduled for investigation in the order received.
 - B. Complaints requiring prompt attention, as noted above, will be investigated within two working days. These would include allegations which imply that there is an imminent threat to a patient's health, safety, or welfare.
 - C. Complaints will be investigated either by unannounced visits to the facility or through phone contact with the facility administrator. The Branch Head or her designee will decide whether a complaint will be investigated by phone or an onsite visit, based upon the type of investigation method required. An onsite visit will always be made when allegations require monitoring of employee performance or observation of identified conditions.
 - D. When a survey or onsite complaint investigation has been held at a facility within thirty days prior to the receipt of a complaint about that facility, another onsite visit will not be scheduled if allegations can be answered based on findings during the recent survey or investigation.

TN No. 92-25
Supersedes
TN No. New

Approval Date AUG 27 1992

Effective Date 04-01-92

- E. Each investigation will be individually planned to assure that complete information is available for determining the validity of the complaint.
1. Information will be obtained from a variety of sources to determine consistency and accuracy.
 2. Methods will include such things as patient assessments, Record reviews, monitoring of staff performance and interviews with patients, visitors and staff.
 3. Persons and agencies will be contacted as necessary to obtain needed information.
 4. All certification related complaints against skilled nursing facilities and/or intermediate care facilities will be investigated using the Long Term Care (LTC) Process as mandated by Federal Regulation 42 CFR 488.1100 (8) (2)

V. Onsite Investigations

- A. Onsite visits to nursing homes will be unannounced. Announced visits may be made to hospitals and other programs and agencies if this would not compromise the value or collection of relevant data.
- B. Staff assigned to do onsite investigations are responsible for planning strategies for conducting the investigation prior to the onsite visit.
- C. When two or more staff are assigned to an investigation, one person will be identified to serve as team leader. The team leader is responsible for the following:

1. Developing the investigation plan, using input from team members.
 2. Meeting with team members prior to entering the facility to review the investigation plan and make assignments.
 3. Conducting an entrance conference with the facility administrator (or person in charge in his absence) to explain the general nature of the allegations and to review the general plan for the investigation.
 4. Holding a pre-exit conference with team members to share findings and make decisions about any actions to be taken.
 5. Conducting an exit conference with the administrator at the conclusion of the investigation to review the specific allegation(s) and findings of the investigation. If additional data is needed and a final decision cannot be made prior to leaving the facility, the team leader will explain this to the administrator and that he will be notified of final decisions by phone.
 6. Completing the complaint report, required letters, and associated paperwork.
- VI. If state licensure violations are identified as a result of a complaint investigation, these are to be handled according to DFS licensure section policy. If federal deficiencies are identified, certification actions are to be initiated in accordance with the State Operations Manual.

TN No. 92-25
Supersedes
TN No. New

Approval Date AUG 27 1992

Effective Date 04-01-92

- VII. Reports from referred complaints are reviewed by the Branch Head or her designee. If a report identifies possible violations of State or Federal requirements, or otherwise suggests a need for further investigations by the CIB, this will be scheduled.
- VIII. From time to time, certain complaints may be referred for investigation by the office of the Governor, the Secretary, a legislator or from some other source that make it necessary to give the complaint special handling. For such complaints, beside the usual processing procedures, the following additional guidelines shall be followed:
- A. The Branch Head shall insure that the Licensure Section Chief is aware of all complaints received through the offices of the Governor, the Secretary or a legislator.
 - B. When investigations are complete, a report shall be made to the referring office advising of the findings and any actions that may be anticipated in the future. These reports shall be routed through the Section Office.
 - C. In cases where the Governor or Secretary needs to respond directly to a complaint or referring legislator, a draft response shall be prepared and forwarded to the Section Office for review and final processing. Care shall be taken to insure that responses are timely and meet established deadlines.
 - D. Any complaint received that appears to have the potential for becoming a sensitive issue shall be brought to the attention of the Section Chief and he shall be kept

VII. Following an investigation, the team leader or investigator will:

- A. Prepare a report which will include the allegation(s), summary of the investigation, conclusion(s), and action taken using the complaint investigation report form (attached. Following completion reports will be given to the Branch Head or her designee for review and routing to the Licensure Section Chief prior to its being filed.
- B. Send a letter to the administrator within ten day of the investigation stating whether or not the complaint was substantiated.
 1. If recommendations were made, these are to be included in the letter.
 2. If deficiencies were cited, the DFS-4093 and instructions sheets and the HCFA 2567 are to accompany the letter.
 3. If administrative action is recommend, this is to be stated in the letter and that management action, is taken, will be sent in a separate mailing.
- C. Write a letter to the complainant to be sent within sixty days from the receipt of the complaint. This letter should include at a minimum:
 1. The date of the investigation.
 2. A summary of the investigation methods used.
 3. Whether the allegations were substantiated, not substantiated, or partially substantiated.

TN No. 92-25
Supersedes
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informed of any unusual developments as the investigation proceeds.

Signature: Jean W. Smith

Title: Branch Head

Date: 2/13/90

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AUG 27 1992
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: North Carolina

False Claims Act Compliance Plan

This document outlines how the Medicaid agency identifies, notifies and reviews providers that meet the definition of “entity” each year and thus fall under the requirements for employee education about false claims recovery outlined in Section 1902(a)(68) of the Social Security Act. This document also describes how the agency will review providers on an ongoing basis for compliance and the frequency of review.

Annually, beginning with 2007, the Medicaid agency will identify providers and contractors that provide Medicaid health care items or services that were paid \$5 million dollars or more. The identified providers and contractors will be notified by letter that they were paid a minimum of \$5 million dollars last calendar year and, as such, are subject to the requirements for employee education about false claims recovery as cited in 1902(a)(68) of the Social Security Act. The providers and contractors will also be required to sign a letter of attestation that they have complied with the requirements of 1902(a)(68) of the Social Security Act. Providers will be notified by September 30th of each year if they were paid \$5 million or more and will have 30 days to submit signed letters of attestation. These signed letters of attestation will be stored by the agency as either a hard copy or as an electronically signed document.

The Medicaid agency will collect signed letters of attestation for all providers at initial enrollment and re-enrollment in the Medicaid Program. Providers and contractors whose Medicaid payments meet or exceed \$5 million annually, that fail to attest that they have complied with the requirement of employee education about false claims recovery as cited in 1902(a)(68) of the Social Security Act (to the agency), will have all future Medicaid payments suspended. The Medicaid agency will review the policies and procedures of the identified providers through routine and random audits on an ongoing basis to assure compliance with 1902(a)(68) of the Social Security Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Attachment 7.2-A

MEDICAL ASSISTANCE PROGRAM

State: North Carolina

NONDISCRIMINATION

The State plan assuring compliance with Title VI of the Civil Rights Act of 1964 is on file in the Regional Office of the Department of Health, Education, and Welfare.

Rec'd 12-26-73

R.O. Action 7-19-74

Eff. Date 10-1-73

Obsoleted by _____

Dated _____

North Carolina Department of Health and Human Services
Division of Social Services

Methods of Administration
For
Title VI Compliance
Of the
Civil Rights Act of 1964

Name of Program: MEDICAL ASSISTANCE (TITLE XIX MEDICAID)

I. Assignment of Responsibility

- A. Over all coordinating responsibility for the Department of Health and Human Services Mr. Harold Maness, Director of Plans and Programs
- B. Title VI Compliance in nursing homes and hospitals
Mr. John A. McCann, Civil Rights Coordinator, Division of Facility Services
- C. Title VI reviews of physicians, drug stores, and other vendors
Assistant Chief of Practitioner Services, Medical Services
Section of the Division of Social Services. The Assistant Chief of Practitioner Services consults with Mr. James E. Coats, Civil Rights Coordinator for the Division of Social Services

II. Dissemination of Information

- A. Staff
All staff are provided copies of the North Carolina Department of Health and Human Services Title VI policy statement. In addition, staff is briefed on the Division of Social Services plan and the Title XIX Methods of Administration. This information includes departmental and division responsibilities, vendor responsibilities, staff responsibilities, the dissemination of information procedures, clients rights to services, procedure for clients filing of complaints, methods of handling of complaints, and procedures for handling instances of non-compliance. This information is provided at the first in-service orientation for staff. Thereafter, it is discussed infrequently at staff meetings and supervisory conferences.

