

**Virginia Medicaid
Hospital Presumptive
Eligibility (HPE) Provider
Manual**

**The
Department
of Medical
Assistance
Services
(DMAS)**

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Hospital Presumptive Eligibility Process

Basis of Hospital Presumptive Eligibility (HPE)

The Affordable Care Act requires states to allow approved hospitals to enroll patients who meet certain covered groups in Medicaid for a limited time (temporary) based on their presumptive eligibility. The Department of Medical Assistance Services (DMAS) is responsible for coordinating the HPE Agreement with hospitals, providing training and technical assistance, monitoring the appropriate use of the HPE enrollments, and overseeing the enrollment of HPE enrollment. HPE is not available to individuals already enrolled in Medicaid or FAMIS.

The Hospital's Role

The Hospital Presumptive Eligibility process allows qualified hospitals to make an eligibility determination for a limited Medicaid coverage category. These hospitals will:

- Identify an individual who may be eligible for Medicaid health coverage and could benefit from temporary medical assistance;
- Make an immediate Medicaid (limited period) eligibility determination for these individuals;
- Provide the individual a printed copy of the (approved or denied) Notice for Hospital Presumptive Eligibility for temporary Medicaid coverage in Virginia;
- Receive an email from Cover Virginia (the entity that performs Medicaid enrollment) with a Notice of Presumptive Eligibility (approved or denied), and provide a printed copy of this notice to the applicant; and
- Educate and assist individuals with applying for full Medicaid health coverage prior to being discharged from the hospital through the Cover Virginia Call Center (855-242-8282) or online via CommonHelp at www.commonhelp.virginia.gov;

Becoming a Qualified Hospital

To be an approved HPE determination site for Virginia Medicaid, hospitals must:

- Be enrolled with the Department of Medical Assistance Services (DMAS) as a participating provider;
- Notify DMAS of their decision to be a HPE determination site by completing and submitting the Hospital Presumptive Eligibility Qualified Entity Responsibilities and Agreement (page 18) along with the Virginia Qualified Entity Agreement for Hospital Presumptive Eligibility (page 19);
- Agree to make determinations consistent with Medicaid policies and procedures.
- Agree to meet established quality standards; and
- Ensure hospital staff performing any determinations have read this HPE provider manual and completed the HPE provider trainings. Training slides and information are available on the DMAS website under Provider Information/HPE Information. DMAS also holds training webinars periodically.

HPE eligibility determinations through the online web portal must be conducted by hospital staff only. Hospitals may not contract HPE site functions to other entities or use contracted hospital personnel to make HPE determinations. Certified Application Assistants (contracted entities and staff thereof) may

assist, gather information, and reach out to individuals who may be eligible for HPE. However, determinations themselves, on the online HPE web portal must be made by qualified hospital employees.

Qualified hospital employees are those employed by a DMAS participating provider (a hospital which has submitted and been approved as an HPE Provider) and completed the DMAS HPE provider training.

Who Can Apply for Coverage?

Any individual seeking immediate Medicaid coverage may apply. There is no requirement the individual be admitted to the hospital or seeking hospital services in order to apply, and no requirement for the individual to be uninsured when applying.

When Does HPE Coverage Begin and End?

HPE coverage begins on the day the determination for HPE is made. Start dates may not be backdated prior to the determination date for HPE coverage.

HPE coverage ends with the earlier of:

1. The day the local Department of Social Services (LDSS) makes a decision on the application for full Medicaid or FAMIS eligibility; or
2. The last day of the month following the month in which the determination of HPE was made in the case where the applicant has not filed a full Medicaid application. (Example: if the determination date for HPE is July 12, the coverage end date would be August 31.); or
3. If an HPE recipient has filed a full Medicaid application and it has not been determined when HPE is to end, the LDSS worker would extend HPE coverage until a determination is reached.

What Is Covered?

HPE covers all services covered under Medicaid, and those services that may be available under the eligibility group the person is approved for. This may include dental, vision, and mental health services. HPE allows hospitals to be reimbursed for covered services provided during the temporary coverage period even if the individual is ultimately determined ineligible for Medicaid or FAMIS.

Exceptions:

1. Pregnant women are covered for ambulatory prenatal care only. Labor and delivery are not covered. Pregnant woman may be determined for HPE at time of delivery; however, the hospital should submit a full Medicaid application. If she is determined to be eligible for full coverage Medicaid, based on the timely submission of a Medicaid application, the period including the labor and delivery may be covered retroactively.
2. Plan First covers only family planning services. Specific services and billing codes are available at www.dmas.virginia.gov under Program & Services.

What Eligibility Covered Groups Are Included?

