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Medicaid Coverage of Assistive Technology for Adults

Policy Scan and Literature Review

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Medicaid and CHIP Payment and Access Commission

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Overview

- Project objective
- Background
- Policy scan
- Literature review
- Next steps

Objectives

- MACPAC aims to identify the statutory and regulatory framework that governs how states cover assistive technology (AT) and assess whether there are barriers to coverage of and access to AT
- MACPAC is focusing on coverage of AT for adults to manage our scope and because adults may experience less robust coverage of AT than children due to the early and periodic screening, diagnostic, and treatment (EPSDT) requirement
- We have completed a policy scan and literature review; we are also planning to interview key stakeholders and analyze claims data

Background

Background

- AT refers to a wide range of items that help individuals maintain or improve their functional capabilities
  - AT can help individuals perform more activities of daily living independently
  - AT may reduce some burden on the home- and community-based services (HCBS) workforce by decreasing the effort needed to support individuals
- In Medicaid, there is no statutory or regulatory definition of AT
  - States often provide AT through HCBS programs under Section 1915(c) of the Social Security Act (the Act)
  - The Section 1915(c) technical guide defines AT as “an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants”

Background, cont.

- States have flexibility in how they cover AT
  - Some states may include items like personal emergency response systems as part of AT or as a standalone service
  - States often cover items commonly considered AT, like wheelchairs, as durable medical equipment (DME), which is a state plan benefit
  - It is important to assess a wide range of services and benefits to gauge how states are using their flexibility to cover AT
- MACPAC is considering multiple items covered in HCBS programs and state plan benefits as categories of AT

Scope of Medicaid AT in HCBS Programs and State Plans

HCBS programs – Services defined in the Section 1915(c) technical guide	State plans – Benefits defined in federal regulations
• Assistive technology	• Durable medical equipment[1]
• Specialized medical equipment and supplies	• Prosthetics
• Individual directed goods and services	• Dentures
• Personal emergency response systems	• Eyeglasses
• Electronic/remote monitoring	• Physical therapy
• Home accessibility adaptations	• Occupational therapy
• Vehicle modifications	• Speech, hearing, and language services
	• Preventive services
	• Rehabilitative services

Notes: AT is assistive technology. HCBS is home- and community-based services. HCBS programs include Section 1915(c) waivers, Section 1115 demonstrations, and Section 1915(i) and Section 1915(k) state plan amendments. State plan benefits include mandatory and optional benefits under the state plan that provide items that may be considered AT.
[1]Durable medical equipment is a mandatory benefit in the state plan.

Sources: Review of the Section 1915(c) technical guide and 42 CFR Part 440.
Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024. Instructions, technical guide and review criteria. Baltimore, MD: CMS. https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.

Policy Scan

Policy Scan

- MACPAC conducted a policy scan of all HCBS programs operating under Section 1915(c) waivers, Section 1115 demonstrations, and Section 1915(i) and Section 1915(k) state plan amendments serving adults age 21 or older
- Most HCBS programs cover some AT, primarily in Section 1915(c) waivers
  - Of the 263 programs reviewed, 87 percent cover at least one category of AT
  - Almost all Section 1915(c) waivers cover AT and less than half of Section 1915(i) state plan amendments cover AT
- AT coverage differs by category of AT, state, population served by the HCBS program, how a state defines services and any limits a state may place on the service

