



## JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

### ISSUE BRIEF

# Medicaid's Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today

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Eric Carlson, Directing Attorney

## EXECUTIVE SUMMARY

As a practical matter, federal policy allows Medicaid coverage to start from the first day for nursing facility care, but not for Home and Community-Based Services (HCBS). As a result, persons needing immediate help often have no choice but to move into a nursing facility.

Too frequently, a forced nursing facility admission has devastating and long-lasting consequences. Low-income persons find themselves essentially trapped, unable to arrange for the housing and services necessary to move out of the nursing facility and back into the community. The unwanted nursing facility stay harms both the person and the state Medicaid program, which pays unnecessarily for expensive nursing facility care.

The underlying problem is federal policy that prohibits Medicaid programs from covering HCBS provided prior to the approval date of an HCBS service plan. This counterproductive policy could be addressed legislatively. A small change to federal law could allow HCBS services to be covered retroactively—the same way that coverage for many types of health care is approved after care has been provided. With this change, a person needing immediate assistance would be able to fairly choose between HCBS and nursing facility care, rather than being forced into a nursing facility by lack of an alternative.

# CURRENT FEDERAL POLICY

In general, Medicaid allows services to be covered up to three months prior to the month in which Medicaid coverage is requested, for any month in which the person met eligibility standards.<sup>1</sup> As a result, a person can enter a nursing facility in September and not file a Medicaid application until December, but still receive Medicaid coverage beginning retroactively in September. Or, in a more common type of fact pattern, a person can enter a nursing facility, apply for Medicaid that same month, and ultimately have coverage be granted effective back to the first day in the nursing facility, even if the Medicaid application is not approved until weeks or months later.

The federal Centers for Medicare & Medicaid Services (CMS), however, excludes Home and Community-Based Services from these procedures. CMS guidance for HCBS waivers forbids any retroactive coverage of HCBS, and states that HCBS will not be covered for any date preceding the date on which a Medicaid HCBS service plan is approved.<sup>2</sup> This policy was recently challenged by Medicaid beneficiaries but the challenge was rejected by the federal Sixth Circuit Court of Appeals.<sup>3</sup>

Nursing facility services and HCBS are different mechanisms for providing long-term services and supports (LTSS), but the policy discrepancy between the two is glaring. Recall that nursing facility coverage can begin on the first day of services, even if the Medicaid application is not approved until weeks or months later. If, by contrast, the same person chose HCBS instead of nursing facility services, Medicaid coverage could not be effective until weeks or months later.

As a practical matter, the consequences of this policy discrepancy are clear: many low-income persons are forced to move into nursing facilities. They need services immediately, but the Medicaid program will provide coverage only for nursing facility services and not HCBS. In sum: Medicaid beneficiaries are forced into nursing facilities, and Medicaid programs pay unnecessarily for expensive nursing facility care.

## A REAL-WORLD EXAMPLE

Because life and health can be unpredictable, no one knows precisely when they might first need long-term services and supports. Broken bones, strokes, falls, infections—all of these can occur without warning, leaving someone with precious little time to set up necessary services. Furthermore, a person generally cannot apply in advance for Medicaid coverage of long-term services and supports, since needing LTSS is one criterion for coverage.

To illustrate a typical situation, assume Sonia is an 80-year-old woman living alone with a limited income. Her health care coverage is provided by Medicare, which does not cover HCBS and covers nursing facility care only on a restricted, time-limited basis. Her finances are within Medicaid eligibility limits for LTSS coverage but she hasn't applied to this point, since she hasn't needed that type of care.

One day, however, Sonia suffers a stroke. She is hospitalized and then, following a week of hospitalization, is told that she will be discharged the following day. Although she is now out of immediate danger, she remains in a much weakened condition, needing significant everyday assistance with bathing, dressing, walking, and other routine activities. Also, because of her fragile medical condition, she should not be alone for days at a time, as was the case prior to the stroke.

