GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance
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Department of Health Care Finance Informational Bulletin

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SUBJECT: **LTC Eligibility Transitions**

This bulletin provides routine updates pertinent to the Medicaid long-term care system in the District, as well as providing an important update to the process of updating individuals' Medicaid eligibility when moving between long-term care programs.

Changing eligibility for individuals moving between long-term care programs

With the launch of new programs like PACE during the public health emergency (PHE), as well as increasing capacity for community-based care through newly enrolled Medicaid assisted living facilities (ALFs), DHCF is aware of increasing process challenges in certain cases when District residents transition from one long-term care program to another (e.g., from a nursing facility to an EPD Waiver ALF placement, or from the Waiver to PACE). DHCF, as the District's Medicaid agency, is strongly committed to a long-term care system that promotes beneficiary choice and facilitates high-quality, person-centered care in the least restrictive setting. As a result, DHCF is reissuing the 1346 "Request for Action" form used to process eligibility transitions to, from, and between long-term care Medicaid programs to ensure such care transitions are processed as expeditiously and effectively as possible.

Basic information about the 1346 "Request for Action" form

The 1346 must be completed for the following, along with a Medicaid application if applicable:

- Initial admissions to nursing facilities
- Initial admissions to PACE
- Transfers from nursing facilities to community
- Transfers between facilities
- Transfers between waiver programs
- Discharges from nursing facilities
- Discharges from the Medicaid program

The 1346 is completed by:

- A nursing facility, for initial admissions to nursing facilities, transfers between facilities, transfers between nursing facilities and the community, and discharges from nursing facilities (including deaths)

- The PACE Organization, for initial admissions to PACE, transfers from PACE to other programs, or discharges from PACE
- Case managers or care managers, for discharges from programs or Medicaid (e.g. disenrollment from the EPD Waiver)
- DHCF or its designee, in certain circumstances where delays in 1346 processing pose unreasonable risk to care delivery for a beneficiary

All sections of the form must be completed, including with applicable dates and signatures. Section 2 of the 1346 is completed by the eligibility processing team at DHCF. Nursing facilities receive a completed version of the 1346 after admissions.

When should the 1346 be submitted?

- The 1346 should be submitted as soon as possible for admissions and transfers and accompanied by any applicable application documents (refer to the Quick Reference Guide to ensure appropriate documents are included).
- At latest within 24 hours of a discharge; DHCF accepts and encourages 1346 forms submitted in advance of transfers between programs to ensure safe and effective care transitions.

Changes to the form

The new version of the form includes only one new field: *application filing date*. For cases transitioning between long-term care programs – that is, for a person currently covered by Medicaid long-term care programs, moving to another Medicaid long-term care program – care transitions can be improved by processing the application in advance. The 1346 may be submitted in advance of a change (for example, a discharge from a nursing facility) and the submitted can include both the date the application is submitted (e.g., January 15) and the date of the planned transition (discharge date of February 15).

The *application filing date* field does not have to be completed for 1346 forms *not* related to eligibility transitions (e.g., a discharge due to death, a transfer between nursing facilities, or a discharge from the Medicaid program). If the *application filing date* field is left blank, the DHCF Medicaid Branch, which processes all Medicaid long-term care application documents, will process the request according to the discharge date only.

If a person is not transitioning between long-term care programs, or the 1346 is submitted after discharge, the *application filing date* field may be left blank.

Finally, DHCF is implementing one additional process change outside the form; in the event a 1346 cannot be obtained on a timely basis from partners / providers, DHCF or its agent will complete the form on behalf of the beneficiary. Such forms will be tracked and shared with applicable partners. DHCF expects to take such action only when obtaining the 1346 is the essential and missing piece to a safe transition between services.

Helpful links:

- Current 1346
- LTCA-relevant forms, including information about eligibility processing

Other news since our last bulletin:

- **The continuous enrollment period ended March 31, 2023.** Medicaid beneficiaries began to receive notices regarding upcoming recertification obligations effective April 1, 2023. Individuals required to recertify their Medicaid eligibility who do not do so on a timely basis may be subject to a lapse in coverage.
    - More information can be found in the District's unwinding plan here.
    - DHCF has a landing page on its website for Medicaid Renewal information here.
    - A renewal and restart communications toolkit for our partners and providers can be found here.