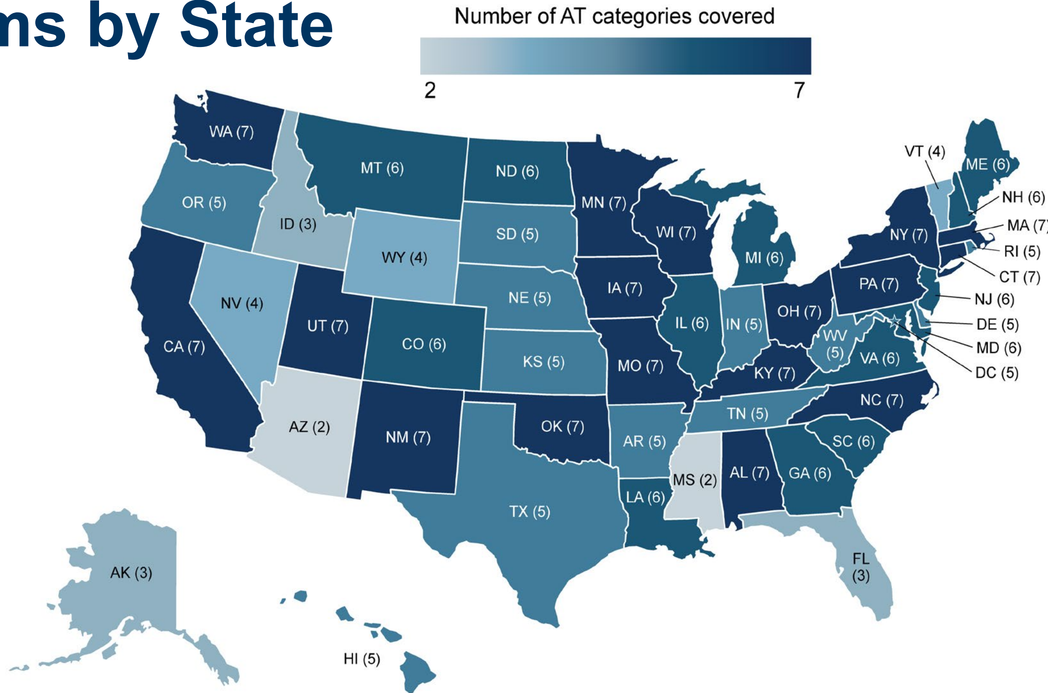
Medicaid Coverage of AT Categories for Adults in HCBS Programs Across States

Category of AT	Number of states covering AT
Home accessibility adaptations	51
Personal emergency response systems	50
Specialized medical equipment and supplies	43
Assistive technology	40
Vehicle modifications	39
Electronic/remote monitoring	35
Individual directed goods and services	29

Notes: AT is assistive technology. HCBS is home- and community-based services. AT in Medicaid is defined by the Section 1915(c) technical guide as “an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants” (CMS 2024). Categories of AT include AT, specialized medical equipment and supplies, individual directed goods and services, personal emergency response systems, electronic/remote monitoring, home accessibility adaptations, and vehicle modifications. State counts include the District of Columbia.

Sources: MACPAC analysis of Section 1915(c) waivers, Section 1115 demonstrations, and Section 1915(i) and Section 1915(k) state plan amendments and review of the Section 1915(c) technical guide.
Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024. Instructions, technical guide and review criteria. Baltimore, MD: CMS. https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.

Medicaid Coverage of AT Categories for Adults in HCBS Programs by State



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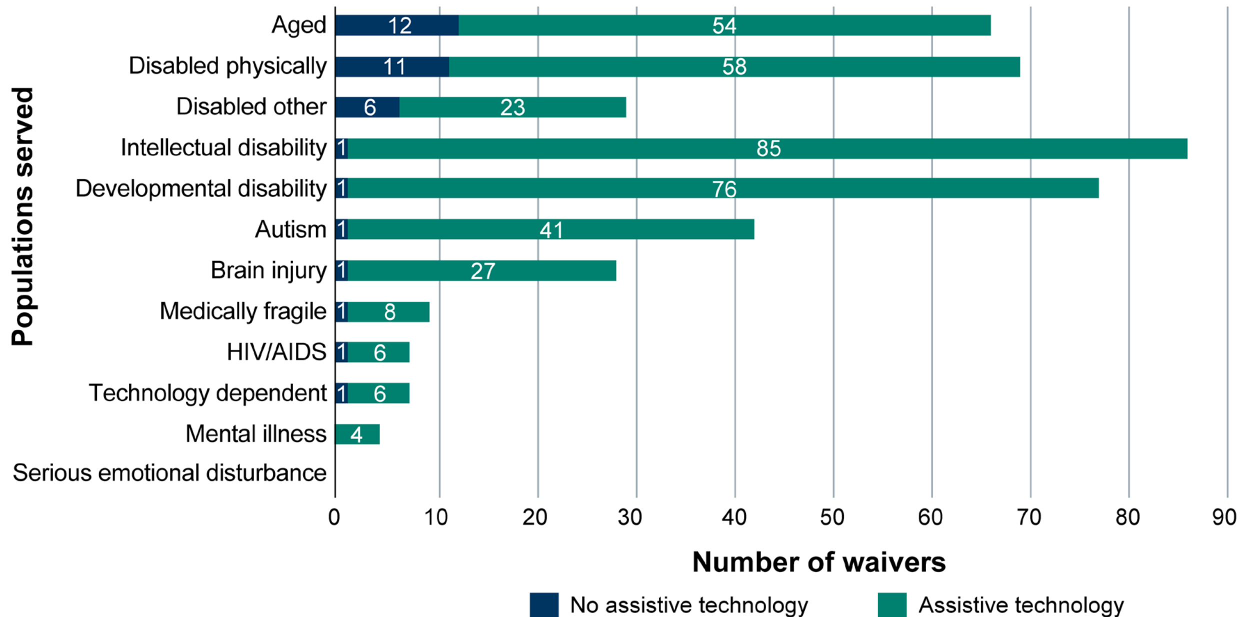
Medicaid Coverage of AT for Adults in Section 1915(c) Waivers by Population



