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Timely Access to Home- and Community-Based Services

Environmental Scan Results

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Overview

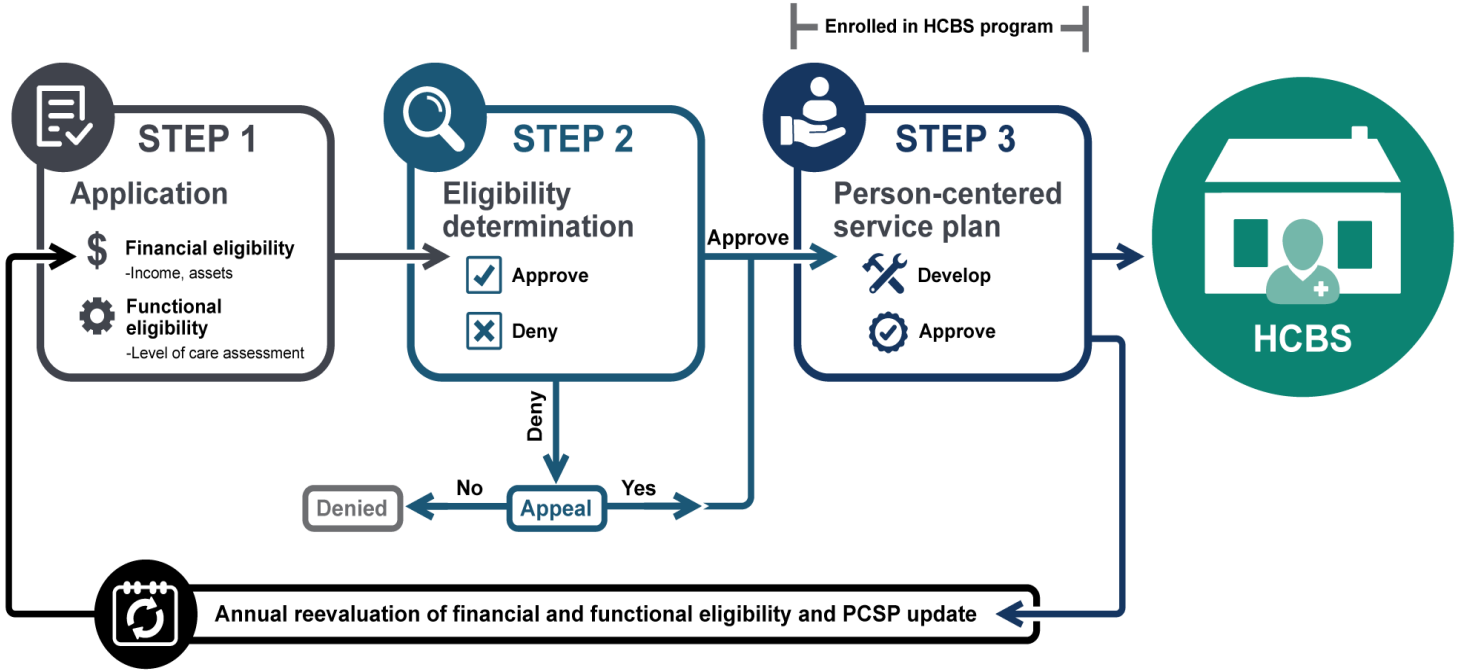
- Background
- Key findings
  - Eligibility and other streamlining flexibilities
  - Level of care determinations
  - Person-centered service plans
- Next steps

