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CMCS Informational Bulletin

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SUBJECT: ***Ensuring Continuity of Coverage for Individuals Receiving Home and Community-Based Services (HCBS)***

The purpose of this CMCS Informational Bulletin (CIB) is to highlight federal renewal requirements and available flexibilities to promote continuity of coverage for individuals eligible for Home and Community-Based Services (HCBS) through Medicaid. HCBS is a cornerstone of long-term services and supports (LTSS) in the Medicaid program, enabling certain Medicaid enrollees to live and receive care and services in their home or the community rather than an institution and in such a way that promotes individual choice, control, and access to services. The loss of HCBS can pose a risk to beneficiaries' health or result in institutionalization. In 2021, 86% of people who used Medicaid LTSS were exclusively served in home and community-based settings through 250 HCBS programs across 50 states.[1] States have an ongoing obligation to conduct periodic renewals of eligibility in Medicaid consistent with federal regulations at 42 CFR § 435.916[2] and to facilitate continued access to HCBS for those who remain eligible.

The Social Security Act (the Act) authorizes state Medicaid agencies to provide HCBS to Medicaid beneficiaries through a number of pathways. These include waivers under section 1915(c), state plan amendments under sections 1915(i) and (k), and demonstrations authorized under section 1115(a) of the Act. This CIB outlines relevant federal Medicaid renewal requirements for individuals receiving HCBS through any of these authorities and highlights an

[1] Wysocki, Andrea, Caitlin Murray, Aparna Kachalia, Alexandra Carpenter, and Cara Stepanczuk. "Trends in the Use of and Spending for Home and Community-Based Services as a Share of Total LTSS Use and Spending in Medicaid, 2019–2021." Mathematica, July 24, 2024. https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html

[2] "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes" final rule (89 FR 22836) available at: https://www.federalregister.gov/d/2024-06566 makes changes to federal renewal requirements, including aligning renewal requirements for individuals eligible based Modified Adjusted Gross Income (MAGI) and non-MAGI methodologies. The final rule is effective June 3, 2024, at which time requirements related to renewals and redeterminations based on changes in circumstances described at 42 CFR § 435.916 are redesignated within 42 CFR §§ 435.916 and at 435.919. States have up to 36 months from the effective date of the final rule to implement certain provisions related to renewal requirements. For additional information on the implementation timeline of this final rule, see 89 FR 22836.

array of available strategies and approaches that states may implement to facilitate continued enrollment of eligible individuals with access to HCBS.

Federal Medicaid Renewal Requirements

CMS has been working closely with states and other stakeholders to ensure that renewals of Medicaid eligibility are conducted in accordance with regulations at 42 CFR § 435.916. CMS has also worked with states to implement policies and strategies that minimize state and beneficiary burden and promote continuity of coverage for eligible individuals. An individual receiving HCBS may be eligible for Medicaid based on either Modified Adjusted Gross Income (MAGI) or non-MAGI methodologies. In general, all Medicaid renewal requirements apply to individuals receiving HCBS. Further, states must ensure that renewal practices and systems are accessible for individuals with disabilities, including by providing support, information, communication technology, and auxiliary aids and services at no cost to the individual. In addition, states must take reasonable steps to provide meaningful access to individuals with limited English proficiency (LEP).[3]

CMS has previously provided states with information on federal renewal requirements, including in the CMCS Informational Bulletin (CIB), "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements" (Renewal CIB).[4] While this CIB provides a general overview of the renewal requirements, states should refer to the federal requirements at 42 CFR § 435.916 and the final rule "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes" (CMS-2421-F2) that appeared in the Federal Register on April 2, 2024 for a complete explanation of current federal renewal requirements. The final rule was effective June 3, 2024, and compliance with each provision will be phased-in over 36 months. Many of these key requirements are described below.

Per the regulations at 42 CFR § 435.916, states must conduct periodic renewals of eligibility for all Medicaid beneficiaries.[5] At renewal, states are required to first attempt to renew eligibility for all MAGI and non-MAGI beneficiaries based on reliable information available to the state agency without requiring information from the individual. Such renewals are referred to as *ex parte* renewals.[6] Recognizing that many individuals receiving HCBS are enrolled on a non-MAGI basis in eligibility groups that require an asset test, we want to remind states of the requirement to use information from the state's Asset Verification System (AVS) to verify financial assets at renewal as set forth in in section 1940(b) of the Act. Because states are required to attempt an *ex parte* renewal for all beneficiaries using all reliable information contained in the individual's account or other more current information available to the agency,

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[3] 42 CFR §§ 435.905(b); 435.907(g); 435.916(e); 435.917(a)(2).