The information provided to staff is being developed and copies will be forwarded the Region IV Office for Civil Rights. The information will contain the meaning of Title VI with examples of what to look for in observing compliance or non-compliance.

Rec'd 12-26-73

73-45

Dated 12/21/73

R.O. Action 7-19-74

Eff. Date 10-1-73

Obsoleted by _____

Dated _____

B. Vendors

All vendors are advised of Title VI requirements at the time of admission to the program. Each vendor receives semi-annual visits from Medical Services staff at which time they are reminded of Title VI requirements. Vouchers contain a compliance agreement.

Copies of Title VI information sent to vendors is being drafted and will be forwarded to the Region IV Office for Civil Rights. This information is mailed to all vendors and is reviewed by the Provider Representative upon an on-site visit.

C. Clients and Applicants

The responsibility for giving Title VI information to clients and applicants is delegated to county department of social services intake workers, eligibility specialists, and social workers. Clients and applicants are advised that if they feel they are the subject of discrimination, they may receive an administrative hearing at the county level, or they may request a formal hearing from a state staff appeals and hearings officer. If they wish to file a written complaint of discrimination, forms are provided at the county level. They may call the complaint in on the Department of Health and Human Services "Hotline" or they may write to the state office or to the Regional or National Department of Health, Education, and Welfare. When this information has been provided, a notation to that effect is entered in the client's record. The client and/or applicant is given a booklet of program information which includes Title VI information. There is no scheduled periodic reissuance of this in-client is reminded of rights under Title VI.

D. Public

Booklets which contain information in reference to services available to clients and applicants are available in lobbies and waiting rooms of county departments of social services. These booklets contain a Title VI statement. The Division of Social Services issues a statement of non-discrimination news release to all news media. Social Services staff are advised to mention Title VI policy when meeting with community groups and making presentations.

III. Maintaining and Assuring Compliance

A. Reviews of Hospitals and Nursing Homes

The Division of Facility Services has six staff persons to review these facilities via annual on-site visits. These reviews include information as to the following:

The service area and population by race
Principal administrator
Licensed bed capacity
Number of rooms: private, semi-private and wards
Room occupancy inspection (patient count)
Physicians and dentists in the service area with racial breakdown
Staff privileges by race
Courtesy titles
Training programs with minority participation
Title VI and open admissions information
Patient(room transfers)
Board chairman and racial makeup of boards

written which includes all aspects of the information obtained. Wherein necessity dictates, community residents and/or others may be contacted in order to ascertain the extent of the problem. The complainant as well as the accused is notified of the results of the investigation. The complainant is informed of his rights and options for pursuing the matter further if he desires.

When a complaint is filed against an individual provider, Mr. James E. Coats, Civil Rights Coordinator for the Division of Social Services, coordinates and participates in all investigations jointly with Medical Services personnel. When a violation is determined to exist, the Director of the Division of Social Services will, by certified mail, notify the offender of the areas of non-compliance. A stated period of time is allowed to correct deficiencies or face suspension from the program. The offender is also informed of his right to a hearing with the Director or an appointed hearings officer.

When a complaint is filed against a facility, Mr. John A. McCann, Civil Rights Coordinator for the Division of Facility Services, will coordinate and participate in all investigations. When a violation is determined to exist, the Director of the Division of Facility Services will notify the offender within the same conditions as described above.

The Secretary of the Department of Human Resources will review the findings of the hearing and will render a final decision in the matter of non-compliance.

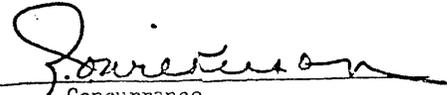
V. RECRUITMENT AND TRAINING

- A. All persons are employed from a State Merit System Register. Placements on the register are in accordance with test grades.
- B. Training for the specific job is a requirement for all employees, and is so stated at the time of employment. All employees receive the same training through orientation and supervision regardless of race, color, or national origin. "All applicants and all staff are advised of the availability of training."



Signature of Responsible
Departmental Official
Director, Division of Social Services

June 17, 1974
Date



Concurrence
Director, Division of Facility Services

June 18, 1974
Date

Rec'd 12/26/73 11 #73-45 Date 12/21/73

R.O. Action 7/19/74 to 10/1/73

Obsolated by _____ Dated _____



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

Yes No

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A qualified hospital is a hospital that:

Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of

its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance

with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

Pregnant Women

Infants and Children under Age 19

Parents and Other Caretaker Relatives

Adult Group, if covered by the state

Individuals above 133% FPL under Age 65, if covered by the state

Individuals Eligible for Family Planning Services, if covered by the state

Former Foster Care Children

Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

Other Family/Adult groups:

Eligibility groups for individuals age 65 and over

Eligibility groups for individuals who are blind

Eligibility groups for individuals with disabilities

Other Medicaid state plan eligibility groups

Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.



Medicaid Eligibility

Yes No

Select one or both:

- The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

The State will require a threshold of 95% for full Medicaid applications submitted by individuals determined presumptively eligible by a hospital. Hospitals cannot serve as the applicants' authorized representative on either a presumptive or regular Medicaid eligibility application during the presumptive period. Hospital providers shall participate in Department-approved training on North Carolina policies and procedures. The Department shall disqualify a hospital from conducting presumptive eligibility determination if, within six consecutive months of qualifying or for any subsequent rolling six month period, the hospital does not make presumptive eligibility determinations in accordance with North Carolina policies and procedures and federal laws and regulations or does not meet the standards set forth in this State Plan and does not improve its performance in meeting the standards within three months of completing an additional training and implementing a Department-approved corrective action plan, if required. A hospital disqualified from conducting presumptive eligibility determinations shall not be eligible to reapply as a qualified hospital unless the hospital has a change of ownership as defined in G.S. 108C-10(a). A qualified hospital shall report a change of ownership or any change in the staff authorized to conduct presumptive eligibility to the Provider Services section of the Department of Health and Human Services, Division of Medical Assistance.

- The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards:

The State will require that 95% of individuals who are determined eligible for presumptive eligibility and who submit a regular Medicaid application will be determined eligible for Medicaid. The Department shall disqualify a hospital from conducting presumptive eligibility determination if, within six consecutive months of qualifying or for any subsequent rolling six month period, the hospital does not make presumptive eligibility determinations in accordance with North Carolina policies and procedures and federal laws and regulations or does not meet the standards set forth in this State Plan and does not improve its performance in meeting the standards within three months of completing an additional training and implementing a Department-approved corrective action plan, if required. A hospital disqualified from conducting presumptive eligibility determinations shall not be eligible to reapply as a qualified hospital unless the hospital has a change of ownership as defined in G.S. 108C-10(a). A qualified hospital shall report a change of ownership or any change in the staff authorized to conduct presumptive eligibility to the Provider Services section of the Department of Health and Human Services, Division of Medical Assistance.

- The presumptive period begins on the date the determination is made.

- The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- Periods of presumptive eligibility are limited as follows:



Medicaid Eligibility

- No more than one period within a calendar year.
- No more than one period within two calendar years.
- No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- Other reasonable limitation:

	Name of limitation	Description	
+	Limitation based on the presumptive eligibility date.	No more than one period within 24 months of the date of the presumptive eligibility determination.	X

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

- Yes No
- The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
- The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

All attachments submitted

- The presumptive eligibility determination is based on the following factors:
 - The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
 - Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.
 - State residency
 - Citizenship, status as a national, or satisfactory immigration status

- The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

All attachments submitted

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

DMA ADMINISTRATIVE LETTER NO: 11-13, HOSPITAL PROVIDER INSTRUCTIONS FOR DETERMINING PRESUMPTIVE ELIGIBILITY

DATE: November 3, 2014

SUBJECT: Hospital Provider Instructions for Determining Presumptive Eligibility

DISTRIBUTION: Enrolled Presumptive Eligibility Hospitals
County Directors of Social Services
Medicaid Eligibility Staff

I. BACKGROUND

Effective January 1, 2014, the Affordable Care Act (ACA) of 2010 gives hospitals the option to determine eligibility presumptively for individuals who appear to qualify for certain Medicaid programs. The purpose of this letter is to provide procedures for Qualified Medical Providers (QMPs) to determine Presumptive Eligibility (PE).

