Presumptive Eligibility for Medicaid Home- and Community-Based Services

As the primary payers for long-term care, states have a vested interest in identifying cost-effective ways to deliver long-term services and supports (LTSS) through Medicaid. In their efforts to manage LTSS expenses, states increasingly choose to reject Medicaid's structural bias towards institutions (such as nursing facilities) in favor of home- and community-based services (HCBS), which are preferred by beneficiaries and typically less expensive than comparable institutional care.[1,2,3] Research shows that expanding Medicaid HCBS saves states money in the long term (following a short-term transitional spending bump), with greatest savings realized by states that offer the most extensive non-institutional options.[4] The literature also indicates that a greater volume of HCBS is correlated with reduced risk of nursing facility placement among Medicaid beneficiaries.[5]

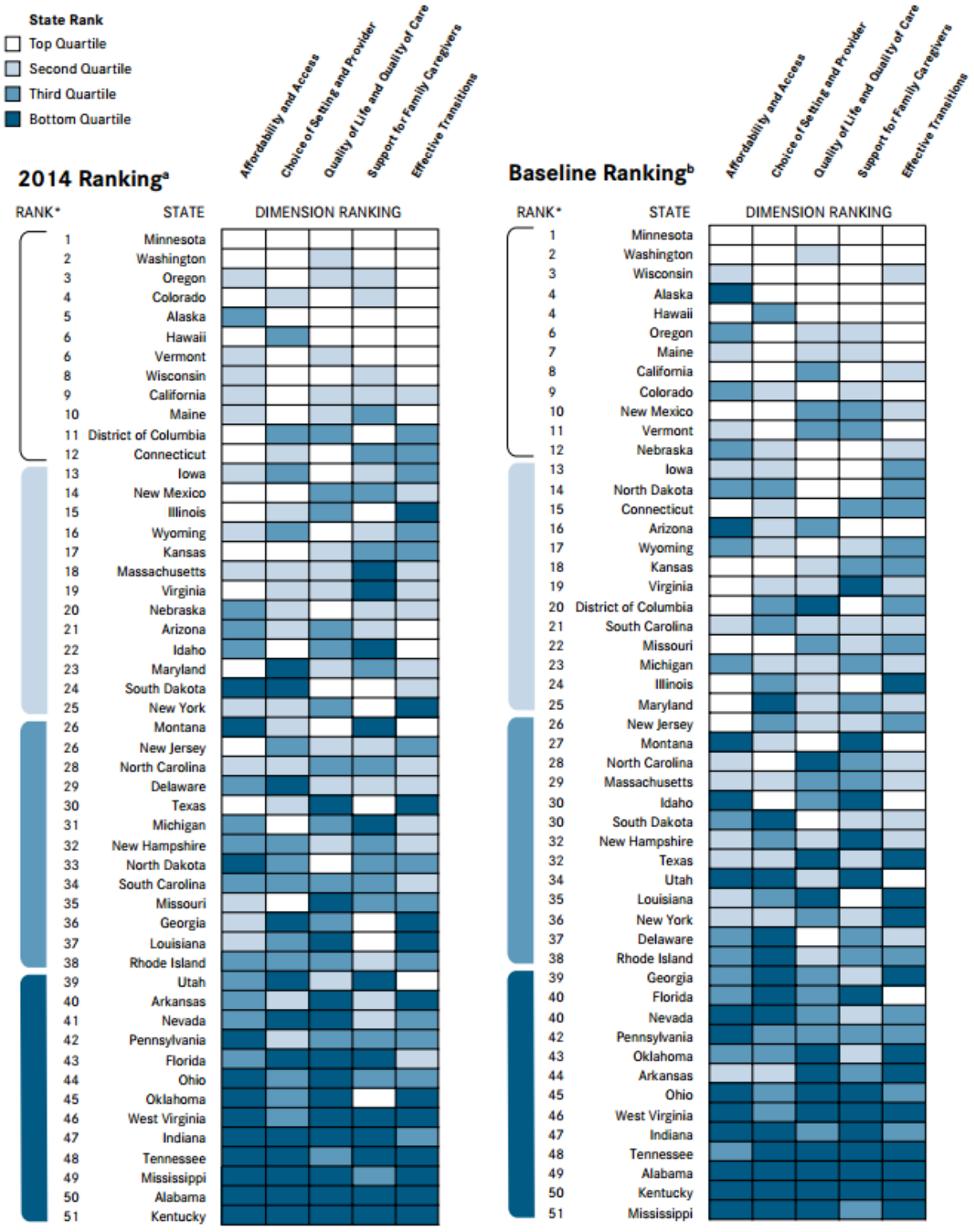
Unfortunately, by failing to quickly embrace the national trend towards community-based care delivery, Kentucky may be leaving millions of dollars in savings on the table.[6] In a 2014 "State Scorecard" report[7] by AARP, the Commonwealth Fund and the SCAN Foundation, Kentucky was ranked last—out of 50 states and the District of Columbia—in overall LTSS system performance (see table on next page). Of particular note, the state received bottom marks in the "Choice of Setting and Provider" dimension, which considers the percent of Medicaid and state-funded LTSS spending going to HCBS. According to the report, Kentucky spent only 22.0% of its LTSS budget on HCBS in 2011, a far cry from top-performing states like Vermont (44.5%) and Washington (62.5%). A recent analysis by Deloitte affirms an imminent need for Kentucky to expand HCBS to alleviate the Commonwealth's "continuing capacity constraints and the strain from long-term care expenditures on the Medicaid budget".[8]

