Modernizing Medicaid Eligibility Rules to Bring Care Home

Pennsylvania Homecare Association

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The Pennsylvania Homecare Association is a state trade association representing more than 700 organizations that provide care and support to individuals in their own homes. PHA helps its members tackle every day challenges. With a member-centered focus, the association champions efforts that range from advocating on behalf of patients and consumers, interpreting and developing regulations and legislation to exploring needs and business strategies.

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Where Do You See Yourself at 85?

Picture yourself years from now, celebrating your 85th birthday, surrounded by your family, friends and loved ones as you blow out the candles. Are you envisioning this celebration at home in your living room or in a nursing home? The answer is so obvious that the question itself borders on the absurd. Everyone would rather be at home, living as independently as possible for as long as they can.

The financial, emotional and health benefits of care at home for seniors are equally obvious. More than that, these benefits are supported by research and experience. But the option to stay at home to receive care is not readily available for thousands of families in Pennsylvania because of systematic delays in the Medicaid financial eligibility process. Allowing homecare agencies to presume that someone is eligible for Medicaid would save valuable time for the senior – AND save money because in-home care is much less costly than nursing home care.

Easy Access to Medicaid-Funded Nursing Home Care

Nursing homes are empowered to presume Medicaid eligibility so they can admit an individual and begin care while they help the resident and family complete the full financial application. The resident is admitted at once, the (*very expensive*) clock starts ticking, and the nursing home receives payment for this care retroactively when the application is finally approved months later.

However, if a person chooses to remain at home, Medicaid rules prohibit in-home care providers from doing the same thing.

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To be fair, this state-of-affairs exists largely because of outdated federal entitlement program policies that were enacted at a time when nursing homes, or "poor houses" and "rest homes," were the only option for seniors when they were no longer able to support themselves at home. Since that time, however, the options for care have evolved, with homecare, assisted living, adult day centers, and more. Prompt and unfettered access to these options for people who qualify is not only good for seniors and their families, but also for state budgets.

What is Presumptive Eligibility?

Presumptive eligibility, also referred to as deemed eligibility, is an expedited process that allows providers to determine the likelihood of Medicaid eligibility for applicants who need services. The presumption is based on a quick summary of the applicant's finances and assets. A care provider can easily ascertain that the applicant will probably be eligible for Medicaid, meaning he or she has no more than $8,000 in assets and a monthly income below $2,205. The estimation by the provider allows the applicant to access services immediately while their application goes through the full process, which today can take anywhere from six to nine months.

There are two steps for an individual to be eligible for Medicaid-funded in-home care:

1. **Functional Eligibility Determination:** An in-person assessment from a local Area Agency on Aging (AAA) staff member to determine how much help an individual needs with daily tasks, such as bathing and dressing. The result determines whether the individual is Nursing Facility Clinically Eligible (NFCE), or frail enough to need help to stay at home.

2. **Financial Assessment:** A thorough examination of the individual's financial assets and monthly income, performed by the County Assistance Office (CAO), using bank records and other documentation going back as far as five years.

A presumptive or deemed eligibility program does not change income eligibility requirements, but rather it expedites the start of services and ensures the individual will be able to access less costly care at home rather than entering a nursing home. As applicants wait for the financial paperwork to be completed by the CAO, families and friends lose the financial and emotional stamina needed to keep care going at home and many individuals turn to a nursing home, which can accept them right away. As time goes on and eligibility is finally established, it can be nearly impossible for nursing home residents to move back home because the supports, and sometimes even the home, are gone.

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Options for Pennsylvania

The Pennsylvania House of Representatives unanimously passed legislation (House Bill 1829) in December 2017, which would establish a presumptive or deemed eligibility program for homecare, home health and adult daily living centers. The bill does not make any changes to the income or asset limits or the functional criteria needed to qualify for Medicaid, nor would it result in more individuals being eligible for Medicaid than would otherwise be eligible under current law. It simply empowers these providers to make the same decision that nursing homes do today: accept an individual for care now and receive payment later. The full risk is on the provider to make the right decision about an individual's eligibility. Nursing homes take this risk today and sometimes, although very rarely, the cost of the care provided is simply a loss for the company.

