Presumptive Eligibility for Medicaid Home and Community-Based Services Can Expand Consumer Options

Susan C. Reinhard, Robert L. Mollica, Claudio W. Gualtieri, and Carrie Blakeway Amero
AARP Public Policy Institute

Introduction

Older adults and people with disabilities overwhelmingly prefer to remain at home and receive care in the community for as long as possible. Unfortunately, Medicaid’s complex eligibility process does not necessarily reflect this preference, nor does the process account for the practical realities most individuals and family caregivers face when they wish to avoid a nursing home admission under stressful circumstances—an unexpected hospitalization or a rapid deterioration of health at home. In those situations, timely access to services can mean the difference between someone returning to the community or entering a nursing home.

This Spotlight explores how presumptive eligibility can empower consumers to access publicly funded home- and community-based services (HCBS) without lengthy determination delays. The AARP Public Policy Institute LTSS State Scorecard, a multifaceted assessment of state LTSS performance, recognizes presumptive eligibility as a high-performing function of Aging and Disability Resource Centers (ADRCs). Enhanced ADRC or No Wrong Door


systems—where consumers can get information, counseling, and assistance connecting with the public and private services they need regardless of what agency or entity they go to first—can help consumers obtain HCBS without delay.

**Eligibility Rules Can Create Access Barriers to Timely HCBS Options**

Many people experience some degree of disability and increased functional need gradually as they age. For others, a serious accident or health episode can lead to a sudden need for significant support. In either case, most people can continue to live at home if they get the right in-home services and supports. Individuals who cannot afford to pay for in-home services out of pocket can apply for Medicaid HCBS waiver or state plan service. However, in all but a few states, the individual must wait until a final Medicaid eligibility determination before Medicaid will start HCBS. On the other hand, nursing homes are generally willing to admit someone after hospital discharge or from the community and start services, even while the person’s ability to pay for services and/or eligibility for Medicaid is determined. If someone a nursing home admits is ultimately found to be ineligible and is unable to pay, the home assumes the cost for the services the patient received.

The time period between application and final approval of a Medicaid HCBS eligibility can be particularly perilous for individuals with limited resources who want to stay at home. Individuals who need care and wish to avoid a nursing home admission must either privately pay for services or rely on family caregivers during that period. While family caregivers can help fill service gaps and provide temporary relief, the care needed to support an individual at home may exceed what the typical family caregiver can provide. Most family caregivers work part or full time, and many do not have access to workplace flexibilities that would allow them to take extended leave for caregiving duties. Given these constraints, timely care is essential to ensure consumers receive appropriate care in the setting of their choice.

While federal rules require states to make timely financial determinations—within 45 days from the date of application and within 90 days of when a disability determination is made—administrative complexities can delay the process. Applications for older adults are often much more complicated than for other beneficiaries such as children and families because they have different paths to Medicaid eligibility. For example, older adults may qualify with different income levels than younger populations (up to 300 percent of Supplemental Security Income [SSI]). Others may qualify in the “medically needy” category because they have spent down their private resources on healthcare, because they are eligible for SSI, or because they fit into other poverty-related categories. The eligibility process for older adults can be further complicated by transfer-of-asset rules and the time it takes to organize and collect necessary documents, produce proof of value for any transfers of assets, and other application requirements. Combined, these administrative barriers can result in lengthy delays.

Those delays have serious consequences for an individual’s choice to remain in the community. Since nursing homes are generally more willing than home care agencies to admit individuals while their Medicaid application is under review and bear the risk that a client will be found ineligible, nursing home care may be the only viable option for individuals with immediate care needs.
Presumptive Eligibility: What Is It and How Can It Help?

Presumptive eligibility is a strategy several states have pursued to fast track access to Medicaid and other publicly funded HCBS. Currently, five states actively use presumptive eligibility for Medicaid HCBS to connect older adults and people with physical disabilities with publicly funded LTSS in the community. Under presumptive eligibility, waiver case managers, nurses, or social workers can use basic financial information and screening tools to quickly presume a low-income individual is eligible for Medicaid and commence services, even before an official Medicaid determination is made.

Presumptive eligibility allows applicants who appear likely to be eligible for Medicaid to start receiving HCBS when a need arises. In states with presumptive eligibility, an individual can receive services in his or her home while his or her Medicaid application is being processed; the financial risk that someone will ultimately be found ineligible is either fully assumed by the state or shared with HCBS providers. This flexibility ensures individuals have access to critical services in the setting of their choice without having to go into a nursing home. By quickly providing a continuity of care in the community, individuals can maintain their independence and forgo more expensive institutional care.