HPE Full Benefit Eligibility Groups:

- Children under age 19 with income at or below 148%* of the Federal Poverty Level (FPL).
- Adults age 19 – 64 years old with income at or below 138%* FPL-MAGI Group; and
- Parent/Caretaker-relative of a child under age 18, or if a child is age 18 and expected to graduate

high school by their 19th birthday (income limit varies based on locality where individual lives).

Eligibility individuals in the MAGI Group

Adults age 19 – 64 years old with income at or below 138% FPL must:

- Not be entitled to or enrolled in Medicare Part A or B;
- Not be eligible in a Medicaid mandatory covered group or the BCCPTA covered group; or
- Meet any other criteria as outlined in another particular HPE covered group.

HPE Full Benefit Eligibility Groups where no income requirement is required:

- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) participant - limited to hospitals which have the Every Woman’s Life program or operating under the Breast and Cervical Cancer Early Detection Program (BCCEDP)--No income test required; and
- Former Foster Care youth under age 26 who were receiving Medicaid and foster care services in any state at the time of his/her 18th birthday (No income test required).

HPE Limited Benefit Eligibility Groups

- Pregnant Women with income at or below 148%* FPL; and
- Plan First with income at or below 205%* FPL.

* It is important to remember that certain eligibility groups allow a 5% FPL standard disregard.

Income Guidelines

The individual must self-attest to total income in his/her household, which is used to determine eligibility. Hospitals are responsible to use current Federal Poverty Limits (FPL) income guidelines. The current income guidelines can be found at the Cover Virginia website at <https://www.dmas.virginia.gov/providers/information-resources/hospital-presumptive-eligibility-information/> The FPL income guidelines can change annually and DMAS will post updated income determination guidelines.

Can Newborns Be Covered?

A separate HPE determination is required to cover a newborn. Newborns born of women during the HPE period are not considered as a Medicaid deemed eligible newborn. The hospital may make a HPE determination on the infant and assist the mother in applying for full coverage Medicaid for herself and the newborn.

If a woman who was presumptively eligible when pregnant and is later determined to be eligible for Medicaid based on the timely submission of a Medicaid application, the newborn’s status would change to a deemed eligible newborn and would not need to a HPE determination.

Applicant’s Responsibilities

When applying:

Provide true and accurate information for the Hospital Presumptive Eligibility determination.

If approved for hospital presumptive coverage:

- If interested in pursuing ongoing (uninterrupted) eligibility, the individual must submit a completed

Medicaid application prior to the end of the month following the month of hospital's determination.

- If ineligible or denied for hospital presumptive coverage:
- If an individual is interested in obtaining full Medicaid eligibility, a Medicaid application must be submitted. The individual can call Cover Virginia and apply online, or apply through <https://www.commonhelp.virginia.gov/#get-started>

Hospital Responsibilities

What to do before making an eligibility determination:

- Check the Virginia Medicaid Web Portal or call the MediCall audio response system to check if the individual is currently receiving (enrolled) Medicaid or FAMIS coverage or if they have already received HPE in the current calendar year or during the current pregnancy.
The Virginia Medicaid Web Portal can be accessed by visiting: <https://vamedicaid.dmas.virginia.gov/provider> A valid NPI is required when accessing the portal.
The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996.
- If the individual has active Medicaid or FAMIS coverage, or has had HPE in the current calendar year or for the current pregnancy, the individual is **not eligible** for HPE *and must be denied coverage*. If current active coverage is in a limited benefit category (such as Plan First) encourage the person to complete a full Medicaid application.

Making an eligibility determination

The hospital is responsible for making an **immediate** eligibility determination using the following guidelines:

- In the online eligibility form, the hospital worker will choose the correct covered group based upon the information provided by the individual and the HPE eligibility guidelines; and
- The hospital worker will gather all of the information from the individual and enter into the HPE online eligibility form;
- Ask the individual if all information is current and truthful;
- Use current Federal Poverty Level income guidelines;
- The hospital worker will attest all the information entered into the online form is correct;
- Use the online eligibility form to make the eligibility determination;
- If the individual does not meet HPE eligibility guidelines, he/she is considered ineligible. The individual must be provided a printed denial notice of action;
- Hospital staff should submit the determination timely to ensure the individual is enrolled to access health care services. Eligibility is based on when the determination was completed and entered.

