

**Long-Term Services and Supports Scorecard:
Promising Practices**

Expediting Medicaid Financial Eligibility Determinations to Promote Access to Long-Term Services and Supports

Robert Mollica
Independent Consultant



www.longtermscorecard.org



The
COMMONWEALTH
FUND



THIS PAGE INTENTIONALLY LEFT BLANK

Expediting Medicaid Financial Eligibility Determinations to Promote Access to Long-Term Services and Supports

Robert Mollica
Independent Consultant

Research Report #2019-19
November 2019
DOI: <https://doi.org/10.26419/ppi.00085.001>

AARP's Public Policy Institute (PPI) informs and stimulates public debate on the issues we face as we age. Through research, analysis, and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

The views expressed herein are for information, debate, and discussion and do not necessarily represent official policies of AARP.

THIS PAGE INTENTIONALLY LEFT BLANK

Marge: A Case Example

Marge, 82 years old, is excited to be leaving the hospital soon. However, Marge, who in the past has lived alone, now needs help getting dressed, taking a bath, getting to the toilet, fixing meals, going shopping, and performing other tasks. She also is unsteady on her feet, is at risk of falling, and needs blood pressure monitoring. Although Marge has a few neighbors who look in on her to see how she is doing, she has no relatives who live nearby.

A social worker will meet with Marge to explain her options. She could go to a nursing home, where she would receive the care she needs onsite, or the social worker could work with community organizations to see if adequate services could be provided in her home. Marge prefers to go home.

The social worker can refer Marge to an Aging and Disability Resource Center to arrange for in-home services, but it would take a week or more to schedule a home visit to assess her needs and determine if she is eligible for services under the state's home- and community-based services waiver program. Next, Marge would have to apply for Medicaid; it could take six weeks or more to find out if Medicaid would pay for her care. In the meantime, she is at risk of falling, and her health will deteriorate without someone to care for her. Marge is worried that if she goes home without services for six weeks or more, she might end up back in the hospital or in a nursing home.

If Marge lived in some states, she would not face such challenges. If she lived in one of the states described in this report that expedites Medicaid eligibility, she would receive services in her home while her application for Medicaid is processed.

About This Paper

This paper describes promising practices on the use of presumptive eligibility to improve access to long-term services and supports (LTSS) in five states. These states can presume financial eligibility for Medicaid LTSS, and some of these states also can fast-track the determination process to arrange for timely home- and community-based services. These promising practices can help people with LTSS needs live in their own homes and communities.

Table of Contents

MARGE: A CASE EXAMPLE.....	i
ABOUT THIS PAPER.....	ii
BACKGROUND	1
TRADITIONAL ELIGIBILITY PRACTICES	2
Presumptive Eligibility	2
STATE VARIATIONS.....	3
PROMISING PRACTICES	4
Washington	4
Rhode Island	5
Michigan.....	6
Ohio	7
Vermont	7
New Hampshire.....	8
Key Features of Active State Programs	8
SUMMARY	10
APPENDIX: POTENTIAL DESIGN PARAMETERS OF PRESUMPTIVE ELIGIBILITY DETERMINATION	11

THIS PAGE INTENTIONALLY LEFT BLANK

Background

Long-term services and supports (LTSS) refers to assistance with activities of daily living, home health services, or other tasks necessary to live independently in one's own home. When someone needs LTSS and has limited resources, a hospital social worker may refer the individual either to an Aging and Disability Resource Center that helps consumers find and access in-home services or to an agency that provides access to in-home LTSS. A spouse, family member, or friend may also contact such an organization on the individual's behalf.

The process, starting with determining LTSS need, has many steps and can involve multiple organizations. To determine if the individual meets the functional criteria established to qualify for publicly funded LTSS, the LTSS agency typically completes a functional assessment, which is an evaluation of a person's ability to perform certain tasks. Either a state agency or a state-contracted care management agency conducts the assessment. If the agency determines an individual meets the criteria to receive services, it develops and then implements a care plan. The assessment agency then refers applicants to the local office of the state agency that determines financial eligibility for Medicaid. Two separate agencies usually perform these two processes, which can delay the initiation of services.

Delays in determining Medicaid eligibility may affect a person's decision to enter a nursing home or return to his or her home. Nursing homes are more willing than home care agencies to admit individuals while their Medicaid application is pending. Residents who are found ineligible can be charged for services delivered and are expected to pay. Nursing homes can assess a resident's income and resources to judge whether he or she will become a Medicaid beneficiary or pay privately.

Determining functional and financial eligibility proceeds along dual tracks and can take several weeks. The delay can be critical for someone who needs LTSS to avoid admission to a nursing home. Beginning services right away, rather than waiting for the financial eligibility determination to be made, can make the difference between an individual returning home from a hospital, staying at home, or entering an institution that he or she is unlikely to ever leave.