Presumptive Eligibility

Kentucky's limited commitment to HCBS is fiscally unsustainable and a patent rejection of beneficiary choice. Fortunately there are ways state leadership can immediately begin to expedite access

[1] Musumeci, M., & Reaves, E. (2014). *Medicaid Beneficiaries Who Need Home and Community-Based Services: Supporting Independent Living and Community Integration*. Kaiser Family Foundation.
[2] Mitchell, G., Salmon, J., Polivka, L., & Soberon-Ferrer, H. (2006). *The relative benefits and cost of Medicaid home- and community-based services in Florida*. The Gerontologist, 46(4), 483–494.
[3] Sands, L. P., Xu, H., Weiner, M., Rosenman, M., Craig, B., & Thomas, J. (2008). *Comparison of resource utilization for Medicaid dementia patients using nursing homes versus home and community based waivers for long-term care*. Medical Care, 46(4), 449–453.
[4] Kaye, H.S., LaPlante, M. & Harrington, C. "*Do Non-Institutional Long-Term Care Services Reduce Medicaid Spending?*" Health Affairs 28, no. 1 (January/ February 2009).
[5] Sands et al. (2012) *Volume of Home- and Community-Based Services and Time to Nursing-Home Placement.* Medicare & Medicaid Research Review, 2 (3).
[6] Using data from Connecticut's Home Care Program for Elders (FY 2011), the Connecticut Association of Area Agencies on Aging estimated that preventing premature institutional care for one month for 25% of program applicants would save the state $3,251,787.00.
[7] Reinhard, S.C. et al. (2014). *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. AARP, the Commonwealth Fund & The SCAN Foundation.
[8] (2013*). The Commonwealth of Kentucky: Health Care Facility Capacity Report*. Deloitte.

State Scorecard Summary of Current and Baseline LTSS System Performance Across Dimensions



to this cost-saving, beneficiary-preferred option, including an enrollment process known as "presumptive eligibility". Under a presumptive access policy, applicants for Medicaid HCBS are temporarily assumed to be eligible and may begin receiving services immediately, when the need arises, rather than waiting for the often-lengthy Medicaid eligibility verification processes to be finalized. This is especially critical for people who are in crisis or undergoing hospital discharge, as failure to connect these individuals with HCBS in a timely manner can result in unnecessary hospitalizations and nursing facility admissions.