Completing the HPE Determination

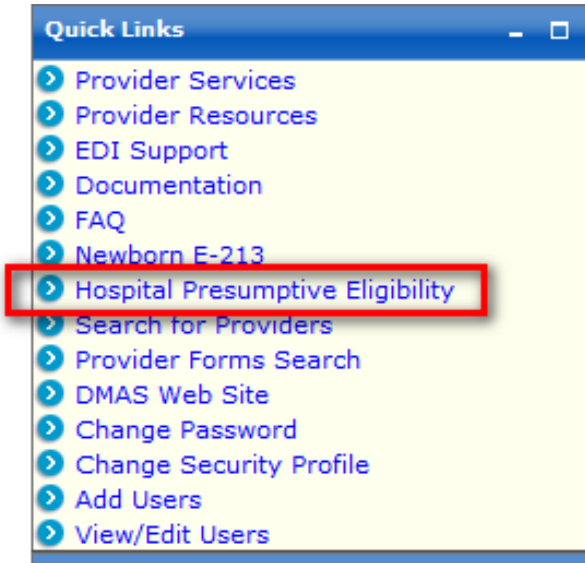
Regardless of the eligibility decision, the hospital is responsible for ensuring completion of the HPE

determination. The hospital determination of an HPE decision cannot be appealed by the applicant or the hospital.

Self-Attestation of Individual is Needed for Determining HPE Eligibility	<p>The following information is needed from the applicant:</p> <ul style="list-style-type: none"> • Does person have active Medicaid or FAMIS coverage • Resident of Virginia • Immigration Status (Use the Guide located on page 16 of this manual) • Household size • Gross monthly income for the household
Recommended Information	<p>The following items are not required but would recommend to gather at time of application:</p> <ul style="list-style-type: none"> • Social security number • Preferred language • Telephone number • Race and ethnicity of applicant (may select unknown)
Required Information for Submission of HPE Determination	<p>The following information is necessary to complete the HPE determination:</p> <ul style="list-style-type: none"> • Confirm if any previous period(s) of HPE within the time frame(s) • Decision Date for HPE determination • Applicant's date of birth • Applicant's full legal name • Gender of applicant • Physical address • City or County of Virginia residency • Size of household • Household gross monthly income • Citizenship or Immigration Status • Meets the requirements for the covered group applied for

Submitting the HPE Online Eligibility Determination Form

Hospitals will enter HPE information using the Online Eligibility Determination Form. The online form is located at <https://vamedicaid.dmas.virginia.gov/provider> at the Provider Web portal. Once the hospital worker signs into the DMAS portal using the hospital's NPI, the Quick Links menu will show an HPE link, as shown below.



Notifying the Applicant

When a presumptive eligibility determination is made, the hospital will provide the applicant with an immediate printed notice of action, which is the HPE determination outcome. An interim notice of action will be available for download from after the submission of the HPE application. Depending on the outcome of the determination, the hospital will provide the applicant with an *Interim Approval letter of Hospital Presumptive Eligibility* or an *Interim Denial Notice of Action*.

Notices Provided and/or Action Needed	Approval	Denial
<i>Interim Approval Notice of Hospital Presumptive Eligibility:</i> Produced at the time of the eligibility determination at the hospital and is provided to applicant. This is produced and downloadable from the online portal after the online application is submitted.	X	
<i>Denial Notice of Action:</i> Produced at the time of the eligibility determination at the hospital and is provided to applicant.		X
<i>Approval Notice of Action (NOA):</i> System-generated after enrollment into the Medicaid eligibility system, and includes the Medicaid ID Number. The NOA is mailed to the applicant and a copy is emailed to the hospital worker who submitted the application.	X	
<i>A Mailed Denial Notice of Action:</i> If active Medicaid coverage is discovered after an interim approval of eligibility was made, a denial letter is mailed to applicant and emailed to the hospital worker who submitted the application. This denial notice nullifies an <i>Interim Approval letter</i> .		X

<i>Covered Services Fact Sheet</i> relevant to approved covered group.	X	
Request and assist the applicant with completing a full Medicaid application as soon as possible, and prior to the end date of coverage as listed on the Interim Approval and the Approved Notice of Action.	X	
Explanation that the denial is based on the applicant's attestation (their statement of information).		X
Assist individuals in completing a full Medicaid application, or information on resources to help the individual complete and submit an application.	X	X
Applicants are not provided the right to appeal a HPE determination.		

Recordkeeping Requirements

The hospital is responsible for maintaining the following records/documents for (3) three years from the date of the HPE determination.

HPE Records/Documents Retention Schedule	
Document Description	Retain on file:
Eligibility determinations approved	<ul style="list-style-type: none"> • Copy of the Interim Approval Notice of Hospital Presumptive Eligibility. • The Notice of Action with the applicant's Medicaid member ID and enrollment period of HPE benefits.
Eligibility determinations denied	<ul style="list-style-type: none"> • Copy of the Denial Notice of Action

DMAS Responsibilities

Processing a Hospital Presumptive Eligibility Approval

Upon receipt of an approved eligibility determination from the hospital, DMAS will:

- Confirm the hospital is a qualified hospital;
- Enter the individual into the enrollment system;
- Not override current Medicaid/FAMIS coverage with HPE coverage;
- Produce a Denial Notice of Action and mail it to the applicant if he/she has current Medicaid or FAMIS coverage during the requested HPE period; and
- Enter the eligibility effective date as when the Hospital completed the determination for HPE.