Presumptive eligibility (PE) is a promising practice that addresses these delays. It allows eligibility workers, case managers, nurses, or social workers responsible for the functional assessment and level-of-care decision to determine whether the individual is likely to be financially eligible and to initiate services before Medicaid eligibility staff make the official determination. The AARP Public Policy Institute LTSS State Scorecard, which measures and ranks states' LTSS systems, identifies PE as a high-performing function of Aging and Disability Resource Centers.¹ These “no wrong door” systems—a term used to describe systems in which users arrive at what they need regardless of the agency they reach out to first—can help consumers access much-needed home- and community-based services.

This paper describes promising practices in five states—Washington, Rhode Island, Michigan, Ohio, and Vermont. A sixth state, New Hampshire, passed a law that authorized the use of PE in 2014, but the program has not been funded. A side-by-side description of these state programs' key features can be found in table 1 (p. 9). This paper updates a report authored by Robert Mollica in August 2004.

¹ Susan C. Reinhard et al., *Picking Up the Pace of Change. A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, June 2017), <http://www.longtermcorecard.org>.

Traditional Eligibility Practices

Individuals either being discharged from a hospital or facing a crisis while living in the community may apply for admission to a nursing facility or for Medicaid home- and community-based waiver and state plan services. However, because the process is complicated, applicants can experience lengthy delays before their eligibility is determined.

Federal law requires that states designate a single state agency (SSA) to administer all state responsibilities under Title XIX of the Social Security Act. SSAs may be an umbrella agency (e.g., an Executive Office of Health and Human Services) or a department or division within a larger agency. Designating an umbrella agency allows the SSA to delegate specific activities, such as financial eligibility determination, to a department or division within the umbrella agency. Medicaid responsibilities can be administered solely by the SSA or they can be delegated to other government entities, such as another state agency or a unit of county government. Several states use a county agency to perform financial eligibility while the state supervises the activity.

Historically, financial eligibility has been delegated to the agency that determines financial eligibility for Transitional Assistance for Needy Families benefits due to long-standing ties between Medicaid and income-maintenance programs. Financial eligibility staff generally process applications for all Medicaid eligibility groups. In most states, individuals seeking LTSS are reviewed along with other groups, which may include determining eligibility for benefits under the Supplemental Nutrition Assistance Program (SNAP—formerly known as food stamps). Because states are penalized for SNAP program errors above a threshold, there is a clear financial incentive to give priority to these applications over older adults.

Older adults and individuals with disabilities account for about 25 percent of all Medicaid

beneficiaries. Children and families comprise 75 percent of beneficiaries, and their applications are typically far less complicated to process than applications for older adults, who have more pathways to eligibility than women and children do. The Medicaid eligibility categories include Supplemental Security Income (SSI) and related, poverty-related, medically needy (spend down), special income level (up to 300 percent of SSI), Medicaid buy-in, and others.²

Most people prefer to live in their own home whenever possible; however, the Medicaid eligibility process may not always reflect consumer preferences to remain in their own home or the immediate need for services. Before Medicaid LTSS can be received, the individual must be deemed financially eligible to receive Medicaid benefits and his or her functional eligibility must be determined to receive waiver program services. Federal rules require that determinations of financial eligibility for Medicaid be made within 45 days from the date of application and within 90 days of when a disability determination must be made. The final determination can take much longer depending on the assets of the individual applying for Medicaid and the time it takes for applicants to submit documentation of their income and assets.

PRESUMPTIVE ELIGIBILITY

PE addresses issues most likely to cause delays—individuals not submitting a complete application or not providing the necessary documentation. Under PE arrangements, staff, usually affiliated with the agency responsible for administering and managing LTSS, assist the individual or family member in completing the application and submitting the necessary documentation (e.g., income, bank accounts, and other assets) to allow the financial eligibility worker to make a decision. Expedited

2 Medicaid and CHIP Payment and Access Commission (MACPAC), *Eligibility for Long-Term Services and Supports* (Washington, DC: Medicaid and CHIP Payment and Access Commission, n.d.), <https://www.macpac.gov/subtopic/eligibility-for-long-term-services-and-supports/>.

processes reduce the time it takes to complete a financial application using the normal channels.

States do face some financial risk if an applicant is presumed eligible and later found ineligible for Medicaid. However, the risk is minimal.

Only 1 to 2 percent of the applications presumed eligible are eventually denied, and the cost to Medicaid is far less than the savings generated by substituting LTSS for nursing facility care.

Two states, Washington and Rhode Island,

received approval from the Centers for Medicare & Medicaid Services (CMS) to include PE in the home- and community-based services component of their LTSS section 1115 waivers,³ thereby sharing the risk between the federal and state Medicaid programs. (Section 1115 waivers, the name of which refers to the relevant section in the Social Security Act, allow for states to apply to have certain requirements waived so they can implement experimental or pilot initiatives in their Medicaid programs.)