[4] CMS, CIB, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," December 4, 2020, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

[5] Most states conduct renewals of eligibility only once every 12 months. Some states may conduct renewals of eligibility more frequently than once every 12 months for some or all non-MAGI beneficiaries until the state implements provisions in CMS-2421-F2 that require states to align certain renewal requirements for MAGI and non-MAGI beneficiaries. States have 36 months from the final rule effective date of June 3, 2024 to implement this requirement for non-MAGI beneficiaries.

[6] An *ex parte* renewal is sometimes referred to as auto renewal, passive renewal, or administrative renewal.

including for beneficiaries subject to an asset test, use of the AVS is a required part of the *ex parte* renewal process. If the agency can renew eligibility based on available reliable information, the agency must provide notice of the determination and basis for eligibility, and the individual must not be required to sign and return the notice if all information is accurate.

If information is insufficient to renew or redetermine eligibility on an *ex parte* basis, the state Medicaid agency must send a renewal form and request only the information necessary to redetermine eligibility. The agency must provide clear instructions for all beneficiaries on how to complete the form and correct any inaccurate information, how the form and other documentation can be returned, and the timeframe in which the individual must respond.[7] Renewal forms and notices must be accessible to individuals with LEP and persons with disabilities.[8] All beneficiaries, MAGI and non-MAGI, must be allowed to submit their renewal form through all modalities required at application as specified at 42 CFR § 435.907(a) (i.e., online, by phone, by mail, in person or through other electronic means). Renewal forms must be signed under penalty of perjury. Telephonic and electronic signatures, as well as handwritten signatures submitted electronically, must be accepted. An individual must be allowed to designate a person or organization of their choosing as their authorized representative as described in regulation at 42 CFR § 435.923 to complete and submit the renewal form on their behalf.

The state must consider all other bases of eligibility prior to determining an individual is ineligible for Medicaid. The agency must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested documentation unless and until they are determined to be ineligible.[9] If an individual is no longer eligible or is eligible with increased cost-sharing or fewer services, the state must provide a minimum of 10-days advance notice of adverse action. The advance notice must include the beneficiary's right to a Medicaid fair hearing. If the individual requests the fair hearing prior to the date of the action, the individual has the right to continue to receive benefits pending the fair hearing decision.[10] If an individual is disenrolled for failure to return their renewal form or requested information, the state must reconsider the individual's eligibility without requiring the individual to complete a new application if the individual returns their renewal form or missing information within 90 days from the date of termination (or longer, at the state's option).[11]

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[7] As described in CMS-2421-F2, 42 CFR § 435.916 requires states to provide all beneficiaries with a renewal form that is prepopulated with available information needed to renew eligibility and a minimum of 30 days to return the renewal form, which was previously a state option for non-MAGI beneficiaries. States have 36 months from the final rule effective date of June 3, 2024 to implement the requirement to provide both MAGI and non-MAGI beneficiaries with a prepopulated renewal form and a minimum of 30 days to return the form.

[8] 42 CFR §§ 435.905(b) and 457.340; CMS, CIB, "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," December 4, 2020, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

[9] 42 CFR § 435.930(b)

[10] 42 CFR § 431.230

[11] Some states may not offer a reconsideration period or provide a minimum 90-day reconsideration for non-MAGI beneficiaries until the state implements provisions in CMS-2421-F2 that require states to align renewal requirements for MAGI and non-MAGI beneficiaries. States have 36 months from the final rule effective date of June 3, 2024 to implement a minimum 90 day reconsideration period for non-MAGI beneficiaries.

Renewing Eligibility for Individuals Enrolled in HCBS

As noted above, whether a state covers HCBS under a section 1915(c) waiver, under its state plan, or through a section 1115 demonstration (subject to approved Special Terms and Conditions), federal eligibility and renewal requirements apply.

- Individuals receiving HCBS must be included in an eligibility group that is covered under the Medicaid state plan.
    - If an eligibility group is not included in the Medicaid state plan, it may not be included in the HCBS program.
    - If an eligibility group is included in the Medicaid state plan, a state has the option to include the eligibility group in the HCBS program.
- Individuals enrolled in HCBS under the special income level group described at 42 CFR § 435.217 must also require an institutional level of care[12] and receive a waiver service.