Will Providers Accept the Risk?

Prior to the unanimous House passage of H.B. 1829, Pennsylvania officials opposed implementing presumptive eligibility because of the risk that the presumption will turn out to be false and federal Medicaid matching dollars will not be available. H.B. 1829 brings a new approach to the table, calling for providers to risk retroactive payment if they do not make the right decision about the applicant's potential eligibility. With the risk shifted to providers, how can we be sure the program will benefit Pennsylvanians who need this care?

Participation in the program will be voluntary. For agencies that choose to participate, the risk is minimal that they will lose out on retroactive payment from the Commonwealth. Nationally, presumptive eligibility programs show an error rate of approximately 1-2%, meaning that the provider makes a false presumption and the individual is ultimately ineligible.

Let us examine a scenario using real data from Pennsylvania's waiver program, as discussed in the Governor's Proposed Fiscal Year 2018-2019 Budget. H.B. 1829 permits presumptive eligibility for individuals age 60 and over, who would be receiving services in the Aging waiver program. Enrollment data from the Office of Long-Term Living, which administers the waiver, shows that in each month from February 2017 to February 2018, an average of 574 individuals enrolled in the Aging waiver. If 2% of monthly applicants, or 12 people, are falsely presumed eligible for Medicaid, providers will collectively be at risk for about $45,000 each month. (The average monthly cost of home and community-based services in the Aging waiver ($3,694) multiplied by the 12 individuals that might ultimately be ineligible for Medicaid reimbursement.)

Without the presumptive eligibility option for homecare, these 574 applicants would either wait without care at great risk or end up in a hospital or a nursing home. With the average monthly cost of nursing home services at $5,129, if all of those applicants enter a nursing home while they wait for eligibility, the Commonwealth would spend $2.9 million each month, when it could be spending $800,000 less to care for the same group at home. The math is clear: homecare is always the better option.

CHC Doesn't Correct the Problem

Community HealthChoices (CHC), Pennsylvania's new Medicaid managed care program, will soon be the program for people who are dually eligible for Medicare and Medicaid to receive physical health services and long-term services and supports. CHC has already been implemented in the southwest region of the state in January 2018 and will continue its rollout in the southeast in January 2019 and the rest of the state in January 2020. Apart from some additional care coordination and a few new available benefits, the experience of Medicaid participants will be the same as it is today in the waiver programs. **Most importantly, the process and criteria that individuals use today to qualify for Medicaid waiver services will not change. The CHC transition will not affect the long waiting time that Medicaid applicants face when accessing home-based care.**

About 267,046, or 64%, of the individuals that are included in CHC are considered "Healthy Duals" or "Community Wells," meaning they are using Medicaid coverage for something other than long-term services and supports. For instance, some people receive payments from Medicaid to cover Medicare Part B premiums and cost-sharing responsibilities. Beneficiaries in these categories have not yet encountered a need for long-term care and so they have not received a Functional Eligibility Determination from the AAA. In addition, the financial determination that led to their eligibility is different than the eligibility that establishes homecare coverage. Therefore, any Healthy Duals that develop a need for homecare or home health must complete the same procedure as someone that has never received Medicaid coverage. The managed care organization (MCO) they select will be able to help them understand the process and can refer them to the Independent Enrollment Broker (IEB) to apply for homecare coverage, but the process remains the same regardless of the individual's inclusion in CHC.

Perhaps a CHC-MCO will choose to provide some personal care at home while a Healthy Dual waits for long-term care coverage to begin. However, the MCO is only paid a small per member per month (PMPM) capitation rate of around $100 for each Healthy Dual in its network. While the MCO will certainly be incentivized to keep the individual out of a nursing home while they wait for eligibility, it is still tied to a strict budget to care for the thousands of beneficiaries that might be in the same situation.