Exhibit 1: State Policies Allowing Presumptive Eligibility for Medicaid HCBS

---

For the purpose of this paper, states with active presumptive eligibility programs are Michigan, Ohio, Rhode Island, Vermont, and Washington. New York has some statutory authority for presumptive eligibility, but those provisions have limited practical applicability. Oregon uses presumptive eligibility for individuals who are applying to Medicaid as disabled only. The decision is based on readily available medical information and income data. If income and resource information is not readily available, the state accepts self-declaration during the COVID-19 period. A decision is made within five days. Eligibility staff process about 100 per month. New Hampshire implemented presumptive eligibility under NH Rev Stat § 151-E:18 (2013) and established administrative rules (now expired). However, House Bill 4, “An act relative to state fees, funds, revenues and expenditures” (2019) suspends presumptive eligibility for HCBS for the biennium ending June 30, 2021.
State Variations in Presumptive Eligibility Policies

Presumptive eligibility practices vary across states. For example, states may choose to use different Medicaid authorities. Some states operate separate state-funded programs and initiate services under those programs while the Medicaid application is pending. States may also differ in the role case managers, staff, and registered nurses play in presuming eligibility and assisting with the application process.

Among the states that implement presumptive eligibility, a few key trends have emerged. States that choose to co-locate staff responsible for eligibility determinations with agencies responsible for HCBS can quickly and more easily collaborate to process applications. Additionally, states that cross-train their staff can answer questions and troubleshoot eligibility issues at all points in the process; this helps deal with potential issues immediately and keeps the process moving forward.

Exhibit 2 summarizes some of the key design features from five states that use presumptive eligibility for Medicaid HCBS.

<table>
<thead>
<tr>
<th>State</th>
<th>Features</th>
<th>Financial Approach</th>
</tr>
</thead>
</table>
| **Michigan**| • All waiver agencies are capitated and those waiver agencies have the option to implement presumptive eligibility. They are not required to implement presumptive eligibility, but if a waiver agency elects to use presumptive eligibility, it assumes the financial risk.  
• Eligibility workers are out-stationed with waiver agencies whenever possible.  
• The state does not require waiver agents to implement presumptive eligibility; therefore, presumptive eligibility may not be available through all waiver agencies. | • The state share for eligible individuals comes from the relevant Medicaid line item.  
• If the person is found ineligible for Medicaid, the Area Agencies on Aging (waiver agents) pay from their own funds. |
| **Ohio**    | • State-funded programs assist eligible individuals while their Medicaid applications are processed for eligibility for waiver programs.  
• The error rate for presumptive eligibility enrollment has been less than 1 percent since the inception of the program.* | • Federal reimbursement is claimed when the person is determined eligible for Medicaid.  
• State revenue is used for people found ineligible. |
| **Rhode Island** | • The Centers for Medicare and Medicaid Services (CMS) pays the federal share of costs for people found ineligible under a section 1115 Global Consumer Choice waiver program.  
• Case managers can approve services for up to 90 days before Medicaid eligibility is determined.  
• A proposal to modify and simplify the functional eligibility process was not approved by CMS at the time of renewal in 2018. | • The state share for eligible individuals comes from the relevant Medicaid line item.  
• If the person is eventually found ineligible, the federal government shares the cost of services provided through the 1115 waiver program. This lowers the state’s financial risk. |
| **Vermont** | • The Waiver While Waiting program can initiate services when Medicaid eligibility is pending.  
• Registered nurses assess applicants for functional eligibility and forward a form to the provider approving services.  
• Providers complete a form indicating when services started. | • The state share for eligible individuals comes from the relevant Medicaid line item.  
• State revenue can be used for people found ineligible. |
### State Features

<table>
<thead>
<tr>
<th>State</th>
<th>Features</th>
<th>Financial Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington</td>
<td>Presumptive eligibility applies to two 1115 Medicaid waivers.</td>
<td>The state share for eligible individuals comes from the relevant Medicaid line item.</td>
</tr>
<tr>
<td></td>
<td>A “fast-track” process expedites Medicaid eligibility for people seeking HCBS waiver or state plan services who filed their Medicaid application.</td>
<td>If the person is eventually found ineligible, the federal government shares the cost of services provided through the 1115 waiver program. This lowers the state’s financial risk.</td>
</tr>
<tr>
<td></td>
<td>Care managers assist consumers in completing financial applications.</td>
<td>The state does not receive federal reimbursement for fast-track cases that are found ineligible.</td>
</tr>
<tr>
<td></td>
<td>A functional assessment is required before fast track starts.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial and service eligibility staff work in the same department.</td>
<td></td>
</tr>
</tbody>
</table>


### Barriers to Presumptive Eligibility: Is the Financial Risk Overblown?

Across all state variations, one of the biggest barriers to state implementations involves the perceived financial risk to the state. While it is true that the state could be on the hook to pay for HCBS when an individual is ineligible for Medicaid, that risk is relatively low and can be contained.