Thought leaders in long-term care have endorsed presumptive eligibility as a compassionate, commonsense approach to connecting vulnerable individuals with Medicaid-funded HCBS in a timely manner. For example, the 2011 version of the "*State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*" by AARP, SCAN, and the Commonwealth Foundation, researchers wrote that "[f]ailing to serve new beneficiaries in HCBS settings can have negative impacts for an extended duration", and they endorsed state adoption of presumptive eligibility policies to "…quickly establish that a person will be able to qualify for public support for HCBS, thereby preventing unnecessary nursing home admissions".

Section 10202 of the Affordable Care Act (ACA) provided increased flexibility to support states' growing interest in presumptive eligibility as a cost-effective way to provide Medicaid long-term care services. Specifically, the legislation authorized the Balancing Incentive Payments Program (BIP) to provide an enhanced Federal Medical Assistance Percentages (FMAP) to states that spent less than 50 percent of long-term care dollars on care provided in home and community-based settings in 2009, with the goal of increasing the percentage of care provided in the community setting in these states. Per the statute, BIP grantees must propose basic structural changes to their community-based LTSS systems, which may include presumptive eligibility. The BIP Implementation Manual, developed under the direction of the Centers for Medicare and Medicaid Services (CMS), encourages states to adopt the presumptive eligibility option as a tool to help achieve spending targets. As a BIP grantee state, Kentucky is well-placed to pursue a presumptive eligibility policy for Medicaid HCBS.

Not surprisingly, a number of states have implemented—or are seeking to adopt—presumptive eligibility for HCBS. Notably, an increasing number of states are proposing a statutory path to presumptive eligibility (rather than through Medicaid waiver or regulation), in order to ensure legislative buy-in and certainty in implementation. A snapshot of such policies, both proposed and enacted, is presented below.

Supporting documentation, including proposed statutory language regarding a presumptive eligibility policy for Kentucky's Homecare Program for the Elderly, may be found attached.

Statutory Authority

Connecticut

On February 24, 2014, Representative Kevin Kelly (R-21) introduced Senate Bill 254, *An Act Concerning Presumptive Medicaid Eligibility for the Connecticut Home-Care Program for the Elderly*.

Under this proposal, presumptive eligibility would be available to applicants for the Connecticut Home Care Program for Elderly who have been pre-screened to meet functional eligibility and deemed likely to meet Medicaid's financially eligibility criteria. Individuals who require a skilled nursing level of care and who have been deemed presumptively eligible under this program are authorized to receive up to ninety days of services, and the Department of Social Services is required to issue a Medicaid eligibility determination within forty-five days following receipt of a completed Medicaid application.

Section 1(a) of the bill includes a budget neutrality provision specifying that the program must be structured such that the net cost to the state for long-term facility care, in combination with the community-based services provided through the program, "…shall not exceed the net cost the state would have incurred

without the program". Savings to the state are further assured through a stipulation that the annualized cost of the community-based services provided under the program "…shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities".

The measure also calls for an annual evaluation analyzing the impact of the program, to include: 1) number of persons diverted from placement in a long-term care facility as a result of the program; 2) the number of persons screened; 3) the average cost per-person in the program; 4) the administration costs; 5) the estimated savings; and 6) a comparison between costs under the different contract.

As noted above, the Connecticut Association of Area Agencies on Aging (AAA) offered legislative testimony on the measure when it was introduced in February 2013 as Raised Bill 6461. In their testimony, the Association reports that the state could save $6,033.00 per month for every client presumptively determined eligible.[9] If Connecticut prevents premature institutional care for one month for 25% of the Connecticut Home Care Program applicants, the Association testified, Connecticut would save $3,251,787. The testimony also cites data from the Kaiser Family Foundation indicating that the general error rate for presumptive eligibility is less than two percent.

Hawaii

Senate Concurrent Resolution No. 198, adopted in 2007, requested the Healthcare Association of Hawaii to conduct a study of patients in acute care hospitals who are waitlisted for long-term care The study's final report to the legislature discussed the problem of waitlisted patients and the regulatory barrier of Medicaid eligibility determinations. This included several concerns, particularly the amount of time and effort required by applicants, families, and medical staff to successfully complete a Medicaid application. The report also identified lags in the processing time for Medicaid applications, which result in delays in access to care for Medicaid beneficiaries.