    - DHCF is happy to take your post-PHE questions through dedicated email boxes:
        - Medicaid.Restart@dc.gov for general questions about Medicaid Restart (including eligibility, operations, and authorities related to the PHE)
        - Medicaid.Renewal@dc.gov for specific questions about Medicaid eligibility renewals and the return to normal eligibility operations
- **Many PHE flexibilities in the waivers will sunset November 11, 2023.** More information can be found in the District's unwinding plan here. Key flexibilities ending that providers and partners should know include, but are not limited to:
    - Elimination of remote ADHP services
    - Resumption of training requirements for SMW participant-directed workers (PDWs)
    - Changes to how services are authorized for Services My Way participants using more than 16 hours per day

Additional resources:

- The latest **LTCA PHE Billing and Documentation Guidance** is online here.
- Some always-applicable tips for successful assessment completion are included in the **Assessment Hints** reference guide also circulated with this Bulletin.
- A provider-specific **Frequently Asked Questions** document is also embedded in this Bulletin and posted to the Informational Bulletins page on DHCF's website.
- DHCF launched the electronic Prescription Order Form (ePOF) on July 1, 2021. You can access the ePOF by clicking this link. Instructions on how to complete the form and the workflow are located on the DHCF website. If you have any questions, please feel free to contact LTCA at 202-442-9533. **Please note:** As of March 1, 2023, electronic or wet signature by physician is required.

DC Health guidance and information:

- As a reminder for all providers, the latest DC Health guidance on all COVID-related matters can be located on their website here.

Additional reminders and resources:

- These Informational Bulletins are being archived on DHCF's website under the Long Term Care Administration tab: https://dhcf.dc.gov/publication/informational-bulletins-ltc-providers

As always, we extend our thanks for your continued partnership and commitment to the care and safety of District residents throughout the COVID-19 public health emergency. We will continue to be in touch with updated information as it becomes available.

Assessment Helpful Hints

Initial Assessment – request this assessment type when the person is not known to Medicaid previously or does not have active Medicaid

Recertification Assessment – request this assessment type for regular recertification of eligibility periods with Medicaid

Change in Condition – request change in condition reassessment with Liberty is used when the beneficiary has had a significant change in their overall condition, this could be for a change in services or discharge planning. This may be manifested by, but not limited to:

1. Changes in at least three functional areas – improved or decline
    a. Dressing – upper and lower body
    b. Personal Hygiene
    c. Walking
    d. Locomotion
    e. Toilet Use
    f. Bed Mobility
    g. Transfer Toilet
    h. Eating
    i. Bathing
    j. Medication Management
2. A new diagnosis that impacts overall status,
3. Three ER visits in 6 months or 2 inpatient admissions in 3 months with similar diagnosis and no PCP visit to evaluate,
4. A change in the availability of informal supports - For example, an informal caregiver can no longer provide support when the PCA is not in the home due to a significant permanent change such as death, change in employment status, major illness or injury, etc.

Any significant change in condition including but not limited to these noted above should trigger a discussion with PCP, and possible request for a change in condition assessment.

Fair Hearing/Reconsideration

A **fair hearing** may be filed for up to 90 days from the date of receipt of a denial/ termination/reduction notice. If it is believed that not all medical information was reviewed during the assessment a **reconsideration** can be submitted with the additional medical paperwork but be submitted within 21 days of receipt of denial letter. A beneficiary can also choose to file a fair hearing in these cases if they so wish.

Please also ensure that you are working closely with your beneficiary to schedule their appointment

COVID-19 Public Health Emergency (PHE): Post-PHE Frequently Asked Questions (FAQ)

Document purpose

As the federal public health emergency related to the COVID-19 pandemic comes to an end, the DC Medicaid agency, the Department of Health Care Finance (DHCF), and its partners are beginning the process of returning to normal, pre-pandemic operations. Over the next several months, DHCF and its partners will roll back a number of flexibilities implemented during the pandemic. This document provides details on those changes, dates, and responses to questions we anticipate from providers and beneficiaries.

What changes are coming first?

- Effective November 1, 2022: In-person assessments conducted by Liberty resume.
- Effective March 1, 2023: Required in-person activities by EPD Waiver providers resume, including collection of "wet" signatures and in-person monthly visits by case managers.
- Effective April 1, 2023: Eligibility redeterminations resume. Adverse actions resume. Notices of renewals will be issued beginning April 1 (for MAGI populations, those with eligibility ending May 31, 2023; for non-MAGI populations, eligibility ending June 30, 2023).
- Effective May 11, 2023: Federal PHE declaration formally ends. Generally, remaining flexibilities will phase out six months after this date.