State Variations

A review of PE practices found a few differences among the five states. Applicants may be presumed eligible by a case manager or a registered nurse who is responsible for conducting an assessment, determining the needed level of care, and authorizing LTSS. In some programs, the clinical staff are also familiar with Medicaid eligibility criteria and assist the applicant. The presumption is made by the staff responsible for determining Medicaid financial eligibility. Washington delegated the determination of Medicaid financial eligibility to the state agency that provides LTSS. Eligibility in Michigan can be presumed by waiver agencies, most of which are Area Agencies on Aging, without an arrangement with the state Medicaid agency.

States with programs funded by state general revenues offer another option for PE. In these programs, the case manager determines if the person is eligible for the state program and whether he or she may be eligible for the Medicaid waiver program. Services are initiated under the state program while the Medicaid application is processed. Once found eligible, the individual is enrolled in the waiver program

retroactive to the date of the application and services are billed to Medicaid.

In 2013, the Ohio legislature created a separate program, funded by general revenues, for people who need to receive services while their Medicaid eligibility is reviewed. The program created a state-funded component of the Department of Aging's Assisted Living and PASSPORT home- and community-based programs. General revenues pay for services when an individual is determined ineligible for Medicaid.

Washington and Rhode Island have federal approval to declare an applicant eligible, and they are reimbursed for services provided if the applicant is found ineligible. Outside of a section 1115 waiver, states are not reimbursed for errors. Both states authorize services for up to 90 days for individuals who are presumed eligible.

Washington also allows care managers to fast-track applications for people who do not participate in the section 1115 waiver programs. PE is available statewide in Washington, Rhode Island, Ohio, and Vermont. PE is an optional initiative for waiver agents in Michigan.

³ Note: Section 1115 waivers are designed to help states test new approaches to eligibility, delivery systems, and financing of Medicaid. They are approved for five-year periods and may be renewed for additional five-year periods.

Promising Practices

WASHINGTON

Washington implemented two initiatives to aid in expediting eligibility—PE and “fast track.” PE and fast track differ in a few respects. PE is used when a person who is applying for Medicaid appears to be eligible for Medicaid services. PE can be approved before the financial application is filed and before the functional assessment is completed. Fast track, on the other hand, is used when a person has already applied for Medicaid. The functional assessment for services must be completed before services begin.

The first initiative addresses PE processes in two section 1115 waiver programs:

- **Medicaid Alternative Care**

This program provides caregiver assistance, home-delivered meals, personal emergency response systems, family caregiver and client training and education, specialized medical equipment and supplies, and respite services. This program supports individuals and their unpaid caregivers to avoid or delay the need for more intensive Medicaid-funded services. Caregivers must be caring for a Medicaid-eligible adult, age 55 or older, who meets nursing home level-of-care criteria. When they apply, individuals must choose whether to receive services under Medicaid Alternative Care or the two other options—the Community Options Program Entry System (COPES) waiver or the Community First Choice state plan program.

- **Tailored Supports for Older Adults**

This program includes adult day services, family caregiver and client training, counseling/support groups, home modifications, housekeeping, information, home-delivered meals, personal emergency response systems, respite care, specialized medical equipment and supplies, and transportation. Individuals who do not have an unpaid caregiver may receive personal care. Benefit packages are capped at \$594 per month. Applicants must meet the nursing facility level-of-care criteria.

Tailored Supports for Older Adults is a new eligibility category that covers adults, ages 55 and older, who are at risk of using Medicaid-funded LTSS but whose income exceeds Medicaid’s financial eligibility criteria. The state uses preliminary information provided through a PE screening to determine if the applicant meets the financial and functional eligibility criteria.

With the second initiative, “fast track” is used for people who are seeking services through either the COPES section 1915(c) waiver or the Community First Choice program, a Medicaid state plan option.

The Medicaid agency, as the single state agency, delegates financial eligibility determination for older adults and adults with disabilities to the Aging and Long-Term Support Administration (AL TSA), which also operates section 1915(c) waivers and Community First Choice. Having both the financial eligibility staff and waiver staff in the same agency simplifies and expedites the application process. Financial eligibility staff work with case managers to share information and coordinate to ensure the financial applications are completed while services are delivered to the applicant.

Under fast track, case managers can expedite the financial eligibility decision. Applicants are not required to make an appointment or come to a state office. The case manager can take applications over the phone, by mail, or during a home visit. Home visits help facilitate the process and can help avoid delays when family members arrive at a state office without necessary documentation. In the person’s home, documentation may be located quickly. A case manager may help the person or family member complete the application and send it to the financial eligibility worker. Applicants must sign an agreement that describes the terms of the agreement, including filing an application for Medicaid within 10 days.