As a direct response to these findings, in 2012 state legislators introduced House Bill 2864, *Medicaid; Presumptive Eligibility; Long-Term Care*, which would have allowed presumptive eligibility for Medicaid-eligible patients who have been waitlisted for long-term care. The measure estimated that at any given time there are approximately 150 patients in acute care hospitals who are medically appropriate for discharge, but who encounter delays in Medicaid eligibility determinations,"…and therefore must remain in a higher-cost hospital setting". The bill provided that if an individual receiving services on a presumptive basis was later found to be ineligible, the Department of Human Services would have reimbursed providers or plans for the period of enrollment. In addition, the measure called for a report of findings and recommendations during program years 2013 through 2017.

Massachusetts

During the current legislative session, the Massachusetts state legislature considered *An Act Regarding Equal Choice and Related Cost Savings* (House Bill 545, Senate Bill 292). One provision of the Act would authorize the Division of Medical Assistance to provide, without requiring prior authorization, up to sixty days of eligibility for MassHealth Home and Community Based Services for individuals who, upon discharge from an acute hospital, medical center, nursing facility, or health care facility, are presumed to be financially eligible. The measure was introduced in January of 2013, and in May of 2014 the Senate Committee on Health Care Financing was directed to study the legislation (S2148).

[9] Legislative Testimony, Aging Committee. (2013). Connecticut Association of Area Agencies on Aging, accessed at: http://www.cga.ct.gov/2013/AGEdata/Tmy/2013HB-06396-R000226-Marie%20Allen%20CT%20Association%20of%20Area%20Agencies%20on%20Aging-TMY.PDF

New Hampshire

Presumptive eligibility for long-term care services is authorized by Title XI Section 151-E:18 of New Hampshire state statute. The law directs the Department of Health and Human Services to authorize medical assistance in the interval between application and final Medicaid eligibility determination pending a face-to-face clinical assessment and a review of the completed Medicaid application. The face-to-face assessment must be completed within twenty business days of a request for medical assistance, and a consumer's application must be reviewed within five days of completion of the assessment. If an applicant is determined ineligible for Medicaid, the Department uses non-Medicaid funds to pay for any waiver services the applicant has already received. In the event an application was filed with fraudulent intent, the Department is entitled to reimbursement of funds expended on behalf of the applicant. The Division of Family Assistance (DFA) implements presumptive eligibility for older adults and individuals with disabilities through the state's Choices for Independence (CFI) Medicaid Waiver Program,.

New York

New York Social Services Law § 364-i authorizes the state's Medical Assistance Presumptive Eligibility program. Under this statue, an uninsured individual transferring from a hospital to a home health agency or other post-acute care setting is presumed eligible for medical assistance for a period of 60 days upon application, provided certain criteria are met. The law stipulates that payment for this care "…shall not exceed sixty-five percent of the rate payable under this title for services provided by a certified home health agency, long term home health care program, hospice, or residential health care facility."

State funds are used to pay for services during the period of presumptive eligibility, but payments are retroactively adjusted to reflect federal financial match, and the local share of costs, once eligibility has been verified. If the consumer is subsequently determined to be ineligible for assistance received during this period, the Commissioner, on behalf of state and local social service districts, has the authority to recoup the cost from the individual. Notably, if upon audit the Department finds that ineligibility determinations occur in at least fifteen percent of cases in which presumptive eligibility has been granted in a local social services district, payments for services provided to ineligible individuals is divided evenly between the state and the district.

Regulatory Authority

New York

In the past, New York's Department of Health and Mental Hygiene held that Social Services Law (SSL) § 133, which provides for "temporary pre-investigation grants" for persons who appear in "immediate need", did not apply to benefits under the Medicaid program, but rather exclusively to cash public assistance grants to indigent individuals. In *Konstantinov v. Daines*, New York State Supreme Court Justice Joan Madden held that SSL § 133 *does* apply to personal care services and that "applicants for Medicaid, and Medicaid recipients are entitled to request immediate, temporary personal care attendant services" pending the completion of an investigation into their eligibility. In a March 2014 Order, Justice Madden indicated that in cases where an individual received temporary personal care services but was later found to be ineligible, "…the local social service district is obligated to pay for such temporary services whether or not the local social services district receives reimbursement from the state"[10].

