September 25, 2026

Medicaid Coverage of Assistive Technology for Adults

Data Analysis and Stakeholder Interviews

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MACPAC

Medicaid and CHIP Payment and Access Commission

Overview

- Purpose and background
- Data analysis findings
- Interview findings
- Next steps

Purpose

- 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
- Since our last presentation on AT, which reviewed findings from our policy scan and literature review, MACPAC has analyzed claims data and interviewed key stakeholders

Background

- AT refers to a wide range of items that help individuals increase, maintain, or improve their functional capabilities
- In Medicaid, there is no statutory or regulatory definition of AT
  - States often provide AT through home- and community-based services (HCBS) programs under Section 1915(c) of the Social Security Act (the Act)
  - AT is an optional benefit and defined in 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"
- States have flexibility in how they cover AT, and findings from our data analysis and stakeholder interviews are specific to AT covered through Section 1915(c) waivers, Section 1915(i) and Section 1915(k) state plan amendments, and Section 1115 demonstrations

Data Analysis Findings

Data Analysis Methodology

- MACPAC analyzed Medicaid claims data using calendar year 2024 data from the Transformed Medicaid Statistical Information System (T-MSIS)
- We restricted our analysis to Medicaid adults enrolled in HCBS
- We analyzed selected types of AT
  - AT and specialized medical equipment and supplies (SMES)
  - Personal emergency response system (PERS)
  - Home accessibility adaptations and vehicle modifications
  - Electronic/remote monitoring
- We segmented data by age, geographic location, dually eligible status, HCBS subpopulation, and HCBS authority and by fee for service (FFS) and managed care

Percent of HCBS Enrollees Receiving Selected Types of AT and Related Spending, CY 2024

Characteristic	HCBS enrollees (thousands)	HCBS spending (millions)[1]	AT and SMES		PERS		Home accessibility adaptations and vehicle modifications	
			Users	Spending	Users	Spending	Users	Spending
Total	**3,572**	**$122,717**	**5.9%**	**0.3%**	**7.9%**	**0.1%**	**1.4%**	**0.1%**
Age								
21–44	1,026	41,232	4.7	0.7	1.5	0.0	1.2	0.1
45–65	1,009	33,595	5.9	0.2	7.1	0.1	1.6	0.2
65 and older	1,537	47,889	6.6	0.1	12.7	0.1	1.4	0.1
Geographic location[2]								
Urban	3,028	106,049	5.5	0.3	7.4	0.1	1.2	0.1
Rural	537	16,400	8.1	0.5	10.6	0.1	2.4	0.3
Dually eligible status								
Full-benefit dually eligible[3]	2,255	87,913	7.2	0.2	10.5	0.1	1.6	0.1
Medicaid-only	1,317	34,804	3.7	0.6	3.3	0.0	1.0	0.1

Notes and Sources (1)

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HCBS subpopulation[4]								
I/DD or ASD	720	55,714	7.1	0.5	1.0	0.0	1.3	0.1
<65 with potentially disabling condition(s)	497	21,717	9.7	0.5	11.2	0.1	3.7	0.3
Older adults	1,537	47,889	6.6	0.1	12.7	0.1	1.4	0.1
Brain injuries	17	1,115	14.5	0.5	13.2	0.1	4.5	0.3
HCBS authority								
Section 1915(c) waiver	2,045	90,426	9.7	0.5	12.8	0.1	2.4	0.2
Section 1915(i) SPA	674	20,660	1.4	0.0	0.7	0.0	0.0	0.0
Section 1915(k) SPA	52	1,489	0.2	0.0	2.1	0.0	0.1	0.0
Section 1115 demonstration[5]	350	4,655	0.1	0.0	-	-	0.1	0.1

Notes and Sources (1)