If Sonia could self-fund LTSS, she would have two choices: either return home with HCBS, or move to a nursing facility. But because she must rely on Medicaid, she effectively is forced to move to a nursing facility. Assume that

she applies for Medicaid coverage the same week that she leaves the hospital. Even if the Medicaid program does not issue an approval until weeks or months later, the nursing facility can receive Medicaid payment back to her first day in the facility (and might also be able to bill Medicare for the initial days or weeks).<sup>4</sup> For HCBS, however, Medicaid coverage for at-home services cannot start for weeks or months later, with the exact date depending on the state's procedures. These types of delays are common across the country. See the Appendix for examples from four specific states.

## FEDERAL LEGISLATIVE SOLUTION

### Legislative Language

Due to federal law and to the many delays endemic in Medicaid LTSS applications, low-income persons across the country are denied HCBS and forced into nursing facilities or, alternatively, left to struggle at home without necessary assistance.

As discussed above, federal Medicaid law allows services to be covered up to three months prior to the month in which a Medicaid application is filed for any month in which the person met eligibility standards.<sup>5</sup> To apply this same principle to Medicaid HCBS, the relevant statute could be revised to specify that approval of an HCBS plan of care can be applied retroactively. The following language could be added at the end of Section 1902(a)(34) of the Social Security Act (42 U.S.C. § 1396a(a)(34)):

If care or services are provided through a plan of care or any similar document, including but not limited to services provided under the authority of any provision of 42 U.S.C. §§ 1315 or 1396n, medical assistance must be available pursuant to this subsection without regard to whether the plan of care or similar document was developed or approved before or after the care or services were provided.

If this language were enacted, Medicaid providers would be willing to provide HCBS immediately, since they would know that they could be reimbursed subsequently. As a result, low-income older adults like Sonia could make reasoned decisions to utilize HCBS, rather than being forced into a nursing facility by the lack of an alternative.

### Implementing the Legislative Language

The proposed legislative change would bring Medicaid HCBS procedures into alignment with common health care reimbursement processes. As a practical matter, health care providers routinely treat the patient first and then submit a claim for reimbursement. The insurer—whether a private insurer, Medicare, or Medicaid—provides payment as long as the treatment meets pre-existing standards. And, because providers become familiar with those standards, they are willing to provide care prior to receiving payment.

This is true even in instances when the patient is not yet enrolled for Medicaid coverage of long-term services and supports. In these situations, even though the patient has not yet applied for Medicaid, nursing facilities routinely admit them based on the expectation that Medicaid will first grant eligibility and then approve payment for nursing facility care retroactively.

If the legislative language were enacted, HCBS providers could provide and bill for treatment in the same way—providing care when it is needed, and receiving payment subsequently. Notably, payment is made only when the Medicaid program has determined both that the person is eligible and the services are necessary and appropriate.

The financial risk is borne by the provider and the patient, each of whom is willing to accept the risk in order to access and provide necessary care.

## CONCLUSION

Medicaid beneficiaries should be able to fairly choose between HCBS and nursing facility care, rather than being forced into nursing facilities by lack of an alternative. To accomplish this, federal law could be changed to allow HCBS to be provided promptly and then approved for payment subsequently.

## APPENDIX

### State Examples: HCBS Approval Processes Can Be Lengthy

As mentioned above, the exact nature of the HCBS-delay problem varies from state to state, depending on how the state evaluates and approves Medicaid HCBS applications. Each of these state-specific discussions generally follows the example above: Sonia requiring ongoing assistance after a stroke and a week-long hospitalization.

For each of these examples, remember: in general, under current federal policy, HCBS coverage cannot start until the date on which a service plan is approved. If HCBS service plan approval requires weeks or months, those are weeks and months during which the applicant can receive nursing facility services but not HCBS.

#### NEW HAMPSHIRE

In New Hampshire, the Choices For Independence (CFI) program provides HCBS for adults whose needs would qualify them for nursing facility care. A CFI information sheet from the state advises applicants that “it can take up to 45 days for the application materials to be processed once the application and supporting documentation has been submitted.”<sup>6</sup> Forty-five days is lengthy enough—although advocates report that the complete process frequently requires several months.

After applying for CFI, Sonia would meet with a financial eligibility worker, and a nurse would assess her condition and care needs. Additional delay occurs from data entry protocols: if and when the nurse finds that Sonia’s condition meets medical criteria, the eligibility date is not the date of the assessment, but rather the date on which the determination is entered into the eligibility system.