Background

Components of Timely Access

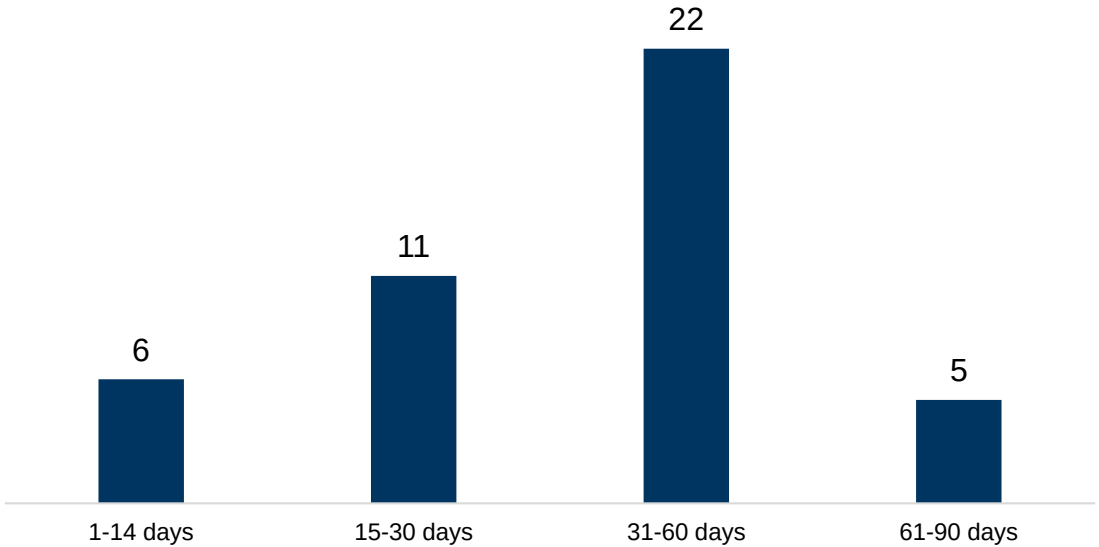
- States have several options to streamline enrollment into Medicaid home- and community-based services (HCBS) programs, including Section 1915 and 1115 demonstration authorities
- Eligibility flexibilities
  - Presumptive eligibility
  - Expedited eligibility
  - Retroactive coverage
- Level of care (LOC) determination process
- Person-centered service plan (PCSP) process

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.

States' Average Non-MAGI Application Processing Times, July 2022



Notes: MAGI is modified adjusted gross income.
Data is from 44 states; in 7 states, average processing times were unknown.
Source: Musumeci et al. 2022.

Methods

- Contracted with The Lewin Group (Lewin) to conduct 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 LOC determinations and develop PCSPs
- The scan found that as of March 2024:
  - Section 1915(c) waivers: 46 states and DC
  - Section 1115 demonstrations that cover some HCBS: 15 states
  - Section 1915(i) state plan HCBS benefits: 16 states and DC
  - Section 1915(k) Community First Choice program: 8 states
- States were sent the scan for review; 34 states responded

Eligibility and Other Streamlining Flexibilities

Presumptive Eligibility

- Allows individuals who have not yet been determined eligible for Medicaid to obtain 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-MAGI populations (42 CFR 435.1110(c))
- Providers furnishing 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

Presumptive Eligibility: Scan Results

- Nine states use presumptive eligibility for HCBS
- States use various mechanisms to implement presumptive eligibility:
  - California, New Jersey, and Oklahoma used Section 7.4 Medicaid Disaster Relief state plan amendments (SPAs) to temporarily expand hospital presumptive eligibility to non-MAGI populations
  - Washington and Vermont used Section 1115 demonstrations
  - Louisiana used a Section 1915(i) SPA
  - New Hampshire used an American Rescue Plan Act (ARPA, P.L. 117-2) spending plan to pilot the use of presumptive eligibility
  - Michigan proposed a pilot on the use of presumptive eligibility in a state bill
  - Ohio describes in its administrative code the use of presumptive eligibility for two different Section 1915(c) waiver populations. Ohio's program is funded with state-only dollars.

Expedited Eligibility

- When an individual's Medicaid application is processed in an accelerated manner for the purposes of making a Medicaid eligibility determination
  - Also referred to as fast track eligibility
- 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

Expedited Eligibility: Scan Results

- Four states currently use expedited eligibility for HCBS, one state is expanding a pilot, and one state is planning to use it in the future
  - Four states (California, Colorado, Illinois, Indiana) use or plan to use it for both functional and financial eligibility
  - Rhode Island only allows for self-attestation of financial eligibility
  - Hawaii's policy, put in place during the COVID-19 public health emergency (PHE), allows for self-attestation of functional eligibility