Notes: AT is assistive technology. AT in Medicaid is defined by the Section 1915(c) technical guide as “an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants” (CMS 2024). AT includes specialized medical equipment and supplies, individual directed goods and services, personal emergency response system, electronic/remote monitoring, home accessibility adaptations, and vehicle modifications. A Section 1915(c) waiver can serve multiple populations.

Sources: MACPAC analysis of Section 1915(c) waivers, Section 1115 demonstrations, and Section 1915(i) and Section 1915(k) state plan amendments and review of the Section 1915(c) technical guide.
Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024. Instructions, technical guide and review criteria. Baltimore, MD: CMS. https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.

Service Definitions and Limits

- States may include different items under the same service definitions or chose to designate some items as standalone services
- Some services include a list of items that are included or excluded from coverage
- Many services are limited to items that are not otherwise provided by the Medicaid state plan
- Many services have expenditure caps
- Some services may only be permitted within a certain time frame

Literature Review

Federal Medicaid Guidance

- Aside from the Section 1915(c) technical guide, there is limited federal Medicaid guidance on AT
  - Environmental assessments can be covered by federal financial participation in multiple ways, including as an administrative expense, as environmental modifications under an HCBS waiver, or as another service cost (State Medicaid Director Letter Olmstead Update No: 3)
  - Medicaid DME can provide items for use in settings outside the home, such as community or employment settings (42 CFR 440.70)
  - States may develop a list of approved DME, but the state must also have a procedure for requesting items that do not appear on the list (42 CFR 440.70(b)(3)(v))
  - Federal Medicaid reimbursement is prohibited for certain DME expenditures that are, in the aggregate, in excess of what Medicare would have paid (Section 1903(i)(27) of the Act)

State Flexibility

- States have significant flexibility in how they cover AT under Medicaid state plan benefits and HCBS programs
  – States have significant flexibility in how they cover AT under service definitions in HCBS programs
  – States may establish limits on AT to manage Medicaid costs, such as expenditure caps
  – Managed long-term services and supports programs exhibit flexibility in how they treat AT, such as by covering AT as a defined benefit or as an in-lieu of service

Impact on Beneficiaries

- HCBS users report an unmet need for AT
  - Across five domains of unmet need for HCBS users in 2018, AT was found to have the highest prevalence at 54 percent
- AT has been shown to improve quality of life and independence for beneficiaries, including fewer hospital readmissions and more community engagement
- AT often requires repairs and maintenance in order to be beneficial to users
- Beneficiaries may need training in how to use their AT, and some states cover this training
- AT may help address pressures on caregivers
- Data on the impact of AT are limited, which may hinder state uptake

Population-Specific Findings

- HCBS populations: The Assistant Secretary for Planning and Evaluation reports that tying AT coverage to functional assessments instead of medical necessity criteria may better meet the goals of HCBS programs
- Dually eligible beneficiaries: Misalignment between DME in Medicaid and Medicare can create confusion about coverage for dually eligible beneficiaries, reluctance by DME suppliers to provide equipment, cost shifting from Medicare to Medicaid, and administrative inefficiency
- Aged and physically disabled: AT coverage is more expansive for individuals with intellectual and developmental disabilities than for those who are aged and physically disabled

Provider Findings

- The process of becoming an AT provider varies by type of AT
- Training for providers on how to use AT items is not widely covered by Medicaid; some states require providers to train beneficiaries
- Prior authorization for AT includes complex documentation, frequent re-assessments, diagnosis-linked eligibility criteria, slow approvals for repairs, and coding or billing gaps, which can delay or derail AT provision

Payment Findings

- AT billing and payment differs across states and types of AT, and some types of AT do not have specific standardized billing codes
- Medicaid is the payer of last resort, which may create challenges for obtaining AT in a timely manner, especially for dually eligible beneficiaries
- Medicaid coverage of new technologies typically follows behind technological advancements and other payers

Next Steps

Next Steps

- Staff will return during the next analytic cycle with findings from our interviews and analysis of claims data
- For discussion:
  - Did any of the barriers raised in our literature review stand out to you?
  - What areas would Commissioners flag for further investigation in our interviews and analysis of claims data?

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APRIL MEETING

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