What does this mean? What is changing?

Beneficiaries are already being assessed in person by Liberty staff. As communicated in prior meetings and materials, effective March 1, DHCF will require case managers and other EPD Waiver providers to complete activities in person that were allowed to be delivered either remotely or in person during the pandemic, including obtaining actual signatures instead of attestations of consent.

New federal requirements end the FFCRA compliance requirements March 31, 2023, which directs states to initiate Medicaid renewals April 1. This means that notices regarding required renewal applications – sent 60 days in advance for MAGI populations and 90 days for non-MAGI beneficiaries – will be issued beginning April 1. Enrollments that are not renewed on a timely basis will lapse. Adverse actions resulting from assessment findings will resume.

Is this consistent with federal guidance?

Federal requirements during the public health emergency required the Medicaid agency to suspend terminations of Medicaid enrollment for individuals who had no other creditable medical coverage. As such, the District has *not* involuntarily terminated Medicaid coverage for individuals who enrolled in Medicaid prior to or during the pandemic for whom recertification would have otherwise been required during the pandemic. Federal requirements passed by Congress in December 2022 "delinked" eligibility renewal requirements from the formal end of the PHE, instead ending the FFCRA compliance requirements March 31, 2023. Thus, while the PHE is also ending May 11, 2023, the District has a different timeline required for eligibility and assessment processes.

DHCF expects to continue payment flexibilities and PHE-specific services as long as PHE-specific flexibilities permit, and DHCF intends to continue PHE payment rates and services not authorized outside of the PHE consistent with that direction. The federal government has indicated the federal PHE

declaration will end May 11, 2023, and some payment and other flexibilities will continue up to six months post-PHE.

How will beneficiaries learn more about these changes?

All beneficiaries subject to changes in their services or coverage receive legal notices about those changes prior to their implementation. For other process changes, DHCF has developed informational materials our providers can share with beneficiaries when they meet with them or provide care. These informational materials will also be shared with advocacy organizations and other community partners.

My beneficiary didn't receive a notice.

Prior to changes in services – whether a reduction or termination of services – a notice will be issued. If a beneficiary you serve did not receive a notice, contact LTCA, UHC, or the entity who issued the notice to confirm it was sent. If a notice was, in error, not sent, a new notice will be issued.

When eligibility redeterminations resume, notices will be issued 90 days prior to the end of each beneficiary's certification period. Beneficiaries, their caregivers, and case managers should respond promptly to requests for information about recertifications.

Finally, beneficiaries, families and providers should take care to ensure that beneficiaries' address information is up to date with the Medicaid program. Beneficiaries can update their information with their case manager, through any service center, or online via District Direct.

What if my beneficiary refuses something that is now required?

Beneficiaries will need to participate in required activities consistent with Medicaid regulations. For beneficiaries enrolled in the EPD Waiver program, case management activities are required, including in-person case manager visits. Until Medicaid redeterminations are in effect, beneficiaries will not be terminated from the Medicaid program for non-compliance with their own roles and responsibilities, but after the PHE, refusal to participate may result in disenrollment, pending appropriate notice.

More information

- DHCF's Medicaid Renewal – The Restart of Normal Medicaid Eligibility Operations guidance document is available on DHCF's website: https://dhcf.dc.gov/page/medicaid-covid-19-updates
- Contact DHCF through dedicated email boxes:
    - Medicaid.Restart@dc.gov for general questions about Medicaid Restart (including eligibility, operations, and authorities related to the PHE)
    - Medicaid.Renewal@dc.gov for specific questions about Medicaid eligibility renewals and the return to normal eligibility operations
- COVID PHE-related Informational Bulletins and Billing & Documentation Guidance: https://dhcf.dc.gov/publication/informational-bulletins-ltc-providers
- COVID PHE-related Health Guidance: https://coronavirus.dc.gov/healthguidance
- Latest DC Medicaid Director Letters: https://dhcf.dc.gov/page/medicaid-director-letters
- Latest DC Medicaid Transmittals: https://dhcf.dc.gov/page/dhcf-medicaid-updates