For individuals who are enrolled in an HCBS waiver and whose Medicaid eligibility is unrelated to receipt of HCBS services (i.e., not enrolled under 42 CFR § 435.217 as described above), the redetermination of financial eligibility at renewal is separate from the annual service plan update and level of care (LOC) evaluation.

- States must not require a service plan be updated, nor confirmation that a person still receives HCBS for the state to complete the redetermination of eligibility.
- States may align the timing of the annual renewal process with the annual service plan and LOC evaluations; however, the redetermination of Medicaid eligibility must be conducted irrespective of the timing of the annual service plan and LOC evaluation, unless the beneficiary is enrolled under 42 CFR § 435.217.

Existing Flexibilities Available to States to Facilitate Continued Coverage/Access to HCBS

Access to HCBS can mean the difference between an individual's ability to continue receiving services and supports in their home or community setting and institutionalization. CMS strongly encourages states to adopt flexibilities and strategies that facilitate ongoing coverage for individuals receiving HCBS. State Medicaid agencies have employed a range of practices to support continued coverage and access, and CMS is available to provide technical assistance to states as needed to implement such practices. With further explanation below, these practices include:

- Considering assets as stable and reliable in an *ex parte* renewal;
- Disregarding income, assets, or both at application and renewal for individuals receiving HCBS;
- Adopting temporary section 1902(e)(14)(A) flexibilities when applicable[13] to facilitate continued coverage:
    - Verify income using other human services benefit programs, including the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF)
    - Conduct *ex parte* renewals for individuals with $0 income

[12] See CMS HCBS Technical Guide section B-4-b: Medicaid Eligibility Groups Served in the Waiver

[13] CMCS Informational Bulletin, Extension of Temporary Unwinding-Related Flexibilities, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf

  - Renew eligibility for certain individuals with income at or below 100% of FPL and for whom no information is returned from financial data sources
  - Renew eligibility for individuals with certain stable income sources
  - Renew eligibility without regard to asset test for non-MAGI beneficiaries
  - Permit Managed Long-Term Services and Supports (MLTSS) plans to provide renewal support
  - Partner with MLTSS plans to update beneficiary contact information
  - Allow applicants/beneficiaries to designate an authorized representative via telephone
- Partnering with local agencies to enhance "No Wrong Door" systems to assist individuals with maintaining Medicaid enrollment.
- Performing level of care evaluation and person-centered service plan review prior to the financial eligibility renewal

Strategies to Help Eligible Individuals Retain Coverage

1. *Consider assets as stable and reliable in an ex parte renewal*
   States must attempt to verify financial assets for non-MAGI beneficiaries subject to an asset test using the state's AVS during the renewal process.[14] States have discretion to determine that the value of certain asset types is unlikely to increase so that the state can rely on the previously verified value of such assets rather than reverify the asset with the individual.[15] This strategy can help facilitate renewals on an *ex parte* basis and support continuity of coverage for non-MAGI beneficiaries. If the state has information that indicates financial assets are at or below the applicable resource[16] standard, and no other sources of asset information are available, states may consider assets verified if:
   a) The beneficiary did not have any countable non-financial assets at their last full determination, or
   b) The beneficiary only has non-financial assets that are stable (i.e., not likely to change in value) and the value of assets returned by the AVS plus the value of the beneficiary's other assets is at or below the applicable resource standard.

   If other asset information in addition to what is verified through AVS is available, states may consider assets verified if: the value of financial assets returned by the AVS plus the value of assets verified through other available sources plus the value of the beneficiary's other stable assets is at or below the applicable resource standard, and the beneficiary does not have other countable assets whose value is subject to change.

   Action: To implement this option, states should clearly document the asset types that are unlikely to appreciate or depreciate in value over time in state verification policies and procedures.

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[14] States must verify assets of individuals excepted from MAGI-based methodologies and subject to an asset test using the state's Asset Verification System under section 1940 of the Social Security Act. Also see 42 CFR § 435.916

[15] See "COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies" October 17, 2022 (question 9) available at https://www.medicaid.gov/sites/default/files/2022-10/covid-19-unwinding-faqs-oct-2022.pdf.

[16] In this document, the terms resource and asset are used interchangeably.

2. *Disregard income, assets, or both at application and renewal for individuals receiving HCBS.*
   Section 1902(r)(2)(A) of the Act permits states to disregard income, assets or both, that are otherwise countable in a non-MAGI eligibility determination. States have the additional authority to target such disregards at individuals who need HCBS authorized under section 1915(c), (i) and (k) of the Act, or comparable HCBS benefits available under a section 1115 demonstration.[17] A state could utilize this authority for a set period of time to disregard all or some countable income, assets, or both (e.g., increase asset limits) at the renewals of individuals who are receiving coverage for HCBS.