The case manager obtains information from the individual and consults with the financial

eligibility worker. Information that requires further review (e.g., trusts, real estate holdings) or raises questions about the final decision precludes the use of fast track. Fast track is available only to people who intend to receive services in their home or in a residential setting. Full applications must be completed within 90 days or the LTSS stop.

Since Medicaid Federal Financial Participation (i.e., a federal matching payment) is not available—except under the two section 1115 waivers—for services delivered if the applicant is not eligible for Medicaid, state funds pay for services in the few instances when the applicant is found ineligible. State officials believe the risk is limited compared with the savings realized by serving a person in the community. Washington officials determined that each fast-track client saves Medicaid an average of \$1,964 a month by authorizing community services for people who otherwise would have entered an institution.

Under the section 1115 waivers, ALISA is required to report to CMS how many applicants are ineligible, which has been fewer than 2 percent. Officials say fast track is not used as much for COPES and Community First Choice applicants as it is for section 1115 applicants. The fast-track process requires a more detailed screening. State officials encourage staff to use it more often, especially when private pay individuals in residential settings spend down and apply for Medicaid. Without a fast-track process, a gap can occur between when private pay ends and when Medicaid coverage begins.

RHODE ISLAND

In 2009, the Rhode Island Executive Office of Health and Human Services (EOHHS) received approval for a section 1115 waiver to create its “Global Consumer Choice Compact.” CMS issued special terms and conditions for the initial waiver, which granted EOHHS the authority to provide LTSS benefits pending verification of financial eligibility criteria for new applicants.

The authority allows EOHHS to accept self-declaration of the financial eligibility criteria for new LTSS applicants for a maximum of

90 days. Under the terms and conditions, eligible individuals are required to complete the clinical and financial application for Medicaid LTSS. EOHHS must verify the clinical eligibility criteria and, subsequently, the individual is required to provide a self-declaration of the financial eligibility criteria to receive a limited benefit package of LTSS for up to 90 days, pending the determination of the full financial application. As written, the section 1115 waiver gives EOHHS the authority to provide a limited benefits package that includes a maximum of 20 hours per week of personal care/homemaker services and/or a maximum of 3 days per week of adult day care services and/or limited skilled nursing services, based on assessment.

If an individual receives an approval of the full financial application, he or she can receive the full LTSS benefit package. The limited community-based LTSS may be offered for up to 90 days or until the eligibility for the LTSS decision is rendered, whichever comes first.

The process requires that a social worker conduct a lengthy functional needs assessment in the home and that medical providers submit a medical evaluation form. Only after receipt of both can EOHHS nurses determine a level of care and authorize services. EOHHS contends this process is unnecessarily time-consuming because it requires that both providers and case workers assess the same person, which delays the delivery of services.

As part of the waiver extension application in July 2018, EOHHS proposed to modify the expedited eligibility process for LTSS to facilitate service delivery. The state proposed an expedited clinical/functional eligibility review process that uses a more streamlined application to find the essential information needed to determine if an individual qualifies for LTSS. Medical health providers would verify that the information is accurate. The information would help confirm an applicant’s level of care and develop an interim service plan. The process for self-declaration of financial eligibility criteria would continue.

EOHHS argued that the proposed changes would allow it to make more timely eligibility functional

determinations for LTSS and provide a broader package of services and supports to individuals who have a “high” need for nursing home care. CMS has not approved the changes to the clinical eligibility process and the expanded services.

MICHIGAN

MI Choice is a section 1915(c) waiver used to deliver home- and community-based services to older individuals and individuals with disabilities, ages 18 and older, who meet the criteria to be served in a nursing facility. MI Choice operates as a managed care program. Section 1915(c) waivers allow states to provide in-services and program flexibility to beneficiaries who need LTSS that is typically not available under the general Medicaid program. In addition to the 1915(c) waiver, a section 1915(b) waiver allows the state to capitate the full array of waiver services for which the waiver agencies are at financial risk if the cost of care exceeds the capitation.

MI Choice operates under contract between the Michigan Department of Health and Human Services and 20 waiver agencies. MI Choice waiver agencies can initiate services before Medicaid financial eligibility is determined.

Local offices determine financial eligibility for Medicaid. Decisions are supposed to be made within 45 days but can take up to 6 months if a disability determination is needed. Decisions about financial eligibility can take longer in the southeastern part of the state because of the heavy caseload.

