

## TITLE 12. HEALTH

### DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

#### Emergency Regulation

**Title of Regulation: 12VAC30-30. Groups Covered and Agencies Responsible for Eligibility Determination (amending 12VAC30-30-70).**

**Statutory Authority:** § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

**Effective Dates:** October 15, 2019, through April 14, 2021.

**Agency Contact:** Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

**Preamble:**

*Section 2.2-4011 B of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006 A 4 of the Code of Virginia.*

*Chapter 2, Item 303 SS 4 a of the 2018 Acts of Assembly directs the Department of Medical Assistance Services (DMAS) to amend the State Plan for Medical Assistance to implement coverage for certain newly eligible individuals. Item 303 SS 4 f authorizes DMAS to promulgate emergency regulations to implement these changes.*

*The amendments expand mandatory eligibility categories by adding a new adult coverage group to implement Medicaid expansion. The new adult expansion group includes adults 19 years of age or older but younger than 65 years of age who have household incomes below 138% of the federal poverty level in accordance with federal requirements stipulating that this covered group must be considered for possible hospital presumptive eligibility covered groups. The changes included in this regulatory action have approved by the Centers for Medicare and Medicaid Services.*

#### **12VAC30-30-70. Hospital presumptive eligibility.**

A. Qualified hospitals shall administer presumptive eligibility in accordance with the provisions of this section. A qualified hospital is a hospital that meets the requirements of 42 CFR 435.1110(b) and that:

1. Has entered into a valid provider agreement with ~~DMAS~~ the Department of Medical Assistance Services (DMAS), participates as a Virginia Medicaid provider, notifies DMAS of its election to make presumptive eligibility determinations, and agrees to make presumptive eligibility determinations consistent with DMAS policies and procedures; and
2. Has not been disqualified by DMAS for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures as defined in subsections C, D, and E of this section or for failure to meet any standards established by the Medicaid agency.

B. The eligibility groups or populations for which hospitals determine eligibility presumptively are: (i) pregnant women; (ii) infants and children younger than age 19 years; (iii) parents and other

caretaker relatives; (iv) individuals eligible for family planning services; (v) former foster care children; ~~and~~ (vi) individuals needing treatment for breast and cervical cancer; and (vii) adults 19 years of age or older but younger than 65 years of age.

C. The presumptive eligibility determination shall be based on:

1. The individual's categorical or nonfinancial eligibility for the group, as listed in subsection B of this section, for which the individual's presumptive eligibility is being determined;
2. Household income shall not exceed the applicable income standard for the group, as the groups are listed in subsection B of this section, for which the individual's presumptive eligibility is being determined if an income standard is applicable for this group;
3. Virginia residency; and
4. Satisfactory immigration status in accordance with 42 CFR 435.1102(d)(1) and as required in subdivision 3 of 12VAC30-40-10 and 42 CFR 435.406.

D. Qualified hospitals shall ensure that at least 85% of individuals deemed by the hospital to be presumptively eligible will file a full Medicaid application before the end of the presumptive eligibility period.

E. Qualified hospitals shall ensure that at least 70% of individuals deemed by the hospital to be presumptively eligible are determined eligible for Medicaid based on the full application that is submitted before the end of the presumptive eligibility period.

F. The presumptive eligibility period is determined in accordance with 42 CFR 435.1101 and shall begin on the date the presumptive eligibility determination is made. The presumptive eligibility period shall end on the earlier of:

1. 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
2. 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 last day of the month following the month in which the determination of presumptive eligibility is made.

G. Periods of presumptive eligibility are limited to one presumptive eligibility period per pregnancy and one per calendar year for all other covered groups.