Retroactive Coverage

- States must provide three months of retroactive coverage (from when a Medicaid application was received) to any Medicaid enrollee if that individual received Medicaid-covered services prior to enrolling in the program but would have been eligible at the time those services were received (42 CFR 435.915)
- Due to the requirement that individuals have a care plan in place before receiving services, states are effectively not able to provide retroactive coverage for HCBS
- In Connecticut, providers can receive payment for certain behavioral health services delivered via Section 1915(c) and 1915(i) authorities up to 90 days prior to enrollment

Other Streamlining Efforts

- Five states are engaging in additional efforts to streamline their eligibility processes, including efforts to automate systems and enhance No Wrong Door (NWD) activities. For example:
  - Maine is developing a web-based referral form that allows consumers to self-assess their needs, which will be automatically entered into data systems to begin provider-level referrals and pre-screen for eligibility
  - Rhode Island is expanding NWD activities, including person-centered options counseling and outreach about HCBS programs to underserved racial and ethnic communities, updating business processes, and integrating IT systems

Level of Care Determinations

Timeline Requirements

- States have timeline requirements for the eligibility determination process, both for conducting the functional assessment and for approving the LOC determination
- Conducting the functional assessment: 32 states have requirements for how long assessors can take to complete the functional assessment, with a range of 2 to 45 days
- Approving the LOC assessment: 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

Assessment Methods: Entities Responsible for LOC Determinations

Type of entity	Number of states[1]		Examples
	Conducts assessment	Approves LOC determination	
Medicaid agency	29	32	• Medicaid agency oversees entire process (such as programs in California, Iowa, Minnesota, Mississippi) • Medicaid agency approves determination, but another entity conducts assessments (such as programs in Massachusetts, North Dakota)
Operating agency	23	20	Operating agencies such as: • Department of Mental Health (Alabama) • Department of Aging and Disability Services (Kansas) • Office for Citizens with Developmental Disabilities (Louisiana)
Government agency under contract with the Medicaid agency	21	5	• Case management agencies (Colorado, Ohio) • Area agencies on aging (Ohio) • Medical professionals employed by LOC entities (Massachusetts)
Other	32	22	• Managed care organizations (Arizona, Delaware) • Quality improvement organizations (Montana) • Contractors or medical professionals (Connecticut, District of Columbia)

Notes: LOC is level of care.

[1] Includes all 50 states and DC. Individual states may be classified under multiple entity types. A state may be counted multiple times when one or more program within the state has implemented an approach.

Assessment Methods, cont.

Assessment method	Number of states
In-person	48
Telephone and virtual	19
Record review	32

- Among the 19 states that allow virtual assessments, 15 used a temporary PHE modification and 10 made the policy permanent

Reassessments

- States are required to reassess participants no less frequently than annually (42 CFR 435.916(b))
  - States use tools or systems which prompt case managers of upcoming reassessment milestones
- Our scan found:
  - All 50 states and DC have at least one program that uses the 12-month reassessment interval
  - Six states use a six-month reassessment interval in select HCBS programs
  - Four states use alternative approaches for scheduling reassessments for one or more HCBS programs

Public Health Emergency Flexibilities

- During the PHE, CMS provided guidance to states on options to pursue temporary flexibilities related to the eligibility and service planning provisions of HCBS programs
- Forty states implemented at least one temporary flexibility related to HCBS LOC assessments. The two most common flexibilities were:
  - extending due dates for reassessments for up to one year (27 states)
  - allowing professionals to conduct assessments by telephone or virtually in addition to in-person (35 states)
- Our scan found that 10 states have made their LOC assessment policy changes permanent

Person-Centered Service Plans

Person-Centered Service Planning Process

- PCSPs are designed to identify the individual's goals and desired outcomes and reflect the services and supports that will assist them in achieving their goals
- Requirements include:
  - The individual leads the process, where possible
  - Includes people chosen by the individual
  - Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices
  - Is timely and occurs at times and locations convenient to the individual
  - Reflects cultural considerations and is conducted by providing information in plain language and in a manner accessible to individuals with disabilities and persons with limited English proficiency

Source: 42 CFR 441.301(c), 441.540, 441.725.

Person-Centered Service Planning Process, cont.

- Requirements, continued:
  - Includes strategies for solving conflict or disagreement, including clear conflict-of-interest guidelines for all planning participants
  - Offers informed choices to the individual regarding the services and supports they receive and from whom
  - Includes a method for the individual to request updates to the plan as needed
  - Records the alternative home and community-based settings that were considered

Source: 42 CFR 441.301(c), 441.540, 441.725.