Financial information may be collected over the phone during the first screening call. During the call, the information and assistance staff explain that MI Choice is a Medicaid-funded program and the individual needs to secure Medicaid eligibility to enroll. When the information obtained over the phone suggests the individual may be eligible for Medicaid, the information and referral staff may further explain that the individual needs to complete a Medicaid application and describe the information that must be provided to the local office. A nurse, a social worker, and a supports coordinator team make a home visit to conduct

the initial assessment. If the applicant is eligible, the team helps him or her complete the Medicaid application and makes copies of the applicant’s financial documents. The team asks the client or family member to sign a financial release form that allows the waiver agent to obtain verifications from banks, insurance companies, and other organizations. Services may be started based on the client’s needs and available funding sources. A Medicaid specialist reviews the financial information; some specialists are co-located with the waiver agent by the Michigan Department of Health and Human Services.

Since waiver agencies in Michigan are managed care entities, they may choose to incur the risk of furnishing services to individuals who appear likely to be eligible for Medicaid once the local office processes the application. Waiver agencies have a pool of funds to cover such contingencies. Not all waiver agencies presume eligibility, though most have such a process. Waiver agency staff follow Medicaid income and asset rules when they presume an individual eligible for Medicaid. For single people, income must be less than 300 percent of SSI and their countable assets must be less than \$2,000.

Determining whether to use PE for couples can be more difficult. The spouse in need of LTSS must still have an income limit of less than 300 percent of SSI, but spousal assets may be up to \$27,284. That amount allows the spouse applying for Medicaid to retain \$2,000 and the spouse living in the community to retain \$25,284 in assets.

Michigan has found it is very effective for waiver agencies to have someone on staff familiar with the Medicaid eligibility rules. This facilitates working with the county eligibility worker, who has someone to contact when key documents, such as a verification of income, are missing.

Michigan staff also say that out-stationed or co-located eligibility specialists are a key feature of a successful program. In this model, the waiver agencies must pay for half the salary of an eligibility specialist stationed at the waiver agent’s office. The funding for this position must not

come from money that has already been federally matched. Hospitals and nursing facilities also use out-stationed eligibility specialists and must pay half of each specialist's salary. CMS covers the remaining half of the salary with Medicaid administrative matching funds.

OHIO

The Ohio PASSPORT and Assisted Living programs are Medicaid waiver programs administered by the Ohio Department of Aging (ODA) through Area Agencies on Aging and Catholic Social Services in western Ohio. They are referred to as PASSPORT Administrative Agencies. The PASSPORT waiver program provides services in private residences. The Assisted Living waiver program provides services in residential care facilities licensed by the Ohio Department of Health and certified by ODA.

State-funded PASSPORT and Assisted Living programs also assist eligible individuals while their Medicaid applications are processed for eligibility for the waiver programs. The services meet individuals' identified needs in their home or in a licensed, ODA-certified residential care facility setting of their choice. The programs provide individuals up to 90 days of services. Without this support, some individuals would likely be admitted to nursing facilities.

Individuals may be determined eligible for the state-funded PASSPORT and Assisted Living programs while Medicaid financial eligibility is being determined by 1 of the 88 county Departments of Job and Family Services. While enrolled in the state-funded program, individuals receive services available through the waiver programs, including case management, to support their health and safety. CMS reimburses for services paid by the state-funded program once the person is determined eligible for Medicaid.

The PASSPORT Administrative Agency assesses individuals for nonfinancial, clinical eligibility

criteria. For state-funded program eligibility, the agency also uses a worksheet⁴ to determine whether the applicant is likely to be eligible for Medicaid.

During calendar year 2018, 10,717 individuals were enrolled in the waiver programs. Of those, 2,954 (27.5 percent) were enrolled in state-funded PASSPORT and Assisted Living programs. Since the inception of PE, the error rate in presumptive eligibility enrollment has been less than 1 percent. State general revenue funds cover costs for services delivered to individuals ultimately not determined to be Medicaid eligible.

VERMONT

Vermont has had a Waiver While Waiting (WWW) eligibility and enrollment process since January 2011. That process allows the Department of Vermont Health Access (DVHA), the Medicaid agency, to grant provisional Medicaid LTSS eligibility and enrollment in the Choices for Care LTSS program. The criteria allowing a person to qualify for WWW include the following:

- The applicant has received SSI or food stamps or was a Medicaid participant in the previous 12 months.
- The applicant reports that he or she has not transferred any resources during the previous 60 months.
- The applicant's gross income minus \$60 is under the current protective income level, which is \$1,066 outside Chittenden County and \$1,158 in Chittenden County.
- The applicant's resources are below the maximum allowed—\$2,000 for a single individual and \$5,000 for a single individual who owns his or her home.
- An applicant with a spouse living at home has resources that are less than \$50,000.
- The applicant meets the clinical eligibility criteria.

4 "Financial Assessment Worksheet," Ohio Department of Aging, updated November 1, 2018, <https://aging.ohio.gov/Portals/0/PDF/ODA1115.pdf>.