Individuals enrolled in HPE will be covered under Medicaid Fee-for-Service and will not be enrolled in a managed care organization (MCO). Health care services can only be provided to HPE enrollees from Virginia Medicaid enrollment providers.

Ending Hospital Presumptive Eligibility Coverage

Coverage will end for an approved HPE individual as follows:

- **For individuals who do not submit a Medicaid application:** HPE (temporary) eligibility ends at the end of the month following the month of the Hospital Presumptive Eligibility begin date.
- **For individuals who submit a Medicaid application timely (prior to date when HPE eligibility is to end):** An eligibility worker from the local department of social services will process the application for Medicaid and, if needed, will extend HPE coverage until a determination is made on the application.
- **For individuals who submit a Medicaid application but HPE coverage has ended:** HPE (temporary) eligibility ends the last day of the month following the month Hospital Presumptive Eligibility coverage began. The Medicaid application will be processed using standard guidelines. If retroactive coverage is requested and approved, it is possible full benefit Medicaid will cover the period prior to an HPE approval.

When Hospital Presumptive Eligibility ends, individuals do not receive a notice of their coverage ending. The Interim Approval letter of Hospital Presumptive Eligibility at the hospital serves as their notice that benefits are temporary and will end (normally within two months of the approval/begin date). A notice of the (approval or denial) determination of a submitted Medicaid application will be mailed to the applicant.

Interim Approval letter of Hospital Presumptive Eligibility



**Interim Approval Notice of Hospital Presumptive Eligibility
for Temporary Medicaid Coverage in Virginia**

Name _____ Date _____
 Address _____
 City, VA Zip Code _____

Dear [Name]:

The following person has been approved for presumptive Medicaid eligibility and enrolled for a limited time period indicated below:

Name	Begin Date	End Date

1. Coverage may be extended if an Application for Health Coverage & Help Paying Costs is filed prior to the end date of coverage above and additional time is needed for the eligibility determination. If you file a Medicaid application and you are determined to be ineligible for Medicaid coverage, your presumptive eligibility will end the date the eligibility determination is made.
2. If you do not file a Medicaid application, you will no longer have presumptive eligibility Medicaid coverage after end date above.

There are four easy ways to apply for Medicaid.

1. Online at www.commonhelp.virginia.gov or
2. Call the Cover VA Call Center at 1-855-242-8282 to apply by phone or
3. Print out and complete a paper application from www.coverva.org and mail it to your local Department of Social Services or
4. Visit your local Department of Social Services in the city or county in which you live

You should have the following information ready when you apply, for you and anyone else in your household who needs health insurance:

- Full legal name, date of birth, Social Security number, and Citizenship or Immigration Status; Most recent federal tax filing information (if available);
- Job and income information for members of your household for the prior or the current month such as pay stubs or a letter from your employer
- Information about other taxable income for members of your household such as unemployment benefits, Social Security payments, pensions, retirement income, rental income, alimony received, etc.
- Current health insurance information

Visit www.cover.va.org for more information about the Medicaid and FAMIS programs or call us toll free at 1-855-242-8282; M-F 8am to 7pm and Saturdays 9am to 12 (noon).

Cover Virginia
 PO Box 1820 ~ Richmond, VA 23219

Denial Notice of Action (at time of determination)



**Denial Notice of Hospital Presumptive Eligibility
for Temporary Medicaid Coverage in Virginia**

Name _____ Date _____
 Address _____
 City, VA Zip Code _____

Dear [Name]:

An application for presumptive Medicaid Eligibility was recently submitted by a hospital for you. Upon further review this request for coverage was denied for the following reason.

Name	Reason
NAME	Denial Reason

Presumptive Eligibility is not a full review for Medicaid eligibility and you are encouraged to apply for a complete review of medical assistance. There is no right to appeal a hospital presumptive eligibility decision.

There are four easy ways to apply.

