NYAHSA | New York Association of Homes & Services for the Aging

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M E M O R A N D U M

TO: RHCF and Community Services Providers

FROM: Patrick Cucinelli, Senior Financial Policy Analyst

DATE: January 28, 2009

SUBJECT: **Medicaid Presumptive Eligibility**

ROUTE TO: Administrator, CFO

ABSTRACT: DOH advises providers on use of Medicaid presumptive eligibility.

Introduction

NYAHSA continues to have discussions with the Department of Health (DOH) regarding the issue of Medicaid eligibility determinations. Specifically, NYAHSA is concerned with the delays in the processing of Medicaid applications in various regions of the state.

Survey Results and DOH Meeting

In a January 21, 2009 meeting with DOH, NYAHSA and NYSHFA presented data from a recent member survey. Out of a sample of 200 agencies responding to the joint survey, a total of $93 million in Medicaid pending accounts receivable was reported with an average of $467,250 per facility. Estimated average processing time for an application ranged from a low of 0.9 months to a high of 11 months, a strong indication of the inconsistency and variability in Medicaid eligibility processing across the local departments of social services (LDSSs) in the state. These results are consistent with the same survey conducted in May of 2008, and continue to demonstrate a serious problem in many areas of the state.

DOH reported on their efforts to deal with the issue, which include increased monitoring of the performance of the LDSSs and targeted training and surveillance of problem areas. NYAHSA emphasized that this remains a serious cash flow problem for providers, and both associations expressed willingness to continue to work with DOH on addressing the issue.

Presumptive Eligibility an Option?

DOH also questioned why providers were not taking greater advantage of Medicaid's presumptive Medicaid eligibility provision. First issued in May of 1997, this provision allows nursing homes, home care agencies, and hospice providers to receive interim payments while a Medicaid application is in process. DOH records indicate that the providers are not utilizing the option, and in the case of nursing homes they have no record of any presumptive eligibility payment ever being made. The details on the provision are found in DOH administrative directive # 97-ADM-10 and can be accessed by going to: http://www.health.state.ny.us/health_care/medicaid/publications/pub1997adm.htm.

According to the administrative guidance:

> *An individual will be determined to be presumptively eligible for Medicaid if the following conditions exist:*
>
> *a. The applicant is receiving care in an acute care hospital at the time of application.*
>
> ***b.** A physician certifies that the applicant no longer requires acute hospital care, but requires the type of medical care provided by a Certified Home Health Agency (CHHA), Long Term Home Health Care Program (LTHHCP), nursing facility, or hospice.*
>
> ***c.** The applicant or his or her representative states that there is insufficient insurance coverage for this type of care and that the applicant would not otherwise be able to pay for the type of care required.*
>
> ***d.** It reasonably appears that 65 percent of the cost of care provided by the CHHA, LTHHCP, nursing facility, or hospice would be less than the cost of continued hospital care computed at the Medicaid rates.*
>
> ***e.** The applicant reasonably appears to meet all the criteria, financial and non-financial, for Medicaid. The Screening Checklist (Attachment I) has been developed for social services districts to use to eliminate those cases from the presumptive eligibility process which require in depth reviews to determine eligibility.*
>
> *The period of presumptive eligibility will begin on the date of discharge from the hospital and continue for sixty days or until the standard eligibility determination is completed, whichever is earlier.*
>
> *Nursing home care, hospice services and services provided by the CHHA or the LTHHCP during a period of presumptive Medicaid eligibility will be reimbursed initially at 65 percent of the Medicaid rate after maximization of any third party health insurance coverage. Medicaid will not reimburse providers if the social services district does not accept the individual as presumptively eligible for Medicaid.*

DOH clarified that the 65 percent payment available under presumptive eligibility is made using a separate rate code and the remainder of the payment is made once eligibility is finally

established. They also noted that in the case of a rejected application there is no recoupment of the payments made under presumptive eligibility.

Member Input Requested

DOH has asked NYAHSA to redistribute this information to our members in order to: 1.) offer an option to those facilities/agencies that are suffering from cash flow problems related to delays in Medicaid eligibility determinations; and 2.) help determine if the provision needs to be revised in order to make it more useful to providers.

It is unclear to DOH why providers are not taking full advantage of this option. The requirement that the presumptive eligibility application must be started in the hospital and that Medicare coverage may trigger the restriction that the applicant cannot have other insurance coverage may make presumptive eligibility inapplicable for most new admissions. Also, the threshold used by some LDSSs for determining a "clean application" for presumptive eligibility purposes may be such that it makes the procedure either unworkable or redundant with the normal processing of the application.

DOH has expressed their willingness to re-visit the provision, especially in light of the current problem with Medicaid eligibility determinations. NYAHSA is asking members to review the presumptive eligibility provision and share any recommendations they may have. It would also be especially useful if members could share any actual experience, both good and bad, with trying to obtain presumptive eligibility determinations. Please share your input by contacting me at pcucinelli@nyahsa.org or call 518-449-2707 ext. 145.

Additional Note

Please keep in mind that this 60-day presumptive eligibility provision is different from the 29-day resource attestation provision available to cover short-term rehabilitation for those applicants/recipients who are not seeking Medicaid long-term care coverage. Details on the 29-day short-term rehab presumptive eligibility provision under Medicaid are available in DOH Administrative Directive # 04 OMM/ADM 6 and can be accessed by going to: http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/04adm-6.pdf.

Please contact me with any additional questions. NYAHSA is also interested in continuing to hear from members on their Medicaid eligibility problems, as this is an issue that we are continuing to address with state policymakers.