January 23, 2025

Timely Access to Home- and Community-Based Services

Review of recommendation and draft chapter for March report

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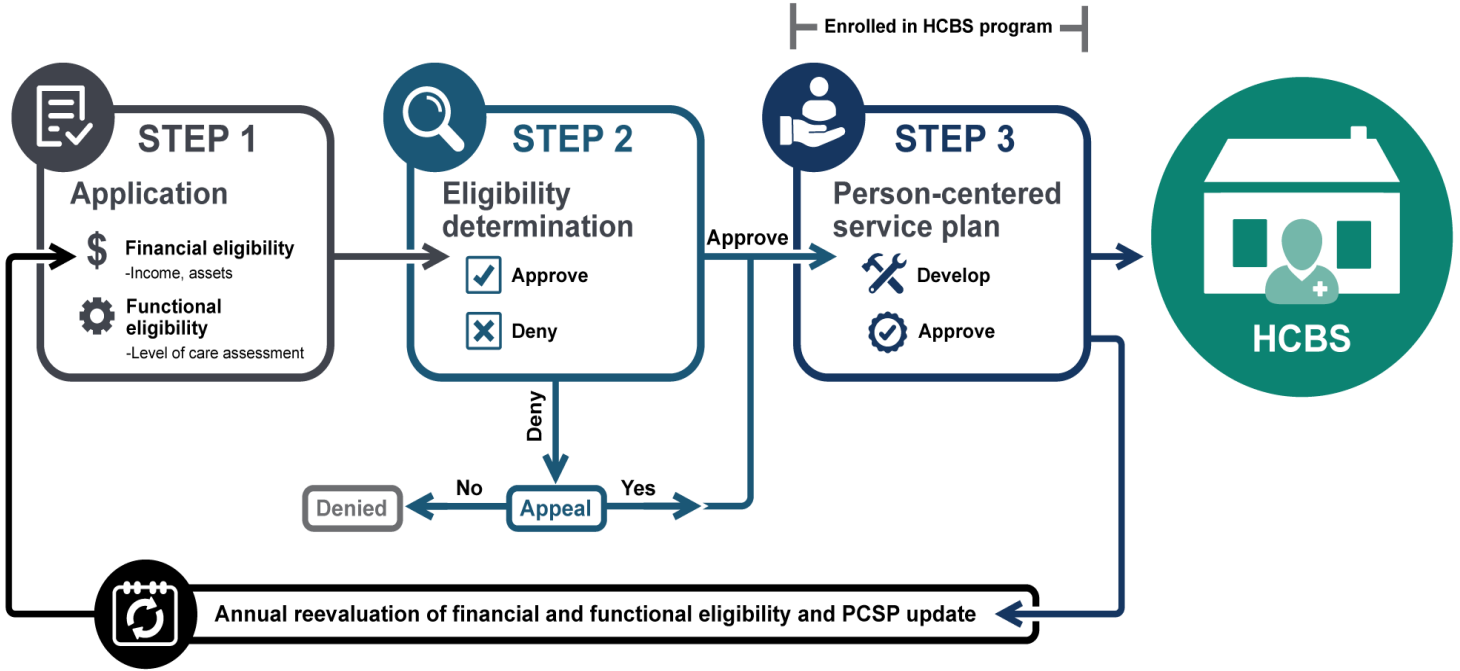
Overview

- Background
  - Presumptive eligibility
  - Expedited eligibility
  - Provisional plans of care
- Themes from stakeholder interviews
- Recommendation
- 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)
- Two options for states to use presumptive eligibility for non-modified adjusted gross income (MAGI) populations:
  - State plan amendment to expand hospital presumptive eligibility
  - Section 1115 demonstration

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

Provisional Plans of Care

- Also called interim service plans
- Identifies the essential HCBS that can be provided in a person's first 60 days of waiver eligibility
- Allowed since 2000, when described in Centers for Medicare & Medicaid Services (CMS) guidance known as Olmstead Letter #3
- States must document in Appendix D-1 of their Section 1915(c) waivers if they allow the use of provisional plans of care

Analytic Approach

- Environmental scan
  - Documents state use of eligibility and other streamlining flexibilities, and how states administer level of care (LOC) determinations and develop person-centered service plans (PCSPs)
- Stakeholder interviews
  - MACPAC staff conducted interviews with officials in 7 states, CMS officials, and experts at 4 national organizations
- Waiver review
  - Reviewed Section 1915(c) waivers for language allowing for use of provisional plans of care

Themes from Stakeholder Interviews

Presumptive Eligibility and Expedited Eligibility

- States most often use Section 1115 demonstrations as the vehicle to streamline eligibility
- 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
- States generally accelerate eligibility determinations by relying on self-attestation, shortened versions of their LOC assessments, and a limited benefit package

Presumptive and Expedited Eligibility, cont.

- States and providers have no financial risk for services provided during a presumptive eligibility period
- Lack of consensus among interviewees about the need for additional CMS guidance for presumptive eligibility
- Providers need trainings to make presumptive eligibility determinations for non-MAGI populations
- The complexity of non-MAGI eligibility determinations does not lend itself to speedy determinations
- 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

Provisional Plans of Care

- Our waiver review found 24 states have language in their Section 1915(c) waivers allowing for the use of provisional plans of care, across 59 Section 1915(c) waiver programs
- Provisional plans of care are most often used for emergency situations, such as natural disasters or hospitalizations
- Provisional plans of care appear to be rarely used; reasons for low state uptake include:
  - Lack of awareness
  - Limited state capacity, administrative complexity, and competing priorities at the state level
  - State operational processes may negate the need for an interim service plan, such as when the level of care assessment and PCSP are developed in the same meeting
  - Provisional plans of care may not be feasible or appropriate for all individuals

Provisional Plans of Care, cont.

- States using Section 1115 demonstrations to offer presumptive eligibility for non-MAGI populations often use a provisional plan of care and offer a limited benefit package as part of the plan
- Mixed feedback from interviewees about the need for additional CMS guidance
  - Multiple public comments expressed value of additional guidance

Recommendation

Rationale and implications

Recommendation 2.1

- The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance on how states can use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k), and Section 1115 of the Social Security Act.

Recommendation 2.1: Rationale

- Lack of awareness and limited use of provisional plans of care indicates a need for additional guidance
- Interview feedback indicated limited state capacity for operationalizing this flexibility
  - Specific guidance could educate state staff, answer administrative questions, and provide reassurance to state agencies that they are operating their programs in accordance with the statutory and regulatory rules governing HCBS
- There is no guidance expressly allowing the use of provisional plans in HCBS authorities other than Section 1915(c) waivers

Recommendation 2.1: Implications

- Federal spending
  - No direct effect
- States
  - Greater clarity for states on how to authorize and implement interim service plans
- Enrollees
  - Could lead to more enrollees having provisional plans, potentially leading to more timely access to HCBS
- Plans
  - In states where plans are responsible for developing PCSPs, staff would need to be trained on how and when to operationalize the use of provisional plans of care
- Providers
  - Providers would need to be educated on the differences between a provisional plan of care and a full PCSP

Next Steps

Next Steps

- Obtain Commissioner feedback and address questions ahead of the vote tomorrow
- Publish chapter in the March 2025 report to Congress
- Staff will return with work on level of care assessments and person-centered planning processes for non-MAGI groups

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