AT Users and Spending in FFS and Managed Care

- Across all types of AT, a larger share of HCBS users received AT in FFS than managed care
  - FFS users: 6.2 percent received AT and SMES, 9.5 percent received PERS, 1.5 percent received home accessibility adaptations and vehicle modifications
  - Managed care users: 4.7 percent received AT and SMES, 5.8 percent received PERS, 1.1 percent received home accessibility adaptations and vehicle modifications
- Spending was also higher in FFS than managed care for AT and SMES and home accessibility adaptations and vehicle modifications

Interview Findings

High-Level Findings from Stakeholder Interviews

- AT may permit greater independence for beneficiaries to successfully live at home and engage in the community
- AT may help support and relieve pressure on caregivers
- States have the flexibility to cover AT in their HCBS programs
- States reported that adoption of AT was lower than expected
- Interviewees identified opportunities and challenges that may influence AT's ability to achieve intended impacts
- We summarize these findings in three sections:
  - How states cover AT
  - Process for obtaining AT
  - How beneficiaries use AT

Interview Findings

How States Cover AT

Medicaid Coverage of AT

- States reported primarily covering AT through HCBS programs, particularly Section 1915(c) waivers
- Some states appreciate the broadness and flexibility of the AT definition in the Section 1915(c) technical guide
- A national association explained that case managers are more likely to discuss AT in the person-centered planning process (PCSP) for intellectual and developmental disability (I/DD) HCBS programs than for aging and disability programs
- States reported the definitions and decision-making processes for AT are more developed in I/DD programs than aging and disability programs

Expenditure Caps and Reimbursement

- Some HCBS programs have caps for a specific AT service or group of services; other programs do not have caps on AT
- States reported approving most AT requests
  - However, caps may limit access to some AT, such as high-cost items or items that may need to be replaced
- Providers reported that Medicaid reimbursement for AT is low, and HCBS programs may not cover AT assessments, fittings, installations, training, and follow-up
- In accordance with the Section 1915(c) technical guide, Medicaid cannot reimburse for utilities or services not rendered

Coverage of New Technologies

- States expressed interest in keeping pace with changing technologies and covering new technologies in their HCBS programs; they also mentioned challenges in doing so
  - The federal requirement for AT to address a functional need may limit the new technologies that HCBS programs can cover, such as dual-use devices and technologies that support independence
  - State definitions of AT can become outdated as technology evolves
- States have the flexibility to develop new services and definitions subject to approval by CMS, and some states have created services to cover new technologies

Interview Findings

Process for Obtaining AT

Completing the PCSP

- The PCSP describes the services and supports that an individual requires to meet the needs identified in their functional assessment
- Because AT must be identified in the PCSP, case managers often play a large role in determining whether a beneficiary receives AT
- Case managers often lack knowledge of AT, and this may impact a beneficiary's ability to access AT
- States reported various ways that they assist case managers with identifying AT in the PCSP
  - For example, some states use AT-specific questions in their PCSP to encourage case managers to discuss AT with beneficiaries and to help identify needs that could be met by AT

Getting an AT Assessment by a Professional and Identifying an AT Vendor

- States may require an AT assessment to identify the item that best meets the beneficiary's needs
- Getting an AT assessment can take time, and there may be waitlists or a lack of providers to conduct AT assessments
- Finding an AT vendor can be difficult
  - AT vendors may be reluctant to enroll as Medicaid providers because the enrollment process is complicated and may bring them relatively few clients
- Case managers are often responsible for finding AT vendors, which may be challenging given competing responsibilities and large caseloads

Ensuring Medicaid is the Payer of Last Resort and Receiving Prior Authorization

- Because of payer of last resort requirements, it is often necessary to coordinate across multiple payers that also provide AT, such as Medicare and AT Act programs
  - This coordination can be challenging and may delay access to AT, especially for dually eligible beneficiaries
- Prior authorization (PA) can make it difficult for beneficiaries and providers to access and provide AT, due to administrative burden and wait times
  - Some states make exceptions to the PA process for low-cost items, repairs, or emergency situations

