UNIFIED LONG-TERM CARE SYSTEM ADVISORY WORKGROUP

NURSING FACILITY ELIGIBILITY SUBCOMMITTEE
REPORT TO THE OHIO GENERAL ASSEMBLY

December 30, 2011

In accordance with House Bill 153 (HB 153) of the 129th General Assembly, the Nursing Facility Eligibility Subcommittee of the Unified Long-Term Care System Advisory Workgroup has reviewed the process of making Medicaid eligibility determinations for individuals seeking nursing facility services. Ohio Administrative Code (O.A.C.), §5101:38-01.2 requires the administrative agency to determine if an individual meets the conditions of eligibility within thirty calendar days from the date of application. If information needed to determine eligibility is not submitted with the application, the administrative agency shall provide the applicant or authorized representative with a written checklist that not only includes a list of the information needed, but the deadline to provide it to the administrative agency. If not received by the stated date, the administrative agency shall contact the individual, in writing, no more than twenty days from the date of application. The contact letter shall state that the required verification has not been received, and that if the information or verification is not received within ten days, the administrative agency shall deny the application. While these timelines may be exceeded for good cause, the Subcommittee has found that there are other factors that contribute to the delay in processing a pending Medicaid application for nursing facility services. For example, there are many complex policies that are inconsistently applied from county to county. The Subcommittee finds that the system can benefit from faster and more efficient eligibility determinations that don't take the full thirty days or more to process. Additionally, the Subcommittee recommends that the rules governing timely determinations be clarified, including an evaluation of the consequences of failing to meet required time frames, to improve compliance with the eligibility determination process.

Membership

- Terry Allton, NCR
- Angie Bergefurd, Ohio Department of Mental Health
- Director Bonnie Kantor-Burman, Ohio Department of Aging
- Beverley Laubert, Ohio Long-term Care Ombudsman
- John McCarthy, Ohio Department of Job and Family Services/Office of Ohio Health Plans (ODJFS/OHP) (Subcommittee Chair)
- Greg Moody, Governor's Office of Health Transformation
- Jowanna Lunsford, Academy of Senior Health Sciences
- Christopher Murray, Academy of Senior Health Services, alternate
- Jacqi Bradley, Ohio Association of Area Agencies on Aging
- Debbie Gulley, Ohio Association of Area Agencies on Aging, alternate
- William Sundermeyer, AARP Ohio
- Diane Dietz, Ohio Health Care Association (OHCA)
- Steve Wermuth, Ohio Department of Health

- Joel Potts, Ohio Job and Family Services Directors' Association (OJFSDA)
- Representative Barbara Sears
- Representative Nicki Antonio
- Senator David Burke
- Senator Capri Cafaro

Schedule

Meetings were held:

November 14, 2011
December 5, 2011
December 13, 2011
December 19, 2011

Process

The Subcommittee was chaired by John McCarthy, Medicaid Director. The Subcommittee met and identified that, in addition to compliance with required time frames, the following eligibility policies are either inconsistently applied from county to county or contributing to the delay in processing a Medicaid application for nursing facility services: 1) spousal cases, 2) asset verification, 3) patient liability proration, 4) guardianship issues, 5) nursing facility as authorized representative, 6) hardship and hearings, 7) county transfers, 8) prescription coverage during the pendency of an application, 9) resource assessment fees, and 10) document imaging compatibility county to county.

1. Spousal cases

Spousal cases are difficult to process for eligibility due to the complexity and nature of resources held by applicants/recipients, completion of resource assessments, and the number of budgets necessary to complete.

While assessing resources and transfers, an administrative agency must consider whether transfers are proper. Additionally, the administrative agency must determine whether a married couple is considered as a couple or two individuals, assess resources, create a financial eligibility budget, and determine the countable assets attributable the institutionalized spouse.

2. Asset verification

There are two challenges to asset verification: 1) the complexity of identifying, obtaining, and reviewing the required documents and 2) the time period for which the resources have to be reviewed. O.A.C. §5101:1-38-01.8(D) requires an individual to meet resource and asset requirements for the covered group. Resources mean cash, personal property, and real property an individual and/or the individual's spouse has an ownership interest in, has the legal ability to access in order to convert to cash (if not already cash), and is not legally prohibited from using for support and maintenance. Resources must be verified, and acceptable documentation

includes information maintained by a government entity, information obtained and verified through the electronic eligibility system, financial institution statements, and legal documents.