Bias Still Favors Nursing Homes

Regardless of how CHC-MCOs choose to assist Healthy Duals in their network, individuals who are not already part of the CHC program will still be directed toward nursing home services when applying for Medicaid. This is already evident in the first few months of CHC. Data from the Office of Long-Term Living show nursing homes as the point of entry for 65% of new CHC participants. Of the 1,661 individuals who were new to Medicaid from January to March 2018 and were found to be NFCE, only 568 started their care at home or in the community. Nursing home enrollment is likely reporting at more than double the community enrollment rate because of presumptive eligibility in nursing homes!

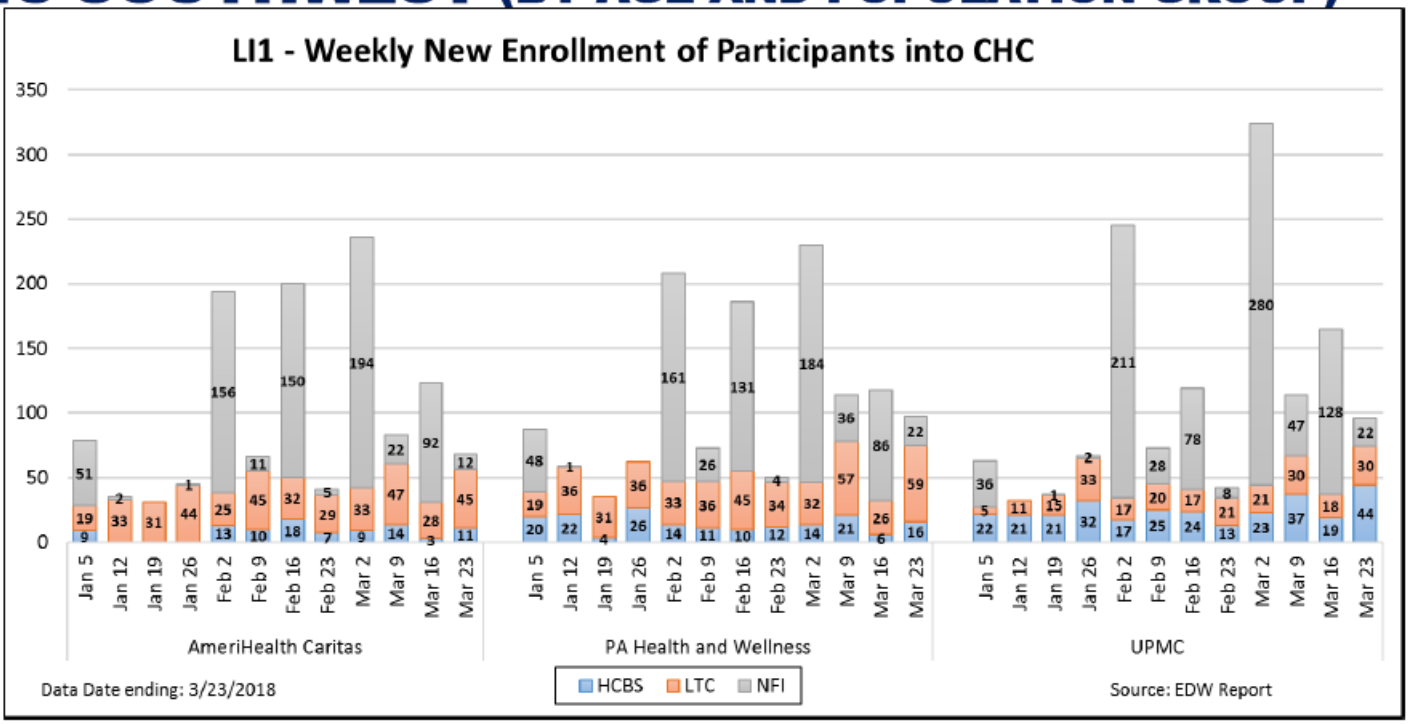
This directly contradicts the argument that the transition to CHC will erase the bias towards institutional placement. Luckily, these individuals will now have a CHC-MCO in their corner to help transition them back to home, however, that process will take months and cost money that could have been saved upfront if homecare were an equally available option *before the individual entered CHC.*

Many are Outside CHC Protective Bubble

This ongoing conversation with Commonwealth officials and legislators has been focused on dually eligible CHC participants and the ability of their CHC-MCO to help them stay at home longer. However, there is still a substantial waiting time for Medicaid applicants that are outside of the CHC program. The MCOs have no connection to this population and their plight cannot be fixed without presumptive eligibility.

