Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Long-Term Services and Supports Presumptive Eligibility

ESSB 5092, Section 204(16)
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TABLE OF CONTENTS

Contents

Executive Summary

Washington state residents should have the same opportunity for timely access to Medicaid-funded community and in-home-based Long-Term Services and Supports (LTSS) as they have to access institutional services. Introducing Presumptive Eligibility (PE) for individuals applying for in-home LTSS means applicants would be able to access immediate, essential services prior to a final financial eligibility determination and a full functional eligibility assessment thus eliminating the institutional bias that currently exists in Medicaid statutes. Importantly, this would include access to appropriate LTSS through Community First Choice and 1915(c) waivers.

Washington state, as directed by the legislature in ESSB 5092, Section 204(16), requested a waiver to apply a PE process to clients discharging from acute care hospitals who need access to Medicaid-funded LTSS. Washington state hospitals face barriers in discharging some patients because they are unable to discharge without community supports related to functional impairments. Under current federal Medicaid rules, LTSS cannot be authorized until full financial and functional eligibility is determined, and a qualified provider has been identified. These processes take time and result in patients remaining in hospital beds beyond medical necessity for treatment.

Due to the COVID-19 pandemic and the resulting Public Health Emergency (PHE), the Department of Social and Health Services (i.e., the department), under temporary authorities, was allowed to streamline eligibility and create a path to presumptive eligibility. The department has been meeting this LTSS access need using the PHE authorities while working with the Centers for Medicare and Medicaid Services (CMS) on a more permanent solution.

Acute care hospital data for 2020 and 2021 (through October) show that there are an average of 707 referrals for LTSS monthly with 52% of those referrals discharging with LTSS. This is a relatively low volume of the overall applications for Medicaid-funded LTSS. We currently have presumptive eligibility authority from CMS for the Tailored Services for Older Adults (TSOA) and Medicaid Alternative Care (MAC) programs. We have an extremely high accuracy rate (98%) in PE determinations for these programs. Extending PE to the limited hospital population, combined with the high accuracy rate, demonstrates the minimal risk to the state and our federal partners in expanding presumptive eligibility to a subset of individuals requesting access to Medicaid LTSS while in an acute hospital setting.

The LTSS PE benefit package will be offered to individuals through a person-centered planning process. Individuals who later become Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid-eligible will no longer be eligible for LTSS PE services. Services offered under this benefit will not duplicate services covered under private insurance, Medicare, state plan Medicaid, or through other federal or state programs.

Based upon consultation and preliminary review by the Office of the Attorney General, it does not appear that any statutory changes would be necessary if the federal government approves the LTSS PE request.

Description

Under today's CMS rules, functional and financial eligibility must be determined prior to the authorization of LTSS. Financial eligibility for Medicaid-funded LTSS requires an interview and verification of eligibility factors including income, resources, any inappropriate transfer of assets, and home equity. Functional eligibility requires an assessment, a review of medical records, and collaboration with the client, their family, and collateral contacts to determine the functional impairments of the client. Once this information is gathered, the case manager works with the client to create a person-centered service plan prior to authorization of services. Under Medicaid rules, the department has up to 60 days to make these determinations and it can take longer if the application and materials submitted are incomplete.

Presumptive Eligibility (PE) is a process that allows immediate access to essential services while the client is waiting for the full financial and functional eligibility determination to be completed. PE is currently utilized in the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs which are included in Initiative 2 of the 1115 Medicaid Transformation Waiver.

The Health Care Authority, in collaboration with the department, submitted an amendment to the 1115 waiver to CMS on January 15, 2021, to extend the presumptive eligibility (PE) process to clients discharging from acute care hospitals and who are diverting from community psychiatric hospitals and need to access LTSS. Washington state hospitals face barriers in discharging some patients because they need community supports related to their functional impairments. Because the process of eligibility takes time, it results in patients remaining in hospital beds beyond medical necessity for treatment. Delays in discharging places a burden on our health care system and increases costs for the state and our federal partners. It also creates adverse impacts for patients and their families who have an interest in receiving care in the most appropriate and least restrictive setting. Note that CMS has communicated to the HCA and the department that they will not be able to review and process our 1115 amendment request to extend PE to acute hospital patients seeking in-home services until sometime in early to mid-2022.

The waiver amendment submitted to CMS would allow the state to establish presumptive eligibility for individuals in need of in-home LTSS under Medicaid state plan and 1915(c) waiver authorities and Medicaid medical coverage when discharging or diverting from an acute or psychiatric hospital stay. The population already determined financially eligible for Medicaid state plan medical benefits would only require a functional PE determination. The department intends to request PE for all LTSS services in the 1115 waiver renewal application which will be submitted to CMS in early 2022. If approved, that waiver would be in effect beginning January 2023.

The state, or a qualified entity, would make a determination that the individual appears to meet functional and financial eligibility requirements. Qualified entities may include an Area Agency on Aging (AAA), a subcontractor of a AAA, or a state-designated tribal entity.