A qualified hospital may elect to make presumptive eligibility determinations on the basis of preliminary information and according to policies and procedures established by the North Carolina Division of Medical Assistance (DMA).

II. A QUALIFIED MEDICAL PROVIDER IS A HOSPITAL THAT:

- A. Participates as a provider under the state plan;**
- B. Notifies DMA of its election to make presumptive eligibility determinations;**
- C. Agrees to make presumptive eligibility determinations consistent with state policies and procedures;**
- D. Has not been disqualified as a QMP by DMA;**
- E. Meets performance measures;**
- F. Does not delegate or contract out presumptive eligibility determination to a third party or other entity; and**
- G. Does not serve as authorized representative of any individual applying for presumptive eligibility.**

III. PROVIDER ENROLLMENT PROCESS

A. Hospitals that elect to apply to make presumptive eligibility determinations may contact DHHS/DMA Provider Services by:

1. Phone at (919) 855-4050, or
2. Written request faxed to (919) 715-8548, or
3. Mailing a written request to: DHHS/DMA Provider Services, 2501 Mail Service Center, Raleigh, NC 27699.

B. Provider Services will forward the Presumptive Eligibility Determination Provider Agreement packet to the provider for completion.

C. The provider must:

1. View training webinars; and
2. Sign the Provider Agreement, and
3. Provide attestation of training, and
4. Identify all staff authorized to determine presumptive eligibility, and
5. Provide each staff member's business North Carolina Identity Management (NCID) for NCFAST portal access. To request a business NCID go to <https://ncid.nc.gov>, and
6. Report all changes in staff authorized to determine Presumptive Eligibility to DMA within 10 days of the change.

All documents should be returned to DMA at the address in III.A.3 above.

D. DMA will authorize the hospital to complete presumptive eligibility determinations upon completion of the requirements in III.C. 1-5 above.

IV. MEDICAID APPLICANT/BENEFICIARY ELIGIBILITY REQUIREMENTS

In order to be authorized presumptively, an applicant/beneficiary (a/b) must:

- A. Attest to U.S. citizenship or lawful presence in the United States.**
- B. Attest to North Carolina residency or intent to reside in North Carolina.**
- C. Not be an inmate of a public institution.**

D. Not be receiving Medicaid in another aid/program category, county, or state.

E. Have gross income equal to or less than the income limit for the individual's applicable group.

F. The presumptive period is limited to:

1. Once per pregnancy for Medicaid for Pregnant Women (MPW).
2. Once in a two year period for all other eligible programs.

Example: Individual is determined presumptively eligible on January 5, 2014. The individual may not be determined presumptively eligible again until January 5, 2016.

V. QUALIFYING GROUPS FOR PRESUMPTIVE ELIGIBILITY

Eligibility for the following groups is based on income and there is no resource test. See current income limit chart attached. The income limit chart change yearly April 1st and can be located on the DMA website under Medicaid Provider's Seminars and Training.

A. Pregnant Women (MPW)

To qualify for presumptive MPW, the applicant must be a pregnant female (any age), have family size income equal to or less than 196% of the federal poverty level, and meet all other non-financial eligibility requirements specified in IV.

In order for a pregnant woman to be authorized presumptively she must attest to pregnancy.

Covered services are limited to ambulatory prenatal services only.

B. Infants and Children (MIC)

To qualify for presumptive MIC, the child must be under age 19, have family size income equal to or less than the federal poverty level for the child's age group, and meet all other non-financial eligibility requirements specified in IV.

Covered services include professional medical services including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

C. Medicaid for Families with Dependent Children (MAF)

To qualify for presumptive MAF, the applicant must be:

1. An individual under age 21, or
2. A caretaker/relative who lives in the home with a child under age 18 and provides the child's day to day care and supervision. The caretaker cannot be incarcerated. Relative is defined as an adult who is related to the dependent child by blood, adoption, or marriage. Refer to MA3235 and MA3350. Examples are:
 - a. Natural, adoptive or stepparent
 - b. Grandparent
 - c. Siblings, including step-brothers and sisters
 - d. Aunt/Uncle
 - e. First cousin
 - f. Nephew/Niece

Caretaker must have family size income equal to or less than the applicable family size income limit and meet all other non-financial eligibility requirements specified in IV.

Covered services include professional medical services including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

D. Family Planning Program (MAF-D)

To qualify for presumptive MAF-D, the applicant must be an individual who is not sterile, have family size income equal to or less than 195% of the federal poverty level, and meet all other non-financial eligibility requirements specified in IV.

Covered services include family planning services, consultation, examination, treatment, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception. Each service may have certain limitations, including the need for prior approval.

E. Former Foster Care Children (MFC)

To qualify for presumptive MFC, the applicant must:

1. Be an individual age 18 up to age 26, and
2. Have been enrolled foster care and North Carolina Medicaid when the individual turned age 18, and
3. Meet all other non-financial eligibility requirements specified in IV. There is no income test.

Covered services include professional medical services including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

F. Breast & Cervical Cancer Medicaid (BCCM)

Providers authorized through the Breast and Cervical Cancer Control Program (BCCCP) are eligible to determine presumptive eligibility for BCCM.

To qualify for presumptive BCCM, the individual must:

1. Be a woman age 18 through 64, and
2. Be enrolled and screened for breast or cervical cancer through a BCCCP, and be found to need treatment for breast or cervical cancer, and
3. Not have any creditable medical insurance coverage including Medicaid and/or Medicare, and
4. Meet all other non-financial eligibility requirements specified in IV.

Covered services include professional medical services, including diagnosis, treatment, surgery, and consultation. Each service may have certain limitations, including the need for prior approval.

VI. PROVIDER INSTRUCTIONS FOR DETERMINING ELIGIBILITY

A. Conduct an interview

Complete the DMA-5032(H), Presumptive Eligibility Determination by Hospital, to determine eligibility.

1. Ask the individual if they have a current Medicaid case or pending Medicaid application.

Administrative Letter 11-13

- a. If active, an application is not necessary. Refer the individual to the local county dss to report changes.
 - b. If pending application exists, a presumptive application may be completed. If determined presumptively eligible, coverage can continue until the full Medicaid determination is complete.
2. When interviewing the applicant about family size income, it is important to obtain accurate and complete information. Ask open-ended questions, such as:
- a. Where do you work?
 - b. Where does your spouse work?
 - c. Do you expect to file taxes?
 - d. Do you expect to be claimed as a tax dependent?
 - e. How do you get the money to pay your bills?
 - f. Who helps you pay your bills?
 - g. Do you or your spouse receive Social Security or other government payments?
 - h. Do you or your spouse receive unemployment benefits?

B. Establish Medicaid household and family size

1. The Medicaid household is called the "Modified Adjusted Gross Income (MAGI) Household". The MAGI household is determined based on whether the individual is a tax filer, tax dependent, or a non-tax filer. Each household member will have their own MAGI household.

Refer to DMA Administrative Letter No: 06-13 for household construction and the MAGI household composition chart.

2. The family size is the number of individuals in the MAGI household. The number in the family size will determine what income is used for Medicaid eligibility.

C. Determine total countable income for each MAGI household.

1. Whose income counts when determining household income

These basic rules are to be used in determining whose income counts in the tax filer or non-filer household.

Administrative Letter 11-13

- a. When using a tax household, do not count the income of tax dependents unless they expect to file a tax return.
- b. When using a non-filer household, if the parent(s) is in the household, do not count the income of the child unless the child expects to file taxes.
- c. When using a non-filer household, if the parent is not in the household, count income of children under 19 and of all siblings under age 19 for all of them. Also, include income of a spouse of the child.
- d. Counting income depends on the type of household (tax or non-filer) and which individual is involved. See chart below for application of the rules.

Counting Income Tax Household

	Tax Filer(s)	Tax Dependent – child of tax filer – does not meet an exception (Exceptions are listed on the MAGI household composition chart in DMA Administrative Letter No: 6-13)
Tax Household	Count income of tax filer and spouse in home, if not in tax household. Only count income of tax dependents who expect to file a tax return.	Count income of tax filer(s) Count income of the tax dependent applicant, and other tax dependents who expect to file a tax return. Count the income of the tax dependent's spouse if not included in the tax household.