   Action: To elect this option, states must submit a request to amend their HCBS program authority.[18]

3. *Adopt section 1902(e)(14)(A) waiver flexibilities to facilitate continued coverage of eligible individuals*
   Separate from the authority described above, states have the option to request authority under section 1902(e)(14)(A) of the Act to temporarily implement strategies that protect beneficiaries by alleviating administrative demands that may lead to fewer procedural terminations.[19] Some of these strategies facilitate renewal for individuals likely to be eligible for Medicaid without requiring additional information from the individual (*ex parte* renewals).

   In May 2024, CMS issued additional guidance related to whether and when states may use a section 1902(e)(14) waiver strategy more than once for the same individual. States should review the CIB, "Extension of Temporary Unwinding-Related Flexibilities"[20] as they consider these strategies. Further, CMS is available to provide technical assistance to states interested in implementing any of these strategies:

   a. *Verify income for individuals whose eligibility is not based on MAGI (Non-MAGI individuals) using income from SNAP or TANF eligibility determinations (Targeted SNAP or TANF strategy (Non-MAGI))*
      In general, states leverage information from programs like SNAP or TANF to verify eligibility and facilitate renewals in a manner that minimizes beneficiary burden. States may also use verified information from other state and federal programs to verify the financial eligibility of an individual. Ordinarily, states use these sources of information about an individual's income while applying relevant Medicaid rules related to income counting to determine eligibility. Under this temporary flexibility, states may redetermine financial eligibility for Medicaid for individuals whose SNAP or TANF gross income and assets, as applicable, are below

[17] Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, section 3(b).
[18] See SMD #21-004 "State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services" available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21004.pdf
[19] CMCS Informational Bulletin, Extension of Temporary Unwinding-Related Flexibilities, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf.
[20] https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf.

applicable Medicaid limits, despite the differences in household composition and income-counting rules between programs.

b. *Renew Medicaid eligibility for individuals with no income and no data returned on an ex parte basis ($0 income strategy)*
States may use this authority for households whose most recent income determination prior to the beginning of the state's unwinding period was no earlier than March 2019 (or within the last 12 months for any state that receives approval to use this flexibility after the unwinding period) and verified a household income of $0; and for whom the state checks appropriate electronic financial data sources at renewal, and no information is received or returned. In order to complete the *ex parte* renewal, the state must take appropriate steps to review the non-financial components of eligibility consistent with the requirements at 42 CFR §§ 435.916 and 435.956.

c. *Renew Medicaid eligibility for individuals with income at or below 100% of FPL and no data returned (100% income strategy)*
States may complete a Medicaid income determination at renewal without requesting additional information or documentation if: (1) the most recent income determination prior to the beginning of the COVID-19 Public Health Emergency (PHE) was no earlier than March 2019 (or within the last 12 months for any state that receives approval to use this flexibility after the unwinding period) and was based on verified income at or below 100% FPL; and (2) the state has checked financial data sources in accordance with its verification plan and no information is received. This strategy may be especially beneficial to improve *ex parte* rates for individuals who are self-employed, especially in states not using tax data as part of an *ex parte* determination.

d. *Streamline income determinations/renew eligibility based on available data for income not likely to change (Stable income renewal)*
States may rely on information which the state determines is highly unlikely to change and complete an *ex parte* income determination at renewal without requesting additional information or documentation of income if: (1) the most recent income documentation was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019), or within the last 12 months for any state that receives approval to use this flexibility after the unwinding period; and (2) the beneficiary only had Title II Social Security or other stable income at the most recent determination.

e. *Renew Medicaid eligibility without regard to the asset test for Non-MAGI beneficiaries subject to an asset test*

States may modify asset requirements for all or reasonable subsets of non-MAGI beneficiaries subject to an asset test. States may complete an *ex parte* renewal process without re-verification of assets.

f. Permit MLTSS plans to assist enrollees in the renewal process (MCO renewal support)
This strategy would permit Medicaid managed care plans to voluntarily assist their enrollees in completing the Medicaid renewal process, including completing certain parts of renewal forms. Managed care plans must limit their renewal form assistance to completing fields in the renewal forms with information provided by the enrollee, excluding any fields associated with managed care plan selection or the enrollee's signature. Managed care plans must not provide choice counseling (defined at 42 CFR § 438.2) services to their enrollees. State payment to managed care plans for work of this type conducted on behalf of the state must be separate from the actuarially sound capitation payments to plans.