A limited benefit package would be provided by the state during a presumptive eligibility (PE) period for those who plan to enroll in one of the following Washington state programs: Community First Choice, COPES, or Medicaid Personal Care. The PE period proposed mirrors that in the existing 1115 waiver. PE begins on the date the applicant is determined to be presumptively eligible and ends with the earlier of:

- In the case of an individual on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or
- In the case of an individual on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Functional eligibility criterion includes nursing facility level of care (NFLOC) and Medicaid Personal Care (MPC) level of care. The limited PE benefit packages would contain some of the services available in the full benefit package of the program being utilized after the PE period (e.g., Community First Choice, COPES, or Medicaid Personal Care). Services offered under these benefit packages would not duplicate services covered under private insurance, Medicare, state plan Medicaid, or through other federal or state programs.

The NFLOC PE benefit package includes:

- Personal care services, up to 103 hours per month
- Nurse delegation
- Personal Emergency Response System (PERS)
- Home delivered meals
- Specialized medical equipment and supplies
- Assistive/Adaptive technology and equipment
- Community transition or sustainability services: goods and services which are nonrecurring set-up items and services to assist with expenses to move from an acute care hospital or diversion from a psychiatric hospital stay to an in-home setting and may include:
    - Security deposits that are required to lease an apartment or home,
    - Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings,
    - Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage,
    - Services necessary for your health and safety such as pest eradication, and one-time cleaning prior to occupancy, and
    - Moving expenses.
- Minor home accessibility modifications necessary for hospital discharge
- Community choice guide: Specialty services which provide assistance and support to ensure an individual's successful transition to the community and/or maintenance of independent living

- Supportive Housing

The MPC PE benefits include personal care services up to 34 hours per month.

Clients enrolled in 1915(c) LTSS PE would be subject to post-eligibility treatment of income (PETI) based on self-attested available income and allowable deductions, including a personal needs allowance (PNA) during the PE period. The cost of care applied during the PE period would not be adjusted retroactively once full eligibility is determined. An individual already financially eligible for a CN or ABP program does not pay toward the cost of care in-home. Once full functional and financial eligibility determinations are complete, an updated PETI will be applied the first of the month following that determination, if appropriate based on client's final eligibility determination.

Medicaid estate recovery requirements would be applied to clients receiving services under the LTSS presumptive eligibility period.

Stakeholder and Tribal Collaboration

To engage with stakeholders and Tribal governments and to obtain public review and comment during the development of the CMS amendment request, the following activities occurred:

- A notice requesting feedback was published on the Health Care Authority (HCA) website.
- An on-line "survey" was created and utilized to submit open-ended comments regarding the amendment. This survey also included a mailing address to allow submission of comments for those without internet access.
- A statewide GovDelivery Notice was distributed.
- A Public Notice was posted via WA State Administrative Register on November 18, 2020.
- Two public informational webinars were hosted by HCA on November 16th and 17th in 2020.
- A series of Tribal Roundtables and a Tribal Consultation were held between Oct 28 – Dec 9, 2020

Implementation Planning Activities to Date

Due to the Covid-19 pandemic and the federal PHE, the state utilized an emergency 1115 waiver authority and temporary verification plan to use a streamlined eligibility process. This streamlined eligibility has been in place since March 2020. It has been used to expedite acute care hospital discharges during the public health emergency. The streamlined eligibility included elements such as verbal attestation of income and resources, and a physician's attestation of ongoing disabilities. This streamlined process allowed the state to determine one's eligibility within a much shorter timeframe that averaged 4 days rather than the typical 45 to 60 days. Once the PHE ends, Washington state will be seeking to retain the flexibility of post enrollment verification for classic

Medicaid applicants which allows clients to self-attest to their situation and then verify after they are enrolled into Medicaid.

The Home and Community Services (HCS) Division within DSHS, who is responsible for determining functional and financial eligibility in order for residents to receive community-based LTSS, confirmed the need to extend the PE process to the hospital discharge/diversion population.

Although permanent authority for streamlining that was allowed under the PHE is an improvement, full functional eligibility continues to be needed without federal approval of PE. Discussions were held with CMS to begin the long-term planning for use of PE for all department LTSS intakes. The intent is to use state plan-funded and the 1915(c) waiver programs to fund PE services for this population but use the 1115 authority for use of PE. Since this is a relatively new concept for CMS, it was decided that Washington would approach this in incremental steps beginning with the acute care hospital population needing in-home services.

Use of PE for clients needing residential settings has more complexity. Considerations need to be explored regarding how a rate would be determined during the PE process and how the assessment and care plan would be developed to ensure that residential providers have the information needed under their regulatory requirements while the full CARE assessment is being completed.

A work group was implemented to outline what would be needed to implement PE for this population. The work group includes HCS staff who currently collaborate with acute care hospital discharge planners, HCS program managers and supervisors, intake staff from both HCS and AAAs, HCA program managers, and HCA deputy directors. Activities include the following:

- Outlining the PE workflow
- Establishing system changes that would be needed for CARE, ProviderOne, and ACES IT systems
- Developing draft financial and functional program WAC in consultation with the Office of the Attorney General
- Drafting policy and procedures

This collaboration will continue with CMS and community partners.