The Department of Aging and Independent Living (DAIL) administers the LTSS program that assesses clinical eligibility and completes a clinical certification for applicants who meet these requirements. DAIL registered nurses send DVHA the name of the highest-cost provider and the start date of LTSS. The service provider submits a form (804)⁵ that indicates when services started. The form is submitted to DAIL and DVHA. DAIL authorizes services after DVHA grants WWW status. Individuals granted WWW status must submit the financial eligibility verification information to DVHA within the deadline for completing the 60-month retrospective review to determine if the applicant has transferred any assets.

All applications for LTSS are received by DVHA, which notifies DAIL of the pending application. DVHA screens all applications to see if they meet the WWW criteria. Once DVHA determines the applicant meets the criteria, DAIL is notified; DAIL then conducts a clinical assessment and identifies the highest-cost provider that will serve the person.

Vermont does not view this process as PE, but it functions in a similar manner—to approve services more quickly for people who are likely to be found eligible for LTSS.

NEW HAMPSHIRE

One state developed a PE policy that never reached implementation stage but is still worth examining. New Hampshire passed a law, effective January 2008, directing the commissioner of the state Department of Health and Human Services to establish a PE program for preventing unnecessary and costly institutionalization of individuals who meet the Medicaid criteria for admission to a nursing facility but choose to receive services in less-

restrictive settings.⁶ The program was not funded and it was discontinued.

The law would have allowed the department to authorize medical assistance between application and final Medicaid eligibility determination if the department determined the applicant likely would have been eligible. PE would have been made available at department district offices, information and referral resource centers, and other qualified providers. The law did not allow the use of home or environmental modifications during the PE period.

A face-to-face clinical assessment of each applicant would have had to be conducted within 20 days of referral. The department would have had 5 business days to review the application for PE from completion of the Medicaid application and the clinical assessment.

The Medicaid applicant would have had to acknowledge in writing the uncertainty of continuing service coverage beyond the PE period and the potential for financial responsibility for costs incurred in the event of Medicaid ineligibility.

If an applicant had been determined ineligible for Medicaid, the department would have had to promptly notify the applicant and the applicant's providers of the finding and the immediate termination of service coverage authorization. In such a case, the department would have been required to use non-Medicaid funds to pay for any waiver services the applicant had already received. In the event an application was filed with fraudulent intent, the department would have been entitled to reimbursement of funds expended on behalf of the applicant.

KEY FEATURES OF ACTIVE STATE PROGRAMS

Table 1 summarizes the key features of the five state presumptive eligibility practices.

5 Form 804 is available at <https://asd.vermont.gov/resources/forms>.

6 Justia, NH Rev Stat § 151-E:18 (2013), *2013 New Hampshire Revised Statute, Title XI - HOSPITALS AND SANITARIA, Chapter 151-E - LONG-TERM CARE, Section 151-E:18 - Presumptive Eligibility* (Mountain View, CA: Justia, n.d.), accessed July 3, 2019, <https://law.justia.com/codes/new-hampshire/2013/title-xi/chapter-151-e/section-151-e-18/>.

EXPEDITING MEDICAID FINANCIAL ELIGIBILITY DETERMINATIONS

TABLE 1
Key Features of Active State Programs

STATE	FEATURES
Washington	<ul style="list-style-type: none"> • PE applies to two section 1115 waivers. • CMS pays the federal share of costs for people found ineligible under both section 1115 waiver programs. • The “fast track” process expedites Medicaid eligibility for people seeking home- and community-based services waiver or state plan services who have filed their Medicaid application. • Care managers assist the consumer in completing the financial application. • The functional assessment must be completed before fast track starts. • Staff who conduct financial and service eligibility work in the same department.
Rhode Island	<ul style="list-style-type: none"> • CMS pays the federal share of costs for people found ineligible under a section 1115 Global Consumer Choice waiver program. • Case managers can approve services for up to 90 days before Medicaid eligibility is determined. • A proposal to modify and simplify the functional eligibility process was not approved by CMS at the renewal time.
Michigan	<ul style="list-style-type: none"> • Waiver agencies are capitated and at risk. • Eligibility workers are out-stationed with waiver agencies whenever possible. • PE is not available in all waiver agencies.
Ohio	<ul style="list-style-type: none"> • State-funded programs can pay for services while Medicaid eligibility is determined. • Federal reimbursement is claimed when the person is determined eligible for Medicaid. • State revenue is used for people found ineligible.
Vermont	<ul style="list-style-type: none"> • The Waiver While Waiting program can initiate services when Medicaid eligibility is pending. • Registered nurses assess for functional eligibility and forward a form to the provider approving services. • Providers complete a form indicating when services started. • State revenue can be used for people found ineligible.