g. Partner with MLTSS plans to update beneficiary contact information (MCO beneficiary contact updates)
States generally are required to contact the beneficiary to confirm the accuracy of updated contact information received from a health plan and to provide a reasonable period for the beneficiary to dispute the information provided by the plan, prior to updating the beneficiary record. States may request authority to temporarily accept updated enrollee contact information from managed care plans without additional confirmation with the individual where doing so would serve to protect beneficiaries in the aggregate. Under this temporary waiver authority, states may treat updated contact information received from the plan as reliable and update the beneficiary record with the new contact information without first sending a notice to the address on file with the state.

h. Allow applicants to designate an authorized representative over the phone with verbal authorization of that designation (Authorized representative designation)
This strategy can maximize the effectiveness of assistors and other community partners who are assisting beneficiaries in completing their renewal forms.

Action: States that are interested in any of the section 1902(e)(14)(A) waiver flexibilities described above and have not received prior approval, must submit a letter to CMS requesting approval for such authority. States that were previously approved to use any of the section 1902(e)(14)(A) waiver flexibilities described above may continue to use for individuals who are due for a renewal through June 30, 2025, as long as the state meets the conditions outlined in CMCS Informational Bulletin, "Extension of Temporary

Unwinding-Related Flexibilities".[21] CMS is available to provide additional information and technical assistance as needed.

4. *Partner with local agencies to enhance "No Wrong Door" systems to assist individuals with maintaining Medicaid enrollment*
   Building on the strength of existing entities such as Aging and Disability Resource Centers (ADRC), Area Agencies on Aging (AAA), and Centers for Independent Living (CILs), No Wrong Door systems provide the opportunity for states to partner with local agencies to create a single, coordinated system to access information and receive one-on-one counseling regarding LTSS including HCBS. The expenses for conducting certain partnership building and collaboration activities may be claimed as an administrative expense.

   Action: To elect this option, states should review CMS guidance on methods for claiming federal matching funds for Medicaid administrative activities performed through No Wrong Door systems and for ensuring non-duplication for any such claims available at: https://www.medicaid.gov/medicaid/downloads/no-wrong-door-guidance.pdf. Additional No Wrong Door resources from the Administration for Community Living (ACL) are available here: https://nwd.acl.gov/sustaining-a-nwd-system.html.

5. *Perform LOC evaluation and person-centered service plan review prior to the financial eligibility renewal*
   For individuals to retain coverage in HCBS programs, a valid level of care determination and person-centered service plan review (with appropriate updates) are required annually. For individuals eligible under 42 CFR §435.217 a valid level of care determination must be completed for the individual to be Medicaid eligible. The level of care determination and annual person-centered service plan review do not need to occur at the same time as financial eligibility renewal. Completing the level of care evaluation and annual person-centered service plan review in the month prior to the month in which financial eligibility renewal is due avoids potential disruptions of services to HCBS enrollees. For individuals eligible under 42 CFR §435.217, this ensures that a level of care determination is in place so that individuals can maintain Medicaid eligibility.

   Action: Implement policies and procedures to perform the level of care evaluations and person-centered service plan reviews/updates prior to the financial eligibility renewal month.

Strategies to Facilitate Reenrollment of Eligible Individuals in HCBS Programs

In some states, a significant number of individuals lose coverage due to administrative processes (i.e., procedural disenrollments) even though they continue to meet Medicaid's substantive eligibility criteria. While states may have procedures in place to reinstate eligible individuals in

[21] CMCS Informational Bulletin, Extension of Temporary Unwinding-Related Flexibilities, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf.

coverage, those individuals previously enrolled in HCBS may have difficulties re-enrolling in their HCBS programs, despite meeting eligibility requirements. States may need to evaluate their renewal approach and their process for reinstating coverage for eligible individuals whose coverage was terminated. This is uniquely challenging for individuals receiving HCBS and states should consider implementing the following strategies to help eligible individuals reenroll.

1. *Reserve HCBS waiver capacity*
   States may limit the number of eligible individuals who may be enrolled in HCBS waiver programs. For states with a limited number of individuals who can be enrolled at a given time, an individual's access to services is contingent not only on meeting the level of care and other eligibility criteria, but also on the availability of a "slot" in the waiver group. A state may reserve a portion of the waiver's capacity (i.e., hold a limited number of waiver slots open) for specified purposes.[22] States may choose to set aside a certain number of waiver slots on a priority basis to accommodate the return of eligible individuals who have lost coverage.

