Report to Congress on Medicaid and CHIP

MARCH 2025

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, Section 1900 of the Social Security Act, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

Report to Congress on Medicaid and CHIP

MARCH 2025

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March 13, 2025

The Honorable JD Vance
President of the Senate
The Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker of the House
The Capitol
Washington, DC 20515

Dear Mr. Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the March 2025 *Report to Congress on Medicaid and CHIP*. This report includes chapters addressing the role of external quality review (EQR) in Medicaid managed care, improving timely access to home- and community-based services (HCBS), and reducing states' administrative burdens to providing HCBS services for Medicaid beneficiaries.

Chapter 1 includes three recommendations on how to improve the managed care external quality review process. Managed care is the primary health care delivery approach in Medicaid, with 73 percent of beneficiaries enrolled in a comprehensive, full-risk managed care organization (MCO). With the growth of managed care, federal and state stakeholders have increasingly prioritized the effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. State Medicaid agencies conduct an annual external independent review of the quality of and access to services under each managed care contract, known as the EQR process. MACPAC examined how states implement federal EQR requirements, the role the Centers for Medicare & Medicaid Services (CMS) plays in overseeing the process, and if the EQR process supports accountability for states and MCOs and improves care for beneficiaries.

MACPAC's analysis revealed gaps in how the EQR process and findings are used to oversee managed care plans and improve quality. Stakeholders expressed challenges with their understanding of states' reporting of EQR findings based on a lack of context and summarization as well as the length and complexity of reports. Finally, we found stakeholders, including beneficiaries, had difficulty accessing EQR reports due to the absence of a centralized repository. The Commission makes three recommendations that are intended to improve the transparency and usability of findings included in the EQR annual technical reports.

Chapter 2 focuses on HCBS and makes a recommendation to improve timely access to these services. Medicaid HCBS are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a home-like setting in the community. HCBS is an optional Medicaid benefit for states but all states choose to cover it. Over the past several decades, federal and state policies have shifted LTSS spending away from institutional services and toward HCBS.

To be eligible to receive Medicaid HCBS, people must meet both financial and functional eligibility criteria. Financial eligibility for individuals with LTSS needs includes both income and assets. Functional eligibility is determined using an assessment tool. States have a number of ways in which they can expedite Medicaid eligibility determinations and enrollment for individuals whose income is not determined using modified adjusted gross income (MAGI) and who need HCBS. The chapter focuses on the use of presumptive eligibility and expedited eligibility flexibilities for non-MAGI populations, as well as provisional plans of care. It provides background on these topics, as well as the findings from our stakeholder interviews, environmental scan, and review of Section 1915(c) HCBS waivers. It concludes with a recommendation to the Secretary of the U.S. Department of Health and Human Services to direct CMS to issue guidance on how states can use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k), and Section 1115 of the Social Security Act.

The final chapter of the March report chapter includes an analysis of federal administrative requirements for HCBS programs and makes a recommendation to reduce the administrative burden for states and the federal government. The primary way in which states cover HCBS is through Section 1915(c) waivers. In MACPAC's June 2023 report to Congress, we analyzed barriers for beneficiaries trying to access HCBS and the challenges states face in managing HCBS programs. In our interviews with state Medicaid officials and other experts, administrative complexity emerged as a particular challenge.

The chapter describes our key findings on administrative complexity across HCBS authorities including opportunities to streamline and a discussion of the rationale for our recommendation. It concludes with a recommendation to the Secretary of the U.S. Department of Health and Human Services to increase the renewal period for HCBS programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and CHIP policy, and we hope this report will prove useful to Congress as it considers future policy development affecting these programs. This document fulfills our statutory mandate to report each year by March 15.

Sincerely,

Verlon Johnson

Chair

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Executive Summary: March 2025 *Report to Congress on Medicaid and CHIP*

MACPAC's March 2025 *Report to Congress on Medicaid and CHIP* contains three chapters of interest to Congress: (1) addressing the role of external quality review (EQR) in Medicaid managed care, (2) improving timely access to home- and community-based services (HCBS), and (3) reducing the administrative burdens for the federal government and states in providing HCBS for Medicaid beneficiaries.

CHAPTER 1: Examining the Role of External Quality Review in Managed Care Oversight and Accountability

Chapter 1 looks at the role of EQR in managed care and makes recommendations to the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) that are intended to improve the transparency and usability of findings included in the EQR annual technical reports.

Managed care is the primary health care delivery approach in Medicaid, with 73 percent of beneficiaries enrolled in a comprehensive, full-risk managed care organization (MCO). With the growth of managed care, federal and state stakeholders have increasingly prioritized the effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. State Medicaid agencies conduct an annual external independent review of the quality of and access to services, known as the EQR process.

MACPAC examined how states implement federal EQR requirements, the role CMS plays in overseeing the process, and if the EQR process supports accountability for states and MCOs. MACPAC's analysis revealed gaps in how the EQR process and findings are used to oversee managed care plans and improve quality. Stakeholders expressed challenges with their understanding of states' reporting of EQR findings based on a lack of context and summarization as well as the length and complexity of reports. Finally, we found stakeholders, including beneficiaries, had difficulty accessing EQR reports due to the absence of a centralized repository.

In this chapter, we make the following recommendations:

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

1.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

1.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

The Commission will continue to examine Medicaid managed care oversight and accountability in the years ahead.

CHAPTER 2: Timely Access to Home- and Community-Based Services

In Chapter 2, we focus on states' eligibility and enrollment processes for HCBS programs and make a recommendation to improve timely access to these services. Medicaid HCBS are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a home-like setting in

the community. HCBS is an optional Medicaid benefit for states, and all states choose to cover it. Over the past several decades, federal and state policies have shifted LTSS spending away from institutional services and toward HCBS.

To be eligible to receive Medicaid HCBS, people must meet both financial and functional eligibility criteria. Financial eligibility for individuals with LTSS needs includes both income and assets. Functional eligibility is determined using an assessment tool. States have a number of ways in which they can expedite Medicaid eligibility determinations and enrollment for individuals whose income is not determined using modified adjusted gross income (MAGI) and who need HCBS. The chapter focuses on the use of presumptive eligibility and expedited eligibility flexibilities for non-MAGI populations as well as provisional plans of care. It provides background on these topics as well as the findings from our stakeholder interviews, environmental scan, and review of Section 1915(c) HCBS waivers.

To receive HCBS, beneficiaries must have an approved person-centered service plan, which is designed to identify the individual's goals and desired outcomes and reflect the services and supports that will assist the individual to achieve their goals. To expedite receipt of Section 1915(c) services, CMS allows for a provisional plan of care, which identifies the essential Medicaid services that can be provided in the person's first 60 days of waiver eligibility. States must document in their Section 1915(c) waivers if they allow the use of a provisional plan of care and their procedures for developing one.

Based on an environmental scan, we found that states rarely use provisional plans of care, but when they do, they are most often used in cases such as natural disasters or hospitalizations. Additionally, states with Section 1115 demonstrations for presumptive eligibility for non-MAGI populations often use provisional plans of care but have added flexibilities afforded by the Section 1115 authority. Limited use of provisional plans of care may be explained by several factors, including a lack of knowledge around these plans of care and limited capacity to operationalize them.

In this chapter, we make the following recommendation:

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance on how states can use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k), and Section 1115 of the Social Security Act.

The Commission will continue to look at how beneficiaries access HCBS services and how states administer their programs.

CHAPTER 3: Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

The final chapter of the March report makes a recommendation to Congress on ways to streamline Medicaid Section 1915 authorities for HCBS and reduce the administrative burden on states and the federal government.

The primary way in which states cover HCBS is through Section 1915(c) waivers. In MACPAC's June 2023 report to Congress, we analyzed barriers for beneficiaries trying to access HCBS and the challenges states face in managing HCBS programs. In our interviews with state Medicaid officials and other experts, administrative complexity emerged as a particular challenge.

To better understand the administrative complexity of the Section 1915 authorities that states primarily use to operate HCBS programs, we reviewed the requirements under each authority and looked for opportunities to simplify or align them across authorities. We also interviewed stakeholders to obtain their insights about the complexity of administering these programs. Through these interviews, we identified three potential areas for streamlining: technical guidance for states using Section 1915(i), federal renewal requirements for Sections 1915(c) and 1915(i), and the statutory cost neutrality requirement for Section 1915(c). The Commission reviewed a

number of policy options in each of these areas that were intended to reduce administrative burden for states. Interviewees shared that the renewal process is resource intensive for states and for CMS but renewals are critical for ensuring state compliance with current policy and overall HCBS program oversight.

In this chapter, we make the following recommendation:

3.1 To reduce administrative burden for states and the federal government, Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of the Social Security Act to increase the renewal period for home- and community-based services programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.

The Commission will continue to monitor access to HCBS within each domain of our provider payment framework, which is based on the statutory goals of efficiency, economy, quality, and access.

Chapter 1:

Examining the Role of External Quality Review in Managed Care Oversight and Accountability

Examining the Role of External Quality Review in Managed Care Oversight and Accountability

Recommendations

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

1.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

1.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

Key Points

- Managed care is the primary delivery system in Medicaid, with almost three-fourths of Medicaid beneficiaries enrolled in comprehensive, full-risk managed care. Stakeholders are increasingly prioritizing effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services.
- An annual external quality review (EQR) of a state's contracted Medicaid managed care plans and their performance is one of the few federal oversight requirements for managed care specified in Medicaid statute.
- The EQR process has focused primarily on validation and compliance with federal requirements. Accordingly, the findings presented in the EQR annual technical report (ATR) have reflected process and regulatory compliance rather than meaningful changes in plan performance and outcomes.
- MACPAC's review found ATRs are lengthy, detailed, and often hard for most audiences to comprehend. Additionally, ATRs can be hard to find on individual state websites.
- Including meaningful data on quality and outcomes that have been reviewed as part of EQR activities would make the ATR a more effective tool for quality improvement and managed care plan oversight.
- A more standardized structure for summarizing and reporting EQR results and actions taken in response to the findings would make it easier to review the ATR and glean the key takeaways on plan performance. Furthermore, posting the ATRs in a central repository will improve the transparency of the EQR findings for stakeholders.
- EQR is part of a larger federal quality and oversight strategy, and EQR activities may overlap with other federal monitoring activities on network adequacy and quality. The Secretary of the U.S. Department of Health and Human Services should also ease the administrative burden by reconciling EQR with other reporting requirements to reduce duplicative reporting.

CHAPTER 1: Examining the Role of External Quality Review in Managed Care Oversight and Accountability

Managed care is the primary health care delivery approach in Medicaid, with 73 percent of beneficiaries enrolled in a comprehensive, full-risk managed care organization (MCO) (MACPAC 2024a). As enrollment in Medicaid managed care has increased, so too has the total share of Medicaid expenditures made through capitation payments to managed care plans; in fiscal year 2023, managed care capitation payments accounted for more than half (56 percent) of Medicaid benefit spending (MACPAC 2024b). Under contracts with state Medicaid agencies, managed care entities manage and provide health care services to beneficiaries enrolled in their plan. With the growth of managed care, federal and state stakeholders have increasingly prioritized the effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. The requirements related to the federal oversight of Medicaid managed care programs can be found in Section 1932 of the Social Security Act (the Act) as well as in part 438 of Title 42 of the Code of Federal Regulations (CFR) (42 CFR 438). An important responsibility of state Medicaid agencies is to conduct an annual external independent review of the quality of and access to services under each managed care contract, known as the external quality review (EQR) process (42 CFR 438.350–370).

As part of its work on managed care oversight and accountability, MACPAC examined how states implement federal EQR requirements, the role the Centers for Medicare & Medicaid Services (CMS) plays in overseeing the EQR process, and if the EQR process supports accountability for states and managed care entities and improves care for beneficiaries. This report continues the Commission's focus on Medicaid managed care oversight that has included studying managed care procurement practices and making recommendations regarding denials and appeals in managed care (MACPAC 2024c, 2022).

This report examines challenges and limitations with the current EQR process based on a comprehensive federal policy review; environmental scan of annual technical reports (ATRs), external quality review organization (EQRO) procurement documents, and state quality strategies; and structured interviews with federal and state regulators, EQROs, health plans, consumer advocacy organizations, and national managed care and quality experts. Overall, the comprehensive analysis revealed gaps in how the EQR process and findings as reported are used to oversee managed care plans and improve quality. We found that EQR activities focus predominantly on process and compliance rather than measurement of the managed care plans' performance. Also, stakeholders expressed challenges with their understanding of states' reporting of EQR findings based on a lack of context and summarization as well as the length and complexity of reports. Finally, we found stakeholders, including beneficiaries, had difficulty accessing EQR reports due to the absence of a centralized repository.

To address these challenges and improve the usability and transparency of EQR findings, the Commission makes three recommendations:

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

1.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes

EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

1.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

This chapter begins with background on the current EQR requirements and the evolution of federal policy in this area, including the 2024 managed care final rule. It then reviews challenges in the EQR process and gaps in the accessibility and usability of findings. Next, the chapter presents three recommendations, associated rationale, and implications for stakeholders. The chapter concludes with a look ahead at the Commission's continued work in Medicaid managed care accountability.

Background

As Congress has amended federal Medicaid law to provide greater flexibility for states' use of managed care, it has also added provisions to ensure the federal government holds states accountable—and that states hold managed care plans accountable—for the services they have agreed to provide to enrollees. The requirements related to the federal oversight of Medicaid managed care programs can be found in Section 1932 of the Act as well as in the managed care regulations at 42 CFR 438.

The Medicaid statute establishes a broad oversight role for CMS in regard to Medicaid managed care, with few specific federal responsibilities. Section 1932 of the Act prescribes the managed care enrollment process, beneficiary protections, and requirements governing information and communication but establishes only two direct oversight and monitoring requirements:

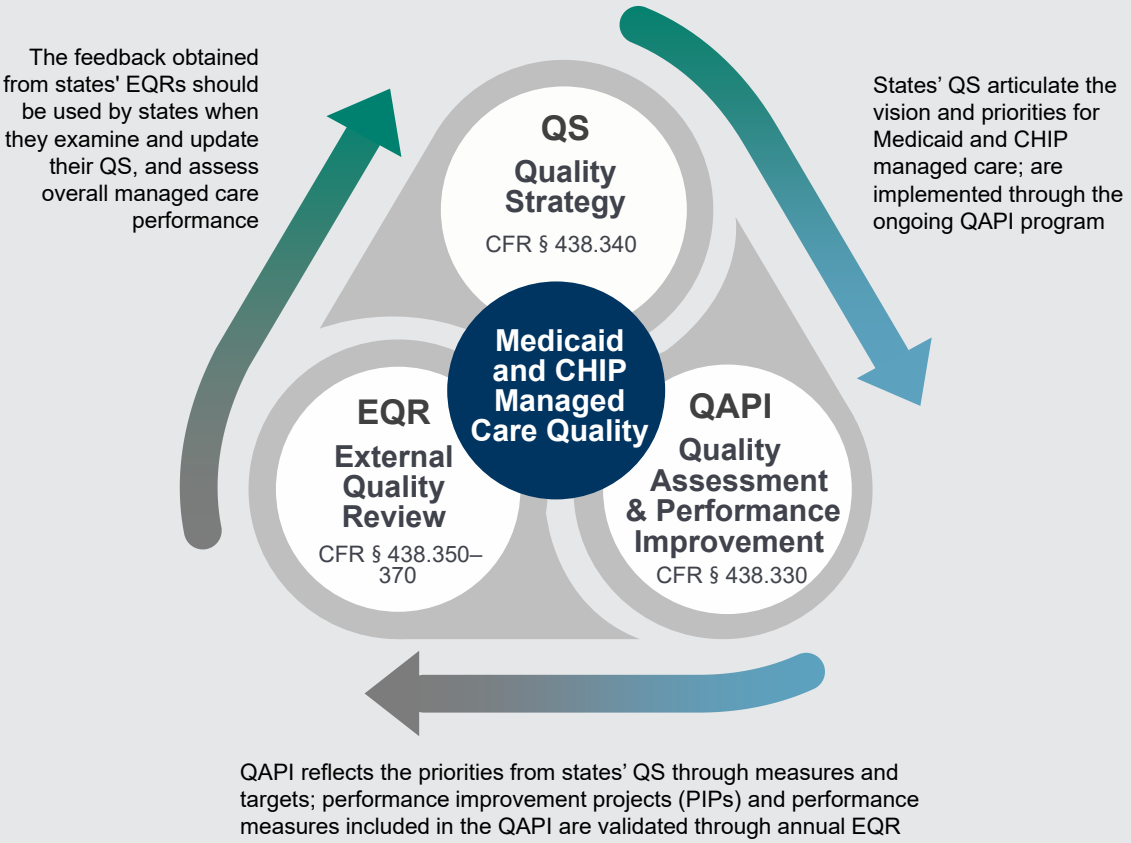
1. A state must develop, implement, and update a managed care quality assessment and improvement strategy that includes access standards and procedures for monitoring and evaluating the quality and appropriateness of care and services, meets the standards set by CMS, and is subject to monitoring by CMS; and

2. A state must conduct an annual external independent review of the quality of and access to services under each managed care contract.

CMS has promulgated detailed federal regulations and subregulatory guidance implementing these requirements (42 CFR 438). The first requirement is divided into two major components: states contracting with managed care plans must develop and implement a quality strategy for assessing and improving the quality of care and services provided by plans (42 CFR 438.340), and managed care plans must establish and implement an ongoing and comprehensive quality assessment and performance improvement (QAPI) program. The QAPI program must reflect the priorities articulated in the state quality strategy and include performance improvement projects (PIPs) aimed at driving "significant and sustained" improvement on measures and targets included in the quality strategy (42 CFR 438.330). Many detailed EQR requirements (e.g., guidelines for developing protocols, qualifications of EQROs, mandatory and optional activities, and options for exemption and non-duplication) are described in regulation, while detailed review protocols are described in subregulatory guidance (42 CFR 438.350–370).

These three activities are intended to function as an interrelated set of compliance and quality requirements (Figure 1-1). For example, federal rules require the annual EQR process to validate performance measures and PIPs that are included in the QAPI, with results included in the state's EQR ATR. The EQR ATR must also include recommendations from the EQRO on how states can target quality strategy goals and objectives to support improvements in quality of care.

FIGURE 1-1. Managed Care Quality Oversight Requirements



Notes: EQR is external quality review. CFR is Code of Federal Regulations. QS is quality strategy. CHIP is State Children's Health Insurance Program. QAPI is quality assessment and performance improvement.

Source: Adapted from Centers for Medicare & Medicaid Services (CMS). 2019. CMS External Quality Review (EQR) Protocols. October 2019.

External Quality Review

Each state contracting with MCOs, prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) must ensure that a qualified independent EQRO performs an annual review of the quality, timeliness, and access to services for each managed care contract (Section 1932(c)(2) of the Act, 42 CFR 438.350).[1] States that use managed care for their separate State Children's Health Insurance Program (CHIP) plans and Medicaid-expansion CHIP plans are also subject to the EQR requirements.

Federal rules describe a number of specific quality review activities that EQROs must conduct and report on as well as several activities that the state can choose to have its contracted EQRO conduct. The EQRO must provide the state and CMS with a detailed ATR, including an assessment of each managed care plan, and these reports are intended to be used by regulators to monitor quality and outcomes, conduct oversight of managed care contracts, and hold plans accountable for their performance. As of 2024, 45 states and the District of Columbia contract with plans that are subject to EQR.[2]

Requirements for EQR were established in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and initially codified in 2003 (CMS 2003). The rule defined which entities qualified to conduct EQR and what activities could be conducted as part of EQR and qualify for enhanced federal financial participation (FFP) at the 75 percent rate.[3] The rule also specified the circumstances under which states could use findings from Medicare or private accreditation review activities to avoid duplicating EQR activities or exempt certain MCOs and PIHPs from all EQR requirements. These initial EQR requirements applied only to comprehensive risk-based MCOs and PIHPs.

In 2016, CMS updated the Medicaid managed care regulations and made a number of changes to the requirements relating to EQR (CMS 2016). These changes expanded EQR to cover PAHPs and primary care case management (PCCM) entities, added a new mandatory activity (validation of network adequacy) and an optional activity (assisting with quality ratings of plans) to the EQR process, clarified that only EQR-related activities for MCOs were eligible for enhanced FFP, and strengthened conflict of interest provisions for entities serving as EQROs (CMS 2016). In 2020, further regulatory changes added a new requirement for states to annually post online which Medicaid plans are exempt from EQR and specify when the exemption began as well as a requirement for states to identify exempted plans in the ATR beginning July 1, 2021 (CMS 2020).[4]

On May 10, 2024, CMS issued a final rule on managed care access, finance, and quality in Medicaid and CHIP (CMS 2024). The 2024 managed care rule added new requirements to managed care access and quality monitoring and reporting, including the EQR process. The rule removes PCCM entities from the scope of mandatory EQR, adds new EQR requirements to report outcomes data for some mandatory activities, expands the optional activities that states may have their EQRO conduct, and adds new transparency requirements (CMS 2024).

Mandatory and optional activities

States implementing Medicaid managed care through MCOs, PIHPs, and PAHPs (with some exceptions) are required to perform four mandatory EQR activities:[5]

- validate PIPs to determine the methodological soundness in the design, conduct, evaluation, and reporting of a health plan's PIP;
- validate plan-reported performance measures to ensure plans collect and report required measures properly;
- review, within the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with standards in subpart D of 42 CFR 438 relating to access, care coordination, amount, duration, and scope of covered services and other applicable plan standards;[6] and
- validate plan network adequacy.[7]

In the 2024 managed care rule, CMS added a definition for the 12-month review period for all but one of the mandatory EQR-related activities (validation of PIPs, performance measures, and network adequacy) to create more consistency in reporting across states. For these activities, the 12-month review period begins on the first day of the most recently concluded contract year or calendar year, whichever is nearest to the date of the EQR-related activity.

Additionally, the 2024 managed care rule no longer requires states to include PCCM entities in the scope of mandatory EQR activities; however, the EQRO may validate performance measures and performance improvement projects conducted by PCCMs at the state's discretion.

States can also choose to conduct one or more optional activities that can help advance their program goals. These optional activities include the following:

- validate encounter data reported by plans;
- administer or validate enrollee or provider surveys of quality of care;
- calculate performance measures in addition to those reported by plans;
- conduct PIPs in addition to those conducted by plans;

- conduct quality studies that focus on a particular aspect of specific clinical or non-clinical services;
- assist with developing quality ratings of MCOs, PIHPs, and PAHPs consistent with the Medicaid managed care quality rating system (QRS);[8] and
- assist with the required evaluation of state quality strategies, state directed payments, and in lieu of services (newly added in the 2024 managed care rule).

Protocols

CMS is required to develop protocols for mandatory and optional EQR activities to guide and support the annual process for states and the EQROs with whom they contract. Section 1932(c)(2)(A)(iii) of the Act requires CMS to coordinate with the National Governor's Association and to contract with an independent entity, such as the National Committee for Quality Assurance, to develop the protocols.

EQR protocols provide tools and guidance to states and EQROs based on current industry methodologies and best practices for creating the ATR. The CMS protocols outline the purpose of the EQR-related activity; identify acceptable methodologies for conducting each activity within the protocol; specify data sources and data collection activities to promote data accuracy, validity, and reliability; propose methods for analyzing and interpreting the data; and provide instructions, guidelines, worksheets, and other tools that may be used in implementing the protocol (CMS 2023).

CMS issued the first set of protocols in 2003 and is required to review the protocols and make necessary revisions every three years. CMS updated the protocols in 2019 to incorporate regulatory changes contained in the May 2016 managed care final rule to be more user friendly for the EQRO conducting the activities and to offer practical tips for reporting EQR findings. In February 2023, CMS issued revised EQR protocols to incorporate regulatory changes contained in the 2020 managed care final rule, clarify federal requirements for the EQR process to promote compliance, respond to state and EQRO feedback about the protocols, and include the network adequacy validation protocol (CMS 2023). CMS will need to update the EQR protocols in response to the 2024 managed care final rule, and states will have one year from the issuance of the applicable protocol to comply.

Annual technical reports

Federal regulations require states to publish an ATR that compares and evaluates the managed care plans subject to EQR. A plan that is exempt from EQR will not be included in the ATR, but the state must note the exemption on its website and in its EQR report. The ATR must be posted on the state website by April 30 of each year and must include the following components:

- a detailed explanation of the EQRO's methodology for collecting, aggregating, and analyzing data from all EQR activities conducted;
- the EQRO's assessment of each managed care plan's performance on quality, timeliness, and access to care;
- recommendations for improving the quality of health care services furnished by each managed care plan and recommendations for how the state can target goals and objectives in the state quality strategy;
- methodologically appropriate comparisons of performance across all plans; and
- an assessment of the degree to which each managed care plan addressed quality improvement recommendations from the previous year's EQR.

In the 2024 managed care rule, EQROs are required to include any outcomes data and results from their quantitative assessments of PIPs, performance measures, and network adequacy in the ATR. The fourth mandatory EQR activity—the triennial compliance review of the managed care plans' compliance with standards in subpart D of 42 CFR 438—was not included in this updated requirement to include outcomes data. CMS will release protocols to implement these changes, and states will have one year from the issuance of the associated protocol to comply.

In the 2024 managed care rule, CMS added a requirement that states notify CMS within 14 calendar days of posting their ATR to their website. Additionally, CMS is requiring states maintain at least the previous five years of ATRs on their websites.

States must comply with this requirement to maintain five years of reports on their webpage no later than December 31, 2025.

CMS publishes summary tables based on the EQR ATRs, including a list of the EQROs contracting with states, the number and type of plans included in each state's EQR technical report, validated performance measures, whether a state reported performance measure rates, and the areas of care and populations covered by PIPs.

