Chapter 2:

Timely Access to Home- and Community-Based Services

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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.

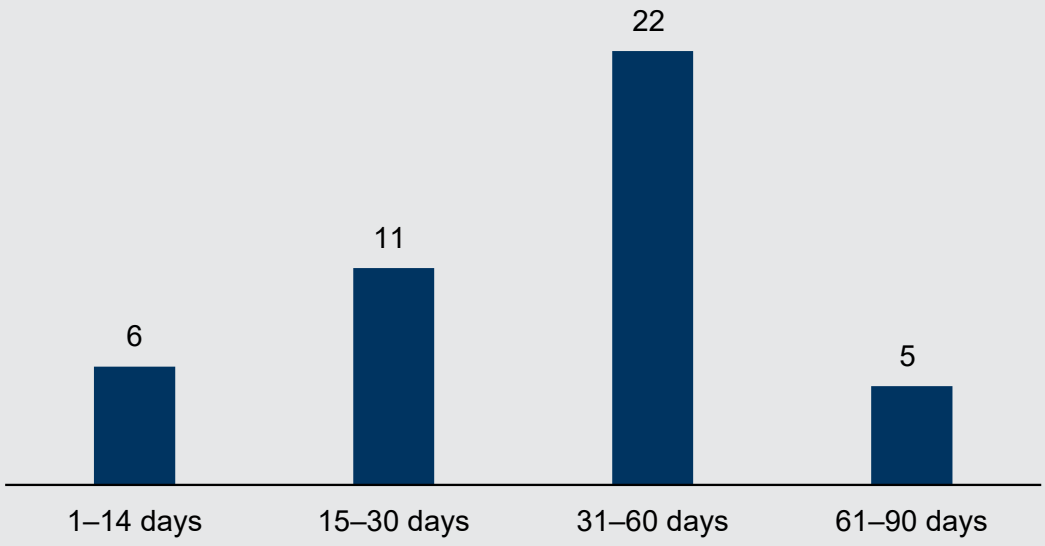
Background

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).

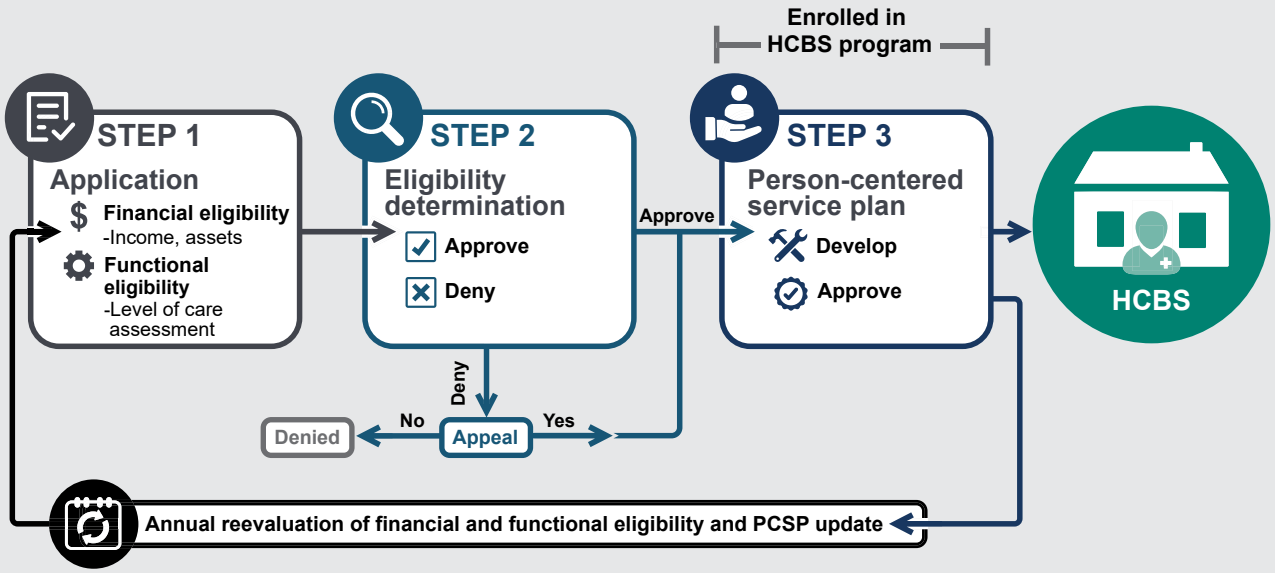
FIGURE 2-1. States' Average Processing Times for Non-MAGI Applications, July 2022



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.

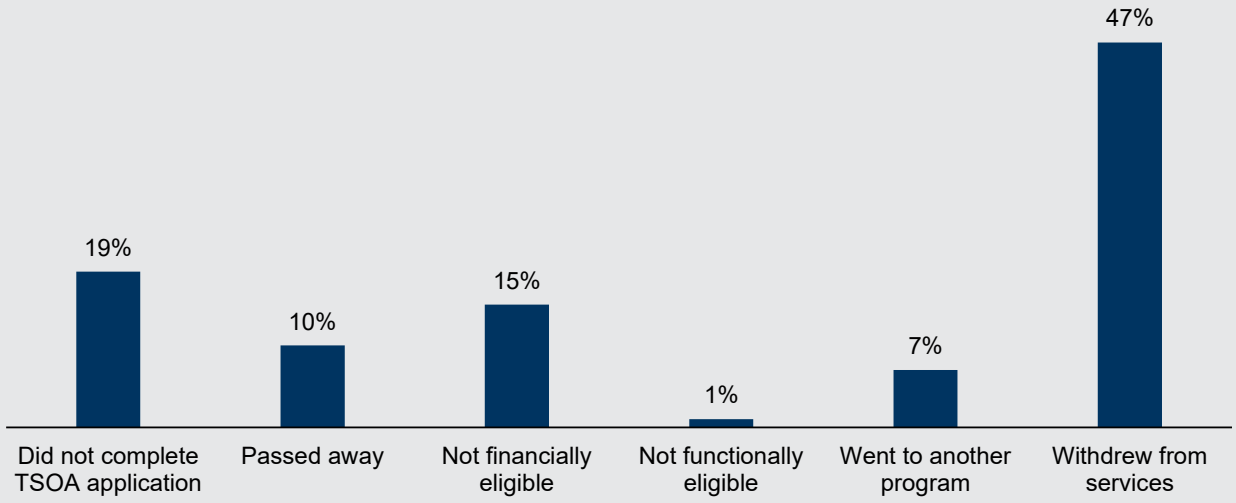
Expedited eligibility

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	