1. Online at www.commonhelp.virginia.gov or
2. Call the Cover VA Call Center at 1-855-242-8282 to apply by phone or
3. Print out and complete a paper application from www.coverva.org and mail it to your local Department of Social Services or
4. Visit your local Department of Social Services in the city or county in which you live

You should have the following information ready when you apply, for you and anyone else in your household who needs health insurance:

- Full legal name, date of birth, Social Security number, and Citizenship or Immigration Status; Most recent federal tax filing information (if available);
- Job and income information for members of your household for the prior or the current month such as pay stubs or a letter from your employer
- Information about other taxable income for members of your household such as unemployment benefits, Social Security payments, pensions, retirement income, rental income, alimony received, etc.
- Current health insurance information

Visit www.cover.va.org for more information about the Medicaid and FAMIS programs or call us toll free at 1-855-242-8282; M-F 8am to 7pm and Saturdays 9am to 12 (noon).

Cover Virginia
 PO Box 1820 ~ Richmond, VA 23219

Approval Notice of Action



**Approval Notice of Hospital Presumptive Eligibility
for Temporary Medicaid Coverage in Virginia**

Name _____ Date _____
 Address _____
 City, VA Zip Code _____

Dear [Name]:

The following person has been approved for presumptive Medicaid eligibility and enrolled for a limited time period indicated below:

Name	Medicaid ID	Begin Date	End Date

1. Coverage may be extended if an Application for Health Coverage & Help Paying Costs is filed prior to the end date of coverage above and additional time is needed for the eligibility determination. If you file a Medicaid application and you are determined to be ineligible for Medicaid coverage, your presumptive eligibility will end the date the eligibility determination is made.
2. If you do not file a Medicaid application, you will no longer have presumptive eligibility Medicaid coverage after end date above.

There are four easy ways to apply for Medicaid.

1. Online at www.commonhelp.virginia.gov or
2. Call the Cover VA Call Center at 1-855-242-8282 to apply by phone or
3. Print out and complete a paper application from www.coverva.org and mail it to your local Department of Social Services or
4. Visit your local Department of Social Services in the city or county in which you live

You should have the following information ready when you apply, for you and anyone else in your household who needs health insurance:

- Full legal name, date of birth, Social Security number, and Citizenship or Immigration Status; Most recent federal tax filing information (if available);
- Job and income information for members of your household for the prior or the current month such as pay stubs or a letter from your employer
- Information about other taxable income for members of your household such as unemployment benefits, Social Security payments, pensions, retirement income, rental income, alimony received, etc.
- Current health insurance information

Visit www.cover.va.org for more information about the Medicaid and FAMIS programs or call us toll free at 1-855-242-8282; M-F 8am to 7pm and Saturdays 9am to 12 (noon).

Cover Virginia
 PO Box 1820 ~ Richmond, VA 23219

Denial Notice of Action (active coverage found prior to enrollment)



Notice of Presumptive Eligibility

John Doe
600 East Broad Street
Richmond, VA 23219

April 15, 2015

Dear John Doe:

An application for Presumptive Medicaid Eligibility was recently submitted by a hospital for you.

Upon further review we show that you have active coverage.

If you have any questions, please contact **Cover Virginia** at **1-855-242-8282**.

Visit www.cover.va.org for more information about the Medicaid and FAMIS programs or call us toll free at 1-855-242-8282; M-F 8am to 7pm and Saturdays 9am to 12 (noon).

Cover Virginia
PO Box 1820 ~ Richmond, VA 23219
www.coverva.org ~ 1-855-242-8282 TDD: 1-888-221-1590
M-F 8:00am-7:00pm, Saturday 9:00am-12:00pm