Challenges in the EQR Process

MACPAC conducted a comprehensive study of the EQR process and state practices to assess how states structure their EQR approaches, how states use EQR findings to hold plans accountable and improve care for beneficiaries, and how CMS engages in oversight of the EQR process to ensure states are in compliance with federal law and regulations. The study included a review of federal policy, ATRs, EQRO procurement documents, and state quality strategies as well as interviews with a range of stakeholders. Overall, the project identified five gaps in how the EQR process and findings are used to oversee managed care plans and improve quality, which are discussed further below:

- the connection between EQR and state quality strategies has been limited;
- the EQR process and protocols focus predominantly on process measures, validation, and compliance;
- states vary in whether they enforce EQRO findings and the tools used to improve plan performance;
- although states post their ATRs publicly, there can be challenges with accessibility and usefulness of report content; and
- CMS oversight of the EQR process appears limited.

The connection between EQR and state quality strategies has been limited

The EQR process should be connected to other federally required quality monitoring and improvement requirements in Medicaid managed care, including the state quality strategy (42 CFR 438.340(c)(2)(iii), 438.364(a)(4)). Together, these tools inform oversight and accountability of health plans and quality of care for beneficiaries. However, the environmental scan did not always find a clear link between the EQR process and the state managed care quality strategy. Interviewees agreed that historically, most states and EQROs did not attempt to align EQR activities with the state quality strategy. One interviewee noted that these two activities were, and often still are, not integrated activities, and other stakeholders described the EQR and quality strategy as parallel activities. However, a number of interviewees noted recent attempts by states to connect and integrate their EQR activities and technical reports to support their quality strategies. Some state Medicaid agencies indicated over time they have experienced increased communications from CMS regarding their quality strategies and posting of ATRs. For example, one state noted there has been more CMS feedback on its quality strategy since CMS issued the Managed Care Quality Strategy Toolkit in June 2021, which described how states could use information from the ATRs in revising and aligning the state's quality strategies (CMS 2021).

The EQR process and EQR protocols focus predominantly on process measures, validation, and compliance

The four mandatory EQR activities that states must conduct (validation of PIPs, validation of performance measures, triennial compliance review of 42 CFR 438 subpart D standards, and validation of network adequacy) have traditionally been focused on validation and compliance with federal managed care requirements and the elements of CMS-designed protocols. Accordingly, the findings presented in the ATRs have been reflective of process and regulatory compliance, rather than meaningful changes in plan performance and outcomes over time.

To a lesser extent, states focus on other managed care contractual requirements. For example, during compliance reviews of coverage denials, EQROs typically look at whether policies and procedures align with federal rules and state requirements, such as assessing health plan compliance with timelines, qualifications of plan staff who were involved in coverage determinations, and the content of notices to beneficiaries regarding decisions and their rights to appeals and grievances. EQRO representatives indicated that occasionally a state may ask them to review whether the coverage determination was medically appropriate, but that appears to be more of the exception than the rule.

The stakeholder interviews voiced a consistent theme that outcomes-driven EQR activities revealed trends in performance across states, plans, and quality measures that informed their work. State and federal officials indicated these trends highlight areas of concern for the Medicaid program and help determine where changes may be needed or where additional resources may be allocated. In general, consumer advocacy groups commented they would like to see the EQR process and report findings structured to allow comparisons across states and to national benchmarks for particular measures.

This limitation of EQR is somewhat addressed in the 2024 managed care rule under the new requirement that EQROs include any outcomes data and results from their quantitative assessments of PIPs, performance measures, and network adequacy in the ATR. However, this requirement for outcomes data and results from quantitative assessments does not apply to the fourth mandatory EQR activity—triennial compliance reviews—that evaluates compliance with federal Medicaid regulatory standards and related provisions in the contracts between the state Medicaid agency and its managed care plans (CMS 2024).

States vary in whether they enforce EQRO findings and the tools used to improve plan performance

States are not required by statute or regulation to act on the findings or recommendations included in the ATR. The federal regulations do require the ATR summary to include an assessment of how effectively each MCO, PIHP, or PAHP has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR (42 CFR 438.36(a)(6)). States vary in the degree to which they base their managed care plan oversight tools on findings from EQR activities, ranging from noting plan performance to financial penalties. Tools we heard about include using the results to inform potential contract changes with MCOs, corrective action plans (CAPs), financial penalties, reducing or freezing auto-assignment of enrollees to health plans, and including EQR results in scorecards used by enrollees when selecting a managed care plan. Notably, one state had a quality-based auto-assignment algorithm that calibrates to EQRO findings.

States we interviewed appear to take a collaborative and iterative approach with managed care plans to address areas of subpar performance or non-compliance revealed during EQR activities. States, their EQROs, or both will provide technical assistance to plans as needed and oftentimes provide an opportunity to address findings in the draft EQRO report before the report is finalized. In other words, nothing in the report is a surprise to the states, and by the time of publication, the plan may have already addressed the deficiency through a CAP.

Notably, some interviewees suggested the need for more assistance to states and more investments by states and CMS to effectively oversee managed care programs, which now serve a majority of Medicaid beneficiaries. It is worth noting that states engage in a competitive bid process for their EQRO contract and must pay the EQRO for the activities the state wants them to conduct. Although a state hires an EQRO to conduct a mandatory EQR activity using CMS-developed protocols, the state may not have the financial ability to pay that same EQRO to engage in optional activities to support ongoing monitoring, performance improvement, or revalidation of the findings from that activity.

Although states post their ATRs publicly, there can be challenges with accessibility and usefulness of report content

Although states typically meet the federally required April 30 deadline to post ATRs on their state websites, reports can sometimes be hard to find, and the information in them can be difficult to use, even for CMS and state Medicaid agencies. Given that EQR is an important statutory oversight mechanism related to managed care, the lack of accessibility of some reports can hinder the ability of stakeholders to monitor health plans' performance.

Although the ATRs are lengthy, highly technical reports that are designed to report on specific protocols, there is not a required template for reporting EQR activities or results. As such, it can be difficult for interested stakeholders to review these reports and glean the key takeaways on plan performance. ATRs lack consistency in layout and content that can make it easier for stakeholders to digest the findings and recommendations from EQROs. The organization of ATRs can vary considerably from state to state and sometimes even within a state across years. One interviewee noted that mismatched data made it hard to identify trends that could help identify areas to allocate resources or identify best practices that could be shared across states and plans. However, interviewees noted that CMS has recently been reviewing ATRs and EQR activities in closer detail and providing feedback on the presentation of information.

MACPAC's review found that, generally, it can be hard to find meaningful results in the ATRs. Many reports lack a clear synthesis of EQR findings. Some reports do not highlight substantial EQR results and instead report on aggregate results that may gloss over areas of deficiency for certain plans or certain components of the EQR. ATRs note areas for which all or certain MCOs were non-compliant or partially compliant for a particular EQR component. Often, a reader is not able to clearly determine the extent to which a plan's non-compliance was significant. Additionally, it can be challenging to identify what actions a state took to address plan non-compliance findings.

Additionally, MACPAC's review of ATRs found that states use different approaches for evaluating plan performance. Some EQR technical reports scored plans using a binary compliant or non-compliant approach. Other reports categorized plan compliance as being met, partially met, or not met. Some EQR technical reports referred to the percentage of reviewed components for which a plan or the group of plans was found to be compliant within each type of requirement, such as grievance and appeals. This variation in how states rate plans' compliance makes it difficult for individuals to clearly determine the extent to which a plan was compliant or the extent to which a plan's non-compliance was significant.

CMS oversight of the EQR process appears limited

CMS's role in EQR includes promulgating the regulations governing the EQR process; designing, reviewing, and updating EQR protocols when necessary; providing technical assistance to states with their EQR activities; reviewing both EQRO contracts with states and the ATRs drafted by EQROs for compliance with federal requirements; and ensuring states are undertaking the EQR process and monitoring managed care performance. However, our study did not reveal that any stakeholders saw CMS as using the EQR process to directly monitor or oversee the performance of managed care plans or states.

To date, CMS has primarily been concerned with state compliance with EQR protocols, but there are no regulations or guidance regarding possible CMS actions if a state fails to follow the established protocols. Similarly, there are no federal policies describing the process and criteria for reviewing and approving state EQRO contracts, although there is a requirement for states to receive enhanced FFP for EQR. Although CMS requires states to submit the EQR annual reports and publish summary tables derived from them, it is unclear if or how CMS uses the information for compliance monitoring or quality improvement.

Despite this lack of clarity regarding CMS's oversight role, feedback from stakeholder interviews suggests CMS is increasing its presence in the process. CMS is strengthening its review of health plan compliance, examining how EQROs record information in the ATRs, and providing more technical assistance to states. Interviewees noted that CMS is trying to strike a balance between having standardized components

with letting states have the flexibility to customize their EQR approaches. Consumer advocacy groups suggested that CMS should create a bigger role for itself with respect to sharing findings from ATRs, providing technical assistance to states on how to increase transparency of EQR findings, and using findings in their own oversight of managed care plans.

Commission Recommendations

The Commission makes three recommendations to the Secretary of the U.S. Department of Health and Human Services to direct CMS to make improvements to the current EQR process. The following recommendations seek to shift the focus of EQR activities from process and compliance to meaningful outcomes and actionable data and to improve the usability of EQR findings for all stakeholders through reporting consistency, summarization, and transparency. In carrying out the recommendations, CMS should take a holistic view of EQR in relation to other requirements within the overall federal quality and oversight strategy and identify ways to ease the administrative burden for CMS, state Medicaid agencies, and MCOs by reducing duplicative reporting.

Recommendation 1.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

Rationale

The triennial compliance review is one of the four mandatory EQR activities that states must have their contracted EQRO perform for managed care plans subject to the requirement. States and CMS use this review activity to determine the extent to which a state's managed care plans' policies and procedures are in compliance with 14 federal standards detailed in 42 CFR 438, including standards related to access, coverage and authorization of services, and care coordination. EQROs conducting this activity evaluate plans' compliance not only against the federal standards but also the related provisions in the plans' contract with the state Medicaid agency. The triennial compliance review is the most comprehensive EQR activity required by CMS, assessing each plan's core operational areas from health information systems, through coverage and authorization of services, to grievance and appeals systems. Many stakeholders we interviewed, including state officials and managed care plan representatives, identified the compliance review as the most important EQR activity and detailed the extensive time and resources devoted to preparing for, executing, and responding to the review.

In the Commission's view, it is important that the EQR ATR capture and report meaningful data on quality and outcomes that have been reviewed as part of the four mandatory EQR activities. Currently, EQROs may be collecting and reviewing outcomes data and results from quantitative assessments during the triennial compliance review; however, because there is no requirement that any such data be included in the ATR, it is unknown, not reported, and not available for review by stakeholders. This recommendation is consistent with the 2024 managed care rule's new requirement to include outcomes data and results from quantitative assessments from the mandatory EQR activities that validate PIPs, performance measures, and network adequacy in the ATR. In the preamble of the rule, CMS stated that the new requirement for reporting these data would result in more meaningful ATRs. Consequently, the ATR would become a more effective tool for states to use in quality improvement and managed care plan oversight. MACPAC and other stakeholders noted in their comments to the proposed rule that this change to require outcomes data and quantitative assessments for EQR activities may help place a greater emphasis on performance outcomes and comparability (CMS 2024).

In its commentary, CMS did not explain why the triennial compliance review activity was not included in this new requirement to report outcomes data and results from quantitative assessments in the ATR. In discussions with CMS after the release of the 2024 managed care rule, officials did not identify a specific rationale for excluding the triennial compliance review from this new requirement. As detailed in the CMS-

designed protocol, the triennial compliance review involves extensive review of state and plan documents as well as interviews with plan leadership and operational area staff. Although the compliance review protocols focus primarily on the managed care plan's policies and procedures, there are areas of review that could include such data.

The 2023 protocols identify several applicable plan documents for the EQRO to review, including measurement or analysis reports on service availability and accessibility, data on enrollee grievances and appeals, data on claims denials, and performance measure reports that could generate outcomes data. The EQRO should include in the ATR any outcomes data and the results from quantitative assessments reviewed or generated as part of the triennial compliance review activity, thus providing evidence of how the plan's policies and procedures were implemented. Areas of focus could include the availability and furnishing of services and timely access that would not necessarily be captured in other mandatory EQR activities. Reporting data on service authorization denials, grievances, and appeals that may have been reviewed as part of the EQR activity would be in line with recommendations the Commission made in the March 2024 report to Congress to collect, report, and use these data in monitoring and continuous improvement activities (MACPAC 2024b).

This recommendation is not intended to create new measures or mandate specific data be collected and reported but rather to report information that EQROs are already reviewing or generating as part of the compliance review. As such, it would not require fundamental changes to the triennial compliance review EQR protocol issued by CMS nor substantial preparations for this activity by state Medicaid agencies or managed care plans.

Implications

Federal spending. The Congressional Budget Office (CBO) does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation could increase federal discretionary spending to cover CMS administrative activities related to implementation.

This recommendation would result in increased administrative effort for the federal government, including the rulemaking process to update the regulations and modifying the EQR protocol to include reporting of outcomes or quantitative assessments as part of the triennial compliance review activity. CMS will already have to update the protocols for the other three mandatory activities to incorporate the new reporting requirements from the 2024 managed care final rule, so some efficiencies may be gained by updating all four mandatory activity protocols simultaneously.

States. States with managed care plans subject to EQR already contract with EQROs to conduct the triennial compliance review activity. Additionally, the 14 federal standards evaluated by the EQRO are already required by CMS in states' contracts with managed care plans. Because the recommendation is expected to report on information that EQROs are already reviewing, states should not see a substantial increase in either cost or administrative burden. Furthermore, the new information could generate additional insights for states that would inform and improve its managed care program quality strategy.

Enrollees. With the inclusion of additional meaningful outcomes data in the ATR, such as information on the availability and furnishing of services or the grievance system, enrollees will have additional information on the quality of care and access being provided by different health plans. The public reporting of this information could create additional incentives for managed care plans to improve the quality of and access to care being provided to enrollees.

Plans. Managed care plans should not see a substantial increase in either cost or administrative burden because they are already providing data and reports as requested by the state and EQRO for the compliance review. Plans may face an increased administrative burden if the state and EQRO ask for information that the plans do not already collect; however, states and EQROs already have the ability to ask for this information under existing regulations.

Providers. This recommendation would not directly impact providers as they are not included in the triennial compliance review activity beyond information that has already been provided to the state Medicaid agency and managed care plans. Added transparency

in the EQR reporting may inform providers regarding areas for potential quality improvement or focus.

Recommendation 1.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

Rationale

More than 20 years after the first EQR protocols were published by CMS in 2003, the EQR process has expanded along with the growth of managed care in states' Medicaid programs. States subject to EQR now have 11 total EQR activities, including 4 mandatory activities, intended to improve states' ability to oversee managed care plans and help plans improve their performance on quality, timeliness, and access to care for Medicaid beneficiaries. Additionally, EQR is part of a larger federal quality and oversight strategy that was expanded further with new reporting requirements on access and quality in the 2024 managed care rule.

CMS provides technical assistance to states, EQROs, and managed care plans with EQR protocols for each mandatory and optional activity. The protocols outline acceptable methodologies for how EQR activities are to be conducted, including suggested questions for the EQRO to ask plan representatives and recommended reports and documentation for the EQRO to collect and review. Federal regulations require state Medicaid agencies to publish an ATR in April for all EQR activities conducted the year prior that compares and evaluates the managed care plans subject to review. State Medicaid agencies customize use of their contracted EQROs based on the states' managed care program, budget, and overall resources. This flexibility includes how states and EQROs structure the EQR scope of work, conduct the EQR activities, and report findings in the ATR. Although the EQR protocols identify tips for drafting compliant and effective ATRs, there are few requirements in terms of content or structure (CMS 2023).

Stakeholders we interviewed voiced support for EQR protocols that require states to establish a clear link between EQR activities and the state managed care quality strategy. In our interviews, both state Medicaid agencies and plans valued the flexibility CMS has given states to design their EQR process, but they also thought it could be better balanced with standardization and consistency to help stakeholders find, interpret, and align EQR findings and bring efficiency to the EQR process. Some stakeholders we spoke to indicated that flexibilities in the implementation of EQR protocols can lead to inconsistent interpretation and reporting across states, programs, and EQROs. Additionally, inconsistent reporting makes it difficult for stakeholders, including state and federal officials, to extract key findings from the ATR, place EQR findings in context, or synthesize EQR findings with other required quality and oversight activities.

MACPAC's review found ATRs are lengthy, detailed, and often hard for most audiences to comprehend. The majority of ATRs are hundreds of pages long, often with additional appendices or attachments. Additionally, our review found states use different approaches for evaluating plan performance, making it difficult for individuals to clearly determine the extent to which a plan was compliant or the extent to which a plan's non-compliance was significant. Some EQROs scored plans using a binary compliant/non-compliant approach. Other reports categorize plan compliance as being met/partially met/not met. Some reports referred to the percentage of reviewed components for which a plan or the group of plans was found to be compliant within each type of requirement. This variation in how states rate plans' compliance makes it difficult for individuals to clearly determine the extent to which a plan was compliant or the extent to which a plan's non-compliance was significant.

A more standardized structure for summarizing and reporting EQR activities, results, or action taken by the state Medicaid agency in response to the findings would make it easier for interested stakeholders to review these reports and glean the key takeaways on plan performance. The organization of ATRs can vary considerably from state to state, and sometimes even within a state across years, especially if the state has

contracted with different EQROs for different activities or in different years. One interviewee we spoke to noted that mismatched data made it difficult to identify trends that could help regulators and managed care plans prioritize the allocation of resources or identify best practices that could be shared across states and plans.

The recommendation is focused on standardizing reporting structures and summarizing key findings. It is not intended to create new measures or mandate specific data be collected. Standardizing aspects of the ATR could improve the usability and digestibility of the findings while still maintaining state and EQRO flexibility to design and implement the EQR process to meet the state's needs. As such, CMS could develop a standardized template to summarize key findings and EQRO recommendations in an executive summary and still allow for flexibility in the structure and presentation of findings in the main body of the report. For the template, CMS could build on the guidance and tips for effective reporting that are included in the EQR protocols. For example, CMS suggests displaying previous recommendations, plan responses and actions, and new recommendations in one chart (CMS 2023). This chart could also include a description of how the state quality strategy has been updated to address the EQR findings and recommendations (CMS 2021).

Additionally, EQR is part of a larger federal quality and oversight strategy. Many EQR activities have some overlap with other federal requirements that were established in the 2024 managed care rule. For example, the network adequacy mandatory EQR activity may evaluate similar information as data in the Network Adequacy and Access Assurances Report (NAAAR). Similarly, the performance measures that are validated under the EQR activity may overlap with the mandatory measures included in the QRS. To help reduce the state's administrative burden, CMS should identify areas in which there is overlap with other federal monitoring activities, such as the NAAAR and QRS, to reduce duplicative reporting.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation could increase federal discretionary spending to cover CMS administrative activities related to implementation. CMS would be operating within its current statutory and regulatory authority to make EQR mandatory activity protocols more consistent.[9] CMS would have some increase in administrative burden to update EQR protocols, develop EQRO and state Medicaid agency guidance, and offer technical assistance. This administrative burden could be offset if CMS identifies how EQR interacts with other federal quality and oversight reporting requirements and identifies how states can leverage findings and data across requirements to reduce burden on federal regulators reviewing state reports.

States. States would need to work with their EQRO to modify their ATRs to comply with the standardized reporting requirements. States could benefit from reduced administrative burden if CMS issues guidance and updates the protocols to reduce EQR reporting in areas in which information is duplicative of other federally mandated reports. States would have one year from the issuance of any updated protocols from CMS to comply.

Enrollees. Medicaid enrollees and other beneficiary advocacy organizations would be able to find information on the quality of care being provided by different managed care plans if ATRs were more transparent and accessible. The changes to the ATR could improve the oversight of managed care plans and result in improved performance in quality and outcomes.

Plans. Managed care plans would not necessarily see an increased burden unless the EQRO makes changes in the information requested from the plans. Plans could benefit to the extent that any standardization could lead to EQR activities being performed in a more predictable and consistent manner year after year and regardless of the EQRO selected by the state. Plans operating in multiple states could also benefit from a reduction in variability across states.

Providers. Added transparency in the EQR reporting may inform providers regarding areas for potential quality improvement or focus.

Recommendation 1.3

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require

states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

Rationale

Although there are federal requirements for states to post their ATRs publicly, our environmental scan found that the most recent reports can often be hard to find. CMS could improve transparency by developing a central repository for these ATRs on the Medicaid.gov website similar to the way they have recently begun posting the managed care program annual reports (MCPARs).

Federal regulations require states to post their ATRs by April 30 of each year for all activities conducted by the EQRO the previous calendar year. Although states typically meet this deadline with few exceptions, reports can sometimes be hard to find, and the information in them can be difficult to use even for CMS and state Medicaid agencies. Given that EQR is an important statutory oversight mechanism related to managed care, the lack of accessibility of reports can hinder the ability of stakeholders to monitor health plans' performance.

In the 2024 managed care rule, CMS added a requirement that states notify CMS within 14 calendar days of posting their ATRs to their state websites. Additionally, the rule requires that states maintain at least the previous five years of EQR technical reports on their websites. States must comply with this requirement to maintain five years of reports on their websites no later than December 31, 2025. Although these new regulations should improve the accessibility of ATRs, it may still be challenging for stakeholders to collect information across states. Posting all of the ATRs in a central location such as Medicaid.gov would reduce the effort needed to locate each state's report.

CMS publishes summary tables based on the ATRs on Medicaid.gov, including a list of the EQROs contracting with states, the number and type of plans included in each state's EQR technical report, validated performance measures, whether a state reported performance measure rates, and the areas of care and populations covered by PIPs. However, these summary tables are generally a count of states and do not include any findings from the ATRs. As such, stakeholders are not able to use these summary tables to assess plan performance.

Officials at CMS indicated that it would be challenging to post the ATRs on the Medicaid.gov website due to issues with ensuring compliance with accessibility requirements of Section 508 of the Rehabilitation Act of 1973. Due to the variation in style and format across states, CMS did not have the resources to ensure each ATR was 508 compliant before posting. CMS has been able to post other reports such as MCPARs because a standardized template is available. To address these issues, CMS should require states and their EQROs provide their EQR ATRs in a 508-compliant format. Existing regulations require that states make the EQR ATRs available in alternative formats for persons with disabilities when requested, including compliance with Section 508 guidelines (42 CFR 438.10(a), 438.10(c), 438.364(c)(3)). Requiring states and their EQROs to submit a 508-compliant ATR to CMS would ensure these reports are available and accessible to persons with disabilities. Alternatively, CMS could require a standardized executive summary in a 508-compliant format in addition to the entire report. This executive summary would simplify the process of making the EQR findings 508 compliant so that CMS could post these summaries in a central location and provide stakeholders easier access to the key EQR findings across states.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation could increase federal discretionary spending to cover CMS administrative activities related to implementation. This recommendation would result in increased administrative effort for the federal government to post the ATRs in a central location.

States. States may incur an initial increase in administrative burden to coordinate with their EQROs to implement any new requirements on a standardized and 508-compliant format. This burden would diminish over time once the initial template was finalized.

Enrollees. This recommendation would benefit enrollees by having all EQR information in a central location.

Plans. Managed care plans may face an initial increased burden should the EQRO require any information in a different format. This burden would diminish over time once the initial template was finalized and could potentially result in reduced administrative burden for plans due to standardization.

Providers. Added transparency in the EQR reporting may inform providers regarding areas for potential quality improvement or focus.

Looking Ahead

The recommendations to improve the EQR process in this chapter are intended to build on MACPAC's ongoing work examining effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. This work includes a current study of Medicaid managed care accountability and the tools available to state Medicaid agencies and CMS to oversee managed care performance, hold plans accountable if their performance is below expectations, and improve performance over time. The Commission will continue to examine data from MCPARs available through CMS and will continue to monitor the effect of requirements from the 2024 managed care rule as they are implemented over the next few years.

Endnotes

[1] To qualify as an EQRO, an organization must have experience and knowledge of Medicaid policy and service delivery, quality improvement and performance measurement, and research design and methodology. It must also demonstrate sufficient physical, technical, and financial resources and relevant clinical or non-clinical skills to complete the necessary activities. There are also conflict of interest provisions for eligible entities (42 CFR 438.354).

[2] Alaska, Connecticut, Maine, Montana, and South Dakota do not have managed care plans subject to EQR. Oklahoma implemented a Medicaid managed care program in 2024. Alabama has only primary care case management entities, which are now excluded from mandatory EQR activities as stated in the 2024 managed care rule (MACPAC 2023).

[3] The enhanced match of 75 percent is available for both mandatory and optional activities conducted by a qualified EQRO. States must submit EQRO contracts for CMS approval before receiving the enhanced match. A 50 percent match rate applies to EQR-related activities performed on entities other than MCOs, such as PIHPs, PAHPs, PCCM entities, or other types of integrated care models. Enhanced match for the optional activity to assist with quality ratings and the new optional evaluation activities added under the 2024 managed care rule will be available for EQR on MCOs after CMS releases a final protocol. Until that time, states that choose to engage EQROs in these optional activities will receive the standard administrative match of 50 percent.

[4] States can also exempt MCOs (but not PIHPs and PAHPs) from the annual EQR process if the MCO has both a current Medicare Advantage contract and a current Medicaid contract; the two contracts cover all or part of the same geographic area in the state; and the Medicaid contract has been in effect for at least two consecutive years before the exemption date, and during those same two years, the MCO has been subject to EQR and met quality, timeliness, and access to health care services standards for Medicaid beneficiaries (CMS 2020).

[5] The state, its agent that is not an MCO, PIHP, or PAHP, or an EQRO may perform the mandatory and optional EQR-related activities (42 CFR 438.358). The majority of states contract with a qualified EQRO to conduct some or all of the mandatory activities.