Summary

A review of the five states that expedite Medicaid financial eligibility revealed several key recommendations for effective programs:

- State LTSS agencies that are part of an umbrella agency serving as the single state Medicaid agency may be assigned responsibility for determining both functional and financial eligibility. Medicaid financial eligibility is determined more quickly when both the case managers who complete the functional assessment and the financial eligibility workers are employed by the same agency and work near one another.
- As in Michigan, Medicaid eligibility workers also can be out-stationed to the organization responsible for determining whether the applicant meets the nursing home level-of-care criteria.
- When eligibility staff and care coordinators are in separate agencies, more cooperation and coordination is needed. Eligibility workers assigned exclusively to LTSS applications can specialize in complex verifications and work more closely with care managers to process applications. Eligibility staff who also handle applications for women and children and the food stamp program are more likely to process applications as they arrive, may not understand the impact of delayed financial determinations on service choices, and face competing pressures that may interfere with the processing of LTSS applications.
- While the risk of paying for ineligible applicants is low, if states are concerned about this, other funds may be available, including state general revenues or Social Services Block Grant funds. Alternatively, the Medicaid agency could forgo claiming the match from CMS to cover services approved for individuals found to be ineligible for Medicaid.
- For states with both home- and community-based services waiver programs and state-funded home care programs, the process simply determines which program will cover the cost of services.
- The PE process should have deadlines by which the applicant must submit a financial application for Medicaid.
- Case managers need to track the status of the formal application to make sure it has been filed and acted on.
- A clear explanation should be given to applicants that services may be terminated if the Medicaid application is not submitted or the person is found to be ineligible.

A 2002 draft report on PE to CMS by David Stephenson, Joanne McDonald, and Brian Burwell suggested a range of parameters that could be used to shape Medicaid coverage under home- and community-based services waivers. The list and a brief discussion of each parameter is presented in the appendix.

Appendix: Potential Design Parameters of Presumptive Eligibility Determination

A 2002 draft report on PE to CMS by David Stephenson, Joanne McDonald, and Brian Burwell suggested a range of parameters that could be used to shape Medicaid coverage under home- and community-based services waivers. The list and a brief discussion of each parameter is presented below because they remain relevant today.

- **Presumptive eligibility is available to a population in need of LTSS.**

The potential pool of applicants may be drawn from those who live at home, those who are in nursing facilities who might lead a higher quality of life at home, and those who are hospitalized and will need LTSS upon discharge. At implementation, people living at home may be the most difficult to serve, necessitating an outreach design as well as the coordination of services necessary to provide PE.

- **Functional assessment of need is based on current state home- and community-based services waiver practices.**

Unlike existing PE programs that proscribe which entities may determine PE, state waiver programs already have processes in place to evaluate functional need and—where such needs exist—to coordinate referrals for eligibility determination. In addition, since waiver programs require CMS approval, states already have received federal sanction of their functional assessment process. Given these factors, it makes sense for states to continue using the functional methodology they have in place rather than using time, resources, and money to modify the determination.

- **Financial determination for PE is completed by an entity of the state's choice.**

Medicaid financial eligibility determinations for LTSS applicants are complicated and difficult to administer. Both income and asset rules can be challenging to interpret, a fact compounded by spousal and transfer of resource provisions. In

addition to knowing the intricacies of Medicaid rules, eligibility workers are often required to have the skills of an accountant, lawyer, detective, and real estate professional. Given these layers of complexity, states may conclude it is too difficult or administratively burdensome to train clinical workers regarding financial eligibility rules. Yet while some states might prefer to have dedicated financial eligibility workers direct the PE determination, others might find it more efficient to combine functional and financial screens for PE.

- **Financial determination for PE is based on declaration of need.**

Applicants must not only meet the financial criteria but also verify that they meet financial eligibility standards. Verifying financial eligibility can be a monumental task involving the participation and cooperation of numerous third parties. Applicants may need to involve, among others, insurance companies (for the current cash value of a policy), banks (for both current and prior value of bank accounts), and real estate and/or car dealers (for the current value of property). The complexities increase considerably when there is evidence of a resource transfer or the applicant owns a trust or second piece of real estate beyond his or her primary residence. The verification process can be challenging for applicants who have substantial impairments that require medical and social supports on a day-to-day basis.

- **The individual's income does not exceed 200 percent of the Federal Poverty Level (FPL).**

Under home- and community-based services waivers, states have several options for choosing the income limits for program participants. Most states (currently 33) use the same income limit that is used in determining eligibility for nursing facility care—300 percent of the SSI income level. Restricting the PE income level to 200 percent

of the FPL⁷ would enhance the integrity of the ultimate Medicaid financial eligibility determination.