Timeline Requirements: Scan Results

- 48 states have timeline requirements for development of the PCSP, with most states requiring completion within 30 to 45 days of enrollment
- Many states had consistent requirements across their HCBS programs
- In a few states, the case manager begins to develop the PCSP during the functional assessment meeting

Timeline Requirements, cont.

- Most HCBS programs require PCSPs to be reviewed and updated every 12 months
- Most states also use the same frequency of review across all their HCBS programs
- Frequency of PCSP review
  - 12 months: 48 states
  - 6 months: 12 states
  - 3 months: 4 states
  - Other timeline: 10 states

Assessment Methods

- PCSPs should be developed at times and locations convenient to the individual and should include any other individuals chosen by the participant (42 CFR 441.301(c))
- Assessment methods
  - In-person: 49 states
  - Telephone and virtual: 25 states
  - Record review: 3 states

Assessment Methods, cont.

- States frequently allow more than one type of professional to lead the PCSP development
- No federal requirement exists that medical professionals be responsible for PCSP development, but CMS sub-regulatory guidance states that their qualifications should be reflective of the nature of the program's population
- Type of professional
  - Case manager: 46 states
  - Licensed nurse: 23 states
  - Licensed physician: 2 states
  - Other: 35 states

Provisional Plans of Care

- In order to expedite receipt of Section 1915(c) services, CMS allows for a provisional plan of care (also called an interim service plan) which identifies the essential Medicaid services that can be provided in the person's first 60 days of waiver eligibility
- Provisional plans of care have been allowed since 2000, when they were described in a State Medicaid Director letter, known as Olmstead letter three, which was issued in response to the 1999 *Olmstead v. L.C.* decision
- Our scan found that 17 states allow provisional plans of care, across 41 waiver programs

Use of Electronic Signatures

- Electronic signature (e-signature) can make signing documents a more efficient process, and their use has increased in recent years, especially since the PHE
- Medicaid HCBS programs can use e-signatures to collect an HCBS participant's signature on the final PCSP following the service plan review meeting
- Our scan found that 33 states permit the use of e-signatures for PCSPs in one or more HCBS program

Summary of Findings and Next Steps

Summary of Preliminary Findings

- 9 states use presumptive eligibility for non-MAGI populations
  - While there are some guidelines for how states can use presumptive eligibility, our scan found state differences by population and qualified entity, among other factors
- 6 states currently use or are planning to use expedited eligibility for non-MAGI populations
  - Little guidance exists on how states can apply expedited eligibility; we found variation in state approaches to self-attestation of eligibility criteria
- Due to the federal requirement that a plan of care be in place before receiving HCBS, states are essentially unable to provide retroactive coverage of HCBS

Summary of Preliminary Findings, cont.

- States set separate timelines to conduct and approve LOC assessments; no federal requirements or guidance establish a timeline for either
  - 32 states have requirements for how long assessors can take to complete the functional assessment, with a range of 2 to 45 days
  - 17 states have timeframe requirements to approve a LOC, with a range of 5 to 30 days
  - Two different entities may conduct and approve LOC assessments
- 47 states and DC reported LOC assessment methods
  - all states offer in person options
  - 19 allow telephonic or virtual options
  - 32 use record review

Summary of Preliminary Findings, cont.

- Individuals must have a PCSP in place before receiving HCBS. Most states require it be completed within 30 to 45 days of enrollment.
- In order to expedite this process, states may allow a provisional plan of care for Section 1915(c) waiver services
  - 17 states do so, across 41 waivers
  - No Section 1115 demonstrations or state plan options (i.e., Section 1915(i) and (k)) use provisional plans of care; it is unclear whether this is permitted
- Thirty-three states permit the use of e-signatures on PCSPs

Next Steps

- Publish the environmental scan on MACPAC's website
- Conduct stakeholder interviews and return in the fall to present over three Commission meetings on each of the three areas of focus:
  - Eligibility and other streamlining flexibilities
  - LOC determinations
  - Person-centered planning processes
- During discussion, it would be helpful to staff for Commissioners to raise any considerations applicable to these three topic areas

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