[6] The standards that are the subject of this protocol are contained in 42 CFR 438: parts 56, 100, 114; subpart D; and the quality assessment and performance improvement program. The scope of those sections includes disenrollment requirements and limitations (42 CFR 438.56), enrollee rights requirements (42 CFR 438.100), emergency and poststabilization services (42 CFR 438.114), availability of services (42 CFR 438.206), assurances of adequate capacity and services (42 CFR 438.207), coordination and continuity of care (42 CFR 438.208), coverage and authorization of services (42 CFR 438.210), provider selection (42 CFR 438.214), confidentiality (42 CFR 438.224), grievance and appeal systems (42 CFR 438.228), subcontractual relationships and delegation (42 CFR 438.230), practice guidelines (42 CFR 438.236), health information systems (42 CFR 438.242), and quality assessment and performance improvement program (42 CFR 438.330).

[7] CMS released the final protocol for network adequacy validation in February 2023, which all states will be required to implement no later than a year from the protocol's release (CMS 2023).

[8] CMS finalized its framework for the Medicaid quality rating system in the 2024 managed care rule (42 CFR 438, subpart G). States must implement the quality rating system by December 31, 2028.

[9] The authority for the Secretary of the U.S. Department of Health and Human Services to develop EQR protocols is established in statute at 1932(c)(2)(A)(iii) of the Act and the requirements set forth in 42 CFR 438.352.

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on January 24, 2025.

Examining the Role of External Quality Review in Managed Care Oversight and Accountability

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

1.1 voting result	#	Commissioner
Yes	16	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Nardone, Snyder
Vacancy	1	

1.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

1.2 voting result	#	Commissioner
Yes	15	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McFadden, Nardone, Snyder
No	1	McCarthy
Vacancy	1	

1.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

1.3 voting result	#	Commissioner
Yes	15	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Johnson, Killingsworth, McCarthy, McFadden, Nardone, Snyder
Abstain	1	Ingram
Vacancy	1	

Chapter 2:

Timely Access to Home- and Community-Based Services

Timely Access to Home- and Community-Based Services

Recommendation

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance on how states can use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k), and Section 1115 of the Social Security Act.

Key Points

- Timely access to home- and community-based services (HCBS) is essential to ensure individuals do not experience delays in receiving services and care in the setting of their choice.
- To be eligible to receive Medicaid HCBS, individuals must meet both financial and functional eligibility criteria. Once determined eligible, designated staff work with the individual on a person-centered service plan (PCSP). Enrollees are required to have a PCSP in place before receiving HCBS.
- States have several ways in which they can streamline the eligibility and enrollment process to enable more timely receipt of HCBS. This chapter explores three such opportunities: presumptive eligibility, expedited eligibility, and use of provisional plans of care.
- Presumptive eligibility allows individuals who have not yet been determined eligible for Medicaid to receive Medicaid-covered services temporarily while completing the full Medicaid application process. The presumptive eligibility period typically lasts up to 60 days, at which time the full eligibility determination must be completed for coverage to continue.
- There is not a uniform definition of expedited eligibility, but the term can be used to describe a number of state actions to streamline eligibility, such as accepting self-attestation of information needed to determine Medicaid eligibility.
- Provisional plans of care, or interim service plans, are typically a shortened version of the PCSP that identifies the essential Medicaid services that can be provided in the person's first 60 days of waiver eligibility to quickly deliver the most critical services until the full PCSP can be developed.
- In 2000, the Centers for Medicare & Medicaid Services (CMS) permitted provisional plans of care when they issued guidance in a State Medicaid Director letter, but our research found that states rarely use provisional plans of care. This low uptake is largely due to a lack of awareness and limited state capacity to make them operational.
- The Commission recommends that CMS provide additional guidance to better describe the intent and use of provisional plans of care, including state examples of how to make the policy operational, both in emergency situations and as a standard step of the enrollment process. Guidance should describe how states can implement provisional plans of care in the least administratively burdensome way possible as well as explicitly say that they can be used for all HCBS authorities.

CHAPTER 2: Timely Access to Home- and Community-Based Services

Medicaid home- and community-based services (HCBS) are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a home-like setting in the community. Though nearly all HCBS are optional Medicaid benefits for states, all states choose to cover HCBS to some extent.[1] In 2021, more than 2.5 million individuals used Medicaid HCBS. Individuals who need HCBS can face barriers that delay access to these services. Timely access to HCBS is essential to ensure individuals do not experience delays in receiving services and care in the setting of their choice.

Over the past several decades, federal and state policies have shifted LTSS spending away from institutional services and toward HCBS (Bernacet et al. 2021). Since 2013 more than half of LTSS spending nationally has been on HCBS compared to institutional care (Murray et al. 2021). A MACPAC analysis found that in 2021, Medicaid spending on HCBS ($82 billion) outpaced spending on institutional care ($68 billion), accounting for 55 percent of all Medicaid spending on LTSS. Access to HCBS, however, varies across states and populations (Murray et al. 2024, Stepanczuk et al. 2024, MACPAC 2023).

To be eligible to receive Medicaid HCBS, individuals must meet both financial and functional eligibility criteria. Financial eligibility for individuals with LTSS needs generally includes both income and assets. Functional eligibility is determined using an assessment tool, and generally, individuals must be found to require an institutional level of care (LOC).[2] Once determined eligible, designated staff (e.g., case manager) work with the individual on a person-centered service plan (PCSP). Beneficiaries are required to have a PCSP in place before receiving HCBS. The time it can take to complete all of these requirements may delay an individual's access to critical services, which can negatively impact health outcomes and cost of care (McGarry and Grabowski 2023, Reinhard et al. 2021).

In line with the Commission's focus on access to HCBS, we have been working to understand states' eligibility and enrollment processes for HCBS programs, particularly the ways in which some states may take advantage of streamlining opportunities to enable more timely receipt of services (MACPAC 2023). This chapter focuses on states' use of presumptive eligibility and expedited eligibility flexibilities as well as their use of provisional plans of care. As a result of this work and Commissioner deliberations at our public meetings, we have concluded that additional federal guidance on provisional plans of care is necessary. Specifically, the Commission recommends:

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance on how states can use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k), and Section 1115 of the Social Security Act.

The chapter begins with background on the steps in the eligibility determination process for Medicaid HCBS, followed by an overview of our analytic approach. It then provides a more detailed explanation of presumptive eligibility and expedited eligibility, followed by a summary of our interview findings. Next follows more specific background on provisional plans of care, the results of a review of Section 1915(c) waivers, and themes from our stakeholder interviews. Finally, the chapter ends with the Commission's recommendation for guidance on provisional plans of care and its rationale.

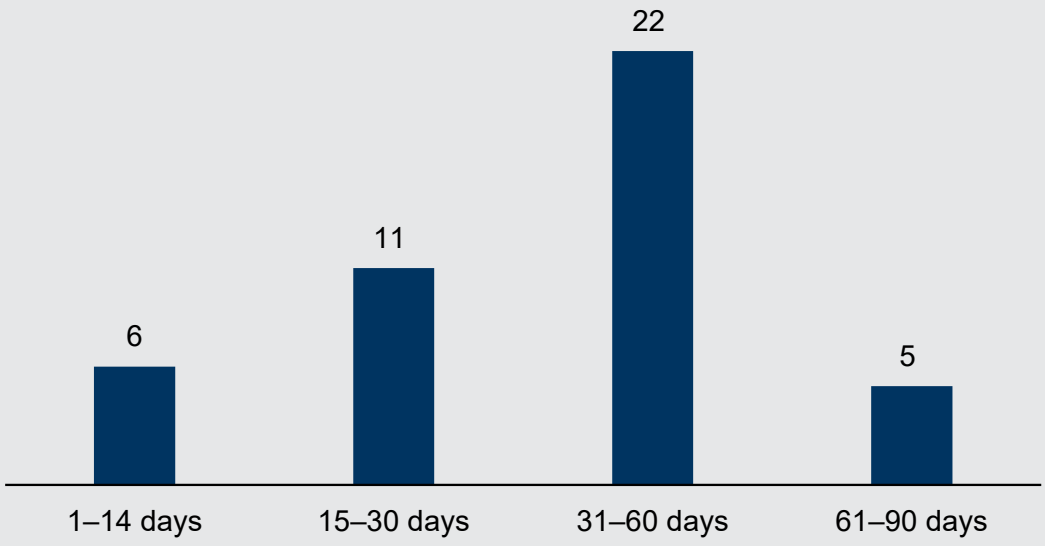
Background

To be determined eligible for Medicaid, individuals generally must fit into a specific eligibility category, meet certain income thresholds, and meet asset tests under certain circumstances. To qualify for LTSS, they must meet additional functional criteria that are based on an individual's physical or cognitive status. For many groups of Medicaid beneficiaries, including children, pregnant women, parents, and adults without dependent children, states use modified adjusted

gross income (MAGI) standards for counting income and household size. Individuals whose eligibility is determined using MAGI standards are typically not subject to an asset test or functional assessment for Medicaid eligibility, and states are required to determine eligibility within 45 days of application (42 CFR 435.912(c)(3)). Many states are able to process MAGI applications faster than applications for individuals whose income is not determined on the basis of MAGI (non-MAGI), since MAGI applications do not require asset determinations. A 2024 report from the Centers for Medicare & Medicaid Services (CMS) showed that 44 percent of all MAGI determinations were processed in less than 24 hours (CMS 2024a).

For non-MAGI groups, which include individuals whose eligibility is based in part on age or disability and who may be seeking Medicaid LTSS, states have up to 90 days to make an eligibility determination (42 CFR 435.912(c)(3)). Most states take between one and two months on average to complete a non-MAGI eligibility determination, but some states take longer (Figure 2-1). There are no national reporting data for non-MAGI application processing times, but the additional documentation required of non-MAGI applicants (e.g., to verify assets), as well as the administrative complexity of making these eligibility determinations, can result in lengthier processing times. For example, the Iowa Health Care Association estimated an average of 71 days to assemble the required income and assets documentation, file the Medicaid application, and receive approval for Medicaid nursing home coverage (Meyer 2019). Most states use electronic data sources to verify income and assets, but some states continue to require paper documentation to verify income and assets. The increased use of electronic data sources can shorten application processing times and alleviate administrative burden for applicants and state staff. One additional flexibility that can shorten processing times is to accept self-attestation of income and assets, but a 2022 study found that only a handful of states adopted this approach (Musumeci et al. 2022).

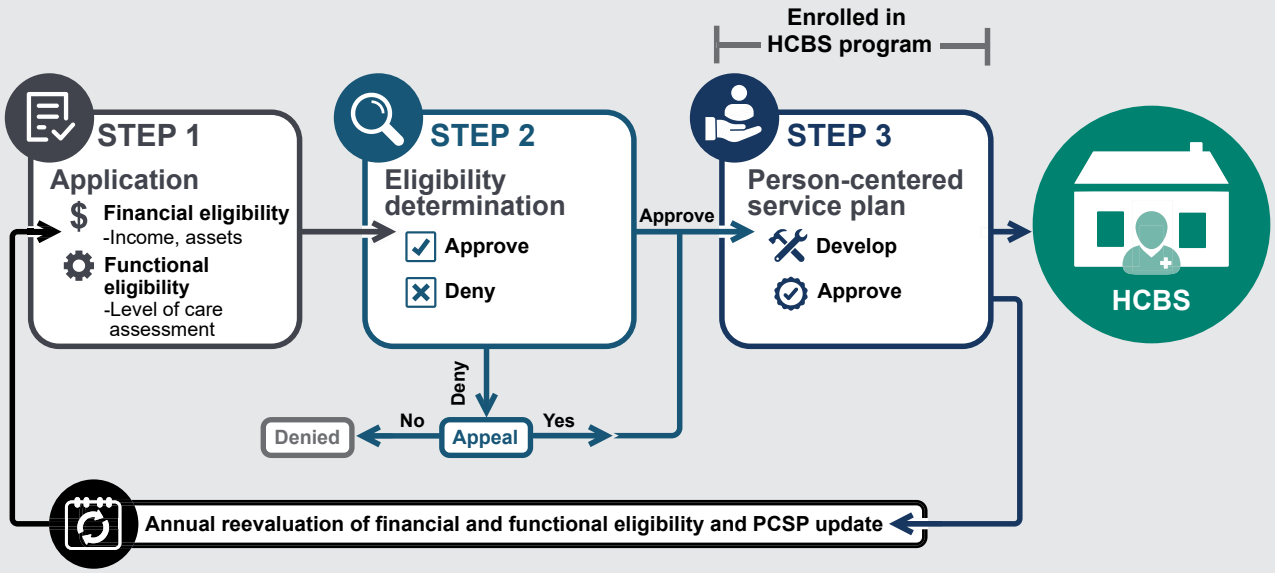
FIGURE 2-1. States' Average Processing Times for Non-MAGI Applications, July 2022



Notes: MAGI is modified adjusted gross income. Data are from 43 states and the District of Columbia; 7 states indicated that their average processing time was unknown.

Source: Musumeci et al. 2022.

FIGURE 2-2. Eligibility Process and Requirements for Individuals Seeking Medicaid Home- and Community-Based Services



Notes: HCBS is home- and community-based services. PCSP is person-centered service plan.

Sources: 42 CFR 441.301, 441.303, 441.535, 441.540, 441.720, 441.725, 435.907, and 435.916.

To determine whether an individual meets a state's LTSS functional eligibility criteria, also referred to as "LOC criteria," states use functional assessment tools, which are sets of questions that collect information on an applicant's health conditions and functional needs.[3] Such tools may also be used to develop a PCSP, which describes the services and supports that an individual requires to meet individual preferences and the needs identified in the functional assessment (42 CFR 441.301(c)(2)). For an individual to receive HCBS, a PCSP must be in place first (Figure 2-2).

States use different authorities to deliver HCBS to eligible individuals (Appendix 2A). With the exception of home health care services covered under Section 1905(a)(7) of the Social Security Act (the Act), HCBS is not a mandatory benefit. All states choose to cover HCBS, and most operate multiple programs within their state.[4] Most states cover HCBS via Section 1915(c) waivers or Section 1115 demonstrations (MACPAC 2024a, 2023). These authorities give states flexibility to limit the number of beneficiaries receiving HCBS, target services to particular populations, or provide services in only certain parts of the state. Some states also offer optional state plan benefits, such as through a Section 1915(i) or Section 1915(k) state plan amendment (SPA).[5] HCBS covered under the state plan must be offered to all eligible beneficiaries; however, they are typically more limited in scope than those provided under waivers. For more information on Medicaid authorities for HCBS, see Chapter 3 of this report.

Analytic Approach

MACPAC contracted with The Lewin Group to conduct an environmental scan of state policies on the use of presumptive and expedited eligibility for non-MAGI populations. The scan also documents select information on LOC assessments and person-centered processes to capture how states administer LOC determinations and develop PCSPs as well as any flexibilities that they incorporate to streamline these processes and accelerate beneficiary access to HCBS.

MACPAC staff then conducted stakeholder interviews with state and federal officials and national experts to better understand state implementation and operation of HCBS programs as well as considerations and potential barriers to state uptake of policies. Finally, MACPAC staff used data from the environmental scan and data received from CMS to compile a list of Section 1915(c) waivers that have language on the use of provisional plans of care (Appendix 2B). The methodology and results of the waiver review are described later in this chapter.

Environmental scan

From September 2023 through March 2024, The Lewin Group reviewed all approved Section 1915(c) waivers, Section 1915(i) and 1915(k) SPAs, and Section 1115 demonstrations for all 50 states and the District of Columbia.[6] The Lewin Group's scan found that as of February 2024:

- 46 states and the District of Columbia operated a total of 251 Section 1915(c) waivers;
- 15 states had Section 1115 waivers that cover some HCBS;
- 17 states offered Section 1915(i) state plan HCBS benefits; and
- 8 states had a Section 1915(k) Community First Choice program.

The Lewin Group also reviewed American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) Section 9817 spending plans; Section 1915(c) Appendix K COVID-19 addendums; Medicaid disaster relief SPAs; CMS-372(S) reports; and select state websites, provider manuals, and state legislation and administrative codes. The Lewin Group used information from these sources to populate the environmental scan (MACPAC 2024a).[7] The scan was then sent to state officials to review and confirm the accuracy of the information. Thirty-four states responded to our feedback request.

Stakeholder interviews

We used the environmental scan to identify states for interviews, choosing states based on authority used, population served, geography, and implementation stage to get a mix of states with newer and more established use of eligibility flexibilities, among other factors. From June through August 2024, we spoke with officials in seven states as well as representatives of four national organizations and officials from CMS.[8] Depending on the state experience or the expertise of the national experts, we spoke with interviewees about presumptive and expedited eligibility, LOC assessments, and PCSPs. After Commissioner questions on states' low take-up of provisional plans of care at MACPAC's October 2024 meeting, we also conducted a few follow-up interviews in November 2024 to answer this specific inquiry.

Presumptive Eligibility and Expedited Eligibility

Presumptive eligibility and expedited eligibility are two flexibilities with similar goals that states can use to streamline the Medicaid eligibility determination process for HCBS. In our stakeholder interviews, no two interviewees defined presumptive eligibility and expedited eligibility in the same way. To discuss these terms and states' use of these flexibilities, we have developed the following definitions. These definitions closely align with those used by CMS and with how they are described in Medicaid statutory and regulatory language and in subregulatory guidance.

Presumptive eligibility

Presumptive eligibility allows individuals who have not yet been determined eligible for Medicaid to receive Medicaid-covered services temporarily while completing the full Medicaid application process. Presumptive eligibility determinations are typically made using self-attestation, such as for an individual's income, to more quickly make an eligibility determination and allow the individual to begin receiving services. The presumptive eligibility period typically lasts up to 60 days, at which time the full eligibility determination must be completed for coverage to continue. States can allow qualified entities, such as hospitals, to make a presumptive eligibility determination for MAGI-based eligibility groups and certain other populations (§§ 1920, 1920(A), 1920(B), 1920(C) of the Act, 42 CFR

435.1100-1103). The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) gave states the option to expand hospital presumptive eligibility to non-MAGI populations, but only one state has done so (CMS 2014a). A hospital may elect to be a qualified entity and conduct presumptive eligibility determinations for Medicaid, regardless of whether the state has adopted any of the options for specific populations (§ 1902(a)(47)(B) of the Act, 42 CFR 435.1110) (MACPAC 2017). Presumptive eligibility is used most often for children and pregnant women (Brooks et al. 2023).[9]

Two options are available for states to use presumptive eligibility for non-MAGI populations: (1) a state plan amendment to expand hospital presumptive eligibility to non-MAGI populations, and (2) a Section 1115 demonstration (§ 1902(a)(10)(A) of the Act, 42 CFR 435.1110(c)). Use of a Section 1115 demonstration gives states additional flexibility to design their programs and use entities other than hospitals, such as case management agencies, to make the presumptive eligibility determination. Regardless of which option states choose, Medicaid reimburses providers (e.g., home health care agency) furnishing HCBS during the period in which a beneficiary is deemed presumptively eligible; however, services during this time must be rendered after a plan of care is established.

Based on the results of our environmental scan and our stakeholder interviews, we identified 11 states that are currently using, planning to use, or have previously used presumptive eligibility for non-MAGI populations. States use various mechanisms to implement presumptive eligibility, the most common of which are Section 1115 demonstrations (Colorado, New Jersey, Rhode Island, and Washington). Our environmental scan found that during the COVID-19 public health emergency (PHE), three states (California, New Jersey, and Oklahoma) implemented presumptive eligibility through Section 7.4 Medicaid disaster relief SPAs to temporarily expand hospital presumptive eligibility to non-MAGI populations (MACPAC 2024a).[10] California is the only state that has submitted a SPA to permanently include non-MAGI populations as part of their hospital presumptive eligibility program. Finally, our scan found that Illinois used a Section 1915(c) Appendix K COVID-19 addendum during the PHE (MACPAC 2024a).

Our environmental scan identified additional ways that states are either implementing or planning to use presumptive eligibility. Louisiana has a Section 1915(i) SPA targeted at adults with behavioral health conditions that allows for presumptive eligibility. Ohio also has a presumptive eligibility program, described in its administrative code, for two different Section 1915(c) waiver populations, but its program is funded with state-only dollars. Michigan is using ARPA funding to pilot the use of presumptive eligibility for its Section 1915(c) MI Choice waiver program (MDHHS 2023). Finally, New Hampshire, in its ARPA spending plan, proposed to pilot the use of presumptive eligibility but, after receiving technical assistance from CMS, decided to move to an alternative initiative that could be implemented within the ARPA spending time frame (NH DHHS 2023).

Data on presumptive eligibility determinations. There are limited publicly available data on the use of presumptive eligibility for non-MAGI populations; however, we have been able to identify a few data points. For example, Michigan's latest ARPA narrative from November 2023 details that 138 individuals have been presumed eligible through the pilot, with 116 individuals receiving full Medicaid approval, 14 individuals with pending determinations, and 7 individuals determined ineligible (MDHHS 2023). In our conversation with officials in California, they shared that in August 2023 there were 1,605 non-MAGI individuals enrolled in its hospital presumptive eligibility program (CA DHCS 2024).

Washington state also publishes data on presumptive eligibility in its Section 1115 waiver quarterly reports, the most recent of which covers October 1 through December 31, 2023 (WA HCA 2024). Four LTSS populations are included in Washington's Section 1115 demonstration: (1) Medicaid Alternative Care (MAC), (2) Tailored Supports for Older Adults (TSOA), (3) individuals discharging from acute care hospitals to in-home settings, and (4) non-hospitalized individuals applying directly for in-home settings.[11] MAC provides a community-based option for people age 55 and older who are eligible for Medicaid LTSS and choose to support an unpaid family caregiver rather than receive paid personal care services. TSOA offers a limited number of personal assistance services for individuals age 55 and older who are at risk of becoming eligible for Medicaid LTSS (CMS 2023a).

During the reporting period, new enrollees included 33 MAC dyads, 215 TSOA dyads, and 403 TSOA individuals.[12] Of these MAC and TSOA enrollees, 281 individuals entered through presumptive eligibility. The report notes that 46 percent of clients remained eligible after the presumptive eligibility period, 24 percent were found ineligible, and 30 percent were still pending a determination (WA HCA 2024). Figure 2-3 provides data on causes of ineligibility for the 24 percent found ineligible.

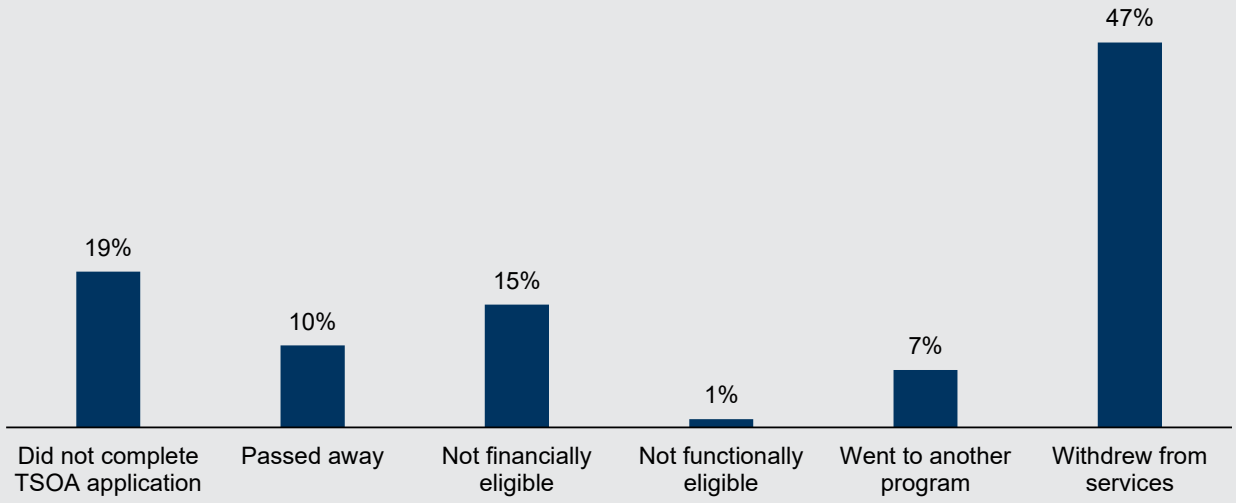
Expedited eligibility

Expedited eligibility, also referred to as "fast track eligibility," occurs when an individual's Medicaid application is processed in an accelerated manner for the purposes of making a Medicaid eligibility determination, but services are not rendered until the determination has been made. There is not a uniform definition of expedited eligibility; instead, states can speed up the process within certain parameters, such as setting specific timeline requirements for Medicaid eligibility approvals. CMS officials described expedited eligibility as a quicker processing of an application but caveated that it is not a term used at the federal level. They acknowledged that some states use the term, and it can be used generally to describe a number of state actions to streamline eligibility, such as accepting self-attestation of information needed to determine Medicaid eligibility (42 CFR 435.945(a)).

Our environmental scan identified a few state examples of expedited eligibility for HCBS. For example, in Indiana, the state's ARPA spending plan describes an expedited eligibility pilot program to improve application processing times, such as through information technology system changes and training LTSS eligibility staff. During the PHE, Hawaii and North Carolina allowed for self-attestation of functional eligibility (MACPAC 2024a).[13]

One state that we interviewed described an expedited eligibility program for individuals seeking LTSS. In this state's program, an individual's LOC assessment is completed first, followed by the financial eligibility determination. In the expedited eligibility program, PCSP development begins while the financial eligibility determination is happening. This approach expedites access to services because with the PCSP being completed at the same time as the full Medicaid LTSS eligibility determination, the individual can immediately begin receiving HCBS once enrolled.

FIGURE 2-3. Reasons Individuals Were Found Ineligible after a Period of Presumptive Eligibility for Washington's Medicaid Alternative Care and Tailored Supports for Older Adults Programs, October–December 2023



Note: TSOA is Tailored Supports for Older Adults.

Source: WA HCA 2024.

