

Supplement: Early Findings on the Impact of Waiver Reforms to Streamline Medicaid Eligibility Processes

Introduction

In this supplement to the draft interim evaluation report, we examine the reforms under the Medicaid Comprehensive Waiver intended to streamline eligibility processes for new applicants and existing beneficiaries in need of long-term care services. The following evaluation hypothesis and research questions in the waiver Special Terms and Conditions document (CMS 2014) are addressed:

Hypothesis 3: “Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.”

Research Question 3a: “What is the impact of the projected spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?”

Research Question 3b: “What is the impact of eliminating the transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100% of the FPL? Was there a change in the number of individuals or in the mix of individuals qualifying for Medicaid due to this provision?”

To evaluate these reforms we draw on statistics from administrative records provided to us by State officials or available in public reports and presentations. We also rely on audit data collected by the State’s Bureau of Quality Control (BQC) and contextual information on the audit process and findings from direct communications with State officials. Although only limited data are available at the time of this interim evaluation, the final evaluation report due in 2017 will build upon the findings presented in this supplement.

Background

Transfer of Assets Self-Attestation

Medicaid eligibility for long-term care services requires that applicants have not transferred any assets or resources for less than fair market value during the five years preceding their date of application. Applicants are often required to furnish bank statements and financial documents proving compliance with this requirement before eligibility can be granted. If a transfer of assets did occur then a penalty period is imposed delaying eligibility for long-term care services.

Under the Waiver, individuals with income at or below 100% of the Federal Poverty Level (FPL) applying for institutional or home and community-based services are permitted to self-attest that they have made no disqualifying asset transfers during the past five years. This attestation is a sworn statement documented on an addendum to the Medicaid application used by County Welfare Agencies for new entrants, or collected during the financial eligibility determination conducted by Managed Care Organizations for existing beneficiaries moving into Managed Long-term Services and Supports (MLTSS) after July 1, 2014. This form, which was approved for use in December 2012, eliminates the need for the time intensive five-year lookback process, and was intended to expedite eligibility approvals for very low-income applicants.

Qualified Income Trusts

The adoption of Qualified Income Trusts (QITs) in December 2014 fulfills the intent of the hypothetical spend-down provision for individuals having a nursing facility level-of-care which was originally proposed in the Waiver. QITs allow clinically eligible individuals whose monthly income is above 300% of the Supplemental Security Income rate (recently \$2,199) to spend down their resources on long-term supports and services (delivered in their homes/communities or in a nursing facility) to become eligible for Medicaid. Income above the threshold is deposited in a separate bank account which is used for cost-sharing expenses. Prior to the Waiver, spend-down for higher income applicants was only available for nursing facility residents (a medically needy designation), which may have led people who could not afford to pay the full cost of care delivered as home and community-based services (HCBS) to choose nursing facilities at a higher cost to the state. QITs effectively create a new eligibility pathway for long-term care services in home and community settings.

Methods

Data Sources

In this section, we use statistics collected by the State for public- and CMS-reporting purposes as well as data collected by the Bureau of Quality Control specifically for evaluation of the self-attestation policy. We also use Medicaid fee-for-service (FFS) claims and managed care encounter data for January 1, 2011 through December 31, 2014.

Measures

Drawing from quarterly reports from DMAHS to CMS, we present counts of self-attestation forms received by the State. Using data from the Department of Human Services' response to the Office of Legislative Services on the budget (state fiscal year 2016-2017), we present here the count of applicants using QITs. We also present trends in settings of care (HCBS v Nursing Facility) for long-term care beneficiaries calculated from Medicaid claims data. Finally, we report the error rate and average time to approval for applications with self-attestations resulting from the BQC's review process.