Immigration Status Quick Guide

Status	What is your immigration status?	Revision Date 11.16.18	Eligible for HPE?
U.S. Citizen	U.S. Citizen or U.S. bational		Yes
baturalized Citizen	baturalized Citizen		Yes
Qualified non-Citizen			
Arrived in U.S. before 8/22/1996	Exempt from 5 year wait	Lawful Permanent Resident (LPR/Green Card Holder) ²	Yes
		Refugees ⁷	Yes
		Granted Asylees ⁷	Yes
		Deportees ⁷ whose deportation is being withheld	Yes
		Cuban or Haitian Entrants ⁷	Yes
		Amerasian immigrant ⁷	Yes
		Victim of Trafficking ⁷ (has a Refugee Resettlement Letter)	Yes
		Afghan or Iraqi Special Immigrant Visa Holder ⁷	Yes
	Conditionals entrants (status granted prior to 4/1/80) ⁷	Yes	
Arrived in U.S. after 8/22/1996	Has met a 5 year waiting period	Lawful Permanent Resident with 40 working qtrs ^{1, 3, 8}	Yes
		Battered non-citizen and their children or parents ³	Yes
		Paroled into the U.S. for <i>at least</i> one year ³	Yes
	Has been in the U.S. 7 years or less ; (5 year period not required)	Refugees ⁵ (eligible for 7 years calculated from the date of entry)	Yes
		Granted Asylees ⁴ (7 years calculated from date status was granted)	Yes
		Deportees ⁴ whose deportation is being withheld (eligible for 7 years calculated from date status was granted)	Yes
		Cuban or Haitian Entrants ⁴ (eligible for 7 years calculated from date status was granted)	Yes
		Amerasian immigrant ⁵ (eligible for 7 years calculated from the date of entry)	Yes
		Victim of Trafficking ^{4,b} (eligible for 7 years as calculated from status granted date and has a Refugee Resettlement Letter)	Yes
		Afghan or Iraqi Special Immigrant Visa Holder ⁴ (eligible for 7 years from date special immigrant status granted)	Yes
Lawfully Present <i>The following eligible statuses only apply to Child under Age 19 and Pregnant Women</i>			
	Lawfully residing Child under Age 19 ²		Yes
	Lawfully residing Pregnant Women ²		Yes
<i>All qualified non-citizen persons (listed below), regardless of date of entry, even if they are subject to the 5 year waiting period, have not met the 40 quarter work quarters, or have exceeded the 7 year limit for eligibility. In addition, a child under Age 19 and Pregnant Women shall be considered lawfully present if he or she is:</i>			
bo arrival or status date required	bo wait period required	Temporary Resident Status	Yes
		Temporary Protected Status	Yes
		Person who is under the Convention Against Torture	Yes
		Person granted withholding of removal under Convention Against Torture	Yes
		Person is an individual with a pending application for asylum, or for withholding of removal under the Convention Against Torture and who:	Yes
		Has been granted employment authorization	Yes
		Is a child under age 14 and has an application which has been pending for at least 180 days	Yes
		Child with a pending application for status as a Special Immigrant Juvenile	Yes
		Visitor (exchange visitors or those visiting U.S. for business or pleasure)	Yes
		Visa holders (e.g. student visa, worker visa, etc)	Yes
		Approved visa petition with a pending application for adjustment of status	Yes
		Paroled in the U.S. < 1 year. Exception is for a non-citizen paroled for persecution, deferred inspection or pending removal proceedings.	Yes
		Granted employment authorization	Yes
		Granted employment authorization <i>and</i> is a pending applicant for a Temporary Protected Status	Yes
		Family Unity beneficiary	Yes
		Deferred Enforced Departure (DED)	Yes
		Administrative Stay of Removal has been granted	Yes
Person lawfully present in America Samoa under immigration laws of American Samoa	Yes		
Deferred action status but not those listed as a Deferred Action Childhood Arrival (DACA)	Yes		

Immigration Status Quick Guide (cont.)

bon-Citizens			
Qualify regardless of date of entry	5 year waiting period not required if otherwise eligible	LPR Active Duty Military or Qualified bon-Citizens Veteran ²	Yes
		Dependent (unmarried) child of LPR Active Duty Military or a Qualified bon-Citizens Veteran ²	Yes
		Spouse of LPR Active Duty Military or a Qualified bon-Citizens Veteran ²	Yes
		Surviving spouse of a deceased LPR Active Duty Military or a Qualified bon-Citizens Veteran <i>and</i> who is not remarried <i>and</i> :	
		Was married for at least one year - <i>or</i> -	Yes
		Was married (for any period of time) and a child was born prior to or out of that marriage - <i>or</i> -	Yes
		Was married prior to a 15 year period of time following the spouse's military service when injury or disease occurred.	Yes
		American Indian born in Canada (ref. 8 U.S.C. 1359)	Yes
		Member of a federally recognized Indian tribe including Alaska native (ref. 25 USC 450B(e))	Yes
		bon-Citizen receiving Social Security Income (SSI)	Yes
bon-Citizen - bot Eligible	bon-Documented / Undocumented persons		bo
	Deferred Action Childhood Arrivals (DACA)		bo
	Persons whose status has expired and does not meet any other status		bo
	LPR without 40 quarters of work history ¹ (unless arrived prior to 8/22/1996)		bo

¹ Work History	Number of quarters of work history under Social Security guidelines
² Exempt from work	Exempt from 40 qtrs of work history
³ 5 year waiting period	Based on the date the individual received a qualified status
⁴ 7 year period status	Limit to 7 year period as calculated from granted status date , not years in the U.S.
⁵ 7 year period date of	Limit to 7 year period as calculated from date of entry in th U.S.
⁶ Refugee letter	Certification or eligibility letter from Office of Refugee Resettlement
⁷ 7 year limit does not	Requirement to limit Medicaid eligibility to the first 7 years of U.S. entry does not apply
⁸ LPR Status Change	LPRs who adjust from a status that is exempt from the 5 year waiting period are not subject to the 5 year waiting period.
LPR	Lawful Permanent Resident

Hospital Presumptive Eligibility (HPE) Full Benefit Coverage

The following describes the medical services available to patients (other than pregnant women) who have been determined to be presumptively eligible for Medicaid. The coverage period for presumptive eligibility begins with the day your HPE is determined by the hospital and ends the last day of the following month.