Other streamlining efforts

There are additional ways outside of presumptive eligibility and expedited eligibility that states can make improvements to their systems, which can also result in more timely access to HCBS. The Lewin Group found examples of five states engaging in such efforts to streamline their eligibility processes, including efforts to automate systems and enhance No Wrong Door activities (MACPAC 2024a).[14] For example, Maine is developing a public-facing web-based referral form that allows consumers to self-assess their needs, which will be automatically entered into appropriate data systems to facilitate provider-level referrals and follow-up and to prescreen for eligibility. New Mexico used ARPA funding for a one-time system update to automate its screening and assessment tools. Rhode Island is expanding No Wrong Door activities to address ease of access and how an applicant navigates the state system. The state is expanding person-centered options counseling and other outreach about HCBS programs to underserved racial and ethnic communities, updating business processes, and integrating IT systems.

Several interviewees expressed interest in allowing states to use retroactive coverage of HCBS for non-MAGI populations (Carlson 2021). Typically, states must provide three months of retroactive coverage (from the date an application for Medicaid was received) to any Medicaid enrollee who received Medicaid services prior to enrolling in the program and met eligibility standards when the services were received (42 CFR 435.915).[15] HCBS, however, are excluded from retroactive eligibility periods (MACPAC 2019a). A 2016 decision by the federal Sixth Circuit Court of Appeals affirmed that states cannot provide retroactive coverage of HCBS because Medicaid funds for HCBS can only be provided pursuant to a written plan of care. In that case, individuals in Ohio were seeking reimbursement for assisted living services that were provided before their PCSPs were approved. The court's opinion states that "the defendants [the director of Ohio's Medicaid program and the director of the Ohio Department of Aging] would have violated federal law if they had used Medicaid funds to pay for assisted-living services provided before approval of a service plan."[16]

Interview Findings: Presumptive Eligibility and Expedited Eligibility

MACPAC conducted interviews to better understand how states are expediting Medicaid LTSS eligibility determinations, including the Medicaid authority used, populations targeted, and implementation considerations. Of the states we spoke with, based on the definitions provided earlier in this chapter, five states are using presumptive eligibility and one state is using expedited eligibility.

States generally use Section 1115 demonstrations as the vehicle to streamline eligibility. Of the six states we spoke with, four use Section 1115 demonstrations. One state expanded hospital presumptive eligibility during the PHE using a disaster relief SPA and has since submitted a regular SPA to make the policy permanent. One state used flexibilities provided during the PHE for one of its Section 1915(c) waivers but did not elect to make it permanent. This state allowed self-attestation of financial eligibility and citizenship during the PHE but decided to return to its normal process at the end of the PHE. The state explained that it has around 100,000 beneficiaries enrolled in the waiver, and the standard pre-PHE process to determine eligibility for applicants ensured that resources were being used appropriately. Finally, this state also noted a workforce consideration to ensure adequate staff were available to make determinations.

We heard from many interviewees that states choose Section 1115 demonstrations to provide presumptive eligibility primarily because the state does not have to assume financial risk for federal financial participation associated with someone who is found presumptively eligible and later determined to be ineligible. Section 1115 demonstrations also allow states to use entities (e.g., case management agencies) other than hospitals to make the presumptive eligibility determinations. We also heard that 1115 demonstrations give states the ability to innovate, design policies to meet their specific state needs, and waive certain elements of federal Medicaid authority, which make this authority an attractive option for states.

States are generally using presumptive eligibility and expedited eligibility for older adults and individuals with disabilities, with a focus on helping individuals transition from hospitals back to the community. Of the states we spoke with, four states currently include hospitalized individuals, and one state is exploring how to expand its population to hospitalized individuals. Three national experts also expounded on how important it is to disrupt the hospital-to-nursing-facility pipeline and identified the potential of these flexibilities to ensure that individuals are able to receive care in the setting of their choice.

States using these flexibilities generally accelerate eligibility determinations by relying on self-attestation, shortened versions of their LOC assessments, and a limited benefit package. For example, one state accepts self-attestation for purposes of financial eligibility and uses a shortened version of its LOC assessment. The applicant can then receive a subset of services during the presumptive eligibility period while their full financial and functional determinations are being completed. This state also offers a limited number of services during the presumptive eligibility period and shared that it chose the services by identifying the most commonly used services in its Community First Choice program and Section 1915(c) waivers as well as what services could be accessed the fastest. A number of interviewees suggested that offering a limited set of services during the presumptive eligibility period can respond to beneficiaries' short-term needs and prevent institutionalization. One state we spoke with allowed individuals to access the full suite of waiver services.

Despite CMS policy that services provided during the presumptive eligibility period qualify for federal match regardless of the final Medicaid eligibility decision, a few interviewees expressed concern about a state's financial risk for services provided to individuals found presumptively eligible for HCBS and then later found ineligible. CMS and experts we spoke with said that states are under no obligation to repay the federal government for services provided during a period of presumptive eligibility for either Section 1115 demonstrations or hospital presumptive eligibility through a SPA (CMS 2014a). Interviewees also noted that error rates are typically very low (Mollica 2019). Providers are also not liable for services provided during the presumptive eligibility period, and a few states noted the importance of educating providers so that they understand there is no financial recoupment (CMS 2014a).

Providers need training to make presumptive eligibility determinations for non-MAGI populations. Three states and CMS officials spoke about how implementing presumptive eligibility requires training for those making the determinations, whether they are hospitals, case management agencies, or state eligibility workers. This is an operational concern for states as they implement new flexibilities.

Interviewees indicated that the entities making presumptive eligibility determinations should understand the diversity of the recipient population. Medicaid beneficiaries who use HCBS are a diverse group, spanning a range of ages with different types of complex conditions and service needs, including physical disabilities, developmental disabilities, and behavioral health needs. States typically have multiple state agencies serving these different populations as well as a host of contractors and other organizations that support the operation of HCBS programs. For example, among states we spoke with, about half used state staff to conduct the eligibility determinations and half contracted with case management agencies. In one state that uses state staff, one agency conducts the financial eligibility determination and another agency conducts the functional assessment. State officials noted that having multiple agencies involved in eligibility functions allows for greater expertise but can also affect the timeliness of determinations, as there can be communication gaps between the two agencies, such as when agencies use different computer systems. In another state with multiple HCBS programs that uses the same case management agency to conduct eligibility reviews for all individuals regardless of program, they spoke about their efficient approach to training that ensures workers understand all the requirements and complete the full eligibility review.

The complexity of non-MAGI eligibility determinations does not lend itself to speedy determinations. A number of interviewees noted that financial eligibility is the most complex and time-consuming portion of the determination. Non-MAGI populations are subject to other criteria beyond what MAGI populations must meet, specifically asset tests, which can take additional time to complete.

One state and CMS officials also noted that disability determinations can be complex and difficult to do quickly and could pose barriers for states trying to figure out how to approach presumptive eligibility for non-MAGI individuals.

A few interviewees had concerns about a "benefit cliff" for individuals who receive services during the presumptive eligibility period but are ultimately found ineligible for Medicaid, though most interviewees acknowledged the rarity of this situation. Interviewees were concerned that people might not understand why they were able to receive services only to subsequently receive a denial notice and be cut off from those services. We also heard from a state official about an example of how services provided during a presumptive eligibility period responded to an individual's short-term needs and allowed them to return home to the community. This individual received services during a presumptive eligibility period after being discharged from a hospital, and although they were ultimately found ineligible, by the time the determination came through, they had recuperated enough that the loss of coverage did not pose a hardship.

There was no consensus among interviewees about the need for additional CMS guidance addressing presumptive eligibility. Of the state officials we spoke with, one state strongly supported the need for guidance on the use of presumptive eligibility for non-MAGI populations, while two other states did not see a need for additional guidance. Other states spoke about the important role of CMS technical assistance in applying for and implementing their flexibilities. Among experts, there was a general feeling that additional CMS guidance is usually helpful for states. One expert noted that since much of this work is being done through Section 1115 demonstration authority, which relies heavily on back-and-forth discussions with CMS and the ability for states to tailor programs to their specific needs, what we are essentially seeing is "policymaking through waiver approvals." In conversations with CMS, they did not indicate plans to issue guidance to states on how to incorporate presumptive eligibility into their Section 1115 demonstrations. Finally, CMS noted that ample guidance exists on the use of hospital presumptive eligibility, in particular pointing to a set of FAQs from 2014 (CMS 2014a).

In sum, interviewees expressed strong support for the use of presumptive eligibility for non-MAGI populations and other expedited eligibility flexibilities that can reduce the amount of time an applicant waits to receive HCBS. Interviewees agreed that timely access to services is critical, particularly when an individual may be in an emergency situation. Interviewees in particular cited concerns around timely determinations for individuals discharging from hospitals, in order to prevent institutionalization. Experts also reiterated that these policy tools support consumer preferences to remain in the community.

Person-Centered Service Plans

All states use PCSPs to identify the services and supports that a person needs to live in the community. The purpose of person-centered service planning is to empower individuals to build the life they choose or aspire to at any age across their lifespan (CMS 2024b). PCSPs, among other purposes, are intended to identify the individual's goals and desired outcomes and reflect the services and supports (paid and unpaid) that will assist the individual to achieve them (Box 2-1). For example, PCSPs may document the supports available for an individual's goals around employment, community engagement, or wellness. They should also reflect the individual's strengths and preferences as well as risk factors and measures in place to minimize them (CMS 2024b).

Provisional Plans of Care

To receive HCBS, beneficiaries must have an approved PCSP. Specifically, the statute states that HCBS are "provided pursuant to a written plan of care" (§ 1915(c)(1) of the Act, 42 CFR 441.301(b)(1)(i)). To expedite receipt of Section 1915(c) services, CMS allows for a provisional plan of care (also called an interim or temporary service plan), which identifies the essential Medicaid services that can be provided in the person's first 60 days of waiver eligibility (CMS 2024b). Provisional plans of care are not intended to be extensive but rather a way to quickly provide the most critical services until the full PCSP can be developed.

Provisional plans of care have been allowed since 2000, when they were described in a State Medicaid Director (SMD) letter, known as Olmstead Letter No. 3, which was issued in response to the 1999 *Olmstead v. L.C.* decision (CMS 2000).[17] In *Olmstead v. L.C.*, the U.S. Supreme Court ruled that unjustified institutionalization of individuals with disabilities by a public entity is a form of discrimination under the Americans with Disabilities Act of 1990 (ADA, P.L. 101-336). *Olmstead v. L.C.* concluded that states must provide treatment for individuals with disabilities in the most integrated setting possible if the individuals are not opposed and such placement is appropriate and can be reasonably accommodated by the state (MACPAC 2019b). To help states meet the requirements of the ADA and the *Olmstead* decision, CMS issued five SMD letters (ASPE 2001). Box 2-2 is an excerpt of the text from Olmstead Letter No. 3 giving the authority to states to use provisional plans of care in their waiver programs.

BOX 2-1. Regulatory Requirements for Person-Centered Planning Process

The requirements for Section 1915(c) waiver person-centered planning processes are detailed in 42 CFR 441.301(c):

(1) ***Person-centered planning process.*** The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) Includes people chosen by the individual.

(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(iii) Is timely and occurs at times and locations of convenience to the individual.

(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.

(viii) Includes a method for the individual to request updates to the plan as needed.

(ix) Records the alternative home and community-based settings that were considered by the individual.

The requirements for Section 1915(k) are detailed in 42 CFR 441.540, and the requirements for Section 1915(i) are detailed in 42 CFR 441.725. The requirements for these state plan authorities are similar to those listed above for Section 1915(c) waivers.

BOX 2-2. Text from Olmstead Letter No. 3 on Provisional Plans of Care, July 25, 2000

Timely home and community-based services (HCBS) waiver eligibility determinations are particularly important to ensure that individuals awaiting imminent discharge from a hospital, nursing home, or other institution are able to return to their homes and communities.

Consequently, we have been asked to clarify the earliest date of service for which Federal financial participation (FFP) can be claimed for HCBS and other State plan services when a person's Medicaid eligibility is predicated upon receipt of Medicaid HCBS under a waiver.

Under current Health Care Financing Administration policy, States must meet several criteria (described below) before they can receive FFP for HCBS waiver services furnished to a beneficiary who has returned to the home or community setting. For example, section 1915(c)(1) of the Social Security Act (the Act) requires that HCBS waiver services be furnished pursuant to a written plan of care.

Policy Change: To facilitate expeditious initiation of waiver services, we will accept as meeting the requirements of the law a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being developed and implemented. A comprehensive plan of care must be in place in order for waiver services to continue beyond the first 60 days.

Earliest Date of HCBS Waiver Eligibility = The Last Date All of the Following Requirements Have Been Met

1. ***Basic Medicaid Eligibility:*** The person is determined to be Medicaid-eligible if in a medical institution. The eligibility group into which the person falls must be included in the State plan.
2. ***Level of Care:*** The person is determined to require the level of care provided in a hospital, nursing facility, or ICF/MR.

   Level of care determinations must be made as specified in the approved waiver.
3. ***Special Waiver Requirements:*** The person is determined to be included in the target group and has been found to meet other requirements of eligibility specified in the State's approved waiver. These requirements include documentation from the individual that he or she chooses to receive waiver services.

The person must actually be admitted to the waiver.

Plan of Care: A written plan of care is established in conformance with the policies and procedures established in the approved waiver.

Policy Change: For eligibility determinations we will initially accept a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being accomplished. A comprehensive care plan, designed to ensure the health and welfare of the individual, must be developed within this time.

Note: ICF/MR is intermediate care facility for individuals with mental retardation, which has since been renamed intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

Source: CMS 2000.

States must document in their Section 1915(c) waivers if they allow the use of a provisional plan of care and their procedures for developing one. The following is an example from Delaware's Division of Developmental Disabilities Services (DDDS) Lifespan Waiver:

> The initial interim plan describes the circumstances that led the participant to seek waiver enrollment and the amount, duration and frequency of each service that is recommended for the participant until the full formal person-centered plan can be developed. The initial interim plan may only be in place for 60 days. A formal person-centered plan that addresses the participant's complete needs must be developed within 60 days of the date of the first receipt of a waiver service. The case manager provides supports and information to the new waiver participant to enable them to direct and be actively engaged in the development of the initial interim plan (CMS 2022).

Waiver review

As part of the environmental scan, The Lewin Group reviewed Appendix D-1-d of the Section 1915(c) waivers on the service plan development process. In doing so, The Lewin Group found language in waivers in 17 states on provisional plans of care. We also received a list of waivers by state from CMS that have language on "provisional," "interim," or "temporary" service plans. After cross-referencing these two data sources, we found that 24 states allow for the use of provisional plans of care, across 59 Section 1915(c) waiver programs (Appendix 2B; CMS 2024c, MACPAC 2024a). Of the 24 states, 5 states have language allowing for the use of provisional plans of care in all of their waivers (Table 2-1). Most states allow their provisional plans of care to be in place for 60 days, although some states specify shorter time frames such as 30 days (e.g., Michigan) or 45 days (e.g., Montana). About half of states that have multiple waivers with provisional plans of care use the same description across all waivers (e.g., Colorado), while other states may use different processes across waiver programs (e.g., Illinois). Among the 59 waivers, the most commonly targeted populations are individuals with intellectual and developmental disabilities (26 and 24 waivers, respectively), followed by individuals with physical disabilities (16 waivers) and older adults (15 waivers) (Appendix 2B, Table 2B-2).

Outside of Section 1915(c) waivers, our environmental scan also found one state, Maryland, that allows for the use of provisional plans of care in its Section 1915(i) SPA and in its Section 1115 demonstration (MACPAC 2024a). The state's Section 1915(i) SPA, which is targeted at youth and young adults with serious emotional disturbance or co-occurring mental health and substance use disorders, allows for the use of provisional plans of care for crisis situations in order to respond to the immediate needs of the participant and their family (CMS 2014b).

Interview Findings: Provisional Plans of Care

We used the results of our environmental scan to identify states that have language allowing for provisional plans of care in their Section 1915(c) waivers, and we spoke with officials in five states. Of these five states, in one state we found language on the use of provisional plans of care in all of its waivers, in two states for half of its waivers, and in two states in only one or two of its waivers.

State use of provisional plans of care

We found that states rarely use provisional plans of care, but when they do, they are most often used in cases such as natural disasters or hospitalizations. Additionally, states with Section 1115 demonstrations for presumptive eligibility for non-MAGI populations often use provisional plans of care but have added flexibilities afforded by the Section 1115 authority.

As indicated by our environmental scan and information we received from CMS, 24 percent of all Section 1915(c) waivers approved by CMS (59 of 251) allow for some use of provisional plans of care; however, our interviews indicated that few states actually use them. Of the four national organizations we spoke with, none of them were aware of any states using provisional plans of care. Of the states we spoke with, one state said it is not currently using this flexibility, two specifically told us that it rarely uses them, and two were unsure. The two states that said they rarely use them were able to provide some data on the percentage

TABLE 2-1. States with Section 1915(c) Waivers with Language Allowing for Provisional Plans of Care, October 2024

State	Number of Section 1915(c) waivers with provisional plans of care	Total number of Section 1915(c) waivers in state	Percentage of Section 1915(c) waivers with provisional plans of care
Total	**59**	**140**	**42%**
Alabama	1	7	14
California	1	5	20
Colorado	10	10	100
Delaware	1	1	100
District of Columbia	2	3	67
Illinois	4	8	50
Indiana	1	4	25
Kansas	1	7	14
Maryland	1	8	13
Massachusetts	3	10	30
Michigan	2	5	40
Missouri	6	11	55
Montana	2	3	67
New York	1	4	25
North Carolina	1	4	25
North Dakota	1	4	25
Ohio	6	6	100
Oregon	6	6	100
Pennsylvania	1	7	14
South Carolina	1	8	13
South Dakota	1	4	25
Tennessee	3	3	100
Washington	1	8	13
West Virginia	2	4	50

Notes: This table includes only states with one or more Section 1915(c) waivers that contain language on the use of provisional plans of care. There are an additional 23 states with Section 1915(c) waivers that are not included in this table. Four states do not operate any Section 1915(c) waivers.

Sources: MACPAC and The Lewin Group analysis of Section 1915(c) waivers (MACPAC 2024a); CMS 2024c.

of new waiver participants per year that had a provisional plan of care:

- One state provided data for four of its waivers, reporting that the percentages were 0 percent, 3 percent, less than 5 percent, and 6 percent.
- Another state reported that for one of its waivers, the percentage was between 1 and 2 percent.

One state official noted that despite their infrequent use, provisional plans of care are an important tool, particularly for those with urgent needs.

State officials and national experts all said that provisional plans of care are most often used for emergency situations, such as natural disasters or hospitalizations. One state noted that it implemented interim service plans at a time when the state was experiencing multiple wildfires. Another state said that it used provisional plans of care for individuals who have been hospitalized or are residing in homeless shelters. Another state said that for its waiver serving older adults, it provides interim services only in situations in which people are in immediate danger of institutional placement.

Our review of waiver language authorizing provisional plans of care aligns with what we heard from stakeholders; we found that some states specifically allow use of interim service plans only for emergency situations (Appendix 2B, Table 2B-1). Colorado, for example, authorized use of interim service plans for emergencies or evacuations for current waiver enrollees for additional services related to the emergency situation. In Kansas, the Technology Assisted Waiver allows for the use of a provisional plan of care for children who need to be discharged from the hospital with services in place before their discharge (CMS 2023b). Finally, Pennsylvania specifies in its Adult Autism Waiver that interim service plans can be used for individuals enrolling in the waiver through a reserved capacity slot for those who have experienced abuse, exploitation, abandonment, or neglect and who have a protective services plan specifying a need for LTSS. The interim service plan allows services to begin immediately to prevent future abuse, exploitation, abandonment, or neglect (CMS 2021).

States using Section 1115 demonstrations to offer presumptive eligibility for non-MAGI populations typically design their programs to use what is essentially a provisional plan of care but have some additional flexibility. Under Section 1115 demonstrations, states typically use a shortened version of their LOC assessment and offer a limited benefit package during the period of presumptive eligibility. For example, one state's limited benefit package includes a maximum of 20 hours weekly of personal care or homemaker services, a maximum of 3 days weekly of adult day care services, and limited skilled nursing services. These services are available for up to 90 days or until an applicant's eligibility decision is rendered, whichever comes first. In contrast, for Section 1915(c) waivers, a provisional plan of care may be in place for only 60 days.

Reasons for low state uptake of provisional plans of care

Limited use of provisional plans of care may be explained by several factors. We heard from interviewees about a lack of knowledge around provisional plans of care and limited capacity to make them operational. In addition, we heard they might not be appropriate for certain groups.

Our research largely points to a lack of awareness of this policy. Although our waiver review found that almost half of states have language in one or more of their Section 1915(c) waivers allowing for the use of interim service plans, the feedback from experts and three states indicates that states are not making this flexibility operational. A couple of interviewees noted that waiver approvals contain legacy language and hypothesized that states had not fully implemented the authorities that CMS provided years ago. Another contributing factor is state staff turnover, which can lead to a loss of programmatic knowledge and ability to update operating procedures. Two interviewees also talked about how there may be a lack of awareness in the hospital discharge planning process about how to use provisional plans of care for Medicaid beneficiaries.

A few interviewees cited limited state capacity, administrative complexity, and competing priorities as reasons states may not be using provisional plans of care. As one state explained, any changes to a waiver program require state staff resources and time to develop a new policy, identify operational changes such as changes to the case management system or Medicaid billing system, and time to educate both state staff and HCBS providers. Also, CMS advises states that want to implement this policy to submit a waiver amendment, which can be a resource intensive and administratively burdensome process, particularly if amending multiple waivers at once. One interviewee noted that states will often wait until they have a number of waiver changes to streamline the amendment process, which can further delay implementation. Finally, among many competing priorities, implementing provisional plans of care may not be at the top of the list. For example, states talked about the time and focus that the final rule on ensuring access to Medicaid will require to implement (CMS 2024d). CMS officials also noted the volume of recent regulatory action, including around person-centered planning, that states have been working to comply with.

State operational processes affect decisions to use provisional plans of care. In particular, three states shared with us that they complete the LOC assessment and develop the PCSP simultaneously, thus negating a need for an interim service plan. States, such as those with managed LTSS (MLTSS), may also set standards through vehicles other than a Section 1915(c) waiver amendment. Commissioner Killingsworth, who was previously the assistant commissioner and chief of LTSS for TennCare, explained at a MACPAC public meeting how Tennessee specifies in its contract language with its MLTSS plans that beneficiaries should receive an interim service plan while their more comprehensive PCSP is being delivered (Killingsworth 2024).

Provisional plans of care might not be feasible or appropriate for all individuals. A few stakeholders noted that the direct care workforce shortage can increase the time needed to identify an HCBS provider, particularly for individuals with complex care needs. Even if states use provisional plans of care, they might not be able to find a provider with the right training and expertise to begin delivering services right away. Interviewees also noted that a provisional plan of care may not be appropriate for some individuals, such as someone who needs the full array of services to safely discharge from the hospital back into the community. Finally, although some individuals may find it helpful to begin receiving some services more quickly, two experts raised a concern about the potential for discrepancies in service authorization between an interim service plan and a full PCSP and how that could have negative effects on the beneficiary and the service provider if a decrease in the level of services is authorized.

Guidance on the use of provisional plans of care

As noted above, provisional plans of care have been allowed since 2000, but no further guidance beyond Olmstead Letter No. 3 has been published. There is a brief mention in the Section 1915(c) technical guide in the review criteria for Appendix D-1 on service plan development: “If the state uses temporary, interim/provisional service plans to get services initiated until a more detailed service plan can be finalized, the state has described the procedures for developing interim/provisional plans and the duration of not more than 60 days for such plans” (CMS 2024d).

Interviewees were mixed on the need for additional guidance on the use of provisional plans of care. The two states that rarely use provisional plans of care shared how this is a long-standing flexibility they have used and they feel comfortable using it; they do not need additional guidance. National experts, however, pointed out that few states are using provisional plans of care, and they expressed a need for additional guidance, as it could encourage more states to use this flexibility. One expert advocated for the more routine use of provisional plans of care to facilitate more rapid deployment of HCBS, not just in emergency situations.

CMS indicated that it does not plan to release additional guidance. CMS officials we spoke with pointed to the Olmstead Letter No. 3 guidance and the long-standing ability for states to use provisional plans

of care, saying that there is no new policy that warrants additional guidance. They also noted they have not received any recent technical assistance requests on this issue. Instead, CMS highlighted how it has promoted the use of provisional plans of care, such as in a recent webinar, the preamble to the access rule, a Center for Medicaid and CHIP Services Informational Bulletin on "ensuring continuity of coverage for individuals receiving home and community-based services (HCBS)," and at recent ADvancing States HCBS conferences (CMS 2024b, 2024e, 2024f). In each of these instances, CMS reiterated the authority provided in Olmstead Letter No. 3 under which states can use provisional plans of care to expedite initiation of waiver services, and clarified that states must submit an amendment to their waiver to elect this option.

Commission Recommendation

Recommendation 2.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance on how states can use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k), and Section 1115 of the Social Security Act.

Rationale

Although interviewees were mixed on the need for guidance, national experts, as well as two states, agreed that additional guidance would be helpful. The Commission heard directly from two national stakeholders during public comment at the October 2024 meeting: ADvancing States and Justice in Aging (Carlson 2024, Dobson 2024). Both organizations strongly support this recommendation. Another advocate, Claudia Schlosberg of Castle Health Consulting, provided public comment in support of guidance (Schlosberg 2024). MACPAC also received public and written comment from the National Academy of Elder Law Attorneys supporting this recommendation (Dugan 2025, Jones 2024).

The lack of awareness and limited use of provisional plans of care indicates a need for additional guidance. Interviewees noted that CMS could better describe the intent of the policy and how provisional plans of care can be used, including state examples of how to make the policy operational, both in emergency situations and as a standard step of the enrollment process. In a number of states where provisional plans of care are allowed, their use is restricted to emergency or similarly limited situations. Guidance could explain how provisional plans of care can be used in routine situations, such as when an applicant wants to initiate in-home services to prevent a medical emergency or a nursing facility admission, or when a resident of an assisted living facility needs to transition to Medicaid coverage after spending down their savings. In addition, one expert noted that it would be helpful to have specific guidance allowing states to offer a standard set of limited HCBS in a provisional plan of care.