Quality Control Review of Transfer of Assets Self-Attestation

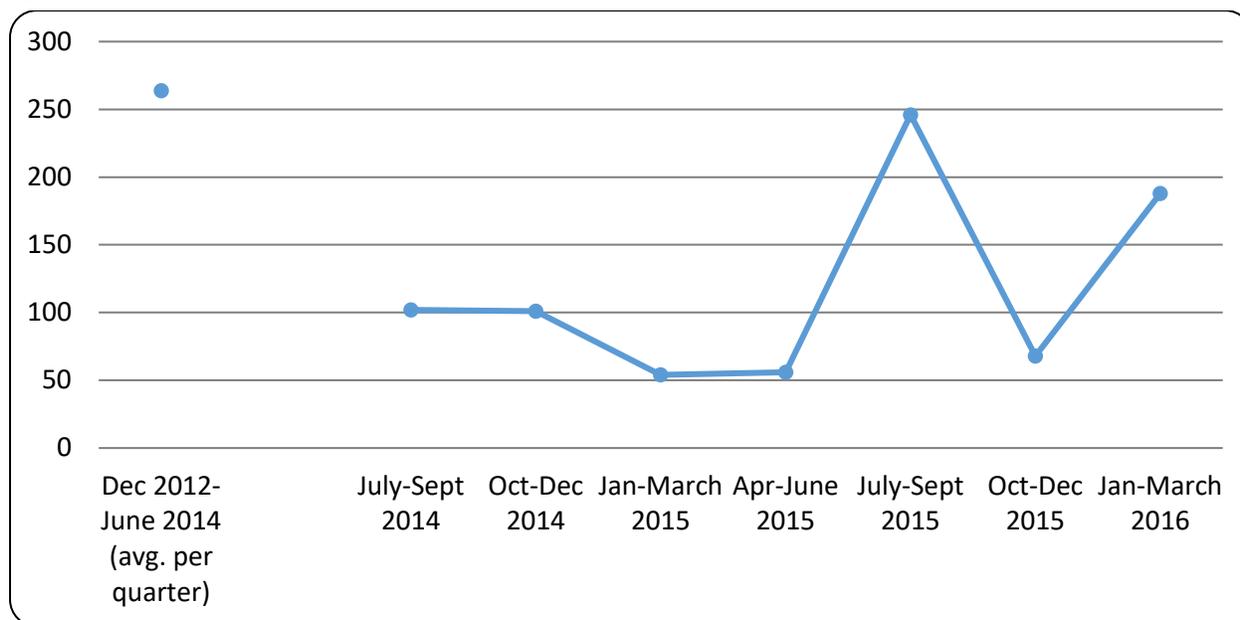
In July through September 2015, the BQC piloted a review protocol to measure the accuracy and effectiveness of the transfer of assets self-attestation procedure. Completed self-attestations provided to BQC each quarter from the Office of Eligibility were sampled for detailed review. First a random sample of 30 forms from each batch was selected, and then 8 of the 30 were randomly selected. The applicants on these 8 forms were then contacted and underwent an audit process. In this process, a representative sample of financial documents (i.e. information on bank accounts, properties, investments, and any other resource or asset) was requested for up to five years prior to the time of application in order to determine whether any assets had been transferred for less than fair market value. Any finding on the sample of 8 would trigger a review of all 30 of the sampled cases. The error rate was calculated as the percentage of all reviewed cases having a positive finding, meaning a transfer penalty would have been imposed under a pre-waiver financial eligibility determination.

At our request, BQC is adding to their protocol a procedure for determining the average time from application to approval in each quarter for all cases reviewed in the audit process. Since this information routes through CWAs and MCOs, depending on the application pathway, it is more challenging to implement in a standardized way and is therefore, not yet available for this interim report.

Results

Figure S.1 shows the number of self-attestations collected during each quarter after MLTSS implementation in July 2014. Prior to MLTSS, 1,670 self-attestations were collected from CWAs and this is presented as an average per quarter on the chart.

Figure S.1: Quarterly number of self-attestation forms received from Medicaid long-term care applicants, December 2012 to March 2016



Source: DMAHS, Quarterly reports to CMS

During fiscal year 2015,¹ 544 QIT applications were approved out of the 1,800 received (30%) (DHS 2016, p.23). Table S.1 shows the number of Medicaid Only beneficiaries with QITs in different settings from December 2014 until March 1, 2016. During that period, there were 1,054 QIT users, of whom 72% were in nursing facilities, 21% were in Assisted Living (considered a community setting) and 7% were living at home.

Table S.1: Cumulative amount of individuals eligible for Medicaid Only using a QIT from December 1, 2014 to March 1, 2016

Setting	Number	Percent
Nursing Facility	763	72%
Assisted Living	218	21%
Living at Home	73	7%
Total	1054	100%

Source: Department of Human Services response to Office of Legislative Services, State Fiscal Year 2016-2017

¹ July 1, 2014 through June 30, 2015 (QIT applications were accepted beginning December 1, 2014).