Counting Income Non Filer

	Tax Dependent – not child of tax filer (non-filer rules)	Adult – age 19 or older	Medicaid age child – under age 19
Non-filer rules	Count income for own household regardless of whether they expect to file taxes and count income of live-in spouse. If the tax dependent has children under age 19 in the household, count income of children under age 19 if they expect to file return. If the tax dependent is under age 19 (see last column for Medicaid age child-under age 19)	Count income of applicant and spouse, if in home. Count income of children in household under 19 only if expects to file return	If parent(s) is not in the household count income for own household regardless of whether they expect to file taxes and count income of live in spouse and live in siblings under age 19. If the Medicaid age child has children under age 19, count income of children under age 19 if expects to file return. If parent(s) is in the household, count the income of the parent(s). Do not count income of the child or siblings under age 19 unless the child/sibling expects to file a tax return.

Administrative Letter 11-13

2. What income is counted

Once the Medicaid household composition is established, determine the total countable income for each household.

a. Countable Income

Countable income includes income such as, but not limited to:

- (1) Wages/tips
- (2) Unemployment benefits
- (3) Pensions and annuities
- (4) Military retirement/pension (Do not count veterans benefits)
- (5) Income from business or personal services
- (6) Interest
- (7) Alimony received
- (8) Social Security benefits (RSDI)
- (9) Foreign earnings excluded from taxes
- (10) Lump sums in the month received
- (11) Self-Employment

b. Non-Countable Income

Do not count the following income:

- (1) Child support
- (2) Veteran's benefits (Count military retirement/pension)
- (3) Supplemental Security Income (SSI)
- (4) Worker's Compensation
- (5) Gifts and inheritances
- (6) Scholarships, awards, or fellowship grants used for educational expenses. Any amount used for living expenses is countable income (room and board).
- (7) Lump sums, except in the month received
- (8) Certain Native American and Alaska Native income.

c. Income Calculation

Convert the average income to a gross monthly amount.

- (1) If paid weekly, multiply by 4.3.
- (2) If paid biweekly, multiply by 2.15.
- (3) If paid semimonthly, multiply by 2.
- (4) If paid monthly, use the monthly gross.

Example: Applicant receives income biweekly. On 9/7, she received \$218.75 gross and on 9/21, she received \$209.38 gross. $\$218.75 +$

Administrative Letter 11-13

$\$209.38 = \428.13 . Divide by 2 (number of pay periods received and used) = $\$214.065$, rounded to $\$214.07$ (average income). Convert to a

monthly amount by multiplying $\$214.07$ by $2.15 = \$460.2505$, rounded to $\$460.25$. This is the gross monthly income

D. Determine Eligibility

Compare the total countable income for each household member to the appropriate family size on the Presumptive Medicaid Income Limits Chart.

1. If countable income for the household member is equal to or below the income limit for the appropriate family size, the individual is presumptively eligible.
2. If the countable income for the household member is greater than the income for the appropriate family size, the individual is presumptively ineligible.

VII. EXAMPLES

1. **Rose (48), Rose's daughter Alice, (17), and Alice's daughter, Kitty (1), are in the home. Rose claims Alice as a tax dependent. Kitty is claimed by her father, Dennis (20), who does not reside in the home.**

Family's financial situation:

\$1560/monthly gross income-Rose's salary

\$600/monthly - Child support payments received by Rose for Alice.

Rose's countable income

Monthly gross **\$1560.00**

Rose's household consists of herself and her tax dependent, Alice. She has a family size of 2.

Rose is a tax household and she is the filer. Count the income of the tax filer and the income of any tax dependent who expect to file taxes. (Child support income received is not countable). Since Alice is not working and does not expect to file taxes, count only Rose's income.

Rose is potentially eligible for Family Planning Program (MAF-D) as her income is under $\$2521$ for family size of 2. Her household income exceeds the income limit of $\$569$ for family size of 2 for MAF.

Alice's countable income

Monthly gross **\$1560.00**

Administrative Letter 11-13

Alice's household consists of herself and her mother, Rose. She has a family size of 2.

Alice is a tax dependent and a child of the tax filer. She does not meet any tax dependent exception. Her household and countable income is the same as her mother's countable income. Since Alice does not expect to file taxes, her income is not counted for herself or Rose.

Alice is eligible for MIC (6-18). Her income is under \$1720 for family size of 2.

Kitty's countable income

Kitty is being claimed as a tax dependent by her father who does not live in the home. This means she is a tax dependent who meets an exception. She is claimed by a non-custodial parent.

Kitty's household consists of herself and her mother, Alice. She has a family size of 2.

Her mother does not have any countable income of her own. Rose is not included in Kitty's household so Rose's income is not countable to Kitty.

Kitty's countable income is \$0. She is eligible for MIC (0-5) as her income is under the income limit of \$2715 for a family size of 2.

Applicant	MAGI Household	Rose	Alice	Kitty	Family Size	Countable Income	Eligibility
Rose		x	x		2	\$1560	MAF-D
Alice		x	x		2	\$1560	MIC
Kitty			x	x	2	\$0	MIC

2. **Sandy (45), her husband Ben (46), and their pregnant daughter, Samantha (17), are in the home. Sandy, Ben and Samantha do not expect to file taxes nor be claimed as tax dependents.**

Family financial situation

\$1200.00/monthly gross income-Sandy's social security benefits
\$250.00/monthly gross income-Ben's veteran's benefits
\$200.00/monthly gross income-Samantha's income from babysitting.

Veteran benefits are not counted.

Sandy's countable income

Gross monthly income \$1200.00

Administrative Letter 11-13

Sandy's household consists of herself, Ben, and Samantha. She has a family size of 3. Samantha is pregnant but the unborn child is not included when the pregnant woman is included in another person's household.

Sandy is a non-filer household. Count the income of the applicant, Sandy, her spouse Ben, and the income of any children in the household under age 19 who expect to file a tax return. Ben's only income is VA and is non-countable. Since Samantha does not expect to file a tax return, her income is not counted.

Sandy is potentially eligible for MAF-D because her income is below the limits of \$3174 for a household of 3. Her income exceeds the MAF limit of \$667 for a family size of 3.

Note: Sandy is potentially eligible for Adult Medicaid (ABD) if her Social Security income is disability or if she is over age 65. Her eligibility for ABD Medicaid will be determined once the full Medicaid application is submitted through ePASS. ABD is not a MAGI program and eligibility cannot be established through the presumptive process.

Ben's countable income

Gross monthly income \$1200.00

Ben's household consists of himself, Sandy, and Samantha. He has a family size of 3. Samantha is pregnant but the unborn child is not included when the pregnant woman is included in another person's household.

Ben is a non-filer household. Count the income of the applicant, Ben, his wife's income of \$1200 per month SSA, and the income of any children in the household under age 19 who expect to file a tax return. Ben's income is VA and it is not countable. Since Samantha does not expect to file a tax return, her income is not counted.

Ben is potentially eligible for MAF-D because his income is below the limits of \$3174 for a household of 3. His income exceeds the MAF limit of \$667 for a family size of 3.

Samantha countable income

Gross monthly income \$1200.00

Samantha's household consists of herself, her unborn child, and her parents, Sandy and Ben. She has a family size of 4 because the unborn child is included in the household of the pregnant woman.

Samantha is a non-filer household. Count her parent's income and the income of any children in the house under 19 who expect to file taxes. Sandy's income is the only income that will count. Ben receives VA which is non countable and Samantha does not expect to file taxes.

Administrative Letter 11-13

Samantha is eligible for MIC. Her income is below the limit of \$2611 for a family size of 4.

Applicant	MAGI Household	Sandy	Ben	Samantha	Family Size	Household Income	Eligibility
Sandy		x	x	x	3	\$1200	MAF-D
Ben		x	x	x	3	\$1200	MAF-D
Samantha		x	x	x+1	4	\$1200	MIC

3. **Mary (51), Mary's son, Bill (22), Mary's twin nephew and niece, Ned (10) and Nancy (10) are in the home. Mary claims all as tax dependents.**

Family financial situation:

\$700.00/monthly gross income-Mary's income from her home business after allowable self-employment tax deductions

\$400.00/monthly gross income-Bill's income from weekend jobs.