Interviewees noted a number of other reasons in favor of guidance. For example, specific guidance on this topic could provide reassurance to states that they are operating their programs in accordance with the statutory and regulatory rules governing HCBS. An expert also noted that having a dedicated SMD letter would be a helpful resource for regional CMS staff working directly with states. Finally, one expert noted that provisional plans of care may help states meet the new timeliness requirements in the access rule.

This recommendation aligns with legislation introduced in 2024 that would direct the Secretary of the U.S. Department of Health and Human Services to issue guidance to states on provisional plans of care for Section 1915(c) waivers.[18,19] This legislation demonstrates Congressional interest in additional guidance.

This recommendation also proposes that CMS clarify for states that provisional plans of care can be used for all HCBS authorities, including Section 1915 state plan options and Section 1115 demonstrations that provide HCBS. Olmstead Letter No. 3 is specific to Section 1915(c) waivers, as it predates the other Section 1915 state plan options. Although we have identified one state that uses provisional plans of care in its Section 1915(i) SPA and 1115 demonstration, as well as three states that use provisional plans of

care as part of their presumptive eligibility programs, no guidance expressly states that this flexibility is allowed for other HCBS authorities. CMS officials said that nothing prohibits the use of provisional plans of care in these other authorities and noted that the regulatory language on person-centered planning is fairly consistent across the Section 1915 authorities. In particular, CMS officials noted that the requirements for Section 1915(i) generally follow those for Section 1915(c). This guidance is consistent with the findings of our work on Section 1915 authorities, which established that states can use the Section 1915(c) technical guide for their Section 1915(i) SPA.

Implications

Federal spending. The Congressional Budget Office does not estimate any changes in federal direct spending as a result of this change, although it does anticipate that this recommendation would increase federal discretionary spending to cover the development of guidance.

States. State Medicaid agencies and operating agencies for HCBS programs may benefit from greater clarity on how to authorize and implement the use of provisional plans of care. Guidance should describe how states can implement provisional plans of care in the least administratively burdensome way possible.

Enrollees. If guidance leads to more states using provisional plans of care, the number of new enrollees who have a provisional plan of care could increase, potentially leading to more timely access to services. In emergency situations, more immediate access to services could enable individuals to remain in or return to the community (e.g., after a hospital discharge) as opposed to going to an institutional setting.

Plans. An increase in the number of provisional care plans can affect the entities responsible for providing them. In states where plans are responsible for developing PCSPs, the staff (e.g., case workers) would need to be trained on how and when to use provisional service plans.

Providers. Use of provisional plans of care may allow enrollees to more quickly be connected with HCBS providers. Providers would need to be educated on the difference between a provisional plan of care and a full PCSP and how services authorized could differ between the two versions. Guidance should also clarify that providers are not financially at risk for services provided via a provisional plan of care.

Next Steps

Our work summarized in this chapter indicates that opportunities exist to streamline eligibility determinations for non-MAGI populations who need HCBS and to improve the timeliness of access to these services.

In the coming year, the Commission will continue its work in this area, focusing on level of care assessments and person-centered planning processes. We will work to better understand states' processes for completing LOC assessments and PCSPs and identify any potential barriers to expediting these steps since they must be in place before a beneficiary can access HCBS. This work will enhance our understanding of how beneficiaries access services and how states administer their HCBS programs.

Endnotes

[1] States are required to cover home health services under Section 1905(a)(7) of the Social Security Act; all other HCBS are optional for states (Appendix 2A).

[2] Section 1915(i) is an exception; it allows states to offer HCBS to people who need less than an institutional level of care.

[3] For more information on functional assessments for LTSS, please see Chapter 4 in the June 2016 report to Congress (MACPAC 2016).

[4] For more information on access to HCBS, please see Chapter 4 in the June 2023 report to Congress (MACPAC 2023).

[5] Section 1915(k) is also known as "Community First Choice." Established in the ACA, this authority provides states with a 6 percentage point increase in the federal medical assistance percentage (FMAP) for HCBS attendant services.

[6] We did not include Section 1915(j) because it is often used in conjunction with another HCBS authority, and financial eligibility criteria is linked to the corresponding authority under which self-direction is permitted.

[7] The compendium is available on our website, along with the accompanying Policy in Brief (MACPAC 2024a, 2024b).

[8] We conducted stakeholder interviews with state officials in California, Colorado, Illinois, Missouri, Rhode Island, Vermont, and Washington. The national organizations we spoke with were AARP, ADvancing States, Justice in Aging, and the National Association of State Directors of Developmental Disabilities Services (NASDDDS).

[9] As of January 2020, 19 states used presumptive eligibility for children, and 30 used presumptive eligibility for pregnant women in Medicaid (Brooks et al. 2023).

[10] New Jersey passed legislation in January 2024 to use a Section 1115 demonstration to implement a presumptive eligibility program (A4049, Leg., 20222023 Sess. (N.J. 2023)). The program must be enacted by July 2026.

[11] Presumptive eligibility for these last two populations started in December 2023, and the report provides partial data on the number of presumptive eligibility assessments for that month; the report states there were 30 presumptive eligibility assessments, with 20 completed assessments and 10 in process (WA HCA 2024).

[12] A dyad includes the Medicaid beneficiary and their caregiver.

[13] Hawaii made permanent the flexibility to allow self-attestation of functional eligibility.

[14] No Wrong Door systems coordinate state and local agencies to create a simplified process for people to access information, determine their eligibility, and provide one-on-one counseling on LTSS options (NCOA 2022).

[15] Some states have used Section 1115 demonstrations to make changes to retroactive eligibility periods, such as eliminating retroactive coverage periods for nearly all Medicaid populations (Kean 2019).

[16] *Price v. Medicaid Director*, 838 F.3d 739 (2016).

[17] *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

[18] H.R. 8106, 118th Cong. § 2 (2024).

[19] H.R. 10445, 118th Cong. § 102(d) (2024).

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APPENDIX 2A: Statutory Authorities Used for Medicaid Home- and Community-Based Services

States cover Medicaid home- and community-based services through one or more statutory authorities, including waivers and state plan options (Table 2A-1).

TABLE 2A-1. Statutory Authorities for Medicaid Home- and Community-Based Services

Type of authority	Authority	Description
Waiver	Section 1915(c)	Allows states to offer a wide range of home- and community-based services (HCBS) to individuals who meet an institutional level of care. Also allows states to forgo certain Medicaid requirements to target HCBS benefits to specific populations, cap the number of beneficiaries who receive these benefits, and create waiting lists for people who cannot be served under the enrollment cap.
	Section 1115	Not specific to HCBS, Section 1115 demonstration authority is a broad authority that allows states to test new delivery models that advance the goals of the Medicaid program.
State plan	Section 1905(a)(7)	States are required to cover home health care services, which includes nursing; home health aides; and medical supplies, equipment, and appliances. States also have the option of covering additional therapeutic services, including physical therapy, occupational therapy, and speech pathology and audiology services.
	Section 1905(a)(24)	Allows states to cover personal care services but does not give beneficiaries using self-direction the authority to manage their own individual service budget.
	Section 1915(i)	Allows states to offer HCBS to people who need less than an institutional level of care, the typical standard for Medicaid coverage of HCBS. States can also establish specific criteria for people to receive services under this authority.
	Section 1915(j)	Gives authority for self-directed personal assistance services (PAS), providing beneficiaries with the ability to hire and direct their own PAS attendant. States may also give beneficiaries the authority to manage their own individual service budget. This authority is used in conjunction with state plan PAS or other HCBS authorities such as Section 1915(c) waivers.
	Section 1915(k)	Known as Community First Choice (CFC), this option provides states with a 6 percentage point increase in the federal medical assistance percentage (FMAP) for HCBS attendant services.

Notes: Under self-direction, beneficiaries, or their representatives if applicable, have decision making authority and responsibility for managing all aspects of their service delivery in a person-centered planning process, with the assistance of a system of available supports. States may allow self-direction under Section 1915(c) waivers; Section 1115 demonstrations; and Sections 1915(i), 1915(j), and 1915(k) state plan options (CMS n.d.).

Sources: Sections 1115, 1905(a)(7), 1905(a)(24), 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act; 42 CFR 440.70(b).

APPENDIX 2B: Provisional Plans of Care

In order to receive home- and community-based services, beneficiaries must have an approved care plan. To expedite receipt of services, CMS allows for a provisional plan of care (also called an "interim service plan"), which identifies the essential Medicaid services that can be provided in the person's first 60 days of waiver eligibility (CMS 2024b, 2000).

States must describe in their Section 1915(c) waivers the procedures used to develop the provisional plan of care. Twenty-four states allow for the use of provisional plans of care, across 59 waiver programs (Table 2B-1).

TABLE 2B-1. States with Section 1915(c) Waivers Allowing for the Use of Provisional Plans of Care, October 2024

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
Alabama	1	The individual and the Support Coordinator develop the initial PCP during the first 60 days of enrollment. Any service needs related to health and safety will be identified early and will be addressed through interim person-centered plan put in place within 14 days of enrollment, that will also include authorization of support coordination.
California	1	In the event Multi-purpose Senior Services Program (MSSP) staff identifies a situation or need of such a critical nature that it must be dealt with immediately rather than waiting for the regular care plan process, an emergency care plan may be crafted. In these situations, the written approval of the Supervising Care Manager can initiate a service or purchase in response to this emergency. The situation must be documented in the progress notes. Prior to an emergency care plan being approved, the LOC must be determined, composed, dated, and signed by the Nurse Care Manager. The need/issue and intervention must be included in the appropriate assessment and on the initial care plan.[1]
Colorado	10	In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
Delaware	1	Using the results of the pre-planning activities, the case manager may complete an initial interim plan called 'HCBS Initial Waiver Service Authorization' that addresses the essential waiver services that the individual must have in order to avoid institutionalization. Prior to development of this initial person-centered plan, the case manager meets with the participant to review the support needs of the individual and to discuss services and supports available to address them. The pre-planning will have gathered information about the participant's preferences, likes, dislikes, level of independence, etc. The initial interim plan describes the circumstances that led the participant to seek waiver enrollment and the amount, duration and frequency of each service that is recommended for the participant until the full formal person-centered plan can be developed. The initial interim plan may only be in place for 60 days. A formal person-centered plan that addresses the participant's complete needs must be developed within 60 days of the date of the first receipt of a waiver service. The case manager provides supports and information to the new waiver participant to enable them to direct and be actively engaged in the development of the initial interim plan.
District of Columbia	1	The initial Individual Support Plan (ISP) meeting is developed within ninety (90) days of enrollment in the IDD HCBS Waiver. Prior to the completion of the initial ISP (completed by the assigned Service Coordinator in the Service Coordination and Planning Division (SPCD)), the intake Service Coordinator arranges for any emergency services such as residential placement, medical, psychiatric, or behavioral intervention.
	1	The initial ISP / Plan of Care (POC) meeting is developed within ninety (90) days of enrollment in the IFS HCBS Waiver. Prior to the completion of the initial ISP / Plan of Care (completed by the assigned Service Coordinator in the Service Coordination and Planning Division (SPCD)), the intake Service Coordinator arranges for any emergency services such as residential placement, medical, psychiatric, or behavioral intervention.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
Illinois	2	For customers who are considered to be in Crisis (homeless, abuse, or neglect), the ISC must complete the Crisis Transition Plan and Funding Request form. The ISC then has 30 calendar days after the date the person begins Waiver services to conduct the discovery process and develop the PCP.
	1	For those customers that are in imminent risk of being placed in a nursing home, care coordinators can request that the customer receive interim services (for new customers) and temporary services increases (TSI) for existing customers requiring a reassessment. Interims and TSIs require service providers to start services within two business days from the date of the customer notice of eligibility or continued eligibility.
	1	In terms of timing, an initial plan is required within 24 hours of admission (89 Ill. Adm. Code 146.245(b), 'The SLF shall complete an initial assessment and service plan within 24 hours after move-in that identifies needs and potential immediate problems'). Initial plans are implemented during the period of time between admission and the development of the PCP. The PCP is due within 7-21 days of admission and includes a more in-depth discussion with the customer, a comprehensive assessment, and an observation period."
Indiana	1	The state will implement interim plans for participants meeting expedited waiver eligibility criteria, which includes completing all standardized assessment and person-centered planning service processes. The interim plan will span a duration which will not exceed 60 days.
Kansas	1	In the event, the Recommended Service Plan/Expedited Service Plan is used, this can occur when children need to be discharged from the hospital with services in place before they can be released. Children's Mercy often requires this in order to discharge the child. The Recommended Service Plan/ Expedited Service Plan can have included waiver services. The Recommended Service Plan/Expedited Service Plan will be in place until the MCO Care Coordinator has their Person Centered Service Plan in place no later than fourteen working days from notification to the MCO of eligibility. The MCO Care Coordinator then follows the process described above.
Maryland	1	Waiver applicants meet with a transitional waiver case manager to receive brain injury waiver program information and develop a provisional POS. A meeting is held 30 days after the transition to the community to finalize the POS.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
Massachusettes	3	To initiate services until a more detailed service plan can be finalized, an interim plan of care is developed by the service coordinator based on the results of the assessments which are available at the time the interim plan of care is developed. This information will be used to identify the participant's needs and the type of services to meet those needs. The interim plan of care will become effective on the day services begin with a full planning meeting occurring no later than 90 days from that date. The interim plan of care includes both the waiver and non-waiver services to be provided, their frequency, and who will provide the service. The duration of an interim plan of care may not be more than 60 days.
Michigan	1	If the enrollee is experiencing a crisis situation that requires immediate services at the time of enrollment and is not ready to fully participate in person-centered planning, an interim IICSP may be developed by the ICO Care Coordinator and LTSS Supports Coordinator, as applicable, and approved by the enrollee. Interim service plans are authorized for no more than 30 days without a follow-up visit to determine the enrollee's status. The first person-centered planning meeting is conducted when the participant is not in crisis and at a time of the participant's choice.
	1	If the participant is experiencing a crisis situation that requires immediate services at the time of enrollment and is not ready to fully participate in person-centered planning, an interim service plan may be developed by the supports coordinator(s) and approved by the participant. Interim service plans are authorized for no more than 90 days without a follow-up meeting to determine the participant's status. The first person-centered planning meeting is conducted when the participant is not in crisis and at a time of the participant's choice.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
Missouri	4	No later than 30 days from the date of acceptance into the waiver program the interdisciplinary planning team develops a support plan with the individual. Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in relationships, things to do, places to be, rituals and routines, a description of immediate needs, especially those that are important to the person's quality of life including health and safety and information about what supports and/or services are required to meet the person's needs. The plan facilitator must make sure that each item in the action plan has enough detail and/or examples so that someone new in the person's life understands what is meant and how to support the person. If the initial plan is not comprehensive, it can cover no more than 60 days, during which time a more comprehensive plan must be finalized.
	2	A provisional care plan may be developed that exhaust all state plan services while waiting for approval of the waiver.[1]
Montana	1	The initial plan of care must be developed by the team with participation of the member within 45 calendar days of the member's entry into waiver services. Oftentimes, a child or adult on the waiting list have case management services. In these cases, when the person is selected for entrance into the Waiver there is already an Individualized Family Support Plan or Personal Support Plan in place to assist in determining initial Waiver services and supports. The service cost plan is temporarily developed in the interim with the full plan of care developed within 45 calendar days. The plan of care is updated at least annually, or more often as needed.
	1	The initial plan is considered an interim plan that is created based on the Level of Care, Level of Impairment, and from information obtained by the case management team. Upon completion of the strength assessment, the PCRP is finalized.
New York	1	An individual may have a preliminary life plan until the initial life plan has been finalized during the application for HCBS waiver services.
North Carolina	1	The dates outline in the waiver are the maximum allowable. If an interim plan is utilized, the plan must be updated as more information is gathered. This interim plan allows for services to begin immediately, if needed for emergency situations.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
North Dakota	1	Interim care plans may be developed for clients who require services immediately, or who are affected by natural disaster or other emergencies once Medicaid waiver eligibility has been determined, and the case management entity is not able to make a face-to-face visit on the day the service is requested. Interim care plans may also be used to ensure continuity of waiver services during a disaster or other emergency if the incident occurs at the time the annual service plan needs to be reviewed and updated and the case manager cannot make a face-to-face visit as required. Interim care plans can begin the day that the consumer is found to be eligible for waiver services, and cannot extend beyond the first 60 days of their annual care plan year, at which time the full comprehensive care plan must be implemented in order to continue the delivery and reimbursement of waiver services. When services are needed immediately the case manager will need to complete a face-to-face visit and complete an assessment within 10 working days of the request. During natural disasters or other emergencies, a face-to-face visit must be made within 60 days of the request. Prior approval from the Department is required.
Ohio	3	Service plan authorizations are completed for the amount of time required to meet the needs of the individual. This may result in short-term authorizations of certain services.[1]
	3	At the time of initial enrollment, in order to assure health and welfare of participants disenrolling from other Department of Developmental Disabilities (DODD)-administered waivers and to allow the participant to have access to a Support Broker if wanted, the SSA and the participant create an interim plan which only identifies the provider of Support Brokerage and the budget associated with the service of Support Brokerage, where applicable. This interim plan authorizes the Support Broker to begin working with the participant and the SSA in the creation of the ISP and individual budget for the other services the individual will receive. The interim plan will indicate that the SSA, Support Broker, and individual will have no more than 30 days from date of enrollment to develop a full Individual Service Plan. The details contained in the interim plan will be transferred to the ISP prior to the expiration of the interim plan.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
Oregon	6	Under certain circumstances when support needs may not be well known or desired outcomes are not able to be articulated, such as when a person is newly enrolled in Oregon's I/DD services, or when an individual enters into a significantly different type of program or setting, a 60 day transition period may exist. At the start of this period, an ISP authorizes the services and supports believed by the case manager to be necessary to preserve the health and safety of the individual. During the 60 days, the case manager and others who may be involved with the individual refine the assessment information and learn the individual's preferences, goals, etc. Before the end of the 60 day period the case manager is required to review and update the ISP as needed to reflect any new information.
Pennsylvania	1	An interim service plan may be used only when a participant is enrolled in the waiver using reserve capacity for adults with ASD who have experienced abuse, exploitation, abandonment, and/or neglect and who have a protective services plan developed pursuant to the Adult Protective Services Act that specifies a need for long-term support. The interim plan will allow waiver services to start immediately to prevent future abuse, exploitation, abandonment, and/or neglect. An interim plan can be used for no more than 45 days. It is used in order to initiate services quickly and in advance of the development of the full service plan. ODP staff will provide supports coordination and work with the participant and representative (if applicable), Adult Protective Services staff, and others identified by the participant to create the interim plan. ODP will use the same process as is used to develop a full service plan except the assessments will not be completed and only those parts of the service plan that are needed to facilitate completion of a temporary plan to prevent abuse, exploitation, abandonment, and/or neglect will be completed.
South Carolina	1	Prior to the first child and family team meeting, the LOC assessment and the eligibility screen will be used to develop a provisional person-centered plan (crisis plan). The family may begin receiving services developed in the provisional person-centered plan (crisis plan) after all eligibility requirements have been met and they are enrolled in the waiver if there are immediate service needs. The provisional person-centered plan (crisis plan) is valid no more than 60 days from the date the child is admitted to the waiver.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
South Dakota	1	The DHS/DDD allows for the use of a provisional service plan to get services initiated until a more detailed service plan can be finalized. A provisional plan of care that designates the specific waiver services that the participant may receive. Transition case management services are limited to 60 days prior to the participant's transition to the CHOICES waiver from an institutional setting, unless otherwise agreed upon within the provisional plan of care approved by the DHS.
Tennessee	3	The intake staff should discuss with the person and any legally authorized representative, the supports the person will need to engage in the development of the initial ISP, and will help to arrange for such supports, and actively engage the person and others he designates in the development of the initial ISP. Intake staff will review the PreAdmission Evaluation (PAE) and the initial ISP with the person and his representative, provide a list of available service providers with contact information, and answer any questions related to the waiver. The initial ISP must be submitted to TennCare as part of the PreAdmission Evaluation (PAE or level of care) application. All initial ISPs are reviewed and approved as part of the PAE. While subsequent plans of care are reviewed and approved by DIDD, they remain subject to the review and approval of TennCare at TennCare's discretion.
Washington	1	After the comprehensive assessment has been completed, an interim PCSP can be put into place to provide services needed immediately. This plan is developed by the participant, Care Consultant and others and is intended to ensure that needed services such as personal care are put into place without delay. The interim plan can be in place up to 30 days, by which time the final PCSP must be completed.

TABLE 2B-1. (continued)

State	Number of Section 1915(c) waivers allowing for provisional plans of care	Section 1915(c) waiver language describing use of provisional plans of care[1]
West Virginia	1	In order to begin services immediately and address any health and safety concerns, an Interim PCSP may be developed and implemented upon enrollment or transition to the members home/community. The Interim PCSP can be in effect up to twenty-one business days to allow time for assessments to be completed, the PCSP meeting to be scheduled and the PCSP to be developed.
	1	An interim service plan is available to be developed by the Case Manager in conjunction with the member. The member informs the Case Manager of their immediate needs, and the Case Manager completes the interim service plan. The interim service plan is communicated to the Personal Attendant Agency and a Personal Attendant is chosen to deliver services until a Person-Centered Assessment and Service Plan can be developed (up to 21 calendar days after activation on the waiver program).

Notes: ASD is autism spectrum disorder. DHS/DDD is Department of Human Services, Division of Developmental Disabilities. DIDD is Department of Intellectual and Developmental Disabilities. HCBS is home- and community-based services. ICO is integrated care organization. IDD and I/DD are intellectual and developmental disabilities. IFS is Individual and Family Supports. IICSP is individual integrated care and supports plan. ISC is independent service coordination. ISP is individual service plan (Ohio and Oregon) or individual support plan (District of Columbia and Tennessee). LOC is level of care. LTSS is long-term services and supports. MCO is managed care organization. ODP is Office of Developmental Programs. PCP is person-centered plan. PCRP is person-centered recovery plan. PCSP is person-centered service plan. POS is plan of service. SLF is supportive living facility. SSA is service and support administrators.

[1] In some cases, language is not directly from a waiver. Instead, in three states—California, Missouri, and Ohio—staff provided descriptive text during their review of our environmental scan, and that text is included in the table; we did not find specific language in these states' waivers describing use of provisional plans of care. All other text is copied directly from states' waivers.

Sources: MACPAC and The Lewin Group analysis of Section 1915(c) waivers (MACPAC 2024a); CMS 2024c.

TABLE 2B-2. States with Section 1915(c) Waivers Allowing for the Use of Provisional Plans of Care by Target Population, October 2024

State	Target population for Section 1915(c) waivers with provisional plans of care											
	Aged	Disabled (physical)	Disabled (other)	Brain injury	HIV/AIDS	Medically fragile	Technology dependent	Autism	Developmental disability	Intellectual disability	Mental illness	Serious emotional disturbance
Total	**15**	**16**	**5**	**3**	**1**	**4**	**1**	**6**	**24**	**26**	**2**	**1**
Alabama										1		
California	1											
Colorado	2	2		1	1	2			4		1	
Delaware								1		1		
District of Columbia									2	2		
Illinois	2	2						2	2	2		
Indiana	1	1	1									
Kansas						1	1					
Maryland				1								
Massachusetts										3		
Michigan	2	2										
Missouri	1	1	1					1	4	4		
Montana									1	1	1	
New York								1	1	1		
North Carolina									1	1		
North Dakota	1	1	1									
Ohio	2	3							3	3		
Oregon	1	2				1			3	3		
Pennsylvania								1				
South Carolina												1
South Dakota									1	1		
Tennessee									2	3		
Washington	1	1	1									
West Virginia	1	1	1	1								

Sources: MACPAC and The Lewin Group analysis of Section 1915(c) waivers (MACPAC 2024a); CMS 2024c.

Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on January 24, 2025.

Timely Access to Home- and Community-Based Services

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance on how states can use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k), and Section 1115 of the Social Security Act.

2.1 voting result	#	Commissioner
Yes	16	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Nardone, Snyder
Vacancy	1	

Chapter 3:

Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

Recommendation

3.1 To reduce administrative burden for states and the federal government, Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of the Social Security Act to increase the renewal period for home- and community-based services programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.

Key Points

- States cover home- and community-based services (HCBS) primarily through Section 1915(c) waivers. In 2024, 46 states and the District of Columbia operated more than 250 Section 1915(c) waivers. States can also cover HCBS in their Medicaid state plans through Section 1915(i), Section 1915(j), and Section 1915(k) in Title XIX of the Social Security Act.
- States consider a number of factors in selecting which federal authorities to use to design their HCBS programs, including state capacity to implement a new authority, which populations they want to cover, and the ability to waive certain federal design flexibilities such as statewideness, comparability of services, and community income rules.
- Most states operate multiple HCBS programs. The administrative complexity in federal statute, regulation, and subregulatory guidance can mean that states must dedicate substantial time and resources to meeting the requirements associated with operating Medicaid HCBS programs.
- Federal requirements under Section 1915 can be grouped into five categories: (1) application, approval, and renewal processes; (2) cost neutrality; (3) public input; (4) conflict of interest; and (5) reporting, monitoring, and quality improvement. Our findings focused on state experience adhering to requirements in these five categories and include feedback from interviewees on challenges and potential opportunities to streamline.
- The Commission considered policy changes in two areas: cost neutrality and renewals. Although states meet the cost neutrality requirement, we did not hear consensus on eliminating the requirement. Instead, feedback was mixed, with some describing it as administratively burdensome and others finding it useful for demonstrating that HCBS cost less than institutional care.
- Section 1915(c) waivers and Section 1915(i) state plan amendments that restrict eligibility to specific populations must be renewed every five years. Renewals help ensure that HCBS programs comply with federal law and provide an opportunity for public input. They are a resource-intensive process for the Centers for Medicare & Medicaid Services (CMS) and for states, with unpredictable timelines for approval from CMS. Experts we talked to supported changing the policy to extend the renewal period from 5 years to 10 years. This change aligns with past CMS practice when select Section 1115 demonstrations were renewed for 10 years and with the standard 10-year window that is part of the congressional budget process.

