

## **Presumptive Eligibility for Homecare and Home Health Services**

### **HB 1829 & SB 912**

#### Common Questions

1. Why is this legislation needed?

Completing the full financial review for Medicaid eligibility can take anywhere from 6-9 months. The County Assistance Office (CAO) must review up to 5 years of financial information to determine whether an applicant meets income requirements. However, if the individual is willing to go to a nursing home, that nursing home can presume his or her financial eligibility and begin providing care right away while the application is completed. Then, the nursing home is paid by Medicaid retroactively when the individual is finally approved.

This option is not available to homecare or home health agencies, even though most Medicaid applicants would rather receive care at home. This inequality forces applicants to wait months with no care at all or enter a nursing home against their wishes.

2. Will this change the rules for Medicaid eligibility?

No. This does not make any change to the functional or financial requirements that an individual must meet to have their care covered by Medicaid. Instead, it allows an agency to provide uncompensated care right away if the agency feels the individual will eventually be found eligible according to all of the same income limits and rules in place today.

3. Who will benefit from this change?

Individuals applying for Medicaid home and community-based services (HCBS) will benefit because they will no longer need to wait to get the care they need at home. During the recent transition with the Independent Enrollment Broker (Maximus) in April 2016, many seniors were waiting on enrollment for so long that their condition worsened and they passed away.

4. Does this affect the role of the AAA or CAO?

No. Area Agencies on Aging (AAAs) are responsible for determining whether an individual meets the functional criteria for Medicaid HCBS through an in-person assessment. To qualify for Medicaid HCBS, that assessment must show the individual needs the level of care provided by a nursing facility (nursing facility clinically eligible or NFCE). This criterion and this process will not be changed by this bill.

The CAO is responsible for the full review of the applicant's income and assets. With presumptive eligibility in place, the homecare or home health agency will perform an

abbreviated review of the individual's finances, which will follow a procedure outlined by the Department of Human Services, much like nursing homes do today. Then, the application process will continue at the CAO while the homecare or home health agency starts to provide care. This bill does not remove the CAO from this process.

5. Will more individuals be eligible for Medicaid as a result of this bill?

No. Because this bill does not make any changes to the income or asset limits or the functional criteria needed to qualify for Medicaid, it will not result in more individuals being eligible for Medicaid than would otherwise be eligible under current law.

6. How does the transition to managed care with Community HealthChoices (CHC) affect this?

Managed care organizations (MCOs) that are participating in CHC will benefit from the ability to coordinate care at home for individuals that need this care but are waiting for the financial eligibility to be completed. About 64% of the individuals that are included in CHC are considered "Healthy Duals," meaning they qualify for both Medicare and Medicaid but they are not using long-term services and supports right now. They use Medicaid benefits to pay for unreimbursed Medicare expenses. That type of Medicaid coverage has its own unique income and asset rules that are different from the rules that allow someone to receive homecare and home health under Medicaid.

So if an individual encounters a need for homecare or home health, he or she will need to apply for Medicaid HCBS coverage like any other person and wait for months for eligibility to be completed. This group, and the MCOs that pay for their home-based care, will benefit from presumptive eligibility as outlined in this bill because any delay in receiving home-based care could result in a nursing home admission, which is quite costly.

7. What costs, if any, are associated with this change?

The bill does not call for any appropriations. To the contrary, it is likely to save the Commonwealth money in terms of Medicaid spending as more individuals will have access to care at home while they wait for eligibility to be completed instead of only having access to more expensive nursing home care while they wait.

In addition, this bill does not call for payment to homecare and home health agencies up front and the associated risk that the Commonwealth will need to recoup those funds if an individual is eventually found ineligible. The bill has been designed to place full risk on the provider that Medicaid might not cover the cost of care provided up front if the presumption of eligibility is incorrect and the individual is not truly eligible.

8. Who takes on the risk if an individual is actually not eligible but has already received care?

The bill has been designed to place full risk on the provider that Medicaid might not cover the cost of care provided up front if the presumption of eligibility is incorrect and the individual is not truly eligible. Some agencies will not be able to take on this risk, given the slim profit margins of Medicaid waiver providers, which is why the bill allows agencies to volunteer to participate in the presumptive eligibility program. It is not mandatory for all homecare and home health providers to make presumptive eligibility determinations.

9. Will the care recipient ever be penalized for receiving care before financial eligibility is established?

The bill gives homecare and home health agencies the authority to bill the individual for the cost of care provided during the presumption of eligibility only if that presumption turns out to be incorrect based on fraudulent information the applicant provided to the agency.

10. What other groups are likely to support this?

Senior consumer groups, AAAs, advocates for individuals with disabilities

11. Is there any opposition?

Because the bill has been structured to create voluntary participation in the presumptive eligibility program, there is no opposition from homecare or home health providers. With no changes to the income and asset rules, there is no additional cost.

It is important to note that presumptive eligibility as outlined in this legislation is different from the Community First Choice program that was piloted previously in the Commonwealth, because it called for upfront payments to providers during the period of presumed eligibility.