Once Sonia is found eligible, the case management agency is chosen, and then a case manager develops a service plan through a specified planning process.<sup>7</sup> When that plan is completed, the case manager requests state authorization for the services designated by the service plan, to be provided by service providers selected by Sonia.<sup>8</sup> Finally, upon review of the assessment and the service plan, the state authorizes services.<sup>9</sup>

New Hampshire enacted a presumptive eligibility process in 2008, but the law has never been truly implemented and is currently suspended through June 30, 2023.<sup>10</sup> (Under presumptive eligibility, coverage is provided up-front, but is subject to revocation if the applicant subsequently is found financially or clinically ineligible.)

## TENNESSEE

In Tennessee, the CHOICES Program provides HCBS through managed care organizations. As is true in any state, Sonia must meet clinical and financial eligibility standards.<sup>11</sup>

Application and enrollment processes require collaboration between TennCare (the state Medicaid program), a local Area Agency on Aging and Disability (AAAD), and participating managed care organizations. If a person applies through an AAAD, the AAAD performs a level-of-care assessment and then submits the assessment and Medicaid application to TennCare.<sup>12</sup>

Applications should be under review by TennCare within ten days.<sup>13</sup> Within TennCare, the Long-Term Services and Supports (LTSS) Unit determines if Sonia's level-of-care needs are sufficiently high, while the Member Services Unit, through a private contractor, evaluates her financial eligibility.<sup>14</sup> Enrollment only occurs after she has been found eligible both clinically and financially.<sup>15</sup> Once all enrollment criteria have been met, TennCare enters Sonia into a county queue through the Tennessee Pre-Admission Evaluation System (TPAES).<sup>16</sup>

The Tennessee manual explicitly describes how enrollment dates vary depending on the type of LTSS. HCBS coverage cannot begin until the date on which the case is authorized in the eligibility determination system, while nursing facility coverage can begin when the person applies for coverage or moves into the nursing facility, whichever is later.<sup>17</sup>

## VIRGINIA

In Virginia, Sonia must apply for Medicaid and also request a level-of-care screening from the Virginia Department of Social Services (DSS). The screening is performed by staff from Sonia's hospital, but would be performed by a team designated by Virginia DSS if Sonia instead were living in the community. In either case, the screening must be completed within 30 days—although advocates report that sometimes this deadline is not met.<sup>18</sup>

If Sonia is found to be eligible, she is asked whether she would like to receive LTSS in the community (at home, for example) or in a nursing facility. If Sonia chooses HCBS, she then is given the further choice between having those services provided by a home care agency, or coordinated by Sonia herself through consumer-directed services. Finally, a care plan is developed to determine the exact services to be provided and covered.<sup>19</sup>

## PENNSYLVANIA

In 2019, the Commonwealth issued a Request for Information to solicit suggestions on how to improve its Medicaid LTSS application and enrollment process, acknowledging that the "current process used to determine if an individual is eligible to enroll in an OLTL [Office of Long-Term Living] LTSS Program is multi-stepped and complex."<sup>20</sup> In the current system, applicants must deal with three different entities: the Independent Enrollment Broker, the Independent Assessment Entity, and the County Assistance Office. A decision does not have to be issued until 90 days after the date of application.<sup>21</sup>

In Sonia's case, she likely would be referred to the enrollment broker to start the process. The enrollment broker could counsel her regarding her options and provide initial advice and assistance with a Medicaid application. From that point, the enrollment broker facilitates a clinical eligibility determination by requesting a level of care certification from Sonia's physician and an assessment

from the assessment entity, which evaluates Sonia’s condition and care needs through a functional eligibility tool.<sup>22</sup>

If Sonia is found clinically eligible, the enrollment broker informs the county assistance office, which is responsible for determining financial eligibility. Also, the enrollment broker would explain service options to Sonia and assist her in completing enrollment forms. Ultimately, once the enrollment broker confirms that Sonia is both clinically and financially eligible, the enrollment broker formally enrolls her, transfers the file to Sonia’s chosen managed care plan, and sends her a notice of enrollment.<sup>23</sup>