CHAPTER 3: Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

Medicaid home- and community-based services (HCBS) are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or in a home-like setting in the community. Medicaid HCBS encompass a wide range of services, such as personal care services, day services, caregiver support, supported employment, and home-delivered meals. Though nearly all HCBS are optional benefits for state Medicaid programs, all states choose to cover HCBS to some extent.[1] The way in which they do so reflects the availability of multiple federal Medicaid authorities in the Social Security Act (the Act) that states can use to design and administer HCBS programs, including waiver and state plan authorities.[2]

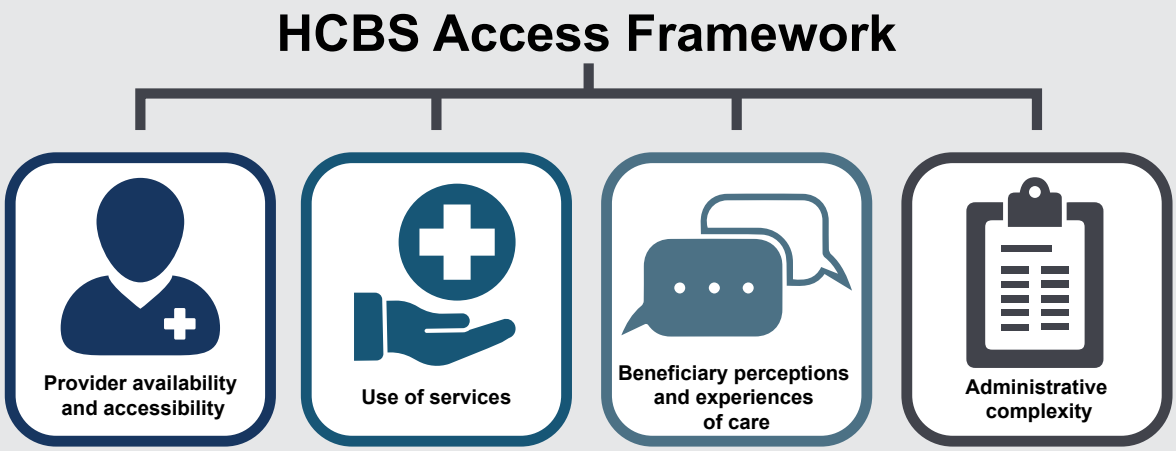
The primary way in which states cover HCBS is through Section 1915(c) waivers. States can operate multiple waivers under the same authority, and in 2024, 46 states and the District of Columbia used Section 1915(c) to operate more than 250 waivers (CMS 2024a, MACPAC 2024). Section 1915(c) gives states the flexibility to waive a number of different Medicaid requirements, allowing states to design their HCBS programs based on their policy goals and needs. States can also cover HCBS in their Medicaid state plans through Sections 1915(i), 1915(j), and 1915(k) in Title XIX of the Act. These authorities generally require that HCBS be made available statewide to all Medicaid enrollees who meet the eligibility criteria established for each of these programs.

Access to HCBS depends on a number of factors, including availability of providers and federal and state budgetary constraints. MACPAC uses an access monitoring framework to analyze access to HCBS (Figure 3-1). It has four key domains: provider availability and accessibility, use of services, beneficiary perceptions and experiences of care, and administrative complexity. In the first domain, provider availability and accessibility measures capture potential access to providers and services, regardless of whether the services are used. In the second domain, we measure realized access by examining use of services and, in some cases, use of specific providers or settings. The third domain in MACPAC's access framework, beneficiary perceptions and experiences, is focused on barriers to accessing care, experiences with care, and beneficiaries' knowledge and understanding of available benefits. The fourth domain in MACPAC's HCBS access framework, administrative complexity, examines state and federal burden in administering multiple HCBS programs often under different federal authorities, constraints on state capacity and resources, and the implications of system complexity for beneficiaries.

In MACPAC's June 2023 report to Congress, we analyzed barriers for beneficiaries trying to access HCBS and the challenges states face in managing HCBS programs (MACPAC 2023a). In our interviews with state Medicaid officials and other experts, administrative complexity emerged as a particular challenge. We heard that administrative complexity in federal statute, regulation, and subregulatory guidance can mean that states must dedicate substantial time and resources to meeting the requirements associated with operating Medicaid HCBS programs. The variation in requirements across federal authorities may create challenges for states administering multiple HCBS programs under various authorities, which most states do, and create confusion for beneficiaries and providers. The federal authorities that states use to administer their HCBS programs and potential opportunities to streamline are the subject of this chapter.

To better understand the administrative complexity of the Section 1915 authorities that states primarily use to operate HCBS programs, we reviewed the requirements under each authority and looked for opportunities to simplify or align them across authorities. We also interviewed stakeholders to obtain their insights about the complexity of administering these programs. Through these interviews, we identified three potential areas for streamlining: technical guidance for states using Section 1915(i), federal renewal requirements for Sections 1915(c) and 1915(i), and the statutory cost neutrality requirement

FIGURE 3-1. Home- and Community-Based Services Access Monitoring Framework



Notes: HCBS is home- and community-based services.

Source: MACPAC 2023a.

for Section 1915(c). The Commission reviewed a number of policy options in each of these areas that were intended to reduce administrative burden for states. Based on this review, the Commission recommends that Congress make the following statutory change:

3.1 To reduce administrative burden for states and the federal government, Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of the Social Security Act to increase the renewal period for HCBS programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.

To provide context for this recommendation, the chapter begins with background on Medicaid HCBS, the federal authorities under Section 1915 that states use to administer HCBS programs, and the variation in the applicable requirements. It then describes our analysis, including the purpose of our work and the approach we used. Then the chapter describes our key findings on administrative complexity across HCBS authorities, including opportunities to simplify and align adminstrative requirements. The chapter concludes with a discussion of the rationale for MACPAC's recommendation and next steps for the Commission's work in this area.

Background

Medicaid beneficiaries who use HCBS need LTSS but can live in the community. They are a diverse group, spanning a range of ages with different types of complex conditions and service needs, including physical disabilities, developmental disabilities, and behavioral health needs. They often receive services and supports for many years, with some beneficiaries receiving services throughout their lives. The types and intensity of services they require vary, both across and within population subgroups.

Medicaid is the primary payer for HCBS, a benefit that Medicare generally does not cover. In calendar year 2021, total federal and state Medicaid spending on HCBS was $82.5 billion, accounting for 55 percent of all Medicaid spending on LTSS and about 18 percent of all Medicaid expenditures.[3] In Fiscal Year 2019, in 29 states and the District of Columbia, HCBS made up 50 percent or more of total LTSS spending (Murray et al. 2021). Over 2.5 million people used Medicaid HCBS in calendar year 2021, representing about 2.6 percent of Medicaid enrollees.

States can choose to operate one or multiple HCBS programs under several authorities simultaneously, which gives them the flexibility to serve diverse

populations or to provide different service delivery options to beneficiaries. Nearly all states use Section 1915(c) waivers to comprehensively serve the needs of specific populations. Some states also choose state plan options that may allow them to serve a larger number of individuals with a select set of services. States weigh factors, such as requirements for statewide coverage or use of enrollment caps, when deciding which Medicaid authorities to use to develop their HCBS systems. States also consider the level of effort required to establish and maintain a new federal authority as well as the time frame within which the new authority can be obtained.

Section 1915 HCBS authorities

Section 1915 of the Act offers states several options for operating an HCBS program (Table 3-1). States most commonly use a waiver under Section 1915(c), but they can also choose to operate HCBS under an amendment to their state plan through Sections 1915(i), 1915(j), or 1915(k) (MACPAC 2023a).[4] As of February 2024, 46 states and the District of Columbia had one or more 1915(c) waivers, 16 states and the District of Columbia had a Section 1915(i) state plan benefit, and 8 states had a Section 1915(k) Community First Choice program (MACPAC 2024). In 2022, a prior environmental scan we conducted found that 8 states used Section 1915(j) in tandem with another authority, most often a Section 1915(c) waiver (MACPAC 2023a).[5]

Analytic approach

MACPAC contracted with Mathematica to better understand the federal administrative requirements for Section 1915 authorities. They reviewed federal statute, regulations, subregulatory guidance, and other technical assistance resources such as the HCBS authority comparison chart to describe the requirements and flexibilities of these authorities (CMS 2024b).

In addition to the federal policy scan, Mathematica conducted 17 interviews with officials in 5 states, federal officials, and policy experts to better understand the purpose of and potential administrative burden associated with each of these requirements.[6] After Mathematica concluded its interviews, MACPAC staff conducted an additional 10 interviews in summer 2024 with officials from the Centers for Medicare & Medicaid Services (CMS) and with policy experts to discuss the evidence gathered and considerations for simplifying or aligning administrative requirements for HCBS authorities.[7]

MACPAC staff analyzed CMS-372 data for Section 1915(c) waivers that were active over three years (2019–2021) to determine how often waivers met the cost neutrality requirement. After standardizing the data, we reviewed 169 Section 1915(c) waivers in 37 states and the District of Columbia for our analysis. The findings are discussed in the cost neutrality section later in this chapter.

State Considerations in Selecting HCBS Authorities

States consider a number of factors in selecting which federal authorities to use to design their HCBS programs: state capacity, target populations, design flexibilities in federal statute, state policy goals, and responses to legal action.

State capacity and resources

We heard through interviews that the initial and ongoing financial investment required to implement a new authority, as well as the capacity to manage and implement the policy and operational changes, are important considerations for states. One policy expert noted that states consider the availability of state funding when deciding whether to move forward with a new authority. Another policy expert shared a state's experience when implementing their Section 1915(k) program. Specific challenges, some of which had financial implications, included balancing direction from both the state legislature and external stakeholders; ensuring that services could be delivered to all eligible individuals; and making necessary policy, information technology, and operational changes.

TABLE 3-1. Section 1915 Authorities for Home- and Community-Based Services

Section 1915 authority	Enacting legislation	Description
Section 1915(c)	Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35)	Allows states to offer a broad array of HCBS to individuals who meet an institutional level of care. States may also choose to expand financial eligibility for waiver services through optional eligibility pathways such as the medically needy pathway or the special income-level pathway.[1]
Section 1915(i)	Deficit Reduction Act of 2005 (P.L. 109-171)	Allows states to offer HCBS under the state plan to people who need less than an institutional level of care, the typical standard for Medicaid coverage of HCBS. Individuals must be eligible for Medicaid under the state plan with income levels up to 150 percent of the federal poverty level.[2] States can also establish other specific criteria for people to receive services under this authority.
Section 1915(j)	Deficit Reduction Act of 2005 (P.L. 109-171)	Gives authority for self-directed personal assistance services (PAS), providing beneficiaries with the ability to hire and direct their own PAS attendant. States may also give beneficiaries the authority to manage their own individual service budget. This authority is used in conjunction with state plan PAS or other HCBS authorities, and financial eligibility criteria are linked to the corresponding HCBS authority under which self-direction is permitted.
Section 1915(k)	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)	Known as "Community First Choice," this option provides states with a 6 percentage point increase in the federal medical assistance percentage (FMAP) for HCBS attendant services provided under the state plan. Individuals eligible for Community First Choice must meet an institutional level of care and either (1) be eligible for Medicaid in an eligibility category that includes access to the nursing facility benefit or (2) be eligible for a Medicaid category that does not include access to the nursing facility benefit and have an income below 150 percent of the federal poverty level.

Notes: HCBS is home- and community-based services.

[1] Under the medically needy pathway, individuals whose incomes are too high to qualify for Medicaid can spend down to a state-specified medically needy income level by incurring medical expenses. Under the special income level pathway, states may cover individuals who meet level of care criteria for certain institutions and have incomes up to 300 percent of the Supplemental Security Income federal benefit rate (MACPAC 2023a).

[2] Section 1915(i) authority also gives states the option to serve individuals with incomes up to 300 percent of the Supplemental Security Income federal benefit rate.

Sources: Sections 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act; 42 CFR 441.715(b); CMS 2024b.

Interviewees also shared states' experiences when expanding access to HCBS, which can place a burden on state resources because of the administrative complexity. For example, we heard that some challenges for states operating Section 1915(c) waivers include the high administrative burden associated with applications, renewals, and amendments; low perceived benefit of annual Section 1915(c) reporting; and demonstration of cost neutrality. We also heard that typically a limited number of state staff have this type of expertise, and staff turnover can lead to loss of programmatic and policy expertise, affecting states' ability to implement new programs. Additionally, experts shared that some states perceive the administrative requirements of a Section 1915(k) state plan amendment (SPA), such as the need to create a development and implementation council, to be burdensome. Interviewees shared that states often consider whether they will need to build out new infrastructure to effectively operate a program under the authority and meet the requirements.

Populations covered

States evaluate the populations that they want to serve and the types of services that they would like to offer. HCBS provided under Section 1915(c), 1915(i), and 1915(j) may be targeted to specific populations; Section 1915(k) services may not. For example, we heard that one state chose Section 1915(i) authority to create an entitlement program for individuals with developmental disabilities, as Section 1915(k) authority would not allow them to limit eligibility to a particular group. Limiting program enrollment to individuals with a certain disability type also allows states to design programs with service packages and service definitions that are developed to meet the specific needs of that group.

Federal design flexibilities

Medicaid HCBS authorities under Section 1915 vary in eligibility requirements and allow states to waive a combination of Medicaid program requirements found in Section 1902 of the Act (Table 3-2).

States may consider other flexibilities when developing their HCBS systems, such as the ability under Section 1915(c) authority to limit the number of HCBS program enrollees to better predict and manage costs (Hayes et al. 2021, ASPE 2016). Although enrollment caps allow states to manage costs, previous interviews with federal officials, national experts, and beneficiary advocates noted that when those caps result in waiting lists, it restricts access to HCBS for some individuals (MACPAC 2023a). States may also consider differences across waiver and state plan authorities in terms of their ability to set program limits on the amount that can be spent on participants; Section 1915(c) is the only authority that allows states to cap individual resource allocations or budgets (Appendix 3A).

State policy goals

State policy goals also influence which authorities states choose to use when designing and implementing an HCBS program. States shared that the enhanced federal medical assistance percentage (FMAP) available via a Section 1915(k) SPA was an incentive to transition some or all personal care services from a state plan benefit under Section 1905(a)(24) to Section 1915(k). States may also select particular authorities based on legislative direction. For example, one state's legislature directed the state to implement a Section 1915(k) SPA using existing state infrastructure. To do so, the state requested a Section 1915(b)(4) waiver—which permits a state to selectively contract by limiting choice of providers—to allow participants to keep their waiver providers as they transitioned to the Section 1915(k) SPA.[8]

Legal action

States also make choices in response to lawsuits. After enactment of the Americans with Disabilities Act of 1990 (P.L. 101-336), which required states to provide services to individuals with disabilities in the most integrated setting, and the 1999 *Olmstead v. L.C.* case, states experienced increased litigation related to institutionalization of individuals with disabilities who could be served in the community (CMS 2020a, Butler 2000).[9] Through technical assistance, CMS indicates that the *Olmstead* ruling requires that a state provide coverage in the community to people with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account

TABLE 3-2. Design Flexibilities Allowed under Section 1915 Authorities for Home- and Community-Based Services

Medicaid statutory provisions that can be waived under Section 1915	Section 1915 authority under which provisions can be waived	Description
Statewideness (§ 1902(a)(1) of the Social Security Act)	Sections 1915(c) and 1915(j)	Under the statewideness provision, a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state. Waiving statewideness allows states to target authorities to areas of the state where there is need or where certain types of providers are available.
Comparability of services (§ 1902(a)(10)(B) of the Social Security Act)	Sections 1915(c), 1915(i), and 1915(j)	Under the comparability of services provision, a Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. Waiving comparability of services permits states to make HCBS available only to certain groups of people who are at risk of institutionalization, such as older adults or adults with intellectual or developmental disabilities. States using an HCBS authority that waives comparability of services might also design their programs to serve an HCBS population subgroup or those with a particular diagnosis or condition (e.g., traumatic brain injury).
Community income rules for medically needy population (§ 1902(a)(10)(C)(i)(III) of the Social Security Act)	Section 1915(c), 1915(i), and 1915(k)	Under community income rules, a Medicaid applicant's family income includes the spouse's income unless the applicant is institutionalized. Waiving community income rules allows states to provide Medicaid HCBS to individuals who would otherwise be eligible only in an institutional setting, often because of a spouse's or parent's income and resources.

Note: HCBS is home- and community-based services.

Sources: MACPAC analysis of Section 1902 and Section 1915 of the Social Security Act; CMS 2024b.

the resources available to the entity and the needs of others who are receiving disability services from the entity (CMS 2020a).

A common component of litigation alleging violations of the Americans with Disabilities Act and *Olmstead v. L.C.* is the pace at which individuals are transitioning from waiting lists to receiving Medicaid HCBS (ADA 2019). For example, one state we interviewed told us that it set priorities for transitioning nursing home residents to waiver services because of an *Olmstead*-related settlement agreement (MACPAC 2020). In 2001, because of a legal settlement, Oregon created a new Medicaid HCBS program for individuals with intellectual or developmental disabilities with no waiting list. Additionally, in 2005 Mississippi expanded enrollment in existing HCBS programs in response to legal settlements with individuals in need of services (GAO 2018).

Administrative Requirements and Key Findings

For purposes of our analysis, we grouped federal administrative requirements for Section 1915 authorities into five categories:

- application, approval, and renewal processes;
- cost neutrality;
- public input;
- conflict of interest; and
- reporting, monitoring, and quality improvement.

Our findings are focused on states' experiences adhering to requirements in these five categories and include feedback from interviewees on challenges and potential opportunities to streamline the process.

Application, approval, and renewal processes

Requirements for states vary by Section 1915 authority for purposes of applying for, approving, and renewing a waiver or state plan. All four HCBS authorities require states to submit applications, either through a web-based portal for waivers or preprints submitted via a different portal for state plan options. CMS has made application templates publicly available for each authority. HCBS authorities differ in application length, time to complete, and availability of a technical guide (Table 3-3). In general, Section 1915(c) waivers have the most time-intensive requirements.

Approval time and renewal requirements also differ by authority. Section 1915(c) waivers have an initial approval period of three years (or five years if the waiver serves individuals dually eligible for Medicaid and Medicare), after which a renewal is required every five years. Sections 1915(j) and 1915(k) SPAs have one-time approvals, are not subject to renewal, and can continue indefinitely. Section 1915(i) has a one-time approval after which the program can continue indefinitely unless a state chooses to exercise the flexibility to restrict eligibility for services to specific populations, in which case they must be renewed every five years (42 CFR 441.745(a)(2)(vi)(A)). Nearly all states with a Section 1915(i) SPA target one or more populations (MACPC 2024). Outside of renewal, states may make changes to their HCBS programs under any of the four Section 1915 authorities by submitting an amendment to CMS, such as for changes to services offered, qualifications of providers, rates, or eligible populations.

Interviewees shared that the statutory requirement to renew programs operating under Sections 1915(c) and 1915(i) exists to ensure that they are compliant with federal law but that the renewal process can be resource intensive. In particular, interviewees described the application and renewal processes for Section 1915(c) waivers, the most widely used HCBS authority, as time- and labor-intensive activities that can involve months of consultation with CMS. They said the renewal process depletes resources—such as quality improvement or designing approaches to meet the needs of beneficiaries in a person-centered way—that could be allocated to other activities. State officials we spoke with also noted that, although CMS is required to approve or deny Section 1915(c) waivers within 90 days of submission, the timelines for approval are unpredictable for states because this 90-day clock can be stopped to allow CMS to request additional information from states. They said that the questions they receive from CMS during the request for additional information can be extensive,

time consuming, and duplicative both within and across waiver programs. For example, officials in one state shared that they renewed four waivers at once, and they received more than 800 total questions from CMS on these four renewals, many of which were duplicative across the waivers. The high volume of questions can cause delays in state responses and, in turn, the implementation of the waiver. Some state officials questioned the need for a renewal process because CMS has the opportunity to review any portion of the waiver whenever a state requests an amendment, something that occurs with some frequency. In 2024, 72 percent of waivers had amendments approved (CMS 2025). CMS can use a waiver amendment to gather information about the service delivery system at that time.

Federal officials at CMS and policy experts said that renewals are critical to ensure that HCBS programs comply with federal law, to ensure overall program integrity, and to provide an opportunity for public input. Unlike amendments that may make only small changes to the waiver and thus prompt only a targeted review, CMS officials shared that renewals support a comprehensive review of the entire Section 1915(c) waiver at the federal and state levels. CMS officials noted that renewals help with program oversight, ensuring that states are compliant with federal requirements and that programs are being operated as approved. Furthermore, they present an opening for states to revisit their estimates for their cost neutrality calculations to ensure they are current. We also heard that renewals allow the public to provide input on the entire waiver, in contrast to amendments for which only substantive changes trigger an opportunity for public comment that is specific to a pending change.[10] One policy expert pointed to renewals as a mechanism to assess quality, outcomes, and beneficiary access.

Policy experts and state officials supported changes to the renewal requirement but differed on whether the change should be an increase in the renewal time period or the elimination of renewals altogether. One state suggested that for established programs, the renewal period should be longer, perhaps 10 years rather than 5 years. Several policy experts supported increasing the renewal time period, with one interviewee suggesting that 10 years may be the highest renewal time frame that Congress would consider. Another offered to give states the option to select a renewal time period of either 5 or 10 years. We heard from interviewees that a renewal period should not extend beyond 10 years but did not hear consensus around a specific time frame. A few interviewees indicated support for eliminating the renewal requirement, but one policy expert expressed concern that doing so could mean that states would be less inclined to scrutinize their spending under the waiver.

Cost neutrality

Section 1915(c) waivers are unique because they are the only Section 1915 HCBS authority that must comply with a cost neutrality requirement (42 CFR 441.303(f), Section 1915(c)(2)(D)).[11] However, other Medicaid authorities have similar requirements such as budget neutrality in Section 1115. The cost neutrality requirement dictates that the average per-person cost of Medicaid services provided to individuals enrolled in a Section 1915(c) waiver should not be greater than

TABLE 3-3. Summary of Differences in Application Requirements across Section 1915 HCBS Authorities

Requirement	Section 1915(c)	Section 1915(i)	Section 1915(j)	Section 1915(k)
Page length (blank application)	129 pages	19 pages	18 pages	27 pages
Estimated time to complete	163 hours	114 hours	20 hours	10 hours
Format	Web-based portal	Preprint	Preprint	Preprint
Technical guide	Yes	No	No	Yes

Note: Average estimated time to complete each application is listed on the document, in accordance with the Paperwork Reduction Act of 1995 (P.L. 104-13). This average includes the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collected.

Sources: CMS 2024c, 2024d, 2017, 2007, n.d.

the average cost of Medicaid services to individuals receiving comparable services in an institution, determined on a per capita basis or in the aggregate (ASPE 2010). States demonstrate compliance with the cost neutrality requirement as part of their annual CMS-372 reports.

Before Section 1915(c) waiver authority was enacted in 1981, there was no statutory pathway for states to provide coverage of LTSS in the community.[12] Interviewees suggested that the statutory requirement for cost neutrality was likely included in the new authority because of concerns about a "woodwork" effect, in which a large number of individuals already eligible for the program would enroll in the program as soon as services were made available (Kaye 2012). We also heard that the requirement was intended to manage spending, given the lack of available data at the time on how costs of providing care in the community would compare to institutional care. Several interviewees considered these concerns outdated because of the now widespread availability of data comparing HCBS costs to institutional care and the prevalence of HCBS programs across the country. Many interviewees shared that states generally meet the cost neutrality requirement, and some interviewees, when asked about the requirement that states demonstrate cost neutrality, supported eliminating the requirement as a way of reducing administrative burden on states.

Because CMS-372 reports are the vehicle that states must use to demonstrate compliance with cost neutrality, we set out to analyze these reports over several years to investigate state success or failure in meeting the requirement. After standardizing the CMS-372 data for comparability purposes, we reviewed 169 Section 1915(c) waivers in 37 states and the District of Columbia. Based on our analysis of three years of data, from 2019 to 2021, all states except one met the cost neutrality requirement in each year across all their Section 1915(c) waivers. One waiver in 2021 did not meet the cost neutrality requirement according to the formula in regulation (42 CFR 441.303(f)(1)).[13] The remaining 168 waivers all showed some level of savings over institutional care. We found that states often had waiver spending that was substantially less than institutional spending. In each of the three years we reviewed, 60 percent or more of waivers had average per capita expenditures that were less than 50 percent of institutional spending (Table 3-4).

TABLE 3-4. Section 1915(c) HCBS Waiver Expenditures as a Percentage of Institutional Spending, 2019–2021

2019		2020		2021	
Waiver costs as percentage of G + G'	Percent of waivers	Waiver costs as percentage of G + G'	Percent of waivers	Waiver costs as percentage of G + G'	Percent of waivers
≥ 90%	2%	≥ 90%	3%	≥ 90%	2%
80–89	4	80–89	4	80–89	5
70–79	5	70–79	4	70–79	7
60–69	12	60–69	9	60–69	7
50–59	17	50–59	17	50–59	15
< 50	60	< 50	63	< 50	63

Notes: The cost neutrality requirement is met based on the formula D + D′ ≤ G + G′, which is found in 42 CFR 441.303(f)(1). *G* is the estimated annual average per capita Medicaid cost for care in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities that would be incurred for individuals served in the waiver, were the waiver not approved. *G'* is the estimated annual average per capita Medicaid costs for all services other than those included in factor *G* for individuals served in the waiver, were the waiver not approved. *D* is the estimated annual average per capita Medicaid cost for home- and community-based services for individuals in the waiver program. *D'* is the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. A total of 169 waivers were included in the analysis.

Source: MACPAC analysis of CMS-372 data, 2023.