Eligibility workers must examine trusts, pre-need funeral contracts, bank accounts, mortgages, promissory notes, annuities, stocks, bonds, loan documents, life insurance, life estates, and life leases for a period of five years prior to the date of application, commonly referred to as the "look back period," to determine whether these resource types are countable or exempt. If an improper transfer is detected, the result is restricted Medicaid coverage periods that are spans of time during which Medicaid will not pay for long-term care services.

3. Patient liability proration

Patient liability should only be prorated when a beneficiary is not receiving Medicaid at the time of the long-term care application and enters the facility after the first of the month, or when a beneficiary is discharged to the community without continuing long-term care Medicaid before the end of the month or dies. Patient liability is prorated when an individual is institutionalized for less than a full month, but is not prorated in transfers between long-term facilities.

4. Guardianship issues

In the absence of a guardian, the administrative agency can assist a beneficiary having mental or physical incapacity with obtaining or naming a guardian with the authority to accompany, assist, and represent the individual in the application or redetermination process. Not having a guardian can create barriers to accessing verifications and means of financial support for an applicant.

5. Nursing facility as authorized representative

A nursing facility may serve as an authorized representative. In accordance with O.A.C. §5101:1-38-01.2(E) (2), an authorized representative shares all responsibilities of an individual. An individual who wishes to designate an authorized representative shall, in writing, identify the authorized representative and the duties the authorized representative may perform on the individual's behalf. In the event written authorization cannot be obtained due to the individual's incompetence, the administrative agency shall waive the written statement and assist in naming a responsible party to act as authorized representative for the individual. Some county caseworkers are not familiar with the authority they have to communicate, including, but not limited to, providing a list of missing documentation needed to determine eligibility, with a properly appointed authorized representative.

6. Hardship and hearings

When an individual resides in a long-term care facility, the individual (or facility) may make a request for an undue hardship, provided the individual is in jeopardy of losing the food or shelter due to a planned discharge resulting from the imposition of a restricted Medicaid coverage period. The individual will not be found to be in jeopardy unless all legal remedies and appeals to challenge the discharge are exhausted and all legal remedies to collect, reconvey, or recover the improperly transferred resources are exhausted. The facility is not required to pursue a legal action if it can document the cost of such an action would exceed the gross value of the assets

subject to recovery in a legal action. Recent revisions in HB 153 were intended to relax and clarify these procedures.

7. County transfers

In accordance with O.A.C., the county department of job and family services (CDJFS) in the county of original residence is required to transfer the case in its current status in the electronic eligibility system within five working days of the reported change. The CDJFS in the county of new residence is required to provide the medical assistance benefits for which the individual is eligible and may not require the individual to reapply or cooperate with a redetermination of eligibility merely due to the change in county of residence. Transfers do not always happen in an efficient or timely manner.

8. Prescription coverage during the pendency of an application

Coverage for prescriptions is prohibited until eligibility is determined. Eligibility is not established until all conditions of eligibility are met. If met, the administrative agency is to approve medical assistance beginning on the first day of the month in which the application is received if an individual is found eligible. Coverage may be retroactive to three months prior to month of application though cannot precede Ohio residency.

9. Resource assessment fees

A $50.00 fee is charged if a resource assessment is not accompanied by an application for Medicaid. The assessment can be requested by couples to determine what they must spend down to eventually qualify for Medicaid. The fee is not charged to applicants for Medicaid. The fee, intended to defray administrative costs, may have the unintended effect of incentivizing non-applicants wanting a resource assessment to file an application, increasing the caseload at the counties, to avoid the fee. These fees should be eliminated.

10. Document imaging compatibility county to county

Counties are using incompatible imaging systems for application documents. The Ohio Department of Job and Family Services (ODJFS) was approved for a Food and Nutrition Services grant (similar to what funded our self service efforts) for a statewide workflow and document imaging system. Currently the ODJFS' Office of Family Assistance is putting together an internal team to include Medicaid staff so that ODJFS can begin designing the new system. The rough time line is that user acceptance testing will occur between October 2012 and December 2012 with implementation completed by December 31, 2012.

SHORT-TERM RECOMMENDATIONS

After careful review of the challenges that may contribute to inconsistencies or inefficiencies with eligibility determinations from county to county and identifying other factors that contribute to the delay in processing a pending Medicaid application for nursing facility services, the Subcommittee recommends the following:

1) ODJFS/OHP (Medicaid) will create a training program and policy interpretations for county workers in collaboration with the counties and nursing facility associations in order to clarify the inconsistencies of eligibility determinations and improve efficiencies, as listed above. This training program will take place no later than July 1, 2012;

2) ODJFS/OHP will create a nursing facility eligibility training manual, including desk aids, fact sheets, and budgeting worksheets no later than July 1, 2012;

3) ODJFS/OHP and the OJFSDA will host a statewide mandatory training for county eligibility workers who work with long-term care cases by July 1, 2012;

4) ODJFS/OHP will provide annual training at the OJFSDA Directors' Training Conference;

5) ODJFS/OHP will provide training to individual counties upon request.