\$500.00/monthly gross income- Ned's SSA survivor's benefits

\$500.00/monthly gross income- Nancy's SSA survivor's benefits

Mary's countable income

Monthly gross \$700.00

Mary's household consists of herself, Bill, Ned, and Nancy. She has a family size of 4.

Mary is a tax filer. Count the tax filer's income and the income of any tax dependents who expect to file taxes. Since Bill, Ned and Nancy are tax dependents and do not expect to file taxes, their income is not counted for Mary.

Mary is eligible for MAF because she is the caretaker of Ned and Nancy. Mary's income is less than the limit of \$744 for a family size of 4.

Bill's countable income

Monthly gross \$700

Bill's household consists of himself, Mary, Ned, and Nancy. He has a family size of 4.

Bill is a tax dependent and child of a tax filer. He does not meet any tax dependent exceptions. His countable income is the income of the tax filer and the income of any other tax dependent who expects to file taxes. None of the tax dependents, including Bill, expect to file taxes. His household and countable income is the same as his mother's countable income.

Bill is potentially eligible for MAF-D. His household income is less than the limit of \$3827 for a family size of 4. He does not qualify for MAF because he does not qualify as a caretaker and he is over age 21.

Administrative Letter 11-13

Ned's countable income

Monthly gross Ned \$500.00
 Monthly gross Nancy \$500.00

Ned's household consists of himself and his sibling, Nancy. He has a family size of 2.

Mary claims Ned on her taxes, but Ned meets an exception because he is a tax dependent of someone other than a spouse or parent. Use non-filer rules for Ned. He is under age 19 and his parents are not in the home. Count his income and the income of his live-in siblings under age 19 regardless of whether they expect to file taxes.

Ned's countable income is his income of \$500 and his sister's income of \$500 per month. His total countable income is \$1000.00. Ned is eligible for MIC (6-18). His income is less than the limit of \$1720 for a family size of 2.

Nancy's countable income

Monthly gross Nancy \$500
 Monthly gross Ned \$500

Nancy's household consists of herself and her sibling, Ned. She has a family size of 2.

Mary claims Nancy on her taxes, but Nancy meets an exception because she is a tax dependent of someone other than a spouse or parent. Use non-filer rules for Nancy. She is under age 19 and her parents are not in the home. Count her income and the income of her live-in siblings under age 19 regardless of whether they expect to file taxes.

Nancy's countable income is her income of \$500 and her brother's income of \$500 per month. Her total countable income is \$1000.00. Nancy is eligible for MIC as her income is less than the limit of \$1720 for a family size of 2.

Applicant	MAGI Household	Mary	Bill	Ned	Nancy	Family Size	Countable Income	Eligibility
Mary		x	x	x	x	4	\$700	MAF
Bill		x	x	x	x	4	\$700	MAF-D
Ned				x	x	2	\$1000	MIC
Nancy				x	x	2	\$1000	MIC

VIII. PROVIDER INSTRUCTIONS FOR APPROVING ELIGIBILITY

- A. Complete the DMA-5032(H), Presumptive Eligibility Determination by Hospital, according to instructions on back of form.
- B. If determined eligible for presumptive eligibility submit the Medicaid application to NCFAST via ePASS.
- C. Provide the applicant/beneficiary one copy of the DMA-5033(H), Presumptive Eligibility Transmittal Form. Send original and one copy to the Department of Social Services (DSS) in the county in which the applicant resides and retain one copy for your files.
- D. The hospital must send the DMA-5032(H) to the DSS within five business days if the applicant is deemed presumptively eligible. Send original to the DSS, one copy to beneficiary, and retain one copy for your files.
- E. If determined ineligible for presumptive eligibility, complete the DMA-5035. Give the original to the patient and keep a copy for your file. Document ineligibility on the DMA-5032(H) and file in your records with a copy of the denial form. **Do not send any copies to the DSS.**

The individual should be encouraged to apply for other Medicaid programs through ePASS or at the local county dss office.

IX. PRESUMPTIVE ELIGIBILITY PERIOD

Eligibility begins on the day the presumptive eligibility is determined and keyed into NCFAST and ends on the following date depending upon whether a regular Medicaid application is made:

- A. If no regular Medicaid application is made, coverage ends on the last day of the month following the month presumptive eligibility was determined.
- B. If a regular Medicaid application is made, coverage ends on the day the DSS makes an eligibility determination on the regular Medicaid application.

X. APPEAL RIGHTS

There are no appeal rights for presumptive eligibility.

MAGI MEDICAID INCOME LIMITS

MAGI groups do not have Reserve Limits - Only MAF-M group
 Revised effective 1/1/2014

196% MPW	1877	2534	3199	3847	4504	5169	5817	6473	7130	7787	854
196% MAF-D	1888	2521	3174	3827	4481	5134	5787	6440	7094	7747	854
194%-210% MIC-1-c1	1858.01-2011	2508.01-2715	3158.01-3418	3808.01-4122	4458.01-4825	5108.01-5629	5757.01-6292	6407.01-6938	7057.01-7639	7707.01-8343	704
194% MIC-N c1	1858	2508	3158	3808	4458	5108	5757	6407	7057	7707	650
141%-210% MIC-1(Age 1-5)	1951.01-2011	1823.01-2715	2295.01-3418	2768.01-4122	3240.01-4826	3712.01-5629	4185.01-6232	4657.01-6938	5129.01-7639	5602.01-8343	704
141% MIC-N (Age 1-5)	1351	1823	2295	2768	3240	3712	4185	4657	5129	5602	473
107%-133% MIC-1(Age 6-18)	1025.01-1274	1383.01-1720	1742.01-2165	2100.01-2811	2459.01-3066	2817.01-3502	3176.01-3947	3534.01-4393	3893.01-4838	4251.01-5284	448
107% MIC-N (Age 6-18)	1025	1383	1742	2100	2459	2817	3176	3534	3893	4251	359
MAF-C/N	434	569	687	744	824	901	976	1058	1098	1189	78
MAF-M	242	317	387	400	433	467	500	525	542	575	MANUAL
Reserve: MAF-M	3000	3000	3000	3000	3000	3000	3000	3000	3000	3000	3000
133%-159% MIC-J (Age 6-18)	1274.01-1523	1720.01-2056	2185.01-2588	2611.01-3121	3058.01-3654	3502.01-4188	3947.01-4719	4393.01-5261	4838.01-5784	5284.01-6317	633
>159%-211% MIC-K (Age 6-18)	1523.01-2021	2056.01-2728	2588.01-3435	3121.01-4141	3654.01-4848	4188.01-5555	4719.01-6282	5251.01-6969	5784.01-7676	6317.01-8382	707

FPL 5% DISREGARD	47.88	64.63	81.38	98.13	114.88	131.63	148.38	165.13	181.88	198.63	16.75
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Patient Record # _____
 Date care initiated _____

**N.C. Department of Health and Human Services
 Division of Medical Assistance**

Eligible _____
 Ineligible _____

PRESUMPTIVE ELIGIBILITY DETERMINATION BY HOSPITAL

1. Physical Address City State Zip Code County

2. Mailing Address (if different) City State Zip Code County

3. Daytime Phone If none, where can we leave a message? 4. E-Mail

5. Household

Name (First, M.I., Last)	Date of Birth (mm/dd/yyyy)	Relationship to applicant	Are you the parent or caretaker relative of a child under age 18?	Sex	Ethnicity (Optional)	Social Security Number (Optional) (Not req'd for non- applicant)	U.S. Citizen, U.S. National or eligible immigration? (Not req'd for non- applicant)	Will this person file federal income taxes for the current year?	If tax dependent, who will claim them?	Does the tax dependent meet any exceptions?	Does applicant claim anyone not living in the home as a tax dependent? If so, who?	Are you being treated for breast and/or cervical cancer?
		SELF										

6. Medicaid Household Composition – Document in section 7 below all members of the applicant's Medicaid household.
NOTE: Use MAGI Household Composition Chart

7. Household Income – Document gross income of all individuals determined to be in applicant's Medicaid Household

Name (First, M.I., Last)	Income Type	Amount	Frequency	Gross Monthly Income	Calculation space

Total Gross Income:	
No. in Family Size:	
Family Size Income Limit:	

I understand that this is a temporary determination of my eligibility for Medicaid and that if I do not file an official application for Medicaid by the last day of the month following the month this form is signed my eligibility will stop on that date. I also attest that I have provided true and accurate information about my household and income.