Covered services include:

- Hospital Care – both inpatient and outpatient hospital services.
- Pharmacy – prescription drugs ordered by a physician or other licensed medical professional.
- Emergency Services – for serious, immediate health problems that require emergency care.
- Physician Services – services provided by physicians or other health professionals licensed to practice medicine, osteopathy, and psychiatry.
- Dental Care Services – routine dental services for individuals under age 21. Medically necessary oral surgery and the services used to determine the medical problem such as X-rays and surgical extractions for individuals 21 and older.
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) limited to individuals under age 21 to detect and diagnose health problems early so needed treatment can be provided.
- Eyeglasses for individuals under age 21.
- Laboratory Services.
- X-ray Services.
- Family planning services/Birth control – services that delay or prevent pregnancy.
- Transportation for medical treatment – emergency transportation and nonemergency transportation through ModivCare: 866-246-9979).

If you file a Medicaid application before the end date of your presumptive eligibility coverage, your eligibility can continue while your full Medicaid application is being processed. If you have questions about this coverage, please contact your local Department of Social Services.

Hospital Presumptive Eligibility (HPE) Limited Coverage for Pregnant Women

The following describes the medical services available to patients (other than pregnant women) who have been determined to be presumptively eligible for Medicaid. The coverage period for presumptive eligibility begins with the day your HPE is determined by the hospital and ends the last day of the following month.

Covered services include:

- Hospital Care – both inpatient and outpatient hospital services.
- Pharmacy – prescription drugs ordered by a physician or other licensed medical professional.
- Emergency Services – for serious, immediate health problems that require emergency care.
- Physician Services – services provided by physicians or other health professionals licensed to practice medicine, osteopathy, and psychiatry.
- Dental Care Services – routine dental services for individuals under age 21. Medically necessary oral surgery and the services used to determine the medical problem such as X-rays and surgical extractions for individuals 21 and older.
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) limited to individuals under age 21 to detect and diagnose health problems early so needed treatment can be provided.
- Eyeglasses for individuals under age 21.
- Laboratory Services.
- X-ray Services.
- Family planning services/Birth control – services that delay or prevent pregnancy.
- Transportation for medical treatment – emergency transportation and nonemergency transportation through ModivCare: 866-246-9979).

If you file a Medicaid application before the end date of your presumptive eligibility coverage, your eligibility can continue while your full Medicaid application is being processed. If you have questions about this coverage, please contact your local Department of Social Services.

Hospital Presumptive Eligibility (HPE) Limited Coverage for Plan First

The following describes the medical services available to patients who have been determined to be presumptively eligible for Plan First, a limited Medicaid benefit for family planning coverage only. The coverage period for Plan First presumptive eligibility begins with the day your HPE is determined and ends the last day of the following month.

Services must be for preventing a pregnancy. Specific service and supply billing codes are posted online at <https://www.dmas.virginia.gov/for-members/benefits-and-services/plan-first/>

Additional materials about Plan First are available on this website, available in English and Spanish.

Presumptive eligibility medical services for Plan First include:

- Annual family planning exams
- Pap smears for women to screen for cervical cancer
- Sexually transmitted infection (STI) testing
- Laboratory services for family planning and STI testing
- Family planning education, counseling, and preconception health
- Sterilization procedures (Tubal Ligation or Essure implant for women and vasectomies for men). Sterilization Consent Form (DMAS-3004-English and DMAS-3004S-Spanish) for sterilization procedures must be signed at least 30 days prior to the surgery being performed.
- Non-Emergency transportation (866-386-8331) to a family planning service
- Most Food and Drug Administration (FDA) approved prescription and over-the-counter contraceptives. Over-the-counter contraceptives require a prescription in order to be covered.

If you file a Medicaid application before the end date of your presumptive eligibility coverage, your eligibility can continue while your full Medicaid application is being processed. If you have questions about this coverage, please contact your local Department of Social Services.

Failure to file a regular, full-benefit Medicaid application may result in missed coverage and/or out of pocket expenses for non-covered services received during a period of presumptive eligibility.

Sanctions and Loss of Qualification

As the Virginia HPE program progresses and standards and criteria are refined, the State proposes to enforce the standards as follows:

If the prescribed standards are not met for a period of one calendar quarter, the State will establish with the hospital a written Plan of Correction (POC) that describes:

- Targets and timelines for improvement;
- Steps to be taken in order to comply with the performance standards;
- How additional staff training would be conducted, if needed;
- The estimated time it would take to achieve the expected performance standards, which would be no greater than 60 calendar days; and
- How outcomes would be measured.