To its credit, the Commonwealth has acknowledged “pain points” within the existing system. Among other things, the system involves two separate vendors—the enrollment broker and the assessment entity—and requires communications between those two entities, the county office, and the applicant’s physician.<sup>24</sup> The Commonwealth’s report specifically notes that the current clinical eligibility process “perpetuates fragmentation in the already complex LTSS eligibility process.”<sup>25</sup>

The Commonwealth’s procedures may change in the near future, based on specifications listed in an August 2020 solicitation for the statewide enrollment broker.<sup>26</sup>

## ENDNOTES

- 1 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a).
- 2 Centers for Medicare & Medicaid Services, Application for a § 1915(c) Home and Community-Based Waiver; Instructions, Technical Guide and Review Criteria, at 52, 73 (Appendix B), 190 (Appendix D-1):  
“Federal financial participation (FFP) may not be claimed for waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual’s service plan. A service plan may not be backdated.” (p. 52)  
“No FFP is available for waiver services prior to the date that the service plan is completed.” (p. 73 (Appendix B)).  
“FFP may be claimed only for those waiver services that are included in the service plan and may not be claimed for services furnished prior to the development of the service or for services not included in the service plan.” (p. 190 (Appendix D-1)).
- 3 See *Price v. Medicaid Director*, 838 F.3d 739 (6th Cir. 2016).
- 4 The Medicare program may be able to pay for nursing facility services if Sonia requires skilled therapy services or intensive nursing services on a daily basis. On average, because of this requirement, the average Medicare-covered stay in a nursing facility lasts for only 28 days. At most, the Medicare program can pay for no more than 100 days of nursing facility care per benefit period, with only the first 20 days paid in full. Days 21 through 100 require a daily co-payment of \$185.50 (in 2021). See 42 C.F.R. §§ 409.30- 409.36, 409.61.
- 5 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a).
- 6 N.H. Dep’t of Health and Human Services, Bureau of Elderly and Adult Services, Choices for Independence (CFI) Case Management Information Sheet, <https://www.dhhs.nh.gov/dcbcs/beas/documents/cfi-case-mgmt-info-sheet.pdf>.
- 7 N.H. Code R. He-E 801.04(d).
- 8 N.H. Code R. He-E 801.05.
- 9 N.H. Code R. He-E 801.06.
- 10 N.H. Rev. Stat. Ann. § 151-E:18 (suspension through June 30, 2021) N.H. H.B. 2-FN-A-LOCAL, p. 7 of introductory material (item #112), p. 187 of bill text (item #410) (extension of suspension through June 30, 2023; bill signed on June 25, 2021).
- 11 Division of TennCare Eligibility Policy Consolidated 130.005, § 1.
- 12 *Id.*, § 4.a.

- 13 *Id.*, § 4.b.iv.4.a.
- 14 *Id.*, § 1.
- 15 *Id.*, § 3.
- 16 *Id.*, § 4.b.iii.4.
- 17 *Id.*, § 5.a.i.
- 18 Va. Code Ann. § 32.1-330.
- 19 The Arc Virginia, CCC Plus Waiver, <https://www.thearcofva.org/ccc-plus-waiver>.
- 20 Penn. Dep't of Human Services, Office of Long-Term Living, Request for Information, at 3, and at 8 (Appendix A, Concept Paper: Improving Application and Enrollment Services for Office of Long-Term Living Long-Term Services and Supports (March 22, 2019).
- 21 Penn. Dep't of Human Services, Office of Long-Term Living, Request for Information, Appendix A, Concept Paper: Improving Application and Enrollment Services for Office of Long-Term Living Long-Term Services and Supports Programs, at 8 (March 22, 2019).
- 22 *Id.* at 9-11.
- 23 *Id.* at 9-11.
- 24 *Id.* at 13-16.
- 25 *Id.* at 14.
- 26 Penn. Bureau of Procurement, RFA 01-19, Application and Enrollment Services for LTSS Programs (Aug. 3, 2020), <http://www.emarketplace.state.pa.us/Solicitations.aspx?SID=RFA%2001-19>.