Date _____ Signature _____

Provider Name/NPI# _____ Completed by (print) _____ Title _____ Signature/Date _____

INSTRUCTIONS FOR PROVIDER

I. General

- A. Use black ink.
- B. Complete 3 copies
- C. Mail or deliver to the County DSS of the applicant's county of residence no later than 5 working days after the presumptive determination.

II. Patient Information

- A. Give the patients current mailing address.
- B. Indicate the name of the county to which the DSS referral will be sent
- C. Document whether patient was determined eligible or ineligible for presumptive.

III. Household – refer to Administrative Letter 18-13 for instructions on how to determine family size.

- A. Enter family members names in the following order:

1. Patient

2. Patient's spouse, if married

TN NO: 14-0903-~~OTHER~~ household members

Approval Date: 12-01-14

Effective Date 01/01/14

- B. Enter birth date for household members.
- C. Enter household member's relationship to the patient.
- D. Enter sex code for each member.
- E. Enter Social Security number for patient. Optional for other household members.
- F. Indicate if patient is a resident of North Carolina.
- G. Indicate if patient attest to: U.S. Citizenship, U.S. National or eligible immigration.

Eligible Immigration:

- | | |
|--|--|
| Lawful Permanent Resident (LPR/Green Card holder) | Asylee |
| Refugee | Cuban/Haitian Entrant |
| Paroled into the U.S. | Conditional Entrant Granted before 1980 |
| Battered Spouse, Child and Parent | Victim of Trafficking and his/her spouse, child, sibling or parent |
| Temporary Protected Status (TPS) | Deferred Enforced Departure (DED) |
| Lawful Temporary Resident | Resident of American Samoa |
| Individual with Non-immigration status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau) | |
| Granted withholding of Deportation/Removal, under the immigration Convention against Torture (CAT) | |
| Deferred Action Status | |

DMA-5032(H) 11/14

TN NO: 14-0003-MM7

North Carolina

Approval Date: 12-01-14

Page 3

Effective Date 01/01/14



N.C. Department of Health and Human Services

Presumptive Eligibility for Hospitals Part I:

Provider Enrollment Overview and Household Determination

Carolyn McClanahan, DMA

Sheila Platts, DMA

Melanie Whitener, DMA

Liz O'Dell, DMA



Agenda

- Overview Presumptive Eligibility for Hospital
- Qualified Presumptive Providers and Enrollment Process
- General Requirements in NC
- Medicaid Programs for Presumptive Eligibility
- Eligibility Determination
- Overview of Income
- Questions



N.C. Department of Health and Human Services

Overview of Presumptive Eligibility for Hospitals

TN NO: 14-0003-MM7
North Carolina

Approval Date: 12-01-14
Page 3

Effective Date: 01-01-14



N.C. Department of Health and Human Services

Current Presumptive Eligibility

- Pregnant woman only
- Determined mostly by Health Departments and Rural Health Centers
- Covers only ambulatory prenatal care



Presumptive Eligibility – 1/1/14

- Qualified hospitals may opt to do presumptive eligibility for Medicaid
 - beginning no earlier than January 1, 2014
- Programs – Income-based programs
 - Family & Children’s Medicaid
- Coverage depends on program



Presumptive Eligibility Requirement

- Hospital cannot delegate/contract presumptive eligibility determination
 - Must be the hospital that determines eligibility
 - No contractors
 - Federal regulation § 42 CFR 435.1102 and 1110



Presumptive Eligibility Requirement

- Hospital cannot be authorized rep for individual and determine presumptive eligibility
 - Mandated by CMS
 - Cannot delegate the authorized rep to a contractor



N.C. Department of Health and Human Services

Qualified Presumptive Providers and Enrollment Process

TN NO: 14-0003-MM7
North Carolina

Approval Date: 12-01-14
Page 8

Effective Date: 01-01-14
8



Who is a Qualified Provider

- Participates as a provider under the state plan.
- Notifies DMA of its election to make presumptive eligibility determinations
- Agrees to make presumptive eligibility determinations consistent with state policies and procedures
- Has not been disqualified by DMA
- Meets performance measures



Provider Enrollment Process

- Submit request to Provider Services – DMA
- Sign agreement for presumptive
- View webinars – hospital provides attestation of completed training for each staff person
- Provide NCID and names of staff determining presumptive eligibility
- Report any changes to Provider Services



N.C. Department of Health and Human Services

General Requirements in NC

TN NO: 14-0003-MM7
North Carolina

Approval Date: 12-01-14
Page 11

Effective Date: 01-01-14



General Hospital Requirements

- Complete process for authorization to do presumptive
- Use NC FAST portal for presumptive and regular Medicaid app
- Must submit or assist in submitting regular Medicaid app
- Identify staff and request NCID for portal access
- Insure staff completes training



Performance Measures

- Meet thresholds established by DMA
 - 95% of approvals submit regular application
 - 95% of approvals who submit app subsequently approved for regular Medicaid
- Correctly determine presumptive eligibility
- Provide access to records for monitoring of presumptive determination



Performance Measures

A provider not meeting the performance standards shall

- Complete one additional DMA approved training on presumptive Medicaid eligibility determination within 10 business days of the date of notice from DMA, and
- Implement a corrective action plan when prescribed by DMA



Disqualification

A provider not meeting the performance measures within 3 consecutive months after the date of completing performance required training or corrective action may be disqualified.



N.C. Department of Health and Human Services

Medicaid Programs

TN NO: 14-0003-MM7
North Carolina

Approval Date: 12-01-14
Page 16

Effective Date: 01-01-14



Presumptive Programs

- MAF – Coverage for Parent/Caretaker or individuals age 19/20
- MIC – Medicaid for children under age 19
- MPW – Medicaid for Pregnant Women
- MFC – Medicaid for Former Foster Care Children to age 26
- MAF-D - Family Planning Medicaid
- MAF-W - Breast & Cervical Cancer Medicaid
- Limited to BCCCP authorized providers

17



Applicant Eligibility Requirements

Applicant must:

- Attest to U.S. citizenship, U.S National or eligible immigration in the U.S.
- Attest to North Carolina residency.
- Not be an inmate of a public institution with the exception of individuals incarcerated in a NC DOP facility who have their eligibility placed in suspension.
- Not be receiving Medicaid from another aid/program category, county, or state
- Gross income equal to or less than income limit for applicable group



MAF

To qualify for presumptive MAF

- Individual under age 21 including individuals age 19 and 20 living outside of parent's home permanently
- Parent/Caretaker-Must have child under the age of **18** in the household and provides the day-to-day care
- Have family size income equal to or less than the federal poverty level
- Meet all other non-financial eligibility requirements



MIC

To qualify for presumptive MIC

- Child must be under age 19
- Have family size income equal to or less than the federal poverty level for child's age group
- Meet all other non-financial eligibility requirements



MPW

To qualify for presumptive MPW

- Applicant must be a pregnant female (any age),
- Have family size income (unborn/s count in family number) equal to or less than 196% of the federal poverty level
- Meet all other non-financial eligibility requirements



MFC

To qualify for presumptive MFC

- Applicant must be an individual age 18 thru age 25
- Have been in foster care in NC when they turned age 18
- Enrolled in Medicaid while in foster care
- Meet all other non-financial eligibility requirements
- There is no income test.



Family Planning

To qualify for presumptive FPP

- Applicant must be able to bear children or cannot be sterile
- Have family size income equal to or less than 195% of the federal poverty level
- Meet all other non-financial eligibility requirements.



