Weekly Checkup

Presumptive Medicaid Eligibility Rule to Increase Wasteful State Spending

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Presumptive eligibility is a rarely discussed provision of the Affordable Care Act (ACA) which is likely to result in wasteful Medicaid spending, placing an increased financial burden upon states. Presumptive eligibility, specified in Section 2202 of the ACA, allows qualified medical entities to make immediate and temporary Medicaid eligibility determinations based upon a preliminary analysis of a person's household income. Once the hospital presumes the patient eligible, Medicaid is responsible for reimbursement, regardless of whether this determination is correct. Proper verification of eligibility generally occurs after the person has received treatment.

In the past, state legislatures solely regulated PE, limiting the privilege to pregnant women (32 states) and children (17 states). Under the ACA, however, hospitals are given greater discretion over presumptive eligibility determinations, irrespective of whether a state currently allows PE determinations or has elected to expand their Medicaid program. Hospitals are now allowed to conduct PE determinations on anyone who might qualify under the ACA's new eligibility rules, including parents/guardians of Medicaid-eligible children and other adults. Shifting the control over PE from states to hospitals and expanding its scope, however, is problematic.

Improper presumptive eligibility determinations are costly to states – in the event services are rendered to an ineligible patient, the state remains "on the hook" for the costs. As a result, hospitals, fearful of the rising costs of uncompensated care, may view PE as a guaranteed form of payment. Guaranteed payment, regardless of the appropriateness of a PE determination, may encourage the over-utilization of PE designations, raising the costs of the Medicaid program for states. Moreover, PE determinations require a very rudimentary verification process, allowing inaccuracies to go unnoticed. Expansive PE determination may promote the fabrication of eligibility requirements by non-eligible patients seeking free, immediate care.

While data regarding the quantity and cost of PE determinations is scant, some states have begun projecting the financial impact of Section 2202 on state coffers. For example, Kansas expects the provision to cost the state an additional $700,000 annually. Given that Kansas' state spending on Medicaid places it near the middle of all states, assuming this figure is consistent across the nation, this new PE scheme could cost states an additional $35 million annually.