Ensuring Continuity of Coverage for Individuals Receiving Home and Community-Based Services (HCBS)
August 2024

Objectives

The objective of this slide deck 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.

These slides are a companion to the CMCS Informational Bulletin:

Ensuring Continuity of Coverage for Individuals receiving Home and Community-Based Services (HCBS).

Overview

- 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.
- States have an ongoing obligation to conduct periodic renewals of eligibility in Medicaid consistent with federal regulations at 42 CFR §435.916 and facilitate continued access to HCBS for those who remain eligible and continue to meet the criteria to receive HCBS.

HCBS Program Eligibility

The Social Security Act authorizes state Medicaid agencies to provide HCBS through several pathways:

- Waivers under section 1915(c)
- State plan amendments under sections 1915(i) and (k)
- Demonstrations authorized under section 1115(a)

- Individuals receiving HCBS may be eligible for Medicaid based on either Modified Adjusted Gross Income (MAGI) or non-MAGI methodologies.
- States may provide HCBS only to individuals otherwise eligible under the state plan. If an eligibility group is not included in the Medicaid state plan, it may not be included 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* and *receive a waiver service* in order to be eligible.

Renewing Eligibility for Individuals Enrolled in HCBS

Federal Medicaid Renewal Requirements

States must conduct renewals of eligibility for individuals receiving HCBS in accordance with the federal renewal requirements listed below. [1,2]

***Ex Parte* Renewals**	Begin the renewal process for all beneficiaries without requiring information from the individual.
Renewal Form	Send a renewal form and request only information needed to determine eligibility when eligibility cannot be renewed *ex parte*. This form must be prepopulated for MAGI beneficiaries.
Reasonable Timeframe and Modalities to Return Form	Provide a minimum of 30 days to return the renewal form and any requested information for MAGI beneficiaries. Beneficiaries must be allowed to return their renewal form online, by phone, by mail, or in-person.
Determine Eligibility on All Bases	Consider all bases of Medicaid eligibility prior to determining an individual is ineligible for Medicaid and terminating coverage.
Advance Notice and Fair Hearing Rights	Provide a minimum of 10 days' advance notice and fair hearing rights prior to terminating Medicaid eligibility or reducing benefits/increasing cost sharing.
Account Transfers	Determine potential eligibility for other insurance affordability programs and timely transfer the beneficiary's electronic account to such program for beneficiaries who are determined ineligible for Medicaid.
Reconsideration Period	Reconsider eligibility without requiring a new application if the individual's renewal form is returned within 90 days (or longer at state's option) after coverage terminated (or longer at the state's option).

1. Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes States have up to 36 months from the effective date of the final rule to implement certain provisions related to renewal requirements.
2. CMCS Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements 42 CFR §435.916.

Redetermination of HCBS Program Eligibility

For individuals enrolled in HCBS and whose Medicaid eligibility is unrelated to receipt of HCBS (i.e., not enrolled under 42 CFR §435.217), the redetermination of financial eligibility at renewal is separate from the annual Person-Centered Service Plan (PCSP) update and level of care (LOC) evaluation.

- States must not require a PCSP to be updated, nor confirmation that a person still receives HCBS, for the state to complete redetermination of eligibility.
- The redetermination of Medicaid eligibility must be conducted irrespective of the timing of the annual PCSP review and LOC evaluation, unless the beneficiary is enrolled under 42 CFR §435.217.

States may align the timing of the annual renewal process and the annual PCSP and LOC evaluation.

Existing Flexibilities to Facilitate Continued Coverage/Access to HCBS

1. Consider assets as stable and reliable in an *ex parte* renewal
2. Disregard income, assets, or both at application and renewal for individuals who are receiving HCBS
3. Adopt temporary section 1902(e)(14)(A) waiver flexibilities to facilitate continued coverage of eligible individuals
4. Partner with local agencies to enhance “No Wrong Door” systems to assist individuals with maintaining Medicaid enrollment
5. Perform level of care evaluation and person-centered service plan review prior to the financial eligibility renewal

1 Consider Assets as Stable and Reliable in an *Ex Parte* Renewal

If the state has information that indicates financial assets at or below the applicable resource standard, and no other sources of asset information are available, states may consider assets verified if:

- The beneficiary did not have any countable non-financial assets at their last full determination of eligibility, or
- 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: States should clearly document the asset types that are unlikely to appreciate or depreciate over time in state verification policies.