BCCM

To qualify for presumptive BCCM

- Individual must be a woman age 18 through 64
- Has been screened and diagnosed for breast or cervical cancer through BCCCP
- Hospital must be authorized by CDC as BCCCP in order to determine presumptive



Coverage

- Determined by program:
 - MAF, MIC, MFC, BCCM – Full Medicaid coverage
 - Family Planning – Limited to Family Planning services

- Pregnancy (MPW) – still limited to ambulatory prenatal care



Coverage

Eligibility Period

- Begins on the day the presumptive eligibility application is signed at the qualified provider.
- Ends on one of the following dates, depending on whether regular Medicaid application is made:
 - If no, then coverage ends on last day of the month following the month presumptive eligibility was determined.
 - If yes, then coverage ends on the day the DSS makes an eligibility determination on the regular Medicaid application.



Coverage Example

- PE application signed and approved 1/6/14.
No Medicaid application was submitted by 2/28/14. PE is limited to 1/6/14 – 2/28/14.
- If Medicaid application was submitted and eligibility decision was made by DSS on 3/19/14, PE coverage will be authorized 1/6/14 – 3/19/14.



Coverage Process

- Hospital determines PE eligibility
- Enters PE application into NC FAST
 - If there is an active Medicaid case or if there has been a presumptive case within the past two years, the following message will display:
 - “An active Medicaid case or previous Presumptive case has been found. You cannot proceed with this application for this person.”
- If eligible complete the DMA-5033(H),
Presumptive Eligibility Transmittal form.



Coverage Process

- If ineligible, complete the DMA-5035, Presumptive Eligibility Denial Form.
- Provide the individual with a copy of the DMA-5033(H) or DMA-5035
- Submit the PE application to DSS via NC FAST.
- DSS authorizes eligibility PE eligibility **one month at a time retroactively**

Draft 11/01/13DRAFT 10/30/13

29



Coverage Process Example

- PE is approved by ABC hospital on January 7, 2014. The PE application and regular Medicaid application is submitted in NC FAST on the same date. The Medicaid application is denied on February 10, 2014



Coverage Process Example

- DSS will authorize the PE in NC FAST by the 5th workday of the following month – February.
- If the regular Medicaid application is still pending, the PE authorization will be 1/7/14 – 1/31/14.
- February coverage entered by 5th working day in March or on the date MA application is disposed.
- Eligibility determined on the Medicaid application on 2/10/14, PE authorization for February will be 2/1/14 – 2/10/14.
- **Total PE eligibility: 1/7/14 – 2/10/14**



Coverage

- If regular Medicaid approved retroactively, it may overlay the PE in NC Tracks.
- If regular Medicaid is denied, PE is still authorized and claims incurred in the PE period will be paid according to the program's scope of covered services.



Coverage

Presumptive Eligibility is limited to:

- Once per pregnancy for Medicaid Pregnant Woman (MPW). (Self attestation acceptable)
- Once in a two year period for all other eligible programs.
 - If there is an active Medicaid case or if there has been a presumptive case within the past two years, the following message will display:

“An active Medicaid case or previous Presumptive case has been found. You cannot proceed with this application for this person.”



N.C. Department of Health and Human Services

Coverage

- Example: Individual is determined presumptively eligible on January 5, 2014. The individual is not eligible for presumptive eligibility again until January 5, 2016.



N.C. Department of Health and Human Services

Eligibility Determination

TN NO: 14-0003-MM7
North Carolina

Approval Date: 12-01-14
Page 35

Effective Date: 01-01-14



Medicaid Terms

- **Parent** - Natural, adoptive, or step
 - **Medicaid Aged Child** - Natural, adopted, or stepchild under the age of 19
- Note: Medicaid still covers under age 21, but they are not considered a Medicaid child in the household of a non-filer**
- **Sibling** - Natural, adoptive, or step
 - **Family Size** - Number in the household



Medicaid Terms

Parent/Caretaker-Must have child under the age of 18
in the household.

- **In addition, there are two other important points:**
 - A specified relative and spouse may both be eligible as the caretakers
 - A specified relative(s) may be the caretaker even if a parent is in the home. (This must be an **ongoing situation** and cannot flip back and forth depending upon who needs Medicaid.)



Medicaid Terms

- **Tax Filer**
 - An individual who expects to file a tax return for the taxable year in which a determination is made for Medicaid/NCHC.

- **Tax Dependent**
 - An individual expected to be claimed as a dependent by someone else
 - May also be a tax filer

- **Non-filer**
 - An individual who is not expected to file a tax return or expected to be claimed as a tax dependent by someone else



Determining Medicaid Household

- There are two different sets of rules to build a Medicaid household
 - Tax household
 - Non-filer



Tax Household

- Tax filer
- Tax filer
- Spouse living with the tax filer
- All persons whom the tax filer expects to claim as tax dependents



Tax Household

- Tax dependent
 - The individual
 - Members of the household of the tax filer who is claiming the tax dependent
 - The tax dependent's spouse
 - If living together and not already included



Tax Dependent Exceptions

- If the tax dependent meets one of the following exceptions, apply the non-filer rules on the next slide
 - The individual is claimed as a tax dependent by someone other than a spouse or a natural, adoptive parent or stepparent
 - A child under the age of 19 living with both parents who do not expect to file a joint tax return. This may include a stepparent.
 - A child under the age of 19 claimed as a tax dependent by a non-custodial parent



Non-filer Household

- **An individual who:**
 - Does not expect to file taxes, and
 - Does not expect to be claimed as a tax dependent, or
 - Is a tax dependent who meets one of the exception
- **The household consists of:**
 - The individual
 - The individual's spouse
 - The individual's natural, adopted, and step children under the age 19
 - If individual is under age 19, the household includes the same as above AND
 - The individual's natural, adoptive live-in parent / stepparent and
 - The individual's natural, adopted, and step live-in siblings under the age of 19



Pregnant Woman Household

- Pregnant woman's household always includes the number of unborn children
- Pregnant woman only counts as one when she is included as a member in another applicant's household. Unborn children are not counted.



Two Important Questions

- **Do you plan to file taxes?**
- **Do you expect to be claimed as a tax dependent?**
- **Note: Document patient's responses, no verification required.**



Let's see how it works!!!

Please use the MAGI Household Composition
flow chart to work through the following
examples



Example 1

Annie, her son Jacob (10), her daughter Miley (7) are in the household. Annie does not expect to file taxes or be claimed as a tax dependent.



Example 1

Annie's household

- Does Annie expect to file taxes? **No**
- Does Annie expect to be claimed as a tax dependent? **No**

Annie's Household: Annie, Jacob, and Miley

A P P L I C A N T		Medicaid/NCHC Household	Annie	Jacob	Miley	Family Size
Annie			√	√	√	3
Jacob						
Miley						



Example 1

Jacob's household

- Does Jacob expect to file taxes? **No**
- Does Jacob expect to be claimed as a tax dependent? **No**

Jacob's household: Jacob, Annie and Miley

A P P L I C A N T		Medicaid/NCHC Household	Annie	Jacob	Miley	Family Size
Annie			✓	✓	✓	3
Jacob			✓	✓	✓	3
Miley						



Example 1

Miley's household

- Does Miley expect to file taxes? **No**
- Does Miley expect to be claimed as a tax dependent? **No**

Miley's household: Miley, Annie and Jacob

A P P L I C A N T	Medicaid/NCHC Household	Annie	Jacob	Miley	Family Size
	Annie	✓	✓	✓	3
	Jacob	✓	✓	✓	3
	Miley	✓	✓	✓	3



Example 2

Whitney (45), her sons, Paul (15) and Jason (12) are in the household. Jason receives SSI benefits. Whitney claims both her sons as tax dependents.



Example 2

Whitney's household

- Does Whitney expect to file taxes? **Yes**
- Does Whitney expect to be claimed as a tax dependent? **No**

A P P L I C A N T	Medicaid/ NCHC Household	Whitney	Paul	Jason	Family Size
Whitney					
Paul					
Jason					



Example 2

Paul's household

- Does Paul expect to file taxes? **No**
- Does Paul expect to be claimed as a tax dependent? **Yes**
- Does Paul meet any of the tax dependent exceptions ? **No**

A	Medicaid/ NCHC Household	Whitney	Paul	Jason	Family Size
P	Whitney				
P	Paul				
L	Jason				
I					
C					
A					
N					
T					



Example 2

Whitney's household is her tax household: Whitney, Paul and Jason

Paul's household is the tax household of the person who claims him as a dependent: Paul, Whitney and Jason.

