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Timely Access to Home- and Community-Based Services

Use of Presumptive Eligibility and Expedited Eligibility for Non-MAGI Populations

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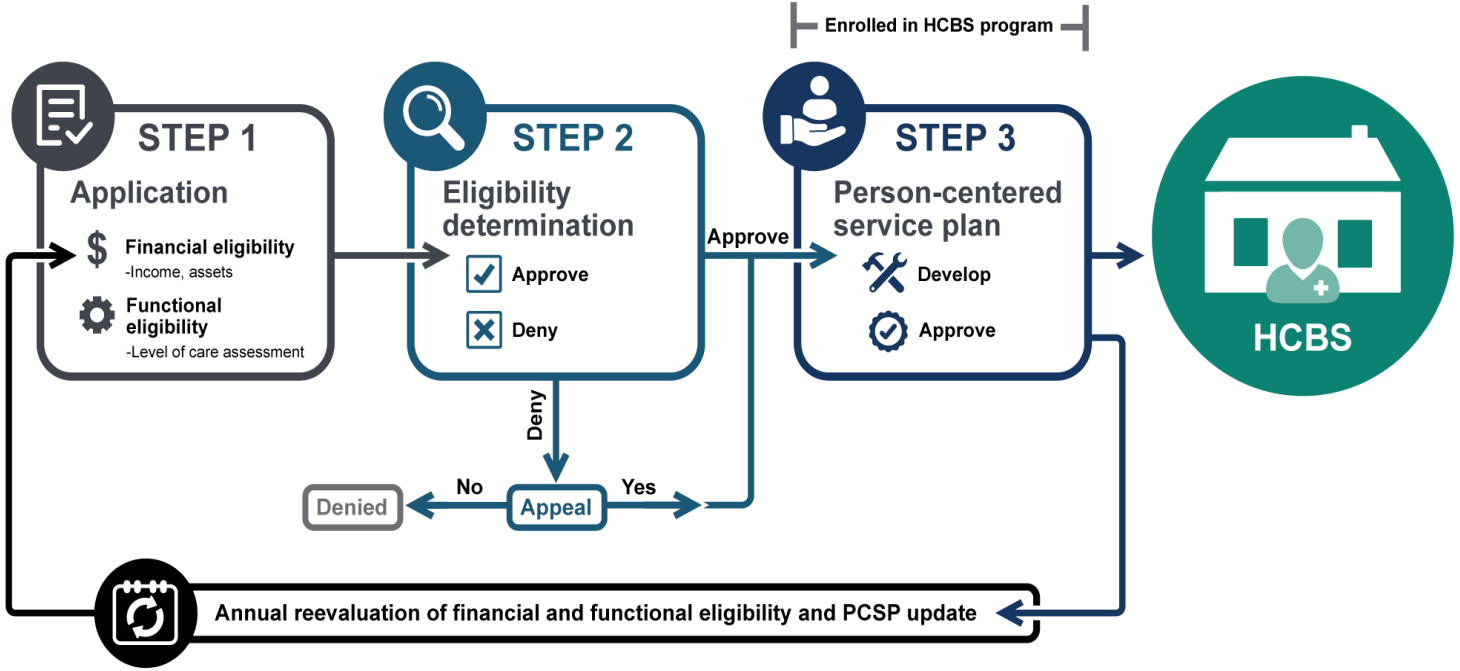
Overview

- Background
- Findings from stakeholder interviews
- Next steps

Background

Eligibility Process and Requirements for Individuals Seeking Medicaid Home- and Community-Based Services



Notes: HCBS is home- and community-based services. PCSP is person-centered service plan.
Source: 42 CFR 441.301, 441.303, 441.535, 441.540, 441.720, 441.725, 435.907, 435.916.

Presumptive Eligibility

- Allows individuals who have not yet been determined eligible for Medicaid to receive Medicaid-covered services while completing the full Medicaid application process
- Presumptive eligibility period lasts for up to 60 days
- States can allow qualified entities, such as hospitals, to make a presumptive eligibility determination (42 CFR 435.1110)
- States have the option to allow hospital presumptive eligibility for non-modified adjusted gross income (MAGI) populations (42 CFR 435.1110(c))

Presumptive Eligibility, cont.