When evaluating the potential financial impact, policy makers should consider several factors, including the following:

- **Potential Cost Offsets:** States should consider not just the financial cost of presuming individuals eligible in error but also the potential savings as a result of avoiding unnecessary or premature nursing home care. On average, states can provide care for approximately three individuals at home for the cost of one in a nursing home. Given the very low error rate and the significant cost savings in home- and community-based care, states are likely to see a net savings. For instance, Washington state officials determined that each fast-track client saves Medicaid an average of $1,964 a month by helping individuals access community services instead of institutional care.

- **Alignment with State-Funded HCBS Programs:** States can also minimize their financial exposure by laddering Medicaid HCBS presumptive eligibility with state-funded programs. For example, states can initiate enrollment in a state program while the Medicaid application is pending. During this period, an individual will be covered with state funds until Medicaid eligibility is confirmed, after which the individual can be enrolled retroactive to date of application and services billed to Medicaid.

- **Ability to Share Risk with the Federal Government:** At least two states, Washington and Rhode Island, have received federal approval to include presumptive eligibility in their 1115 home- and community-based waivers. Section 1115 waivers are named for the applicable section of the Social Security Act that allow states to apply for special flexibility to implement innovative designs or pilot programs in state Medicaid programs. The advantage of operating presumptive eligibility through an 1115 waiver is that the state can share the risk with the federal government. Therefore, Washington and Rhode Island can claim reimbursements for HCBS provided in error to individuals who are later determined ineligible for Medicaid.

---

*bid.

*Mollica, “Expediting Medicaid Financial Eligibility Determinations.”*
COVID-19 Context

The COVID-19 pandemic, which has disrupted almost every aspect of life with devastating consequences, especially for individuals in nursing homes and other long-term care facilities, may be another motivation for states to adopt presumptive eligibility.

In the continuing pandemic, presumptive eligibility is a valuable tool to quickly enroll individuals in Medicaid services that could help avoid unnecessary nursing home admissions, where the spread of the virus and the consequences have been deadly. The current public health emergency also grants states unparalleled ability to experiment and test new Medicaid strategies and learn from those experiences to make evidence-based decisions. Two important temporary changes that merit consideration are expansions in hospital-administered presumptive eligibility and a novel pilot program in Indiana that diverts unnecessary nursing home placement with expedited eligibility determinations for HCBS.

Expanding Hospitals’ Authority to Facilitate Presumptive Eligibility during COVID-19

Eleven states have taken steps to expand hospital-administered presumptive eligibility to certain Medicaid eligibility groups—those who qualify for Medicaid based on eligibility other than income, such as individuals ages 65 and older, those with a disability or who need LTSS—during the COVID-19 public health emergency.

These changes allow hospitals to serve as a qualified entity to make presumptive determinations for some population groups such as those eligible after spending down their private resources on medical expenses and individuals eligible for financial assistance with Medicare cost sharing. This expansion has the potential to expedite access to Medicaid and help low-income individuals access a broader range of services that could support consumers in the community.

Wisconsin, for example, implemented hospital presumptive eligibility—referred to as “express enrollment”—into its BadgerCare Plus program. Wisconsin hospitals can temporarily enroll adults ages 65 and older, as well as adults who are blind or disabled and enrolled in Medicare, with income up to 100 percent of the federal poverty level in BadgerCare Plus. The presumptive eligibility period begins in the hospital, but the enrollment period would extend for two months. The expectation is that individuals who are presumed eligible by a hospital would apply for full benefits during the two-month presumptive eligibility period in order to continue their services. During the presumptive eligibility period, personal care services and any Medicaid-related services are covered. Those services would continue for an individual even after discharge from a hospital for the two-month period while a full application determination is pending.

Using a disaster state plan amendment, California extended its Hospital Presumptive Eligibility to additional coverage groups—including those qualifying on the basis of age and disability categories—and increased the number of eligibility periods allowed during a 12-month period.

---


11Ibid.