Our findings from the analysis of CMS-372 data were further substantiated by interviews with stakeholders. We heard general consensus around states' ability to successfully meet cost neutrality requirements. Federal officials said that although states generally do not encounter challenges with this requirement, if problems arise they are typically related to mistakes such as calculation errors. Some interviewees shared that despite meeting the cost neutrality requirement, some states experienced challenges demonstrating cost neutrality. For example, two states with waivers for beneficiaries with intellectual or developmental disabilities had no ability to demonstrate a comparison to institutional costs within their state since they did not have intermediate care facilities enrolled in the Medicaid program. Those states worked with CMS to identify an approach that would allow them to demonstrate cost neutrality using other states' intermediate care facility costs, meaning that their demonstration of cost neutrality depends on factors outside their control.

As stated previously, the average time for states to complete a Section 1915(c) waiver application is 163 hours (Table 3-3) (CMS 2024d). Eliminating the cost neutrality requirement could reduce administrative burden for states and CMS because information required in Appendix J of applications and renewals demonstrating the lower level of spending on HCBS would no longer be required. We heard that calculating the costs of institutional care to demonstrate cost neutrality in Section 1915(c) waivers can be time consuming. We also heard how reporting cost neutrality data in CMS-372 reports might be burdensome; for example, CMS can ask questions any time a state's annual reporting shows a greater than 10 percent variance from state projections in Appendix J of the waiver application, even if that variance does not impact cost neutrality.

A few interviewees noted the benefit of using the cost neutrality test to show that HCBS programs result in lower federal and state spending relative to institutional care. Federal officials shared that states generally meet the cost neutrality requirement and noted that the test can be useful in demonstrating the lower relative spending in HCBS to state leadership, such as when requesting additional funding for HCBS programs from state legislatures. In particular, they suggested that states should be able to use cost neutrality data as a tool to showcase savings from optional HCBS programs.

Although we heard some support for eliminating the cost neutrality requirement as a way of reducing administrative burden, we also heard concerns from CMS officials and others that doing so could increase HCBS spending to the extent that some states constrain their spending based on how it compares to institutional care. Interviewees raised concerns that if states could design their programs without consideration of their costs relative to institutional care, states would potentially increase HCBS expenditures, which would result in increases at both the state and federal levels because of the federal match on state Medicaid spending. However, potential increases in spending could be mitigated by states' ongoing need to operate within their budget parameters. Based on our review of 2019–2021 data, states are already managing their HCBS spending by keeping it below the cost neutrality ceiling. Because states consistently spend below that ceiling, the cost neutrality requirement does not appear to establish a meaningful cap on HCBS spending. Furthermore, states employ cost containment tools available through Section 1915(c) waivers, such as enrollment caps and caps on individual resource allocations to manage spending and enrollment. Section 1915(c) authority also permits states to waive the Medicaid comparability of services requirement and statewideness. These flexibilities, along with the cost containment tools discussed, provide some cost predictability for states (Hayes et al. 2021).

We also spoke with several state associations to get their insights on eliminating the cost neutrality requirement. The responses were mixed, with some states speaking in support of removing the requirement because of the administrative burden and because the purpose of the test is unclear when all states generally meet it. Other states spoke in support of keeping the requirement because of the usefulness of the test for purposes of demonstrating the cost effectiveness of their HCBS programs and, in at least one case, because they do not see the process as administratively burdensome. One policy expert commented that many states recognize that HCBS are more cost effective than providing services in institutional settings and would prefer that HCBS be the default choice for providing LTSS.

The Commission discussed an amendment to Section 1915(c)(2)(D) to eliminate the cost neutrality requirement but ultimately decided not to proceed with a recommendation because the evidence was not conclusively in favor of removing it. Commissioners agreed that the data show most states are meeting the test and that eliminating it could potentially reduce state administrative burden. However, they also found it compelling that the exercise of demonstrating cost neutrality produces a useful data point for states to show that HCBS cost less than care in an institution.

Public input

All Section 1915 HCBS authorities must comply with federal regulations requiring states to issue a public notice of proposed changes to methods and standards for setting Medicaid payment rates (42 CFR 447.205), and each authority also has specific public notice requirements, with the exception of Section 1915(j).

States and policy experts largely valued public input requirements and noted the benefits of stakeholder feedback on changes being made to waivers or SPAs. Interviewees cited public input requirements as being critical in enhancing transparency among states, community partners, and HCBS participants. One state gave an example of where a provider identified some discrepancies in the proposed rate changes in their SPA during the public comment period. The state agency used the feedback to update the rates before submitting the amendment to CMS.

Section 1915(c) authority requires that states establish and use a public comment process for new waivers or amendments consistent with the requirements in 42 CFR 441.304(f). To comply with the public notice requirements, states must (1) share the entire waiver with the public; (2) ensure that there are at least two statements of public notice and public comment, with at least one being web based and at least one being non-electronic; and (3) establish a public notice and comment period of 30 days, to be completed before submission of the waiver to CMS. However, states may choose to go beyond these minimum requirements. The state must share, in the final waiver application to CMS, a summary of responses to public comments and an indication of whether any modifications were made to the waiver as a result of the public comments. Section 1915(i) authority requires states to provide a minimum of 60 days' notice before modifying the needs-based criteria for the state plan option (42 CFR 441.715(c)(1)).

Several interviewees shared challenges encountered by states related to delays caused by the timing of public input requirements. The public input process can lengthen the timeline for implementation of waiver renewals, waiver amendments, and SPAs. Three states noted that the timeline of the public comment period could delay implementation of proposed changes. For example, one state was unable to include a change in a Section 1915(c) waiver renewal due to the length of the public comment period and had to include the change in a subsequent waiver amendment.

One state noted that the technical guidance provided by CMS, such as what constitutes a substantive change to a program, is sometimes insufficient to determine the necessity of a public comment period. This lack of sufficient guidance can impact state planning, as non-substantive changes to Section 1915(c) and 1915(i) authorities can be made retroactively, whereas substantive changes must be prospective. Substantive changes to Sections 1915(c) and 1915(i) authorities are defined in regulations (42 CFR 441.304(d)(1) and 441.745(a)(2)(v)). However, the state noted that the technical guidance is not always clear on when a waiver amendment is considered substantive and requires a public comment period, resulting in state officials having to confirm requirements with CMS. The extent to which other states experience similar challenges is something that could be explored further.

Section 1915(k) authority requires states to consult and collaborate with a development and implementation council, established by the state, in developing and implementing the SPA. The council must include a majority of members with disabilities, older adults, and their representatives (42 CFR 441.575; CMS n.d.). Interviewees had mixed feedback regarding the development and implementation council. Two states discussed the benefits of the council in providing feedback and implementing new programs. One state shared that the council was helpful in determining which optional services to include in their program as well as how to reinvest the enhanced FMAP into the state's HCBS programs. Another state said the council was involved in

discussions with the state regarding program design when the state was initially setting up its Section 1915(k) program. In contrast, some respondents noted challenges with the council. Policy experts explained that some states delayed or chose not to implement a Section 1915(k) SPA because of the requirement to establish a council. One state that operated a development and implementation council experienced difficulties meeting membership requirements and noted challenges with facilitation and encouraging members to participate.

Reporting, monitoring, and quality improvement

Federal requirements related to reporting, monitoring, and quality improvement vary across the four authorities in Section 1915 and may include sending annual reports to CMS, establishing quality improvement processes, and conducting evidence-based reviews. Sections 1915(c), 1915(i), 1915(j), and 1915(k) authorities all have annual reporting and quality improvement requirements, though the way in which states must demonstrate compliance with these requirements varies by authority. For Sections 1915(c) and the 1915(i) authorities that are subject to renewal, states must comply with an evidence-based review process, also referred to as "evidentiary reports," before renewal (CMS 2014).

Annual reports. All four Section 1915 authorities have annual reporting requirements, but the reporting elements and guidance available differ by authority. Reporting requirements for Section 1915(c) waivers are the most prescriptive, and CMS has published extensive technical guidance for states (CMS 2024c). States must complete the annual CMS-372 reports to submit cost, utilization, and performance measurement data for each waiver they administer (CMS 2024f).[14] Almost all states operate multiple Section 1915(c) waivers; the number of waivers by state ranges from 1 to 11, with an average of 5 per state (MACPAC 2024). CMS predicts that the time burden for states to complete one CMS-372 report is 44 hours (CMS 2024c). CMS provides detailed guidance on how to complete the reports and makes the specific reporting elements available publicly (CMS 2024c).

Sections 1915(i) and 1915(j) reporting elements are defined in statute. Section 1915(i) requires annual reporting of the estimated number of enrollees and the count of enrollees from the prior year (42 CFR 441.745(a)(1)(i)). Reporting elements defined in statute for Section 1915(j) include the number of individuals served and total aggregated expenditures (42 CFR 441.464(e)). One factor that may complicate reporting is the absence of a technical guide for these two authorities. However, CMS has indicated that states can use the Section 1915(c) technical guide for Section 1915(i) programs.

Section 1915(k) annual reporting elements are defined in statute and include data on utilization, expenditures, and quality. Data on enrollees served must be stratified by type of disability, age, gender, education level, and employment status (42 CFR 441.580). Unlike Sections 1915(i) and 1915(j), Section 1915(k) has a technical guide; however, it is less comprehensive than the 1915(c) technical guide and does not specify a format or method for reporting data (CMS n.d.). For example, the technical guide includes this instruction to states: "States must collect the information annually and provide the information to CMS upon request. At this time CMS is not prescribing the format in which the information must be submitted" (CMS n.d.). This direction is in contrast to Section 1915(c) authority, for which an extensive technical guide can be referenced (CMS 2024c).

States told us that unclear guidance from CMS on Section 1915(k) authority requirements and the absence of technical guides for Sections 1915(i) and 1915(j) authorities creates ambiguity about reporting requirements across these authorities. In our review and through interviews, we found that written CMS guidance on Section 1915(k) annual reporting requirements is less detailed than that for Section 1915(c) HCBS waivers. However, a CMS official shared that when states express interest in Section 1915(k) authorities, CMS provides one-on-one technical assistance on the data elements that must be reported to comply with statutory requirements. States shared that, though they value technical assistance from CMS, more detailed, written direction could create efficiencies for both states and CMS by giving states clear guidance upfront, preventing the need for ad hoc engagement with CMS. A policy expert we spoke with recommended that CMS develop

technical guides for Section 1915(i) and Section 1915(j) authorities. Though federal and state officials acknowledged that the Section 1915(c) technical guide serves as a reference for Section 1915(i), reporting and monitoring requirements differ between these two authorities, and states may struggle to identify which requirements apply to Section 1915(i) programs (CMS 2024c). A federal official pointed to the lack of a Section 1915(i) technical guide as the "weakest link" in the availability of CMS technical assistance to support state compliance with reporting and monitoring requirements. We heard the same concern from a state official who noted that the absence of such a technical guide causes uncertainty about the authority's requirements. This could also introduce risk for CMS of increased administrative burden as agency staff interpret and reinterpret requirements, particularly as they experience staff turnover.

Evidence-based reviews. Both Sections 1915(c) and 1915(i) authorities require states to comply with an evidence-based review process, also referred to as "evidentiary reports," before renewal (CMS 2014). As part of this process, states submit evidence demonstrating compliance with federal requirements, and CMS completes a findings report; any items identified by CMS must be addressed by the state before the waiver or SPA can be renewed. Under both authorities, states must submit the results of their evidence-based review process to CMS approximately two years before the waiver or SPA expires (CMS 2016, 2014).

Much of the feedback from interviewees centered around challenges using CMS's reporting templates and waiver submission portal. State officials shared that they experience technological and administrative challenges with report templates in CMS's waiver management system, which is used to submit annual CMS-372 reports as well as Section 1915(c) waiver applications, renewals, and amendments. Interviewees also noted the administrative burden associated with preparing evidentiary reports, citing an "antiquated format" (i.e., a Word document), which can make it time consuming to enter the necessary data, and frequent changes to the evidentiary report templates. Even minor tweaks to reporting requirements can require training for staff and change the way data are captured.[15] A CMS official shared, however, that the agency is working to simplify the 1915(c) evidentiary report process by instead asking states to submit Section 1915(c) HCBS performance measurement data in the annual CMS-372 reports, eliminating the need for a lengthy evidentiary report submission from states.

Quality improvement. All Section 1915 HCBS authorities require states to implement quality assurance and improvement systems, though the way in which states must demonstrate compliance with these requirements varies. CMS has similar quality improvement processes, including creating a quality improvement strategy and addressing deficiencies for states operating Sections 1915(c), 1915(i), and 1915(k) authorities, but each authority also has slightly different requirements. For example, Section 1915(c) authority requires states to demonstrate that performance measures meet or exceed a specific threshold of 86 percent in their CMS-372 reports (CMS 2024e).[16] For the other authorities, information on what states should measure and report on quality is limited.

Several state officials shared that they use the reporting and quality monitoring data required by CMS for their own quality improvement purposes. For example, one state shared that it produces several reports for the state legislature and the Community First Choice Advisory Council on quality-based data collected for their Section 1915(k) program. However, interviewees described more challenges than benefits associated with meeting reporting and monitoring requirements, such as technological and administrative challenges with using CMS's reporting templates and waiver submission portal, and unclear or inconsistent guidance from CMS.

Many interviewees referenced the CMS final rule on ensuring access to Medicaid services, which was published on May 10, 2024, and became effective July 9, 2024, as having possible implications for administrative requirements (CMS 2024f). Some state officials, federal officials, and policy experts discussed the potential impacts of the final rule on reporting and monitoring requirements and generally agreed that the rule would standardize reporting and monitoring requirements by mandating state use of the CMS HCBS Quality Measure Set across Section 1915 HCBS authorities. The final rule aligns with policy experts' recommendations that CMS not only work to

standardize the quality measures across authorities but also streamline the types of measures that states need to report. MACPAC commented in support of the quality provisions in the notice of proposed rulemaking (MACPAC 2023b). The Commission noted that requiring the use of the HCBS Quality Measure Set in Section 1915(c) waiver programs would promote public transparency related to the administration of Medicaid-covered HCBS and would enable comparisons across states on quality performance and the calculation of national performance rates for quality of care. The Commission agreed with CMS that aligning quality metrics across HCBS programs could allow for more comparative data (MACPAC 2023b). MACPAC will monitor state efforts to comply with the quality provisions.

Conflict of interest

When the same individual or entity both provides a service and helps beneficiaries access that service, there is a potential for a conflict of interest. Federal requirements are designed to help prevent and mitigate potential conflicts of interest by separating duties and responsibilities, defining clear roles, and safeguarding conflicts of interest (CMS 2018). In particular, each Section 1915 HCBS authority has requirements in place to ensure that case management services are provided in a way that prevents a conflict of interest:

- Section 1915(c) mandates that HCBS providers, or those who have an interest in or are employed by an HCBS provider, cannot provide case management or develop the person-centered service plan (PCSP), except when the state demonstrates the only available entity in a geographic area to provide case management or develop PCSPs also provides HCBS. In such cases, the state must put in place conflict of interest protections (42 CFR 441.301(c)(1)(vi)).
- Sections 1915(i) and 1915(k) dictate that those who conduct eligibility determinations and level of care assessments and develop PCSPs cannot (1) be related by blood or marriage to the individual or paid caregiver, (2) be financially responsible for the individual, (3) be empowered to make financial or health-related decisions for the individual, or (4) have a financial interest in any entity paid to provide care (42 CFR 441.730(b), 441.555(c)). Similar to Section 1915(c), they cannot be providers of HCBS for the same individuals, except where there is only one entity available in a geographic area.
- Section 1915(j) mandates that when providers are also involved in developing PCSPs, the state must describe the safeguards that are in place to ensure that the provider's role is disclosed to the individual or their representative and that controls are in place to prevent a conflict of interest (42 CFR 441.468(d)).

Most interviewees recognized the importance of conflict of interest requirements to ensure that HCBS programs operate with integrity. Although states did not describe these requirements as burdensome, a few interviewees identified instances in which they can be difficult to adhere to. In some rural areas and tribal communities where provider availability is limited, conflict of interest requirements can further limit provider options for beneficiaries, and it is more likely that case management entities are also service providers. For example, one state cited a situation in which the case managers for its Section 1915(k) SPA are affiliated with the one hospital in the area that provides assisted living facility and personal emergency response units. To mitigate potential risks associated with this conflict of interest, the state requires an annual self-audit of the intake materials that are provided to all HCBS enrollees who have case managers affiliated with the hospital. Another state with tribal populations explained that conflict of interest requirements can be a barrier to culturally competent service delivery. Many of the tribal members in the state receiving HCBS prefer to have a provider from their community, which can increase the likelihood that the HCBS provider is also acting as the case management entity.

Some interviewees described a lack of clarity around compliance with conflict of interest requirements, particularly that CMS guidance is not clear on expectations regarding requirements for managed care organizations that provide case management services. Though CMS guidance indicates that conflict of interest requirements generally do not apply to managed care organizations because they

rarely provide services, a national expert shared that several states have indicated a considerable level of questions from CMS through the request for additional information process for Section 1915(c) waivers and Sections 1915(i) and 1915(k) SPAs (CMS n.d.).

Commission Recommendation

The Commission makes the following recommendation to reduce administrative burden associated with renewals under Sections 1915(c) and 1915(i).

Recommendation 3.1

To reduce administrative burden for states and the federal government, Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of the Social Security Act to increase the renewal period for home- and community-based services programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.

Rationale

The renewal process is resource intensive for states and for CMS, but renewals are critical for ensuring state compliance with current policy and overall HCBS program oversight. This policy change would reduce the frequency of renewals that a state is required to complete for Section 1915(c) waivers and Section 1915(i) SPAs, while also maintaining critical components of HCBS program management, such as oversight and public comment opportunities. This policy change is specific to the renewal period and does not change the frequency of other processes such as evidentiary reports.

The 10-year time frame specified in the Commission's recommendation aligns with past practice when select Section 1115 demonstrations were renewed for 10 years, such as the Healthy Indiana 2.0 waiver (CMS 2020b). That time frame also aligns with the Congressional Budget Office's standard 10-year period for budget projections and cost estimates used in the congressional budget process (CBO 2024, Guth et al. 2020). Also, we heard from interviewees that a waiver renewal period should not extend beyond 10 years.

Any potential loss of oversight opportunities as a result of a longer renewal period could be mitigated by other tools that CMS and states have to continually oversee their HCBS programs, such as the CMS-372 reports for Section 1915(c) waivers and CMS review of waiver amendments. In those reports, states share details about Section 1915(c) waiver service utilization and spending, describe deficiencies in performance measures, and propose remediations to address these deficiencies. Separately, the final rule on ensuring access to Medicaid services includes several changes to reporting requirements that are intended to improve monitoring of state compliance with statutory and regulatory requirements (CMS 2024f). The changes are designed to improve the health and welfare of beneficiaries, such as the establishment of a grievance system for services delivered via fee for service, changes to the compliance threshold for PCSPs, and changes to critical incident reporting.

Any lengthening of the renewal period should maintain meaningful opportunity for public engagement. Stakeholders are given an opportunity for public comment on the entire HCBS program at initial approval and at each subsequent renewal. Additionally, any modifications to Section 1915(c) and Section 1915(i) authority between renewals can also provide an opportunity for public input specific to the change, so long as it is considered a substantive change. States and policy experts largely valued public input requirements and noted the benefits of stakeholder feedback on changes being made to waivers or SPAs. Public input requirements were cited as being critical in enhancing transparency among states, community partners, and HCBS participants. The final rule on ensuring access to Medicaid services also includes changes that support public input and transparency (CMS 2024f). These requirements include (1) creating a new public engagement period biennially specific to HCBS quality measure set updates; (2) changing Medical Care Advisory Committees, renamed as "Medicaid Advisory Committees" under the final rule, which could serve as a resource for public engagement if the renewal time frame was extended; and (3) establishing a state website to publicly report

on HCBS program performance, which could be used by interested stakeholders.[17]

States frequently make changes outside of renewals to their Section 1915(c) and Section 1915(i) authorities by submitting an amendment to their program. Federal officials shared that it is uncommon for a state to reach the five-year mark without making an amendment to an HCBS program, and multiple state officials talked about amending their waivers. Finally, extending the renewal period also recognizes that many of these state programs are well established and known for their effectiveness in facilitating community integration for individuals with LTSS needs and supporting beneficiary preference to remain in the community.

Implications

Federal spending. This recommendation could result in decreased state administrative activities and the federal matching funds that states would otherwise claim for those activities, but the Congressional Budget Office could not estimate effects on direct spending without knowing the details of the potential regulatory changes that would result from this policy change.

States. This recommendation would result in decreased administrative burden for states as they would be required to renew their Section 1915(c) waivers and Section 1915(i) SPAs less frequently.

Enrollees. This recommendation would not have a direct effect on Medicaid enrollees. The public comment period associated with the waiver renewal will occur less frequently, every 10 years instead of every 5 years, so there will be fewer opportunities for public comment on the entire waiver, but enrollees can still make public comments when the amendments include substantive changes.

Plans. This recommendation would not have a direct effect on health plans.

Providers. This recommendation would not have a direct effect on providers. The public comment period associated with the waiver renewal will occur less frequently, every 10 years instead of every 5 years, so there will be fewer opportunities for public comment on the entire waiver, but providers can still make public comments when the amendments include substantive changes.

Next Steps

Our work presented in this chapter highlights that administering HCBS programs is complex and can be challenging to navigate for states. HCBS worker shortages and limited state staff capacity further exacerbate these challenges. Many states are administering multiple HCBS programs with limited resources and competing priorities for staff already juggling multiple responsibilities. Our findings show that policy and operational challenges persist.

In the coming years, the Commission will continue to monitor access to HCBS within each domain of our framework and explore ways to reduce administrative complexity for states. In particular, we will work to better understand use of services, taking into account costs, by exploring HCBS utilization and spending for different subpopulations, including HCBS users with intellectual or developmental disabilities and people who are age 65 or older. These data will enhance our knowledge of Medicaid HCBS utilization and spending and identify potential areas for further research.

Endnotes

[1] States are required to cover home health services under Section 1905(a)(7) of the Social Security Act; all other HCBS are optional for states.

[2] States can also provide HCBS through Section 1115 demonstrations. Although Section 1115 demonstrations are subject to some of the same administrative requirements as Section 1915 authorities, Section 1115 is outside the scope of this analysis. Furthermore, federal officials we interviewed shared that they are working to support state HCBS goals via existing Section 1915 authorities; their view was that only when state policy goals cannot be achieved using that authority should Section 1115 demonstrations be considered.

[3] We analyzed calendar years 2019–2021 HCBS Transformed Medicaid Statistical Information System (T-MSIS) data. Total Medicaid spending data used to calculate the share of HCBS expenditures are from a MACPAC 2024 analysis of CMS-64 Financial Management Report net expenditure data as of November 20, 2024.

[4] States are required to cover home health care services under Section 1905(a)(7) and can choose to offer personal

care services as an optional state plan benefit under Section 1905(a)(24).

[5] In addition to Section 1915 authorities, 14 states choose to offer some HCBS via Section 1115 demonstration authority (MACPAC 2020). Under Section 1115, the Secretary of the U.S. Department of Health and Human Services can waive almost any Medicaid state plan requirement under Section 1902 to allow states to make changes to their Medicaid programs as long as the changes are likely to promote the objectives of the Medicaid program. These demonstrations can cover the entirety or a small portion of a state's Medicaid program. Medicaid spending under Section 1115 demonstrations must be budget neutral, meaning that federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (MACPAC 2021).

[6] Interviewees included officials from five states (California, Michigan, Montana, Texas, and Washington); CMS officials; and HCBS policy experts from the National Association of State Directors of Developmental Disabilities Services, ADvancing States, the National Association of Medicaid Directors, the George Washington University Milken Institute School of Public Health, and the U.S. Government Accountability Office.

[7] Interviewees included CMS officials with responsibility over Section 1915 and Section 1115 authorities as well as seven policy experts from academic institutions, think tanks, and independent HCBS consultants.

[8] Section 1915(b) of the Act, enacted in 1981 as part of the Omnibus Budget Reconciliation Act (P.L. 97-35), provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. States can implement managed care delivery using Section 1915(b)(4); states may use waivers to limit the number or type of providers who can provide specific Medicaid services—for example, for disease management or transportation. This includes selective contracting by states paying providers on a fee-for-service basis. Freedom of choice cannot be restricted for providers of family planning services and supplies.

[9] *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

[10] Substantive changes to Section 1915(c) waivers and Section 1915(i) state plan options are defined in regulations at 42 CFR 441.304(d)(1) and 42 CFR 441.745(a)(2)(v), respectively. Substantive changes for both authorities include revisions to services available under the benefit, such as elimination of or reduction in services; changes in the scope, amount, and duration of services; changes in the qualifications of service providers; changes in rate methodology; and changes in the eligible population.

[11] Cost neutrality is defined as "the annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the estimated annual average per capita expenditures of the cost of services in the absence of the waiver" (42 CFR 441.303(f)).

[12] States have been able to cover home health services since the establishment of the Medicaid program in 1965 under Section 1905(a)(7); the home health benefit became mandatory in 1970 (Social Security Amendments of 1967, P.L. 90-248).

[13] The equation set forth in 42 CFR §441.303(f)(1) specifies the components of the cost neutrality equation: $D + D' \leq G + G'$. The symbol "≤" means that the result of the left side of the equation must be less than or equal to the result of the right side of the equation. *D* is the estimated annual average per capita Medicaid cost for HCBS for individuals in the waiver program. *D′* is the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. *G* is the estimated annual average per capita Medicaid cost for care in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities that would be incurred for individuals served in the waiver, were the waiver not granted. *G′* is the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.

[14] States must submit annual CMS-372 reports for all Section 1915(c) waivers that they operate. In CMS-372 reports, states report details about Section 1915(c) waiver service utilization and spending, calculate cost neutrality, describe deficiencies in performance measures, and share proposed remediations to address these deficiencies.

[15] As part of the evidence-based review process, CMS sends a letter requesting evidence from the state (based on performance measures that were included in the approved authority) demonstrating that the authority is operating in compliance with federal requirements. States must report evidence demonstrating that they complied with all assurances, using the results of performance measures included in their applications. The assurances include

administrative authority, level of care, qualified providers, service plan, health and welfare, and financial accountability.