Interview Findings

How Beneficiaries Use AT

Education to Increase Awareness of AT

- Beneficiaries need education about the availability of AT; it is not widely known that coverage of AT is available in HCBS programs
  - Making beneficiaries aware of their AT options when they are developing their PCSP may increase adoption of AT
- Beneficiaries may be hesitant to adopt technologies that could replace human support, such as remote supports and smart home options
  - Overlap periods, when human support can be provided alongside AT, may make beneficiaries more comfortable with technology
- Engaging with Aging and Disability Resource Centers and AT Act programs may increase beneficiary awareness and adoption of AT

Training on How to Use AT

- Some HCBS programs cover training for beneficiaries, their families, and caregivers
- A lack of available training for beneficiaries can be detrimental to a beneficiary's use of AT and may lead to device abandonment
- Beneficiaries may turn to caregivers or family members for help with AT, but those individuals are not always informed enough to help
- Caregivers may not have much exposure to AT and could face challenges learning and using it
- Incentives for caregivers to learn how to use AT may not always align
  - With some services, such as electronic/remote supports, increased use could lead to reduced hours for in-person caregivers

Repairing AT

- AT often requires repairs and maintenance to be beneficial to users, and many waivers cover repairs for AT
- Some states require PA for repairs, which can add to the time it takes to receive repairs
- Repairs can take time because of a lack of designated, skilled providers and parts not being in stock, which may mean that the beneficiary is without their device for an extended period of time

Next Steps

Next Steps

- Staff will return with policy options at the December 2026 meeting
- For discussion:
  - Did any of the opportunities and challenges raised in our data analysis or stakeholder interview findings stand out to you?
  - Did the findings from the data analysis on HCBS subpopulations align with or differ from your expectations?
  - Given our findings on limited awareness of the AT benefit in Medicaid, what ways would you identify to increase awareness?
  - How may the PCSP be used to identify beneficiary needs that could be addressed by AT?

Figure Notes and Sources (1)

Notes: HCBS is home- and community-based services. AT is assistive technology. CY is calendar year. SMES is specialized medical equipment and supplies. PERS is personal emergency response system. I/DD is intellectual or developmental disabilities. ASD is autism spectrum disorder. SPA is state plan amendment. <65 is under 65 years old. "Potentially disabling conditions" refers to beneficiaries with the presence of diagnosis codes that indicate a possible disability; because there is no disease severity or functional assessment data in the Transformed Medicaid Statistical Information System (T-MSIS) analytic files (TAF), we must rely on diagnosis codes to indicate that the beneficiaries in the subpopulation grouping have at least one condition that could be the basis of a disability. Older adults are those age 65 and older. This table includes data from 50 states and the District of Columbia. Beneficiaries with missing or unknown geographic location accounted for less than 2 percent of the population and are excluded from this table. HCBS enrollees who used electronic/remote monitoring was low (0.2 percent of HCBS enrollees received electronic/remote monitoring, which accounted for less than 0.1 percent of spending), so these data are excluded from this table.

– Dash indicates zero. 0.0 indicates a value less than 0.05 percent that rounds to zero.

[1] Spending includes federal and state spending.

[2] Urban or rural location is classified based on beneficiary ZIP codes using the U.S. Department of Education National Center for Education Statistics Education Demographic and Geographic Estimates locale classification indicators.

[3] Full-benefit dually eligible beneficiaries receive the full range of Medicaid benefits offered in a given state, in addition to their Medicare benefits.

[4] HCBS subpopulations are based on the population defined in the Section 1915(c) waiver application. Not all subpopulations are included due to the limited number of waivers serving these subpopulations.

[5] Section 1115 demonstrations only include demonstrations from Arizonia, New Jersey, and Rhode Island, since these states use Section 1115 demonstrations to operate their HCBS programs.

Source: MACPAC, 2026, analysis of TAF data.

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SEPTEMBER MEETING

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