A P P L I C A N T	Medicaid/ NCHC Household	Whitney	Paul	Jason	Family Size
	Whitney	√	√	√	3
	Paul	√	√	√	3
	Jason				(SSI recipient)



Example 3

Sandy (45), her husband Ben (46), and their pregnant daughter Samantha (17) are in the household. Sandy, Ben and Samantha do not expect to file taxes nor be claimed as tax dependents.



Example 3

Sandy's household

- Does Sandy expect to file taxes? **No**
- Does Sandy expect to be claimed as a tax dependent? **No**

A	Medicaid/ NCHC Household	Sandy	Ben	Samantha	Family Size
P	Sandy				
P	Ben				
L	Samantha				
I					
C					
A					
N					
T					



Example 3

Ben's household

- Does Ben expect to file taxes? **No**
- Does Ben expect to be claimed as a tax dependent? **No**

A	Medicaid/ NCHC Household	Sandy	Ben	Samantha	Family Size
P	Sandy				
P	Ben				
L	Samantha				
I					
C					
A					
N					
T					



Example 3

Samantha's household

- Does Samantha expect to file taxes? **No**
- Does Samantha expect to be claimed as a tax dependent? **No**

A P P L I C A N T	Medicaid/ NCHC Household	Sandy	Ben	Samantha	Family Size
	Sandy				
	Ben				
	Samantha				



Example 3

Sandy's household is Sandy, Ben and Samantha

Ben's Household is Ben, Sandy and Samantha

Samantha's Household is Samantha, her unborn child, Sandy and Ben

A	Medicaid/ NCHC Household	Sandy	Ben	Samantha	Family Size
P	Sandy	✓	✓	✓	3
L	Ben	✓	✓	✓	3
I	Samantha	✓	✓	✓+1	4
C					
A					
N					
T					



Example 4

Rose (48), Rose's daughter Alice, (17), Alice's daughter Kitty (1), are in the household. Rose claims Alice as a tax dependent. Kitty is claimed by her father Dennis (20), who does not reside in the household.



Example 4

Rose's household

- Does Rose expect to file taxes? **Yes**
- Does Rose expect to be claimed as a tax dependent? **No**

A P P L I C A N T		Rose	Alice	Kitty	Family Size
Medicaid/ Household	Rose				
	Alice				
	Kitty				



Example 4

Alice's household

- Does Alice expect to file taxes? **No**
- Does Alice expect to be claimed as a tax dependent? **Yes**
- Does Alice meet any of the tax dependent exceptions? **No**

A P P L I C A N T		Medicaid/NCHC Household	Rose	Alice	Kitty	Family Size
		Rose				
		Alice				
		Kitty				



Example 4

Kitty's household

- Does Kitty expect to file taxes? **No**
- Does Kitty expect to be claimed as a tax dependent? **Yes**
- Does Kitty meet any of the tax dependent exceptions? **Yes**

A P P L I C A N T	Medicaid/NCHC Household	Rose	Alice	Kitty	Family Size
	Rose				
	Alice				
	Kitty				



Example 4

Rose's Household is the tax household: Rose and Alice

Alice's Household is the tax household of the person who claims her as a dependent: Alice and Rose

Kitty's Household: Kitty and Alice

A P P L I C A N T	Medicaid/NCHC Household	Rose	Alice	Kitty	Family Size
	Rose	✓	✓		2
	Alice	✓	✓		2
	Kitty		✓	✓	2



Example 5

Dennis (20), Dennis' daughter Lynn (3) are in the household. Dennis claims Lynn as a tax dependent. Dennis also claims his other daughter Kitty (1) who lives in the household with her mother (see example 4)



Example 5

Dennis' household

- Does Dennis expect to file taxes? **Yes**
- Does Dennis expect to be claimed as a tax dependent? **No**

A P P L I C A N T	Medicaid/ NCHC Household	Dennis	Lynn	Kitty	Family size
	Dennis				
Lynn					



Example 5

Lynn's household

- Does Lynn expect to file taxes? **No**
- Does Lynn expect to be claimed as a tax dependent? **Yes**
- Does Lynn meet any of the tax dependent exceptions? **No**

A P P L I C A N T	Medicaid/ NCHC Household	Dennis	Lynn	Kitty	Family size
	Dennis				
	Lynn				



Example 5

Dennis' Household is his tax household: Dennis, Lynn and Kitty.

Lynn's Household is the tax household of the person who claims her as a dependent: Lynn, Dennis and Kitty.

A P P L I C A N T	Medicaid/ NCHC Household	Dennis	Lynn	Kitty	Family size
	Dennis		✓	✓	✓
Lynn		✓	✓	✓	3



Example 6

Mary (51), Mary's son Bill (22), Mary's twin nephew and niece, Ned (10) and Nancy (10) are in the household. Mary claims all as tax dependents.



Example 6

Mary's household:

- Does Mary expect to file taxes? **Yes**
- Does Mary expect to be claimed as a tax dependent? **No**

A P P L I C A N T		Mary	Bill	Ned	Nancy	Family Size
MAGI Household	Mary					
	Bill					
	Ned					
	Nancy					



Example 6

Bill's household

- Does Bill expect to file taxes? **No**
- Does Bill expect to be claimed as a tax dependent? **Yes**
- Does Bill meet any of the tax dependent exceptions? **No**

A P P L I C A N T					
MAGI Household	Mary	Bill	Ned	Nancy	Family Size
Mary					
Bill					
Ned					
Nancy					



Example 6

Ned's household

- Does Ned expect to file taxes? **No**
- Does Ned expect to be claimed as a tax dependent? **Yes**
- Does Ned meet any of the tax dependent exceptions? **Yes**

A P P L I C A N T						
MAGI Household	Mary	Bill	Ned	Nancy	Family Size	
Mary						
Bill						
Ned						
Nancy						



Example 6

Nancy's household

- Does Nancy expect to file taxes? **No**
- Does Nancy expect to be claimed as a tax dependent? **Yes**
- Does Nancy meet any of the tax dependent exceptions? **Yes**

A P P L I C A N T					
MAGI Household	Mary	Bill	Ned	Nancy	Family Size
Mary					
Bill					
Ned					
Nancy					



Example 6

- Mary's household is her tax household: Mary, Bill, Ned and Nancy
- Bill's household is Mary, Bill, Ned and Nancy (the tax household of the filer who claims him as a dependent)
- Ned and Nancy's household consists of themselves and their live in sibling under age 19.

A P P L I C A N T						
MAGI Household	Mary	Bill	Ned	Nancy	Family Size	
Mary	✓	✓	✓	✓	4	
Bill	✓	✓	✓	✓	4	
Ned			✓	✓	2	
Nancy			✓	✓	2	



N.C. Department of Health and Human Services

Overview of Income



Countable Income

- Income sources used in determining the adjusted gross income include but are not limited to
 - Wages/tips
 - Unemployment
 - Pension and annuities
 - Income from business or personal services
 - Interest
 - Alimony received
 - Social Security benefits (RSDI)
 - Foreign earned
 - Lump sum in the month received
 - Self-employment
 - Military-retirement/pension



Non-Countable Income

- Child support
- Veterans' benefits
- Supplemental Security Income (SSI)
- Gifts and inheritances
- Scholarships, awards, or fellowship grants used for educational expenses. Any amount used for living expenses is countable income (room and board).
- Lump sums, except in the month received
- Certain Native American and Alaska Native income



Provider Summary

- Effective January 1, 2014, hospitals may opt to do presumptive Medicaid eligibility
- Enroll as a PE Provider and meet state thresholds
- Submit all PE and regular Medicaid applications through NC FAST portal



PE Summary

- Limited period of coverage
- Applies to certain Medicaid groups
- Eligibility determined by qualified providers
- Eligibility determined based on household of individual and income



N.C. Department of Health and Human Services

Next Steps in Training

- November 19
- November 26
- December 3
- December 10



N.C. Department of Health and Human Services

Questions

TN NO: 14-0003-MM7
North Carolina

Approval Date: 12-01-14
Page 81

81

Effective Date: 01-01-14