1 Scenario: Consider Assets as Stable and Reliable in an *Ex Parte* Renewal

State Eligibility Business Rules

- State has an income limit of 85% of the FPL ($1,067/month for a household of 1) for non-MAGI adults.
- State has an asset limit of $2,000 for an individual and $3,000 for a couple.
- The primary vehicle is exempt as long as the individual or a member of their household is using it.
- **State has documented in its state verification policies and procedures that the following assets are deemed stable in value and unlikely to increase over time: second vehicle, personal property, and burial funds.**

Fact Pattern

- John, an individual enrolled in the aged eligibility category, is a non-MAGI household of 1.
- At renewal, state verifies:
  - Income against available data sources in accordance with its verification policies. Data from Social Security shows a monthly income of $600.
  - Assets against AVS. AVS returns liquid asset information from Bank of America of $500.
  - The value of John's second car is $1,000.
- At renewal, state does not seek to reverify the value of John's second vehicle as reflected in the eligibility system because the state deems second vehicles as stable assets.

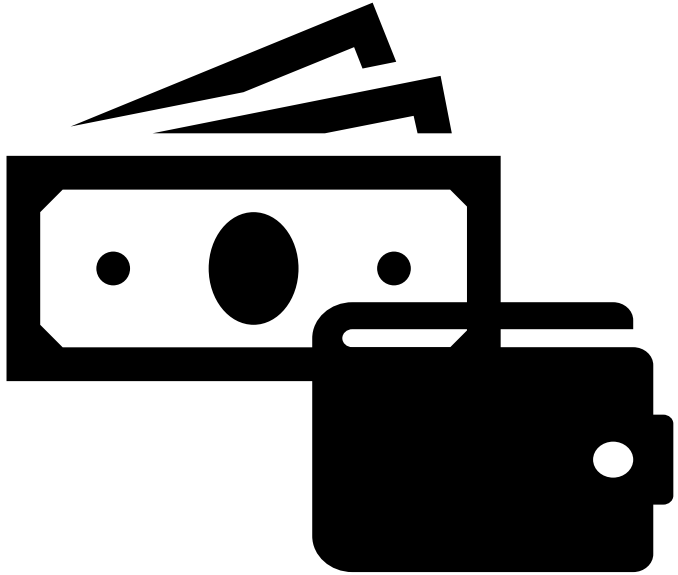
Eligibility Determination

John **continues to be eligible** for Medicaid because he meets:

- ✓ Income eligibility: $600 is less than the Medicaid income eligibility limit for a household of 1 of $1,067.
- ✓ Asset eligibility: John's countable assets of $1,500 (AVS data return + value of second car) is less than the Medicaid asset eligibility limit of $2,000.

2 Disregard Income, Assets, or Both at Application and Renewal for Individuals Receiving HCBS

States can disregard all or some countable income, assets (e.g., increase asset limits), or both at the renewals of individuals who are receiving coverage for HCBS for a set period of time under Section 1902(r)(2)(A) and 1915(c), (i), (k) authorities.[1]



Action: States must submit a request to amend their HCBS program authority.

1. 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

2 Scenario: Disregard Income, Assets, or Both at Renewal

State Eligibility Business Rules

- State has an income limit of 85% of the FPL ($1,067/month for a household of 1) for non-MAGI adults.
- State has an asset limit of $2,000 for an individual and $3,000 for a couple.
- **State has approved Section 1902(r)(2) authority to disregard assets for individuals who are in need of HCBS under Section 1915(c), (i) and (k) and are up for renewal.**

Fact Pattern

- Tom, an individual enrolled in the aged eligibility category, is a non-MAGI household of 1.
- Tom is in receipt of HCBS under Section 1915(i).
- At renewal, state verifies:
  - Income against available data sources in accordance with its verification policies. Data from Social Security shows a monthly income of $600.
- At renewal, state does not seek to verify assets for Tom because he is in receipt of HCBS, and the state is disregarding assets.

Eligibility Determination

Tom **continues to be eligible** for Medicaid because he meets:

- ✓ Income eligibility: $600 is less than the Medicaid income eligibility limit for a household of 1 of $1,067.
- ✓ No asset test is applied per the Section 1902(r)(2) authority.

