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COMMONWEALTH OF MASSACHUSETTS
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August 28, 2026

Chair, Michael J. Rodrigues
Senate Committee on Ways and Means
State House, Room 212
Boston, MA 02133

Chair, Aaron Michlewitz
House Committee on Ways and Means
State House, Room 243
Boston, MA 02133

Dear Chairs,

As required by Chapter 197 of the Acts of 2024, please find enclosed a report on the cost and feasibility of changes to the eligibility requirements for Medicaid long-term care services with the goal of reducing the time applicants spend at acute care hospitals awaiting long-term care eligibility determinations. This report has been reviewed with Massachusetts Senior Care Association, Inc. and the Massachusetts Academy of Elder Law Attorneys.

If you have any questions, please contact MassHealth's Deputy Legislative Director Sarah Nordberg at Sarah.Nordberg@mass.gov.

Sincerely,

Ryan Schwarz, MD, MBA

cc: Kiame Mahaniah, MD, MBA

Report Requirements, Chapter 197 of the Acts of 2024

The division of medical assistance shall study the cost and feasibility of changes to the eligibility requirements for Medicaid long-term care services with the goal of reducing the time applicants spend at acute care hospitals awaiting long-term care eligibility determinations. The study shall consider: (i) improvements to the eligibility determination process; (ii) establishing a rebuttable presumption of eligibility; (iii) guaranteeing payment for long-term care services for up to 1 year regardless of eligibility status; and (iv) expanding the undue hardship waiver criteria. The division of medical assistance shall seek input from the Massachusetts Senior Care Association, Inc., the Massachusetts Academy of Elder Law Attorneys and other interested stakeholders. The division of medical assistance shall submit a report with the results of its study and policy recommendations to the clerks of the house of representatives and the senate and the house and senate committees on ways and means, not later than 180 days after the effective date of this act.

i. Improvements to the eligibility determination process

Process Improvements

Due to federal requirements, there is a significant amount of information that is required before an individual can be determined eligible to receive long term care. See the table below.

REQUIRED INFORMATION
Applicants 65 and older who live in the community, including HCBS waiver applicants, or members 55 and older applying through the PACE program **Application reviewed** based on info such as: ❑ Income ❑ Residency ❑ Immigration ❑ Categorical Eligibility (e.g., disability status) ❑ **Assets such as bank accounts, car(s), property(s), life insurance, and stocks/bonds** ❑ **HCBS/PACE applications require a clinical screening**
Applicants of any age in need of long-term care services in a nursing facility **Application reviewed** based on info such as: ❑ Income ❑ Residency ❑ Immigration ❑ Categorical Eligibility (e.g., disability status) ❑ Assets such as bank accounts, car(s), property(s), life insurance, and stocks/bonds ❑ **Resource transfers over past five year** ❑ **Nursing Facility Status & Admission Form (SC-1)** ❑ **Clinical Screening done by ASAPs**

Generally, the initial application is processed within 10 business days. However, almost all applications require a follow-up request for information given the complexity of asset information and the five-year lookback period. MassHealth reviewed the eligibility process in fall 2024 and implemented two improvements, described below:

Reducing the amount of time from submission of LTC application to decision:

- On September 8, 2024, MassHealth shortened the request for information (RFI) timeline required for the long-term care (LTC) application from 90 days to 30 days, reducing the timeline for processing LTC applications.

Improving the eligibility process by adjusting the SC-1 submission timeline

- In February 2025, long-term care eligibility was updated to allow for an eligibility determination to be made without an SC-1 being submitted. An SC-1 is a 'Status Change' form used to document a changing status (e.g., admissions, discharges, transfers, short-term to long-term) of a MassHealth member in a nursing facility or chronic disease and rehabilitation inpatient hospital.
- Previously, an eligibility determination could not be made without an admit date from a nursing facility, documented and submitted in an SC-1.
- With this change, the SC-1 is no longer required prior to eligibility determination, but must be submitted within 10 days from the date of admission. This removed a barrier to hospital discharges and allows more operational flexibility for nursing facilities.

Mass Senior Care Association (MSCA) strongly supported these changes. MassHealth acknowledges that these changes alone do not fully address the timeliness of Medicaid application review due to the complicated nature of Medicaid eligibility. It still takes an estimated minimum of 3 months for an "easy" application (few asset verifications) to be approved, with MSCA members reporting that most applications take at least 6 months from start to final determination.