- Two options for states to use presumptive eligibility for non-MAGI populations:
  - State plan amendment to expand hospital presumptive eligibility
  - Section 1115 demonstration
- Providers furnishing home- and community-based services (HCBS) during the period in which a beneficiary is presumptively eligible are reimbursed by Medicaid; however, services must be rendered after a plan of care is established

Expedited Eligibility

- When an individual's Medicaid application is processed in an accelerated manner for the purposes of making a Medicaid eligibility determination, but services are not rendered until the determination has been made
- States can accept self-attestation of information needed to determine Medicaid eligibility (42 CFR 435.945(a))
- There is no uniform definition of expedited eligibility and it is not a term used by federal officials

Environmental Scan Recap

- Conducted a comprehensive environmental scan of Section 1915 HCBS authorities, Section 1115 demonstrations, and additional relevant resources
  - The scan captures state use of eligibility and other streamlining flexibilities, and how states administer level of care (LOC) determinations and develop person-centered service plans
- Found that as of February 2024, 9 states use presumptive eligibility for non-MAGI populations and 6 states currently use or are planning to use expedited eligibility for non-MAGI populations
- Published the compendium on macpac.gov with an accompanying Policy in Brief

Methods

- From June through August 2024, MACPAC staff conducted interviews with officials in 6 states, CMS officials, and national experts
  - 5 states with presumptive eligibility
    - 3 states currently use presumptive eligibility
    - 1 state is pending approval
    - 1 state temporary used presumptive eligibility during the public health emergency
  - 1 state with expedited eligibility

Findings from Stakeholder Interviews

Use of Section 1115 Demonstrations

- States generally use Section 1115 demonstrations as the vehicle to streamline eligibility
- States choose Section 1115 demonstrations because:
  - The state does not have to assume financial risk for federal financial participation associated with someone who is found presumptively eligible and later determined to be ineligible
  - Allows states to use entities (e.g., case management agencies) other than hospitals to make the presumptive eligibility determinations
  - Gives states the ability to innovate and design policies to meet their specific state needs, and waive certain elements of federal Medicaid authority

Characteristics of State Programs

- States are generally using presumptive eligibility and expedited eligibility for older adults and individuals with disabilities, with a focus on helping individuals transition from hospitals back to the community
  - Four states currently include hospitalized individuals and one state is exploring how to expand their population to hospitalized individuals

- States generally accelerate eligibility determinations by relying on self-attestation, shortened versions of their LOC assessments, and a limited benefit package
  - Offering a limited set of services during the presumptive eligibility period can respond to beneficiaries' short-term needs and prevent institutionalization

Financial Risk for Services Delivered During a Presumptive Eligibility Period

- A few interviewees expressed concern about a state's financial risk for services provided to individuals found presumptively eligible for HCBS and then later found ineligible despite CMS policy to the contrary
  - CMS and experts said that states are under no obligation to repay services provided during a period of presumptive eligibility for either Section 1115 demonstrations or hospital presumptive eligibility through a SPA
- A few states also expressed the importance of educating providers that there is no financial recoupment for Medicaid services provided during a presumptive eligibility period

Guidance

- Lack of consensus among interviewees about the need for additional CMS guidance
  - Of the state officials we spoke with, one state strongly supported the need for guidance on the use of presumptive eligibility for non-MAGI populations while two states did not
  - The other states spoke about the important role of CMS technical assistance
  - Among experts, there was a general feeling that additional CMS guidance is usually helpful for states
- CMS noted that there is ample guidance on the use of hospital presumptive eligibility, in particular pointing to a set of FAQs from 2014

Other Considerations

- Implementing presumptive eligibility requires training providers to make such determinations for non-MAGI populations

- States we spoke with were mixed in terms of who conducted the eligibility determinations, with about half contracting it out to case management agencies and half using state staff

Other Considerations, cont.

- The complexity of non-MAGI eligibility determinations does not lend itself to speedy determinations
  - Determining an individual's financial eligibility can be time-consuming
  - One state and CMS officials noted that disability determinations are complex and difficult to do quickly, and could pose barriers for states trying to figure out how to approach presumptive eligibility for non-MAGI individuals

- A few interviewees noted concerns about a "benefit cliff" for individuals who receive services during the presumptive eligibility period but are ultimately found ineligible for Medicaid
  - Many interviewees noted that this happens very rarely

Summary and Next Steps

Summary

- Interviewees expressed strong support for the use of presumptive eligibility for non-MAGI populations and other expedited eligibility flexibilities that can reduce the amount of time an applicant waits to receive HCBS
  - These policy tools support consumer preferences to remain in the community
- In particular, interviewees cited concerns around timely determinations for individuals discharging from hospitals and in other emergency situations, in order to prevent institutionalization

Next Steps

- For this session, staff welcome Commissioner feedback specifically on the use of presumptive eligibility and expedited eligibility for non-MAGI populations
- October 2024 presentation will focus on the use of provisional plans of care
  - May also include additional information on the use of presumptive eligibility and expedited eligibility for non-MAGI populations
- Descriptive chapter in the March 2025 report to Congress
- Future work on level of care assessments and person-centered planning processes for non-MAGI groups

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