Table S.2 shows the number of long-term care (LTC) designated² recipients receiving services in nursing facilities or in their homes and communities (which includes assisted living) from 2011-2014. It also shows the percentage of all designated long-term care beneficiaries in an HCBS setting. This percentage increases after the Waiver was approved (2013-2014) compared to the baseline period (2011-2012). While our analysis of Medicaid claims data for the interim evaluation did not extend beyond 2014, data from secondary sources presented in Figure 1, Chapter 2 (p.25) of our draft interim evaluation report shows a continuing increase in the percentage of LTC beneficiaries receiving HCBS from July 2014-January 2016.

Table S.2: New Jersey long-term care population by setting of care, 2011-2014

	2011		2012		2013		2014	
	Total	%	Total	%	Total	%	Total	%
Long-Term Care Beneficiaries	49,912	100.0%	49,534	100.0%	49,337	100.0%	47,721	100.0%
Nursing Facility	37,009	74.1%	36,011	72.7%	35,384	71.7%	34,373	72.0%
HCBS	12,903	25.9%	13,523	27.3%	13,953	28.3%	13,348	28.0%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2014; Analysis by Rutgers Center for State Health Policy

Note: HCBS=Home and Community-Based Services

Table S.3 shows results of BQC’s self-attestation review process for two recent quarters. The error rate on the eight sampled applicants in each quarter was 0%. Data on timing to approval is still pending as of the writing of this supplement.

Table S.3: Error rate and time to approval from quality control review of self-attestation forms

Quarter	Self-attestations received	Number reviewed	Error rate	Time from application to approval
Oct-Dec 2015	67	8	0%	*
Jan-March 2016	183	8	0%	*
April-June 2016	*	*	*	*

Source: DMAHS, Communication from Bureau of Quality Control shared in October 2016

*data being collected, but unavailable for this report

Discussion

This supplemental section presents findings to date on the administrative simplifications approved under the Waiver and designed to ease the application and approval process for existing beneficiaries and new applicants in need of an institutional level of care. These new

² See Chapter 3 (pp.69 & 177) for definition of the long-term care assignment algorithm used in analysis of Medicaid claims data.

processes are being used and monitored, and they very likely have expanded and streamlined the eligibility process for a number of Medicaid applicants. As of March 2016, the availability of QITs has allowed nearly 300 new applicants to qualify for Medicaid home and community-based services who would have otherwise been ineligible at their current income level. With regards to self-attestation for transfer of assets, a 0% error rate on audited cases is promising evidence that the often burdensome five year lookback process can be safely eliminated for many low-income applicants.

Whether these new processes are being used uniformly and equitably is not yet clear. The BQC has noted that, although all CWAs have been provided with the self-attestation form, the counties drawn in the early samples were not representative of the distribution of the Medicaid population in the state, suggesting that some counties may not be regularly using the form. This would mean some applicants who should get the benefit of self-attestation may not be, depending on county-specific practices. The small sample of reviewed cases and uncertainty around its uniform use also mean the error rate may not be representative of the statewide error rate. With regard to QITs, stakeholders have expressed concerns about access to legal assistance for consumers with limited financial or social resources at a disadvantage for drawing up the trust documents and designating a representative to administer the trust over time.

The existence of these new avenues into the Medicaid long-term care system, particularly the establishment of QITs, has the potential to impact the number and mix of individuals in the MLTSS program. While self-attestation could potentially increase the number of eligible beneficiaries by streamlining the process, establishment of QITs would potentially increase the share of beneficiaries in the community. This motivates our examination of the percentage of long-term care beneficiaries receiving HCBS. This shift does appear to be taking place, although we cannot directly attribute it to these administrative changes implemented under the Waiver. We will continue to monitor the number and mix of individuals for our final report, examining changes in the share of beneficiaries requiring a nursing facility level of care being served in their homes and communities.

References

CMS (Centers for Medicare & Medicaid Services). 2014. *Technical Corrections to the New Jersey Comprehensive Waiver Section 1115 of the Social Security Act (the Act) Demonstration (Project No. 11-W-00279/2)*. Baltimore: CMS. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-ca.pdf>.

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