6) ODJFS/OHP will publish, by county and on a quarterly basis, the length of time to process long-term care eligibility determinations. ODJFS/OHP will identify outlier counties and follow-up as deemed appropriate; and

7) ODJFS/OHP will provide long -term care eligibility training materials to hospital-based care coordination teams.

LONG-TERM RECOMMENDATIONS

The Nursing Facility Eligibility Subcommittee recommends the Unified Long-Term Care System Advisory Workgroup conduct an annual review of the short term recommendations. If the short-term recommendations do not reduce the time it takes to properly determine Medicaid eligibility for someone in a nursing facility in a year from when this report is delivered to the Legislature, the following long-term recommendations are offered. Additional authority through changes to Ohio law will be needed to implement these long-term recommendations:

1. Facility Assistance with Determinations through Improved Eligibility Portal

An improved Medicaid eligibility system, from the current Client Registry Information System Enhanced (CRIS-E), is a comprehensive undertaking which will involve many stakeholders and providers outside the skilled nursing profession. It is not an undertaking that can be done in the short-term. However, a new Medicaid eligibility system should be pursued that would allow nursing facilities to contribute to, but not control in any way, the eligibility determination process. The new eligibility system should provide:

- A portal for nursing facilities to review at what point the eligibility application is in the eligibility process,
- The ability for the nursing facility to communicate directly with the caseworker, and

- The ability to upload important documents that family members could provide more readily at the nursing facility location, as opposed to the county office.

Improved technology has afforded many states the ability to achieve efficiencies in the eligibility determination process while greatly improving communication between all parties involved. Technology also allows various parties, including beneficiary families, to safely and securely contribute to the eligibility determination process. These changes would be a great time and personnel/resource saver for both the State and the counties.

2. Upon Admission to Hospital, Care Coordination Teams Shall Identify Individuals Likely to Pursue Long-Term Care Options and Initiate the Discharge Planning Process

To assist with the determination of eligibility, it is recommended that upon hospital admission, care coordination teams identify individuals likely to pursue long-term options and aid the individual and hospital with discharge planning. The care coordination team may include, but is not limited to: the individual, family member(s), hospital social worker, the attending physician, Area Agencies on Aging, CDJFS eligibility worker, and the Admissions Office of the long-term care facility. The primary focus of the coordination team is to work collaboratively to obtain and submit all documentation and signatures required by the administrative agency to determine eligibility and the appropriate care setting. This will reduce delays in processing applications after discharge and at the time of nursing facility admission.

3. Presumptive Eligibility for Nursing Facility Residents

In those instances where all of the following apply, the recommendation is to continue to work toward implementation of presumptive eligibility for nursing homes similar to what has been implemented in the PASSPORT program by examining the financial (impact on budget), systems (technology), and Ohio law changes needed . If it is practicable, presumptive eligibility could be provided under all of the following circumstances:

A. The beneficiary has an application for the Medicaid-funded component pending, and;

B. The department or the department's designee has preliminarily determined that the individual meets the nonfinancial eligibility requirements, and:

C. The department or the department's designee has no reason to doubt that the individual meets the financial eligibility requirements.

Presumptive eligibility offers an objective and fair framework to allow for payment to begin sooner for the Medicaid provider who begins rendering care and incurring expenses serving Ohio Medicaid beneficiaries. A survey is underway at the Ohio Health Care Association (OHCA) to identify the impact of the pending Medicaid eligibility determination process. The survey will also ask facilities for the number of pending Medicaid beneficiaries they have served over a set period of time who never became eligible, leaving the facility with uncompensated care. Anecdotal information indicates that number is relatively small, and many of those cases involve

circumstances by which the family did not comply with providing documentation for a timely determination, the case remained open, the pending beneficiary expired, and collecting payment from the family became virtually impossible.

OHCA indicated that if the State would implement presumptive eligibility, nursing facilities would bear some of the financial risk in the event the presumed eligible beneficiary did not become eligible. Specifically, OHCA proposed providers would reimburse the federal share of the stay in the event timeframes and new rules governing family cooperation are implemented as noted above.