At the suggestion of Mass Chapter of the National Academy of Elder Law Attorneys (Mass NAELA), MassHealth will work to increase awareness of the SC-1 change. Mass NAELA highlighted that many of their members still were not aware that an eligibility determination could be made without an SC-1 on file.

MassHealth, MSCA, and Mass NAELA have agreed to a series of meetings to further explore opportunities for improvement, including, but not limited to, amending MassHealth forms to emphasize the right of a guardian, conservator, or agent to access bank information when a durable power of attorney is in place.

ii. Establishing a rebuttable presumption of eligibility

With CMS approval, states can allow qualified entities, such as hospitals and community-based organizations[i] to make a presumptive eligibility determination.[ii] MassHealth previously enacted *hospital* determined presumptive eligibility (HPE), as detailed in Eligibility Operations Memo 20-06; this policy expired on March 31, 2024.

[i] 42 CFR 435.1110
[ii] [ii] 42 CFR 435.1110(c)

There are two options for states to implement presumptive eligibility for non-Modified Adjusted Gross Income (MAGI) populations:

1. The state can make a state plan amendment to expand hospital presumptive eligibility
2. The state can amend its Section 1115 demonstration

There are a limited number of states that have implemented presumptive eligibility for the non-MAGI population to improve access to community support. MassHealth tried to identify another state that has authorized skilled nursing facilities to make a presumptive eligibility determination or have authorized long-term care through a presumptive eligibility process. In conducting its research, MassHealth reached out to other state Medicaid agencies, conducted online research, and spoke to national industry experts. MassHealth was unable to identify a state where they are currently using presumptive eligibility for skilled nursing facility admissions.

Given the lack of precedent and the current federal landscape, MassHealth does not believe that there is a pathway to obtaining federal approval for presumptive eligibility for the non-MAGI population to gain access to a skilled nursing facility.

iii. Guaranteeing payment for long-term care services for up to 1 year regardless of eligibility status

MassHealth eligibility processes are structured to ensure that the Commonwealth receives Federal Financial Participation (FFP) for medical care provided to MassHealth members in skilled nursing facilities. Generally, the federal government covers 50% of the cost of skilled nursing facility (SNF) services provided to MassHealth members.

Currently, there is no established payment mechanism or process for individuals who are not insured to receive care in a skilled nursing facility.

If the Commonwealth were to implement a policy where it guaranteed payment for long-term care services for up to 1 year regardless of MassHealth eligibility status, it would be exceptionally expensive as noted below and there would be significant negative consequences:

- The Commonwealth would lose a substantial amount of federal revenue because individuals would have no incentive to go through the MassHealth application process, meaning SNF stays that are currently funded 50% federal and 50% state would become 100% funded by the state. MassHealth cannot claim FFP from the federal government if an eligibility determination is not in place.
- There would be a shift in the payer mix. Currently there are three (3) payers for SNF care: Medicare, private pay, and Medicaid. Guaranteeing payment for long-term care services for up to 1 year regardless of eligibility status would likely reduce and potentially eliminate private pay patients.
- The Commonwealth has a longstanding ‘community first’ policy to advance long term care options so that older adults and individuals with disabilities have choices and can return to or remain at home and in their communities for as long as possible. Currently, on average, 1.6 individuals can be served by a SNF bed in a quarter. Ensuring members

return to the community as quickly as possible is a significant focus of payer policies. Additionally, payment pressures do have a role in patient behavior. MassHealth is concerned that a potential unintended consequence of a 1-year payment guarantee would be to decrease the number of individuals that can be served by a SNF bed in a quarter. Any payment policy that extends the average length of stay in a skilled nursing facility will have negative consequences and has the potential to hasten a shortage of beds in skilled nursing facilities.

- Individuals who spend a significant amount of time in a nursing facility often lose their housing making it extremely difficult for them to return to the community. This policy could increase the number of individuals who lose their housing.

MassHealth estimates that this policy shift would increase costs by between $686 million per year to $1.286 billion per year due to a combination of increased utilization and cost shifting. Specifically, if the current empty SNF capacity (6,325) fills up at all state cost it would cost $686 million. Additionally, if you assume that, on average, MassHealth processes 11,400 applications per year and you assume that new applicants would no longer have any incentive to complete the MassHealth application in the 1st year, MassHealth would have to cover the full $1.2 billion cost of the care as opposed to $600 million.