California’s hospital-administered presumptive eligibility program allows qualified individuals to immediately access temporary Medicaid (Medi-Cal) services while they apply for permanent coverage. Hospitals opting to participate as a qualified provider can make presumptive eligibility determinations based on the individual’s self-attested income, household size, and residency information. Depending on the month and how early in the month individuals apply, the typical presumptive period lasts between 31 and 60 days. If the individual applies for permanent coverage during his or her presumptive period, coverage will continue until a permanent determination (approved or denied) is made on the individual’s application.

Applicants who need L TSS still need to apply separately for a Medicaid waiver. To enroll, applicants must meet the nursing home level of care criteria and a waiver slot must be available. However, those individuals still have immediate access to the full range of Medicaid state plan services, which includes personal care services, self-directed personal assistance services, the Community First Choice Option, and HCBS to support independent living in the community pending access to waiver services.

The current emergency authorization for California’s expanded hospital-administered presumptive eligibility program is set to expire at the end of the public health emergency, but the state is evaluating the results and considering options post-pandemic. Administrators are also tracking the percentage of hospital presumptive eligibility applicants who ultimately apply for permanent Medicaid enrollment and the reasons why many individuals do not ultimately submit permanent applications for Medicaid coverage.

Similarly, New Jersey took emergency actions to expand the NJ FamilyCare Presumptive Eligibility program to the older individuals and those who are blind or disabled. This allows uninsured, low-income older individuals and those with disabilities to immediately access health services, securing reimbursement for the hospitals and allowing consumers to efficiently and safely return home with supportive services or to another facility. Presumptive eligibility for the new coverage group is self-attested, meaning hospital-based staff can complete an online application based on unverified information from the applicants themselves. Upon completing the online application, individuals can receive temporary fee-for-service Medicaid coverage for up to 60 days or until a complete Medicaid determination is made, whichever comes first.

**An Indiana Innovation**

Indiana applied for and received an innovative pilot program to expedite eligibility. The pilot program was included as part of an emergency Appendix K waiver request; however, most of the expedited eligibility process did not require special Medicaid authority. The pilot program is designed to facilitate an immediate discharge from a hospital to a person’s home for in-home services and avoid institutional placement. While the program is not officially a presumptive eligibility pilot, it does have similar characteristics.

This first-of-its-kind pilot operates a simplified eligibility process that can quickly make determinations for Medicaid HCBS and start in-home services within 10 days of approval. Eligible individuals or family caregiver representatives can contact 1 of 10 approved providers to complete an expedited waiver application. Those who complete an application through a participating provider and meet eligibility requirements will immediately be granted Medicaid and Aged and Disability waiver eligibility.

---

The pilot program is open to individuals ages 65 and older who are not currently receiving Medicaid benefits and do not have complex financial assets that require a detailed review to determine eligibility. Individuals who wish to apply must also require assistance with three or more activities of daily living (eating, dressing, and toileting), or require a substantial skill need and meet nursing facility level of care for the Aged and Disability waiver. By excluding those with complex financial assets and screening for basic Medicaid requirements, the Indiana pilot is able to expedite approval and limit the financial risk of covering individuals later deemed ineligible for Medicaid. This could be an important factor encouraging other states to adopt this approach.

The early results are encouraging. Indiana began accepting applications on October 13, 2020. In fewer than six months, over 900 individuals applied for HCBS through this option, with an overwhelming majority receiving expedited approval. Individuals who apply for this option but are unable to be approved through the expedited process will still have their application processed under the normal process.

While the current pilot expires after the public health emergency, Indiana is considering sustaining the program post-pandemic.

**Future Solutions**

In addition to testing temporary changes during the COVID-19 pandemic and collecting data on potential benefits and error rates, policy makers should also explore permanent policy changes to expedite Medicaid eligibility for HCBS. To scale up and encourage widespread adoption of this promising practice, policy makers could consider the following:

- **Regulatory Changes:** Policy makers should consider allowing states additional flexibility to target presumptive eligibility for cases in which an individual does not have complex financial disclosures. This limits the potential exposure to erroneously granting eligibility before a formal Medicaid determination. However, the factors must not be subjective. Fairness requires clear guidance on which applications are eligible or ineligible for presumptive eligibility. Policy makers should also conduct careful oversight to ensure those with complex financial disclosures are not unfairly disadvantaged.