   Action: To elect this option, states must submit a request to amend their HCBS program authority, i.e., section 1915(c) waiver or section 1115 demonstration.

2. *Prioritize entrance to the HCBS waiver*
   The state's limit on the number of individuals who participate in a HCBS waiver may result in a waiting list for waiver services (i.e., entrance to the waiver of otherwise eligible applicants must be deferred until capacity becomes available, either as a result of turnover or the appropriation of funding by the state's legislature for additional slots). Instead of serving applicants on a "first come, first serve" basis, states may prioritize entry to the waiver if they have policies that govern the selection of individuals for entrance when capacity becomes available.[23] With this strategy, states may prioritize individuals who experienced a gap in coverage (i.e., lost coverage for HCBS) but reapply within a specified period of time (e.g., 90 days). States' policies should be based on objective criteria and applied consistently in all geographic areas served by the waiver.

   Action: To elect this option, states must submit a request to amend their HCBS program authority, i.e., section 1915(c) waiver or section 1115 demonstration.

3. *Allow "provisional" service plans*
   CMS may allow a provisional person-centered service plan which identifies the essential Medicaid services that will be provided in the next 60 days, while a fuller service plan is being developed and implemented. This will help expedite initiation of waiver services for individuals who reenroll. A comprehensive person-centered service plan must be in place in order for services to continue beyond the 60 days.[24]

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[22] CMS HCBS Technical Guide section B-3-c: Reserved Waiver Capacity
[23] CMS HCBS Technical Guide section B-3-f: Selection of Entrants to the Waiver
[24] State Medicaid Director Letter - Olmstead Update No: 3

Action: To elect this option, states must submit a request to amend their HCBS program authority.

4. *Level of Care*
   For individuals enrolled in an HCBS section 1915(c) waiver or section 1915(k) state plan program, states must determine that the individual continues to meet an institutional LOC. Individuals receiving services authorized under section 1915(i) must meet the state's established needs-based criteria, any applicable targeting criteria, and Medicaid financial eligibility. The LOC must be re-evaluated at least annually.[25] To help eligible individuals who lost coverage, if an individual had a LOC re-evaluation completed within the past 12 months, that LOC determination will suffice for determining eligibility for the section 1915(c) waiver or section 1915(k) program, and a new determination will not be required to reinstate section 1915(c) waiver or section 1915(k) services. For section 1915(i) eligibility, the same applies for assessing individuals against the needs-based criteria, any applicable targeting criteria, and Medicaid financial eligibility.[26]

   Action: To elect this option, states may need to update their internal procedures**.**

5. *Conduct additional outreach on the renewal process and fair hearing process*
   States communicate regularly and proactively with internal and external stakeholders who work closely with individuals receiving HCBS. These stakeholders include ombudsman offices, legal services providers, health care providers, and social and community service organizations. Stakeholders can be instrumental in reminding individuals to anticipate when they will need to complete the renewal process. For individuals whose coverage has been terminated, stakeholders can assist in the appeal process and remind individuals they may request that services continue while a fair hearing is being pursued.[27] States may also update notices to clarify fair hearing rights and provide additional information about community resources available to help with the appeal process. This strategy will protect individuals' due process rights and assist them in maintaining coverage.

   Action: To elect this option, states may need to update internal procedures.

Conclusion

Access to HCBS through Medicaid is critical for millions of eligible individuals who are elderly or disabled. Sustaining these benefits is crucial as states redetermine Medicaid eligibility. States should review their policies, operations, and systems to ensure they are complying with the requirements described above. In addition, states are strongly encouraged to adopt strategies and flexibilities that may assist eligible individuals receiving HCBS to keep those services, remain in the community, and receive support that promotes individual choice, control, and access to

[25] The state may elect to permanently waive the annual recertification required under 1915(k) for an individual in accordance with specific benefit flexibilities under 42 CFR § 441.510(c)
[26] See 42 CFR §§441.302(c)(2) and 441.715(e)
[27] Understanding Medicaid Fair Hearings, available at https://www.medicaid.gov/resources-for-states/downloads/mdcid-fair-hrings-prtnr-rsurce.pdf.

services. CMS is available to provide technical assistance on the strategies outlined in this Bulletin. For additional information about this Bulletin or technical assistance, please contact your CMCS state lead.