

Policy in Brief MACPAC

Compendium on Medicaid Eligibility Policies Affecting the Timeliness of Access to Home- and Community-Based Services

Summary

This compendium documents state use of eligibility flexibilities and processes meant to reduce the time it takes for individuals whose income is not determined using modified adjusted gross income (MAGI) standards, such as individuals who qualify for Medicaid based on age or disability, to be determined eligible for Medicaid and start receiving home- and community-based services (HCBS). This includes: (1) eligibility flexibilities, such as presumptive eligibility and expedited eligibility, (2) level of care (LOC) assessment processes, and (3) person-centered planning processes.¹ States can design these processes to connect beneficiaries to HCBS faster.

State uptake of flexibilities and policies meant to speed up eligibility determinations vary widely. This variation, particularly around the use of presumptive eligibility and expedited eligibility, highlights state efforts to streamline the process for individuals in need of HCBS.

Background

Medicaid HCBS are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a home-like setting in the community. Timely access to HCBS is essential to ensure individuals receive care in the setting of their choice. Delays in an individual's access to critical services can negatively impact health outcomes and cost of care (McGarry and Grabowski 2023, Reinhard et al. 2021).

To be eligible to receive Medicaid HCBS, individuals must meet both financial and functional eligibility criteria. Functional eligibility is determined using an assessment tool, and generally, individuals must be found to require an institutional LOC. Once determined eligible, designated staff (e.g., case manager) work with the individual on a person-centered service plan (PCSP). Beneficiaries are required to have a PCSP in place before receiving HCBS (Figure 1).

Methodology

We contracted with The Lewin Group (Lewin) to create this compendium. From September 2023 through March 2024, Lewin reviewed all approved Section 1915(c) waivers, Section 1915(i) and (k) state plan amendments, and Section 1115 demonstrations for all 50 states and the District of Columbia, as well as additional publicly available documents.

The scan was then sent to state officials to review and confirm the accuracy of the information; 34 states responded to our feedback request.

Findings

Nine states use presumptive eligibility for non-MAGI populations. Presumptive eligibility allows individuals who have not yet been determined eligible to obtain Medicaid-covered services while completing the full Medicaid application process. The presumptive

By the numbers...

(as of February 2024)



46 states and DC operate a total of 251 Section 1915(c) waivers



15 states have Section 1115 demonstrations that cover some HCBS

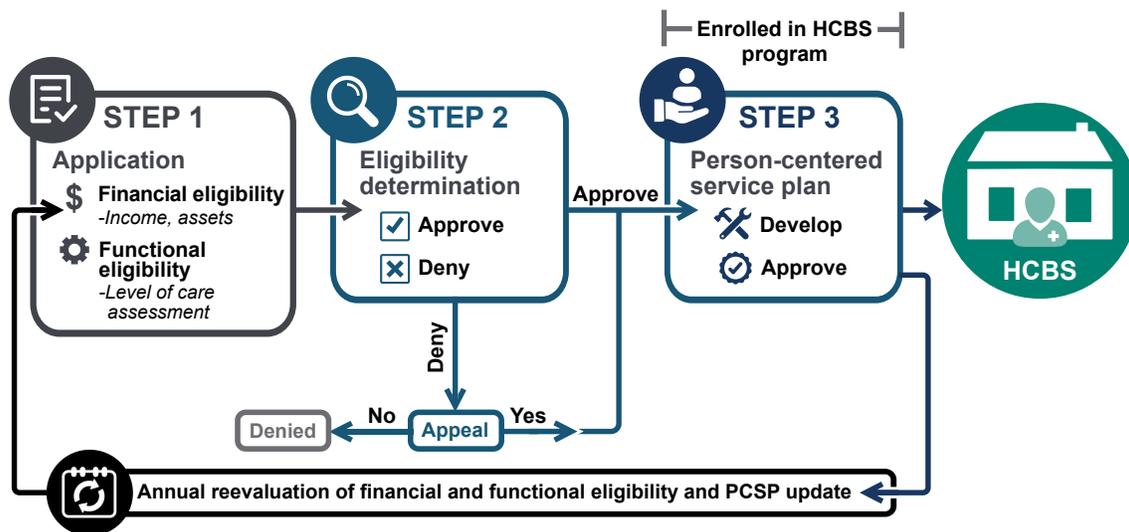


17 states offer Section 1915(i) state plan HCBS benefits



8 states have a Section 1915(k) Community First Choice program

FIGURE 1. Eligibility Process and Requirements for Individuals Seeking Medicaid HCBS



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.

eligibility period lasts for up to 60 days, at which time the full eligibility determination must be completed for coverage to continue. Our environmental scan found state differences by authority, population, qualified entity, and timeline, among other factors.

Six states currently use or are planning to use expedited eligibility for non-MAGI

populations. Expedited eligibility, also referred to as fast track eligibility, occurs when an individual’s Medicaid application is processed in an accelerated manner for the purposes of making a Medicaid eligibility determination. There is not a uniform definition of expedited eligibility; instead, states can make adjustments within certain parameters, such as setting specific timeline requirements for Medicaid eligibility approvals. States can also accept self-attestation of information needed to determine the Medicaid eligibility of an individual (42 CFR 435.945(a)). Of the six states identified in the compendium, most states use or plan to use expedited determinations for both functional and financial eligibility, but a few states only allow for self-attestation of one eligibility component.

States set timelines to conduct and approve LOC assessments. Our scan found that 32 states have requirements for how long assessors can take to complete the functional assessment, with a range of 2 to 45 days. We also found that 17 states have timeframe requirements to approve a LOC assessment for at least one HCBS program in the state, with a range of 5 to 30 days. Two different entities may conduct and approve LOC assessments.

Of the 47 states and DC that reported a LOC assessment method(s), all states offer in person options, 19 allow telephonic or virtual options, and 32 use record review. Record review is always combined with another assessment method, such as in person. During the public health emergency, about two-thirds of states allowed assessments to be conducted by phone or virtually, but not all states made this flexibility permanent.

Most states require the PCSP be completed within 30 to 45 days of enrollment. To expedite this process, states may allow a provisional plan of care to be developed for Section 1915(c) waiver services; 17 states do so, across 41 waivers. Our scan did not find any Section 1115 demonstrations or Section 1915(i) and (k) state plans that use provisional plans of care.

Endnote

¹ Presumptive eligibility allows individuals to obtain Medicaid-covered services while completing the full Medicaid eligibility process. Expedited eligibility is a term that can be used to describe how states accelerate an individual’s Medicaid application in order to make a faster eligibility determination.

References

McGarry, B.E., and D.C. Grabowski. 2023. Medicaid home and community-based services spending for older adults: Is there a “woodwork” effect?. *Journal of the American Geriatrics Society* 71, no. 10: 3143–3151. <https://doi.org/10.1111/jgs.18478>.

Reinhard, S.C., R.L. Mollica, C.W. Gualtieri, and C. Blakeway Amero. 2021. LTSS Choices: Presumptive eligibility for Medicaid home and community-based services can expand consumer options. Washington, DC: AARP Public Policy Institute. <https://doi.org/10.26419/ppi.00138.001>.

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children’s Health Insurance Program (CHIP).