[16] The CMS-372 reports aggregate statistics on enrollment and spending under HCBS waivers. The CMS final rule on ensuring access to Medicaid services increases the threshold from 86 percent to 90 percent, effective July 2027 (CMS 2024f).

[17] The final rule also expanded the scope of the topics to be covered by the Medicaid Advisory Committees to include policy development and effective program administration (CMS 2024f). The final rule also requires states to establish a corresponding Beneficiary Advisory Council, to be composed of beneficiaries and their families and caregivers.

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APPENDIX 3A: Comparing Section 1915 Authorities

TABLE 3A-1. Summary of Similarities and Differences in Flexibilities Allowed by Sections 1915(c), 1915(i), 1915(j), and 1915(k)

Flexibilities	Similarities	Differences
Requirements that may be waived or disregarded	• All four Section 1915 HCBS authorities allow states to waive at least one Medicaid program requirement from Section 1902 of the Social Security Act	• Section 1915(c) waivers allow states to waive statewideness, comparability of services, and community income rules for medically needy populations • Section 1915(i) state plan options can waive comparability of services and community income rules for medically needy populations • Section 1915(j) state plan options can waive statewideness and comparability of services • Section 1915(k) state plan options can waive community income rules for medically needy populations
Limits on number of enrollees served	• HCBS authorities vary on whether they allow limits on the number of individuals who receive HCBS • None of the HCBS authorities can place limitations on the numbers served by population subgroup	• Section 1915(c) and Section 1915(j) allow for limits on the number of enrollees (42 CFR 441.303(f)(6), 42 CFR 441.462(c)) • Section 1915(i) and Section 1915(k) authorities cannot limit enrollment, and services must be offered statewide[1]
Waiting lists	• No similarities	• States may establish waiting lists when demand exceeds the program's approved capacity for Section 1915(c) waivers and Section 1915(j) state plan options • States may not create waiting lists for Section 1915(i) and Section 1915(k) state plan services

TABLE 3A-1. (continued)

Flexibilities	Similarities	Differences
Caps on individual resource allocations or budgets	• Sections 1915(i), 1915(j), and 1915(k) state plan options do not allow caps on individual resource allocations but can determine the process for setting individual budgets for participant-directed services	• Section 1915(c) waivers are the only authority that allows caps on individual resource allocations or budgets

Notes: HCBS is home- and community-based services.

[1] Although states cannot limit enrollment in a Section 1915(i) state plan amendment like they can with a Section 1915(c) waiver, Section 1915(i) authority grants states the ability to restrict the needs-based eligibility criteria if enrollment in Section 1915(i) exceeds the estimated enrollment from the state plan amendment application.

Sources: 42 CFR 441.301(a)(2), 441.303(f)(6), 441.305(a), 441.462, 441.462(c), 441.472(a), 441.515, 441.560(b), 441.710(e), 441.745(a)(1)(ii), 441.745(a)(1)(ii)(C).

Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on January 24, 2025.

Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

3.1 To reduce administrative burden for states and the federal government, Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of the Social Security Act to increase the renewal period for home- and community-based services programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.

3.1 voting result	#	Commissioner
Yes	16	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Nardone, Snyder
Vacancy	1	

Appendix

Authorizing Language (§ 1900 of the Social Security Act)

Medicaid and CHIP Payment and Access Commission

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ''MACPAC'').

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as ''Medicaid'') and the State Children's Health Insurance Program established under title XXI (in this section referred to as ''CHIP'') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

(A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term ''appropriate committees of Congress'' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘‘MedPAC’’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Verlon Johnson, MPA, (Chair), is executive vice president and chief strategy officer at Acentra Health, a Virginia-based health information technology firm that works with state and federal agencies to design technology-driven products and solutions that improve health outcomes and reduce health care costs. Ms. Johnson previously served as an associate partner and vice president at IBM Watson Health. Before entering private industry, she was a public servant for more than 20 years, holding numerous leadership positions, including associate consortium administrator for Medicaid and CHIP at the Centers for Medicare & Medicaid Services (CMS), acting regional director for the U.S. Department of Health and Human Services, acting CMS deputy director for the Center for Medicaid and CHIP Services (CMCS), interim CMCS Intergovernmental and External Affairs group director, and associate regional administrator for both Medicaid and Medicare. Ms. Johnson earned a master of public administration with an emphasis on health care policy and administration from Texas Tech University.

Robert Duncan, MBA, (Vice Chair), is chief operating officer of Connecticut Children's – Hartford. Before this, he served as executive vice president of Children's Wisconsin, where he oversaw the strategic contracting for systems of care, population health, and the development of value-based contracts. He was also the president of Children's Community Health Plan, which insures individuals with BadgerCare Plus coverage and those on the individual marketplace, and Children's Service Society of Wisconsin. He has served as both the director of the Tennessee Governor's Office of Children's Care Coordination and the director of the Tennessee Children's Health Insurance Program, overseeing the state's efforts to improve the health and welfare of children across Tennessee. Earlier, he held various positions with Methodist Le Bonheur Healthcare. Mr. Duncan received his master of business administration from the University of Tennessee at Martin.

Heidi L. Allen, PhD, MSW, is an associate professor at Columbia University School of Social Work, where she studies the impact of social policies on health and financial well-being. She is a former emergency department social worker and spent several years in state health policy, examining health system redesign and public health insurance expansions. In 2014 and 2015, she was an American Political Science Association Congressional Fellow in Health and Aging Policy. Dr. Allen is also a standing member of the National Institutes of Health's Health and Healthcare Disparities study section. Dr. Allen received her doctor of philosophy in social work and social research and a master of social work in community-based practice from Portland State University.

Sonja L. Bjork, JD, is the chief executive officer of Partnership HealthPlan of California (PHC), a non-profit community-based Medicaid managed care plan. Before joining PHC, Ms. Bjork worked as a dependency attorney representing youth in the child welfare system. During her tenure at PHC, she has overseen multiple benefit implementations and expansion of the plan's service area. Ms. Bjork served on the executive team directing the plan's $280 million strategic investment of health plan reserves to address social determinants of health. These included medical respite, affordable housing, and substance use disorder treatment options. Ms. Bjork received her juris doctor from the UC Berkeley School of Law.

Tricia Brooks, MBA, is a research professor at the McCourt School of Public Policy at Georgetown University and a senior fellow at the Georgetown University Center for Children and Families (CCF), an independent, non-partisan policy and research center whose mission is to expand and improve health coverage for children and families. At CCF, Ms. Brooks focuses on issues relating to policy, program administration, and quality of Medicaid and CHIP coverage for children and families. Before joining CCF, she served as the founding CEO of New Hampshire Healthy Kids, a legislatively created non-profit corporation that administered CHIP in the state, and served as the Medicaid and CHIP consumer assistance coordinator. Ms. Brooks holds a master of business administration from Suffolk University.

Doug Brown, RPh, MBA, is senior vice president of value and access at COEUS Consulting, with more than 30 years of pharmacy management experience. Mr. Brown provides executive-level health care consulting and market access support services to life science companies and health care organizations, including the development of value- and outcomes-based contracting strategies with state

Medicaid programs, pharmacy benefit administrators, manufacturers, and the Centers for Medicare & Medicaid Services. Before joining COEUS in 2020, he served in several roles for Magellan Rx Government, including as the chief strategy officer. While at Magellan, he led preferred drug list management for more than half the state Medicaid programs in the country, provided subject matter expertise on federal and state government legislation that impacted state Medicaid programs, and offered policymakers a national view of evolving events in Medicaid. Mr. Brown is a registered pharmacist and holds a bachelor of science in pharmacy from the University of Rhode Island and a master of business administration from Virginia Commonwealth University.

Jennifer L. Gerstorff, FSA, MAAA, is an independent consultant and actuary. Over the course of her consulting career, she has served as lead actuary for several state Medicaid agencies. In addition to supporting state agencies through her consulting work, Ms. Gerstorff actively volunteers with the Society of Actuaries and American Academy of Actuaries work groups, participating in research efforts, developing content for continuing education opportunities, and facilitating monthly public interest group discussions with Medicaid actuaries and other industry experts. She received her bachelor in applied mathematics from Columbus State University.

Angelo P. Giardino, MD, PhD, MPH, is the Wilma T. Gibson Presidential Professor and chair of the Department of Pediatrics at the University of Utah's Spencer Fox Eccles School of Medicine and chief medical officer at Intermountain Primary Children's Hospital in Salt Lake City, Utah. Before this, Dr. Giardino worked at Texas Children's Health Plan and Texas Children's Hospital from 2005 to 2018. He received his medical degree and doctorate in education from the University of Pennsylvania, completed his residency and fellowship training at the Children's Hospital of Philadelphia, and earned a master of public health from the University of Massachusetts. He also holds a master in theology from Catholic Distance University and a master in public administration from the University of Texas Rio Grande Valley.

Dennis Heaphy, MPH, MEd, MDiv, is a health justice advocate and researcher at the Massachusetts Disability Policy Consortium, a Massachusetts-based disability rights advocacy organization. He is also a dually eligible Medicaid and Medicare beneficiary enrolled in One Care, a plan operating in Massachusetts under the CMS Financial Alignment Initiative. Mr. Heaphy is engaged in activities that advance equitable whole person-centered care for beneficiaries in Massachusetts and nationally. He is cofounder of Disability Advocates Advancing Our Healthcare Rights (DAAHR), a statewide coalition in Massachusetts. DAAHR was instrumental in advancing measurable innovations that give consumers voice in One Care. Examples include creating a consumer-led implementation council that guides the ongoing development and implementation of One Care, an independent living long-term services and supports coordinator role on care teams, and an independent One Care ombudsman. Previously, he worked as project coordinator for the Americans with Disabilities Act for the Massachusetts Department of Public Health (MDPH) and remains active on various MDPH committees that advance health equity. In addition to policy work in Massachusetts, Mr. Heaphy is on the advisory committee of the National Center for Complex Health & Social Needs and the Founders Council of the United States of Care. He is a board member of Health Law Advocates, a Massachusetts-based nonprofit legal group representing low-income individuals. He received his master of public health and master of divinity from Boston University and master of education from Harvard University.

Timothy Hill, MPA, is senior vice president at the American Institutes for Research (AIR), where he leads AIR's health division. Before joining AIR, Mr. Hill held several executive positions within the Centers for Medicare & Medicaid Services, including as a deputy director of the Center for Medicaid and CHIP Services, the Center for Consumer Information and Insurance Oversight, and Center for Medicare. Mr. Hill earned his bachelor's degree from Northeastern University and his master's degree from the University of Connecticut.

Carolyn Ingram, MBA, is plan president and senior vice president of Molina Healthcare, Inc., which provides managed health care services under the Medicaid and Medicare programs, as well as through state insurance marketplaces. Previously, Ms. Ingram served as the director of the New Mexico Medicaid program, where she launched the state's first managed long-term services and supports program. She also held prior leadership roles, including vice

chair of the National Association of Medicaid Directors and chair of the New Mexico Medical Insurance Pool. Ms. Ingram earned her bachelor's degree from the University of Puget Sound and her master of business administration from New Mexico State University.

Patti Killingsworth is the senior vice president of long-term services and supports (LTSS) strategy at CareBridge, a value-based healthcare company dedicated to supporting Medicaid and dually eligible beneficiaries receiving home- and community-based services. Ms. Killingsworth is a former Medicaid beneficiary and lifelong family caregiver with 25 years of Medicaid public service experience, most recently as the longstanding assistant commissioner and chief of LTSS for TennCare, the Medicaid agency in Tennessee. Ms. Killingsworth received her bachelor's degree from Missouri State University.

John B. McCarthy, MPA, is a founding partner at Speire Healthcare Strategies, which helps public and private sector entities navigate the health care landscape through the development of state and federal health policy. Previously, he served as the Medicaid director for both the District of Columbia and Ohio, where he implemented a series of innovative policy initiatives that modernized both programs. He has also played a significant role nationally, serving as vice president of the National Association of Medicaid Directors. Mr. McCarthy holds a master's degree in public affairs from Indiana University's Paul H. O'Neill School of Public and Environmental Affairs.

Adrienne McFadden, MD, JD, is vice president and chief medical officer of Medicaid at Elevance Health, where she serves as the strategic clinical thought leader for the Medicaid line of business. After beginning her career in emergency medicine, Dr. McFadden has held multiple executive and senior leadership roles in health care, digital health, and public health. Dr. McFadden received her medical and law degrees from Duke University.

Michael Nardone, MPA, currently leads an independent consulting practice providing strategic advice on Medicaid health policy and long-term services and supports. He has extensive experience in leading health and human services programs at the state, local, and national levels, most recently as director of the Disabled and Elderly Health Programs Group at the Center for Medicaid and CHIP Services. Mr. Nardone previously led the Pennsylvania Department of Human Services as acting secretary and was the state's Medicaid director, serving on the executive committee of the National Association of Medicaid Directors. After leaving Pennsylvania state government, he joined Health Management Associates (HMA) as a managing principal and led establishment of the HMA Harrisburg office. He also served as the city of Philadelphia's deputy managing director for special needs housing and has held government relations positions for the Commonwealth of Massachusetts and the University of Pennsylvania Health System. Mr. Nardone received a master's degree in public affairs from the Princeton School of Public and International Affairs.

Jami Snyder, MA, is the president and chief executive officer of JSN Strategies, LLC, where she provides health care-related consulting services to a range of public and private sector clients. Previously, she was the Arizona cabinet member charged with overseeing the state's Medicaid program. During her tenure, Ms. Snyder spearheaded efforts to stabilize the state's health care delivery system during the public health emergency and advance the agency's Whole Person Care Initiative. Ms. Snyder also served as the Medicaid director in Texas and as the president of the National Association of Medicaid Directors. Ms. Snyder holds a master's degree in political science from Arizona State University.

Biographies of Staff

Annie Andrianasolo, MBA, is the chief administrative officer. Most recently, Andrianasolo managed the chief executive officer's office at the Pharmaceutical Research and Manufacturers of America. Andrianasolo previously worked for various nonprofit organizations, including the Public Health Institute, the Minneapolis Foundation, and the World Bank. Andrianasolo holds a bachelor of arts in economics from the University of the District of Columbia and a master of business administration from Johns Hopkins University.

Gabby Ballweg is an analyst. Before joining MACPAC, Ballweg worked as the project coordinator for the Wisconsin Community Health Empowerment Fund and interned at Action on Smoking and Health. Ballweg graduated from the University of Wisconsin, Madison, with a bachelor of science in biology and political science.

Kirstin Blom, MIPA, is a policy director. Before joining MACPAC, Blom was an analyst in health care financing at the Congressional Research Service. Before that, Blom worked as a principal analyst at the Congressional Budget Office, estimating the federal budgetary effects of proposed legislation affecting the Medicaid program. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office. Blom holds a master of international public affairs from the University of Wisconsin, Madison, and a bachelor of arts in international studies and Spanish from the University of Wisconsin, Oshkosh.

Caroline Broder is the director of communications. Before joining MACPAC, Broder led strategic communications for a variety of health policy organizations and foundations, developing and implementing communications strategies to reach both the public and policymakers. Broder has extensive experience working with researchers across multiple disciplines to translate and communicate information for the public. Earlier positions include working as a reporter covering health and technology policy issues. Broder holds a bachelor of science in journalism from Ohio University.

Drew Gerber, MPH, is an analyst. Before joining MACPAC, Gerber consulted with the Minnesota Department of Human Services on long-term services and supports financing options, and served as project manager for the University of Minnesota's COVID-19 modeling effort. Gerber holds a master of public health in health policy from the University of Minnesota and a bachelor of science in journalism and global health from Northwestern University.

Tamara Huson, MSPH, is the contracting officer and a senior analyst. Before joining MACPAC, Huson worked as a research assistant in the Department of Health Policy and Management at The University of North Carolina. Huson also worked for the American Cancer Society and completed internships with the North Carolina General Assembly and the Foundation for Health Leadership and Innovation. Huson holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of arts in biology and global studies from Lehigh University.

Joanne Jee, MPH, is a policy director. Before joining MACPAC, Jee was a program director at the National Academy for State Health Policy, focused on children's coverage issues. Jee also has been a senior analyst at the U.S. Government Accountability Office, a program manager at The Lewin Group, and a legislative analyst in the U.S. Department of Health and Human Services Office of Legislation. Jee has a master of public health from the University of California, Los Angeles, and a bachelor of science in human development from the University of California, Davis.

Linn Jennings, MS, is a senior analyst. Before joining MACPAC, Jennings worked as a senior data and reporting analyst at Texas Health and Human Services in the Women, Infants, and Children program and as a budget and policy analyst at the Wisconsin Department of Health in the Division of Medicaid. Jennings holds a master of science in population health sciences with a concentration in health services research from the University of Wisconsin, Madison, and a bachelor of arts in environmental studies from Mount Holyoke College.

Patrick Jones, MPP, is an analyst. Before joining MACPAC, Jones served as a consultant at Koné Consulting, LLC, supporting multiple projects related to human services and the Medicaid program. Jones received a master of public policy from Georgetown University's McCourt School of Public Policy and a bachelor of arts from Bard College.

Carolyn Kaneko is the graphic designer. Before joining MACPAC, Kaneko was design lead at the Artist Group, handling a wide variety of marketing projects. Kaneko's experience includes managing publication projects at all stages of design production and collaborating in the development of marketing strategies. Kaneko holds a bachelor of arts in art from Salisbury University with a concentration in graphic design.

Emma Liebman, MPH, is a senior analyst. Before joining MACPAC, Liebman managed the complex care portfolio at Arnold Ventures. Before this, Liebman worked as a research assistant at New York's Department of Health and Mental Hygiene. Liebman received a master of public health from Columbia University's Mailman School of Public Health and a bachelor of arts from Yale University.

Kate Massey, MPA, is the executive director. Before joining MACPAC, Massey was senior deputy director for the Behavioral and Physical Health and Aging Services Administration with the Michigan Department of Health and Human Services. Massey has nearly 20 years of operational and policy expertise in Medicaid, Medicare, CHIP, and private market health insurance. Massey previously served as chief executive officer for Magellan Complete Care of Virginia. Before that, Massey served as vice president for Medicaid and Medicare and government relations for Kaiser Permanente of the Mid-Atlantic States, overseeing the launch of two Medicaid managed care organizations in Virginia and Maryland. Massey also has worked for Amerigroup, establishing its Public Policy Institute and serving as executive director. Earlier positions include working for the Office of Management and Budget, where Massey led a team focused on Medicaid, CHIP, and private health insurance market programs. Massey also served as unit chief of the Low-Income Health Programs and Prescription Drugs Unit in the Congressional Budget Office. Massey has a master of public affairs from the Lyndon B. Johnson College of Public Policy at the University of Texas at Austin and a bachelor of arts from Bard College.

Nick Ngo is the chief information officer. Before joining MACPAC, Ngo was deputy director of information resources management for the Merit Systems Protection Board for 30 years. Ngo began his career in the federal government as a computer programmer with the U.S. Department of the Interior. Ngo graduated from George Mason University with a bachelor of science in computer science.

Audrey Nuamah, MPH, is a senior analyst. Before joining MACPAC, Nuamah worked as a program officer at the Center for Health Care Strategies, working with state agencies and provider organizations. Before that, Nuamah worked for the commissioner of health at the New York State Department of Health. Nuamah holds a master of public health with a concentration in health policy and management from Columbia University Mailman School of Public Health and a bachelor of arts in health and societies from the University of Pennsylvania.

Kevin Ochieng is the senior IT specialist. Before joining MACPAC, Ochieng was a systems analyst and desk-side support specialist at American Institutes for Research, and before that, an IT consultant at Robert Half Technology, focused on IT system administration, user support, network support, and PC deployment. Previously, Ochieng served as an academic program specialist at the University of Maryland University College. Ochieng has a bachelor of science in computer science and mathematics from Washington Adventist University.

Brian O'Gara is an analyst. Before joining MACPAC, O'Gara was a health policy analyst at the Bipartisan Policy Center, with a focus on improving and expanding access to high-quality long-term services and supports. O'Gara graduated from American University with a bachelor of arts in political science and public health.

Chris Park, MS, is the data analytics advisor and policy director. Park focuses on issues related to managed care payment and Medicaid drug policy and has lead responsibility for MACStats. Before joining MACPAC, Park was a senior consultant at The Lewin Group, providing quantitative analysis and technical assistance on Medicaid policy issues, including managed care capitation rate setting, pharmacy reimbursement, and cost-containment initiatives. Park holds a master of science in health policy and management from the Harvard T. H. Chan School of Public Health and a bachelor of science in chemistry from the University of Virginia.

Steve Pereyra is the financial management analyst. Before joining MACPAC, Pereyra worked as a finance associate for the nonprofit OAR, handling various accounting responsibilities and administering the donations database. Pereyra graduated from Old Dominion University with a bachelor of science in business administration.

Ken Pezzella, CGFM, is the chief financial officer. Pezzella has more than 20 years of federal financial management and accounting experience in both the public and private sectors. Pezzella also has broad operations and business experience and is a proud veteran of the U.S. Coast Guard. Pezzella holds a bachelor of science in accounting from Strayer University and is a certified government financial manager.

Allison M. Reynolds, JD, is a principal analyst. Before joining MACPAC, Reynolds was an executive and consultant for leading managed care organizations, state health and human service agencies, and IBM's Watson Health. As an attorney, Reynolds represented abused children and youth charged in delinquency proceedings in the nation's third-largest circuit court juvenile division. Reynolds has a juris doctor and certification from Loyola University Chicago School of Law, where Reynolds was a Civitas ChildLaw Fellow. Reynolds also holds a master of arts in journalism from The University of North Carolina at Chapel Hill and a bachelor of arts in journalism from Michigan State University.

Melinda Becker Roach, MS, is a principal analyst. Before joining MACPAC, Roach was a program director at the National Governors Association (NGA) Center for Best Practices as well as NGA's legislative director for health and human services. Roach previously served as a legislative advisor on personal staff in the U.S. House of Representatives. Roach holds a master of science in health policy and management from the Harvard T. H. Chan School of Public Health and a bachelor of arts in history from Duke University.

Katherine Rogers, MPH, PhD, is the deputy director. Before joining MACPAC, Dr. Rogers served as long-term care director for the Medicaid program in Washington, DC, overseeing day-to-day operations in the Medicaid long-term care system as well as the launch of two new integrated Medicare-Medicaid programs. Before that, Dr. Rogers worked on programs serving people who are eligible for Medicare and Medicaid, long-term care users, and other complex populations in both nonprofit and government roles. Dr. Rogers holds degrees from The George Washington University, the University of Pennsylvania, and Cornell University.

Holly Saltrelli, MPP, is a principal analyst. Most recently, Saltrelli was a director at Guidehouse, leading the independent evaluation of a state's Section 1115 waiver and provided technical assistance to state Medicaid employees on the unwinding of the public health emergency. Saltrelli has worked with the Centers for Medicare & Medicaid Services, health plans, and health care providers to assess value-based payment strategies and conduct data-driven research, including previous roles at FTI Consulting and The Lewin Group. Saltrelli received a bachelor of arts from Amherst College and a master of public policy from Georgetown University.

Sheila Shaheed, MSPH, is an analyst. Before joining MACPAC, Shaheed worked as a health policy analyst and coordinator at CapView Strategies, where Shaheed focused on both the Medicare and Medicaid programs and included projects pertaining to payment and delivery system reform, value-based care, and coverage and access issues. Shaheed holds a bachelor of science from Howard University and a master of science in public health from the Johns Hopkins Bloomberg School of Public Health.

JoAnn Martinez-Shriver, JD, MPH, is a principal analyst. Before joining MACPAC, Martinez-Shriver was a senior advisor and deputy assistant secretary for legislation on oversight at the U.S. Department of Education and the U.S. Department of Health and Human Services. Martinez-Shriver previously served as a senior analyst at the U.S. Government Accountability Office, studying and drafting numerous reports on Medicaid and the State Children's Health Insurance Program as well as other health policy–related topics. Martinez-Shriver holds a juris doctor from The George Washington University Law School, a master of public health from The George Washington University Milken Institute School of Public Health, and a bachelor of arts in political science from the University of California, Los Angeles.

Janice Llanos-Velazquez, MPH, is a principal data analyst. Before joining MACPAC, Llanos-Velazquez was a researcher at Mathematica analyzing Medicaid and CHIP enrollment and administrative data to inform program monitoring and help clients make data-driven decisions. Before Mathematica, Llanos-Velazquez worked for Washington, DC's Department of Health Care Finance, initially working as an analyst on children's health services and then transitioning to a data analyst role with a portfolio including analytic products related to enrollment and eligibility, maternal and child health, long-term services and supports, and other topics. Llanos-Velazquez received a master of public health from The George Washington University Milken Institute School of Public Health and a bachelor of science in biochemistry from Virginia Tech.

Asher Wang is an analyst. Before joining MACPAC, Wang worked as a policy research assistant at the Duke-Margolis Institute for Health Policy. Wang has worked on issues focused on health care payment and delivery reform, including state Medicaid strategies to advance accountable care for safety net providers. Wang received a bachelor of arts from Yale University.

Ava Williams, MA, is an analyst. Before joining MACPAC, Williams worked as a research assistant focusing on suicide demographics in Miami-Dade County. Williams has a master of arts in forensic psychology from The George Washington University and a bachelor of science in psychology from Nova Southeastern University.

Erica Williams is the human resources specialist. Before joining MACPAC, Williams was the human resources information system coordinator and licensure coordinator of a regional health system. Before this, Williams worked for a nonprofit organization as a human resource generalist. Williams graduated from Delaware State University with a bachelor of arts in special education and psychology.

Kiswana Williams is the executive assistant. Before joining MACPAC, Williams had extensive experience in providing administrative assistance to a variety of organizations in government contracting, law, and real estate. Williams also has experience coordinating large meetings with executive leadership. Williams holds a bachelor of science in business administration from the University of Maryland, College Park.

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