The State may impose additional correction periods, as appropriate. If targets are not met after a sufficient period for improvement, as determined in discussions between the State and the hospital, the State may disqualify a hospital from making eligibility determinations under this program. Hospital's termination of HPE cannot be appealed. However a Hospital's participation with DMAS or the DMAS Managed Care Organizations will not be impacted based on participation or termination with HPE or HPE performance standards.

Virginia Qualified Entity Agreement for Hospital Presumptive Eligibility

This is an agreement to become a Qualified Entity for Hospital Presumptive Eligibility (HPE) for the purposes of conducting Presumptive Eligibility determinations. You must participate as a Virginia Medicaid provider to perform Hospital Presumptive Eligibility determinations. Please complete, sign, and return this agreement to the Virginia Department of Medical Assistance Services (DMAS) at the contact below. You may email HPE@dmas.virginia.gov for a .pdf version of this agreement.

Email: HPE@dmas.virginia.gov

Fax: (804) 612-0044

If you have questions about this application or the Hospital Presumptive Eligibility program, please email: HPE@dmas.virginia.gov

Name of Hospital	
Other name (if any used for provider services)	National Provider Identifier
Telephone number	FAX number
Mailing address (no P.O. Box)	City , State, Zip
Primary HPE Contact Person	
Telephone number	FAX number
()	()
Email Address	

Hospital Presumptive Eligibility (HPE) Qualified Entity Responsibilities and Agreement

I understand that the responsibilities as an HPE Qualified Entity include:

- Providing the Department of Medical Assistance Services (DMAS) HPE training to all hospital staff members who will perform HPE determinations before they begin conducting them.
- Offering the HPE program to patients who have an immediate medical need and are without current, confirmed Medicaid or FAMIS coverage;
- Screening interested patients for income eligibility using HPE forms and guidelines;
- Ensuring that all individuals performing HPE determinations are direct employees of the hospital and do not work as contractors or vendors of the hospital;
- Accurately determining HPE;
- Submitting completed HPE enrollment forms with the required information on those patients eligible for HPE to the DMAS designee within recommended time frame of five (5) calendar days;
- Providing in writing (and orally if appropriate), notification to the patient about the outcome of the HPE determination, including approvals or denials;
- Informing patients at the time of the HPE determination that they must file a Medicaid application in order to obtain regular Medicaid coverage beyond the HPE period, including information regarding all ways to apply and providing to the individual a Medicaid application form;
- Informing patients that they may file a Medicaid application regardless of eligibility for HPE;
- Assisting patients to complete an application for Medicaid;
- Keeping current with changes affecting HPE through provider memos, manuals, bulletins, notices, and/or further training;
- Maintaining criteria to continue participation as an HPE provider based on the expectation of meeting the following standards: (1) the proportion of individuals determined presumptively eligible by the hospital who submit a full application; and (2) the proportion of individuals who are determined eligible for Medicaid based on the full application. The state may disqualify an HPE provider if (1) less than 85% of HPE submissions result in a full Medicaid application; or (2) less than 70% of individuals are determined eligible for Medicaid based on a full application. These standards will be assessed and may be revised by DMAS based on the results.
- Participating in additional training by DMAS or other corrective action measures if the HPE provider does not meet the established standards after the data collection period has ended. HPE providers will not be immediately disqualified; rather, DMAS will conduct additional training as part of a 60 -day plan for improved performance. HPE providers may be disqualified for failure to meet standards if performance does not improve after implementation of a 60-day plan for improvement and retraining.
- Not participating in any unfair, unequal, or discriminatory treatment of applicants or recipients.
- Maintain HPE records for a minimum of three years following the determination date.

The Department may revoke, suspend, or deny a qualified provider's authorization to make HPE determinations at any time for any reason deemed sufficient (including failing to meet the above requirements); such revocation, suspension or denial is not subject to appeal.

I, (print name) _____, agree to cooperate with the Department of Medical Assistance Services in complying with the above Qualified Entity responsibilities. I am aware that if I do not comply with these responsibilities and the PE guidelines as outlined in §1902(a)(47)(B) of the Social Security Act and 42 C.F.R. 435.1110, I may lose status as a Qualified Entity. I agree to notify DMAS in writing of any changes in application information at least ten (10) days prior to the effective date of the change. This agreement may be terminated by either DMAS or the qualified provider within thirty (30) days of notice.

Signature	Title of Authorized Agent	Date