Below is data related to SNF occupancy and cost as of January 2025.

Total Licensed NF Beds	39,899
Total NF Occupancy	33,574
Empty Beds	6,325
Avg. Daily Cost /person	$297.00
LTC Applications CY24	11,401

Avg. Cost /year/person	$108,405	*one individual cost per year at State cost
Total NF Bed Cost /day	$11,850,003	
Total NF Bed Cost /year	$4,325,251,095	*all NF beds at State cost
Total Cost Empty Beds /day	$1,878,525	
Total Cost Empty Beds /year	$685,661,625	*remaining capacity beds at State cost
Total Cost LTC Apps/year (upper end)	$1,235,925,405	*upper bound calculated based on total number of new LTC applications received CY24
Total Cost LTC Apps/year (lower end)	$651,378,544	*lower bound calculated based on 95% of empty beds
Avg. Cost LTC Apps/year	$943,651,974	*does not include current NF residents, would exceed capacity

Should the Legislature want to address situations where a facility has acted in good faith with a reasonable belief that an individual will ultimately be found eligible for MassHealth but ends up accruing bad debt, a much narrower policy would need to be crafted.

iv. Expanding the undue hardship waiver criteria

Current Process

The Undue Hardship Waiver is a provision under MassHealth that allows individuals who are otherwise disqualified from Long-Term Care (LTC) benefit from issues like asset transfers or failing the five-year look-back period to request an exception. If approved, the waiver ensures that the individual can still receive benefits because denying them would cause undue hardship.[iii] If denied, the applicant may still request an administrative hearing.[iv]

If an applicant or member feels the imposition of a period of ineligibility would result in undue hardship in accordance with 520.019(L), they should submit the below form and all supporting documentation to MassHealth within 15 days of the date on the MassHealth notice that informed the applicant or member of the period of ineligibility. https://www.mass.gov/doc/masshealth-request-for-a-hardship-waiver-of-a-period-of-ineligibility-0/download.

An Undue Hardship Waiver is most commonly requested in situations where an individual is:

- Denied LTC benefits due to the transfer of assets within the five-year look-back period (i.e., they gave away or transferred assets for less than fair market value before applying for LTC services).
- Facing an imposition of a penalty period (a period of ineligibility for MassHealth LTC benefits) due to such transfers.
- Unable to pay for long-term care services on their own and would be at risk of being evicted from a nursing home or losing critical care services if the waiver is not granted.

As it stands currently, to apply for the Undue Hardship Waiver, you must demonstrate:

- That the denial or penalty would cause a serious deprivation of the individual's medical care or basic life necessities.
- That all legal avenues have been pursued to recover the transferred assets but have been unsuccessful and are not with the intent to defraud Medicaid (e.g., attempts to reverse the transfer of assets or recover funds).
- That denial of MassHealth benefits would result in the individual being left without essential medical care, which could lead to endangerment to their life or serious deprivation of necessities like food, clothing, shelter, or medical treatment.
- In some cases, individuals may apply for an undue hardship waiver based on the needs of a community spouse (the spouse living at home). If the institutionalized spouse's penalty period would severely affect the community spouse's financial well-being, this might also be grounds for a waiver request.

[iii] 130 CMR 520.019(L)
[iv] 130 CMR 610.000

The criteria for a disqualifying hardship waiver to be approved are those in 130 CMR 520.019(L). https://www.mass.gov/doc/eom-24-06-process-for-requesting-a-hardship-waiver-for-a-period-of-ineligibility-due-to-a-disqualifying-transfer-of-resources/download. If a member provides documentary evidence in support of (1)(a) through (1)(d), the hardship waiver can be approved. If any are not verified via documentation, the hardship waiver is likely to be denied. Additionally, a hardship waiver may also be denied if the request was not timely, a penalty period had not been imposed, or the request was not made by an authorized party. MassHealth has made recent efforts to improve the clarity of criteria.[v]

MassHealth's rules for an undue hardship waiver are consistent with the standards set forth in the Social Security Act, Section 1917 (c)(2)(D) and 42 U.S.C. 1396p(c)(2)(D). Additionally, they are consistent with other states like New York and North Carolina. MassHealth does not recommend expanding hardship waiver criteria. MassHealth, MSCA, and Mass NAELA have agreed to a series of meetings to further explore opportunities for process improvement.

[v] Eligibility Operations Memo 24-06