3 Adopt Section 1902 (e)(14)(A) Waiver Flexibilities to Facilitate Continued Coverage

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.[1]

Targeted SNAP or TANF strategy (Non-MAGI)

Verify income for individuals using income from SNAP or TANF eligibility determinations

$0 Income Strategy

Renew Medicaid eligibility for individuals with no income and no data returned on an *ex parte* basis

100% Income Strategy

Renew Medicaid eligibility for individuals with income at or below 100% of FPL and no data returned

Stable Income Renewal

Streamline income determinations/renew eligibility based on available data for income not likely to change

Modify Requirement for Asset Test

Renew Medicaid eligibility without regard to the asset test for non-MAGI beneficiaries subject to an asset test

MCO Renewal Support

Permit Medicaid managed care plans to assist enrollees in the renewal process

MCO Beneficiary Contact Updates

Partner with Medicaid managed care plans to update beneficiary contact information

Authorized Representative Designation

Allow applicants to designate an authorized representative over the phone with verbal authorization of designation

Action: States must submit a letter to CMS requesting approval for such authority. CMS is available to provide technical assistance to states interested in these strategies. 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."

1. Approval subject to state acceptance of conditions/limitations unique to the strategy. CMCS Informational Bulletin, Extension of Temporary Unwinding-Related Flexibilities, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf

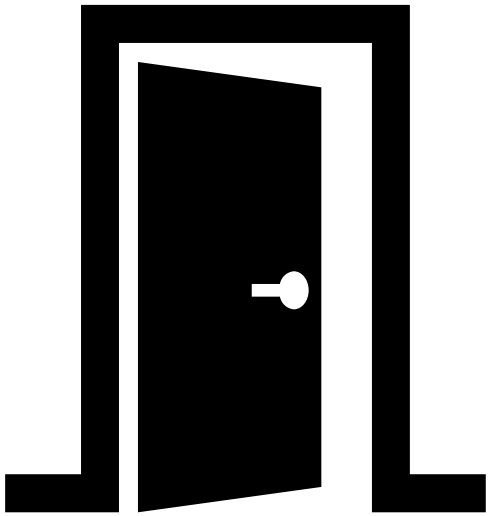
Scenario: Adopt Section 1902(e)(14)(A) Waiver Flexibility to Allow Applicants to Designate an Authorized Representative Over the Phone With Verbal Authorization of that Designation

3

Fact Pattern

- Noah, an individual enrolled in the aged category, is a non-MAGI household of 1.
- Noah works with Joanna who is from a community-based organization application assistance entity that assisted him in completing an application.
- Joanna calls Noah and asks him if he requires assistance to complete his renewal online.
- Noah is very appreciative of Joanna's call and offer of assistance.
- Joanna calls the state Medicaid agency with Noah on the line. Joanna explains that she is calling with Noah and that she provided application assistance for him when he applied. She also explains that she will be assisting him with his renewal.
- The state Medicaid representative asks Noah to confirm that he would like Joanna to help him. Noah confirms that he wants Joanna's help. After verifying Noah's identity, the Medicaid representative asks Noah if he would like to designate Joanna as his authorized representative so that she can submit a renewal on his behalf.
- Noah affirms that he would like to authorize Joanna to be his representative.
- **Pursuant to the state's 1902(e)(14)(A) waiver, Joanna is now Noah's authorized representative.**

4 Partner with Local Agencies to Enhance "No Wrong Door" Systems



- "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 long-term services and supports (LTSS) including HCBS.
- Partner entities include:
  - Aging and Disability Resource Centers (ADRC)
  - Area Agencies on Aging (AAA)
  - Centers for Independent Living (CILs)
- The expenses for conducting certain partnership building and collaboration activities may be claimed as an administrative expense.

Action: States should review CMS guidance on methods for claiming federal matching funds for Medicaid administrative activities performed through No Wrong Door systems.[1]

1. For more information, see https://www.medicaid.gov/medicaid/downloads/no-wrong-door-guidance.pdf and https://nwd.acl.gov/sustaining-a-nwd-system.html.