Seniors and individuals with disabilities who are receiving healthcare services through Medicare and have never used Medicaid, even for premium payments, will not be connected to a CHC-MCO. When that population needs support to stay independent in the community or

CHC SOUTHWEST (BY AGE AND POPULATION GROUP)



Source: OLTL Update Presentation, Managed Long-Term Services & Supports Subcommittee meeting, April 6, 2018

help with personal care at home following an acute illness, they cannot turn to an MCO for charitable care or help with the application process. The CHC plan selection will not take place until the eligibility process has already concluded.

Savings in Other States

The experiences of other state Medicaid programs prove that presumptive eligibility saves considerable money. It is important to note that the wait time in Pennsylvania's program – six to nine months – is an outlier compared to other states, which only have a wait time of a couple of weeks.

The risk allocation in H.B. 1829 is also a notable variation that sets Pennsylvania apart from other states that have implemented a presumptive eligibility, or fast track program, for in-home care. Most programs pay providers upfront for the care delivered during the period of presumed or deemed eligibility, using state funding that is comparable to Pennsylvania's OPTIONS program, which uses Lottery dollars to provide in-home support.

H.B. 1829 does not call for upfront payment, but instead places the full risk on the provider to make the right decision to begin services before the final eligibility decision is made.

Here are some examples of how other states have incorporated presumptive eligibility or similar programs into Medicaid in-home care:

Colorado

The state's PE pilot cost $106,879, but saved the state $407,012 diverting patients from nursing homes to homecare. Colorado officials estimated a third of Medicaid hospital discharges would be diverted to homecare, but the study showed, in fact, 60% avoided nursing home placement.

In Pennsylvania:
61% of Medicaid waiver participants have a hospital stay in the year prior to beginning waiver services.
Source: Level of Care Assessments FY 2014-15

Kansas

Researchers found cost effectiveness could be achieved by diverting as few as five people from institutional care. The PE pilot successfully diverted 11% from nursing homes into homecare. Concerns about costs led lawmakers to create a "safety fund," but the program was so effective, there was <1% error rate in determinations.

In Pennsylvania:
If the Commonwealth is able to divert 11% of Medicaid recipients away from nursing homes, it will save about $6.6 million each month.
Source: Governor's Budget FY 2018-19

Washington

Washington's PE program helped shrink the average wait time to determine Medicaid financial eligibility by 66%, from 37 to 17 days. Officials determined PE saved Medicaid an average of $1,964 a month by authorizing homecare for those who would have entered an institution if services were delayed.

In Pennsylvania:
Data from Maximus (IEB) show that applicants over 60 receive financial determinations in 60 days on average. However in any given quarter, there are 150 to 200 applicants waiting more than 90 days.
Source: LTSS Subcommittee, April 2018

CONCLUSION

We live in a world today that is radically different from when the Medicaid program began in 1965. Then, older people went to the rest home because there were no other services available. Today, people want to stay at home, where they've lived their best years and raised their families. Medicaid eligibility rules need to catch up with this thinking.

The passage of H.B. 1829 would put Pennsylvania at the forefront of long-term care and set us apart from other states whose Medicaid programs have not found a way to adequately prepare for Baby Boomers and their steadfast desire to stay at home for care. The implementation of CHC will surely benefit seniors and adults with disabilities, but it will not take away the growing frustration of families and providers who wait months for financial eligibility.

Our senior population is growing in Pennsylvania, and now is the time to better distribute the resources to support this population. By extending the power of presumptive eligibility to home and community-based providers as well as nursing homes, the Commonwealth will not only ensure that individuals and families have the choice to stay at home together, it will ensure the sustainability of the Medicaid budget for many years to come.