- **Enhanced Federal Medical Assistance Percentage (FMAP):** Policy makers could also consider increasing the FMAP, the federal share of what states spend on Medicaid, for presumptive eligibility. The enhanced federal funds would apply to services provided before the final eligibility determination to help lower potential financial risk to states and provide an incentive to expand presumptive eligibility for HCBS. Many states will face deep budget shortfalls as a result of the COVID-19 pandemic and may hesitate to implement presumptive eligibility or bear any potential financial risk during uncertain economic times, even though the COVID-19 pandemic exposed an urgent need to improve access to nursing home alternatives. An enhanced FMAP would help mitigate these concerns and help reduce the financial exposure of states.

- **Policy Triggers:** States that chose a legislative pathway to implement presumptive eligibility can also fashion appropriate regulatory remedies to control costs if a qualified entity exceeds an acceptable error rate. For example, state agencies could trigger an automatic review and develop additional training resources for eligibility staff when the error rate exceeds an acceptable threshold. Ultimately, if the error rate continued to exceed that threshold, the state could end the program.

---


18.*See, for example, N.Y. Soc. Serv. Law § 364-I (2021) (“Provided, however, if upon audit the department determines that there are subsequent determinations of ineligibility for medical assistance in at least fifteen percent of the cases in which presumptive eligibility has been granted in a local social services district, payments for services provided to all persons presumed eligible and subsequently determined ineligible for medical assistance shall be divided equally by the state and the district.”).
Conclusion

Unlike nursing homes, which provide a comprehensive and straightforward option to meet most basic necessities ranging from housing, workforce, and service needs, HCBS requires individuals and family caregivers to navigate a fragmented, time-consuming, and cumbersome system. Delays and challenges finding services at the time of need can have negative long-term consequences for consumers and limit individuals’ options to live independently in the long run.

Presumptive eligibility can be an important tool to help level the playing field and empower more consumers to live independently. However, presumptive eligibility, in isolation, is not necessarily sufficient to guarantee consumer choice. Other structural, external factors impacting consumer choice must also be addressed. These include current caps on HCBS waiver slots, lack of HCBS providers in some areas, challenges quickly matching individuals with appropriate social and health service providers that can support the consumer’s goals, and community design features such as adequate transportation and housing options. Presumptive eligibility is an important prerequisite to consumer choice, but, ultimately, presumptive eligibility can only expedite eligibility and connect individuals to the services that exist and are available in that community. Without adequate alternatives, consumers will still lack the meaningful choices they deserve.

Presumptive Eligibility: Meeting the Need in the Moment

Presumptive eligibility can help frail older adults or people with disabilities in a moment of crisis, allowing those who need immediate help to remain independent in the community. Consider this example:

Jackie was a full-time family caregiver, providing around-the-clock care for her 97-year-old father, David. David had never applied for Medicaid because Jackie was able to provide the support he needed. In February, a neighbor urgently alerted the state social services agency that Jackie had been hospitalized with a stroke. With Jackie in the hospital and unlikely to return home for a while, the neighbor worried about who would take care of David. David had limited resources to privately pay for home care services, and getting Medicaid in place would take weeks, putting him at risk of injury or nursing home placement. Fortunately, David lived in a state with presumptive eligibility. Services were put in place within a day, and David had an in-home support worker on a weekly basis. Because Medicaid services were in place for David at home while his Medicaid application was processed, he was able to avoid a nursing home placement and live safely in the community without a gap in critical services.

Presumptive eligibility is a game-changer for families in situations like this. In states with presumptive eligibility, they would not face these challenges because they could receive Medicaid services at the moment they need them while the formal Medicaid process is pending. Thus, the choice on where and how to receive care is left to the individual and his or her family, not chance or bureaucracy.
About the Authors

Susan C. Reinhard is senior vice president and director of the AARP Public Policy Institute. She leads the LTSS Choices project and serves as the Chief Strategist for the Center to Champion Nursing in America and Family Caregiving Initiatives.

Robert L. Mollica is a consultant for the AARP Public Policy Institute. He has extensive experience working with states on long-term services and supports as a senior program director at the National Academy for State Health Policy.

Claudio W. Gualtieri was a senior strategic policy advisor at the AARP Public Policy Institute for many years. He joined the Connecticut Office of Policy and Management as Undersecretary for Health and Human Services in March 2021.

Carrie Blakeway Amero is director for long term services and supports at the AARP Public Policy Institute.

Acknowledgments

The authors would like to acknowledge the contributions from Jim Gavin, Ambre Marr, Nina Weiler-Harwell, Bea Rector, Jesse Wyatt and the staff at AARP Indiana, AARP California, California Department of Health Services and the full LTSS Choices team.

https://doi.org/10.26419/ppi.00138.001