4 Scenario: Partner with Local Agencies to Enhance "No Wrong Door" Systems to Assist Individuals with Maintaining Medicaid

"No Wrong Door" Approach

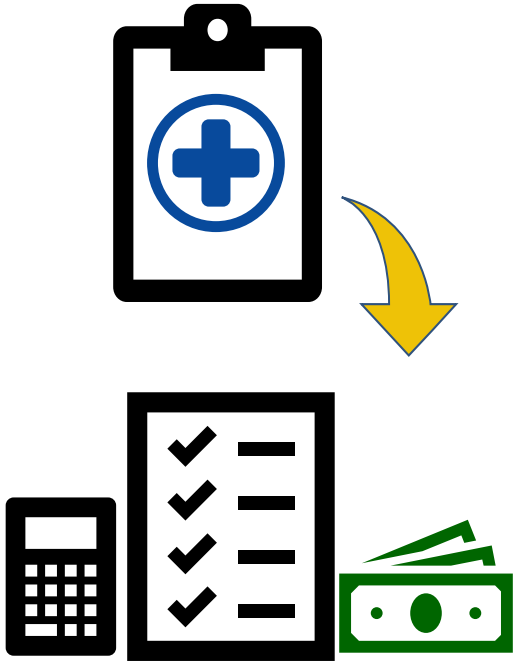
- State uses a "No Wrong Door" systems approach to maintaining Medicaid enrollment.
- **Community partners with expertise in HCBS assist individuals to make informed decisions to achieve their personal goals and preferences.**

Fact Pattern

- State creates Medicaid eligibility and enrollment system training materials targeted to community partners like Aging and Disability Resource Centers (ADRC), Area Agencies on Aging (AAA), and Centers for Independent Living (CILs) with expertise in LTSS, including HCBS.
- State trains and certifies community partners to assist individuals with the Medicaid eligibility process with a focus on underserved and hard-to-reach populations, including people with disabilities and limited English-speaking populations.
- Community partners can provide one-on-one application and renewal assistance to individuals with LTSS including HCBS.

5 Perform Level of Care Evaluation and Person-Centered Service Plan (PCSP) Review Prior to Financial Eligibility Renewal

- The LOC determination and PCSP review are required annually but do not need to occur at the same time as financial eligibility renewal.
- For individuals eligible under 42 CFR §435.217, a LOC determination must be completed for Medicaid eligibility.
- Completing the LOC evaluation and PCSP 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 LOC determination is in place so that individuals can maintain Medicaid eligibility.



Action: Implement policies and procedures to perform the LOC evaluations and PCSP reviews/updates prior to the financial eligibility renewal month.

Strategies to Facilitate Reenrollment of Eligible Individuals in HCBS Programs

Overview of Strategies to Facilitate Reenrollment in HCBS

1. Reserve HCBS waiver capacity
2. Prioritize entrance
3. Allow “provisional” service plans
4. Level of Care
5. Conduct additional outreach on the renewal process and fair hearing process

HCBS Program Strategies

1 Reserve HCBS program capacity

- A state may reserve a portion of the program's capacity (hold a limited number of waiver slots) to accommodate the return of eligible individuals who have lost coverage.

2 Prioritize entrance to the HCBS program

- A state's limit on the number of individuals served may result in a waiting list. Instead of serving applicants on a "first come, first serve" basis, states may prioritize entry for 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).
- State's policies should be based on objective criteria and applied consistently in all geographic areas served by the waiver.

Action: For both strategies above states must submit a request to amend their HCBS program authority, i.e., 1915(c)waiver or 1115 demonstration.

Provisional Service Plan and Level of Care Strategies

3 Allow "provisional" service plans[1]

- States may allow a provisional 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 services for individuals who reenroll.
- A comprehensive service plan must be in place for services to continue beyond the 60 days.

Action: States must submit a request to amend their HCBS program authority.

4 Level of Care

- If an individual had a LOC re-evaluation completed within the past 12 months, that LOC determination will suffice for determining eligibility for the 1915(c) or 1915(k) program. Same applies for 1915(i) needs-based criteria. A new determination will not be required to reinstate services.

Action: States may need to update their internal procedures.

1. State Medicaid Director Letter - Olmstead Update No: 3

Additional Outreach for Renewal and Fair Hearing Strategies

5

Conduct additional outreach on the renewal process and fair hearing 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.

Stakeholders can include:

Ombudsman Offices

Legal Services Providers

Health Care Providers

Social and Community Service Organizations

Action: States may need to update their internal procedures.

CMS Resources to Support States with HCBS Renewals

1. CMCS Information Bulletin, Return to Regular Renewal Operations: Ensuring Continuity of Coverage for Individuals receiving Home and Community-Based Services (HCBS), available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib08192024.pdf.
2. CMCS Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf
3. CMCS Informational Bulletin, Extension of Temporary Unwinding-Related Flexibilities, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf
4. 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
5. CMCS Informational Bulletin, Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib03152024.pdf
6. 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