[10] Konstantinov v. Daines;2014 NY Slip Op 30657(U)

In a proposed rule published on July 16, 2014,[11] New York State sought to comply with Justice Madden's 2010 and 2014 Orders, which directed the Department to draft and implement regulations setting forth the steps that Medicaid applicants and Medicaid recipients may take to request "immediate temporary personal care services," and also provide for the performance of expedited assessments. The proposed regulations provide that state reimbursement is *not* available to social services districts for immediate temporary personal care services provided to presumptively eligible Medicaid applicants in the event that such applicants are ultimately determined to be financially or otherwise ineligible for Medicaid. Instead, the social services districts must bear the costs of these services unless the districts are successful in recouping the costs from the Medicaid ineligible individuals themselves.

The comment period for this rule closed on September 2, 2014. It has not yet been finalized.

State Medicaid Plan

Illinois

The Illinois Act on the Aging (20 ILCS 105/4.02) established the Community Care Program to "…prevent unnecessary institutionalization of persons age 60 and older in need of long term care". The Community Care program is operated as a 1915(c) Medicaid HCBS waiver. Under this program, participants receive a comprehensive face-to-face assessment for services. The Medicaid waiver application stipulates that an individual deemed to be at imminent risk of nursing facility placement during the face-to-face assessment may receive services on an interim presumptive basis. These services must be initiated within two business days. A full eligibility assessment must be completed within fifteen days thereafter.

Ohio

Presumptive eligibility for LTSS in Ohio is authorized by the Ohio Administrative Code, which establishes eligibility criteria for the state-funded PASSPORT Medicaid waiver program (Section 173-40-02) and the Assisted Living waiver (Section 173.544). The PASSPORT and Assisted Living Medicaid waivers have a state-funded component, allowing HCBS to begin, under certain circumstances, when it appears that the consumer will meet Medicaid financial eligibility but before a formal Medicaid eligibility is determined. Individuals may receive services on a presumptive basis for up to ninety days, funded entirely by the state. If an individual is subsequently found ineligible for services, the state does not recoup the cost of services rendered.

A recent analysis by the Ohio Department of Aging—which administers both waiver programs—found that less than one-quarter of one percent (0.17%) of presumptive eligibility cases resulted in no final Medicaid eligibility determination in State Fiscal Year 2014. The 0.17% figure includes consumers who were found not to meet formal Medicaid financial eligibility, as well as consumers who moved, withdrew their application, died, or moved into a nursing facility before the determination was made.

Vermont

The Vermont Choices for Care waiver offers a Waiver While Waiting (WWW) option through which individuals can access home and community based (and other) services before waiver eligibility has been fully determined. This practice was put into place in January 2011. At that time, Vermont estimated that 90% of individuals would be ultimately determined eligible for services.

Washington

[11] Amendment of Sections 360-3.7 and 505.14 of Title 18 NYCRR (07/16/2014)

Washington's Fast Track process authorizes HCBS prior to the completion of a formal financial eligibility determination. If staff determines that a person will most likely be financially eligible for waiver services, services may be immediately authorized for a maximum of 90 days if the person applies for waiver services within the first ten days of the 90-day period. In Washington, consumers are not asked to sign forms indicating that they will be financially responsible. The state will cover costs if necessary, but this happens "infrequently", according to the Kaiser Family Foundation.[12] State officials estimate that it costs less than $100,000 per year to provide services to people who are ultimately found to be ineligible for Medicaid, but that cost is "far exceeded by savings generated by diverting clients from institutional care."[13]

[12] Kaiser Family Foundation (2011). A Challenge for States: Assuring Timely Access to Optimal Long-Term Services and Supports in the Community.

[13] Smith, V et al. (2005) *Making Medicaid Work for the 21st Century: Improving Health and Long-Term Care Coverage for Low-Income Americans*. National Academy for State Health Policy.