- **The individual’s assets do not exceed state limits and are not complex in nature.**

While extending PE to all potentially eligible applicants is desirable, the reality is that not all applicants will be able to establish the value of their assets up front. In addition, eligibility workers will not be able to establish eligibility for some individuals before evaluating necessary documentation. Applicants and eligibility workers alike might have a more difficult time establishing the value of more complex assets, such as out-of-state real estate holdings, without adequate documentation.

As a result, people who own such complex assets should in most instances not be considered for PE. The PE regulation could be written to give states the flexibility to determine those for whom a PE determination could be made; however, this could become very subjective. Preferably, the regulation would provide a concrete list of applicants who should be excluded. Suggested exclusions include individuals with an ownership interest in a trust, individuals with an ownership interest in an annuity, and individuals with an ownership interest in real estate other than the home in which they reside.

- **The individual declares no *disqualifying* transfer of resources has occurred.**

A penalty period of Medicaid ineligibility is imposed on people who have transferred resources for less than fair market value in the previous five years. While a gift of \$5,000 two years in the past may be inconsequential, a gift of \$100,000 in the past six months may be subject to extensive documentation and verification prior to an eligibility determination. Lacking such documentation, a worker cannot make a determination of fair market value or the disqualification period. Since this determination

is both tedious and cumbersome, PE should not be extended to anyone who declares a potentially disqualifying transfer has occurred.

- **Individuals under age 65 meet SSI PE criteria.**

People ages 65 or older are “categorically” eligible for Medicaid, while those under age 65 must meet Title XVI disability criteria. Individuals who qualify for Medicare and/or the Social Security Disability Income program automatically meet this standard. Others must be examined to see if they meet disability criteria. The state’s medical review board has 90 days to complete the review. Applying this time standard to people with disabilities would obviously nullify their ability to avail themselves of the PE benefit.

- **The individual signs an agreement to comply with general Medicaid application requirements and the PE process.**

Depending on an individual’s circumstances, Medicaid may also impose requirements to place a lien on property or recover monies from a beneficiary’s estate. While services might help meet care needs, individuals may choose not to participate in the program once informed of the accompanying rules and requirements. In addition, individuals might not wish to comply with the requirements of the PE process. As a result, individuals should be informed up front of these requirements and sign an agreement to comply with them.

- **Individuals are advised of the consequences of being determined ineligible for Medicaid.**

Individuals should be aware that they might ultimately be determined ineligible for Medicaid. Given the prior design parameters of the regulation, the risk should be minimal. Still, there will be cases in which an individual is rendered ineligible as a result of forgetting about an asset that is countable or improperly evaluating income or assets. While some states may be able to continue care under state-only

⁷ The 200 percent income cap would also apply to a member of a married couple who needs home- and community-based services, using current Medicaid procedures for determining the applicable share of jointly held income.

programs, other states may not have such services available. Individuals need to be made aware of the consequences of losing PE and be able to assess if they should instead pursue other options. In addition, in their applications for home- and community-based services waivers, states should be required to document how the care needs of people who are presumed eligible but then determined ineligible will be handled.

- **Applicants submit a complete Medicaid application form no later than three weeks after the PE determination.**

Unlike current Medicaid PE programs, financial eligibility rules for LTSS are more complex. While it might be reasonable to expect current PE populations to submit necessary forms and verifications (usually pertaining only to income) without substantial guidance or support, individuals who apply for LTSS typically require interaction and assistance from Medicaid eligibility staff. In addition, many states require face-to-face interviews, which can be problematic for individuals with LTSS needs, especially if third parties—who might work or live out of state—must be consulted. Finally, the eligibility process must provide the state agency adequate time to evaluate the form, request necessary verifications, and make a substantive determination of Medicaid eligibility.

- **Individuals who meet all prior requirements are presumptively eligible for 90 days from the date the Medicaid application is submitted or until determination of ineligibility is made, whichever comes first.**

While the complexity for the medical determination is recognized by a 90-day standard, the complexity of the financial determination is not. As a result, many people who apply for LTSS are denied at the end of 45 days, not because they are ineligible but because they have been unable to produce necessary verifications or satisfy all the procedural requirements. This provision is inherently unfair to an incapacitated applicant who is relying on a third party to produce needed documentation.

- **States must ensure that the PE processes are accurate.**

The design parameters of the proposed criteria address ineligible applications in part by restricting financial eligibility requirements, requiring an individual's agreement to comply with all Medicaid requirements, and requiring the submission of a Medicaid application form in an abbreviated period. In addition, states are given a longer period to make a substantive Medicaid eligibility determination. While these parameters will help ensure ultimate Medicaid eligibility, cash-strapped states may still be motivated to relax the administration of these standards in order to maximize matching Medicaid federal administrative funds for home- and community-based services waiver applicants.



www.longtermscorecard.org



The COMMONWEALTH FUND

