March 18, 2025

MACPAC RECOMMENDS INCREASED USE OF HCBS PROVISIONAL SERVICE PLANS

To Support State-Level Advocacy, Justice in Aging Offers Template Memorandum and Other Resources

A March 2025 report from the Medicaid and CHIP Payment and Access Commission (MACPAC) highlights strategies to facilitate prompt access to home and community-based services (HCBS). In chapter 2, the MACPAC report includes discussions of presumptive eligibility, expedited eligibility, and provisional service plans. Each of these strategies can be used productively -- oftentimes in conjunction. This resource focuses on the use of provisional service plans.

Access to Medicaid home and community-based services (HCBS) is frequently limited by federal Medicaid policy that requires that a service plan be completed before HCBS coverage begins. Assume, for example, that a person breaks a hip and, after a short hospitalization, needs daily long-term services (such as assistance with dressing, bathing, and preparing food). They would prefer to receive needed services at home, but an HCBS service plan cannot be finalized for several weeks or months, while Medicaid nursing facility coverage can start immediately. This policy discrepancy tends to drive persons into nursing facilities unnecessarily, against individual preferences and with higher costs.

An underutilized solution for this issue is a provisional service plan, as originally described in the federal government's Olmstead Letter No. 3, Attachment 3-a (2000). A provisional service plan sets forth the basic HCBS required by the person, allowing Medicaid HCBS coverage to begin immediately. The provisional plan remains in effect for 60 days or until finalization of a comprehensive person-centered service plan, whichever occurs first.

MACPAC found that 24 states use provisional plans of care, across 59 separate HCBS waiver programs. To increase use of provisional plans of care, MACPAC recommends that the federal government issue guidance to states on relevant policy and operational considerations.

See below for a template memorandum, a list of resources, and a question-and-answer document. The template memorandum can be adapted for use in your state to support advocacy for provisional service plans. The resource information, along with the Q & As, can be included with the memorandum or not, at your discretion.

Feel free to use any part of these materials and to delete, add and edit as you choose in order to meet your needs. You may especially want to add state-specific information to more precisely address your state's system of long-term services and supports.

We encourage you to contact Justice in Aging to let us know of any advocacy in your state on these issues. Working together we can increase HCBS access and eliminate the institutional bias that too frequently incentivizes nursing facility care over HCBS.

THE TEMPLATE MEMORANDUM

The Problem: State Medicaid Policy Is Forcing Older Adults to Receive Needed Care in Nursing Facilities Rather than at Home

It's a common situation. Someone suffers a medical setback (a broken hip or stroke, for example) and now needs continuing assistance with daily activities such as dressing, bathing or eating. Or, alternatively, they need help due to a chronic condition such as dementia. In all these situations, unfortunately, [your state]'s Medicaid program often forces them to receive the necessary assistance in a nursing facility instead of at home.

A critical issue is the difference in the Medicaid effective date between home and community-based services (HCBS) and nursing facility services. For HCBS, Medicaid payment cannot become effective until a service plan is approved, which may take weeks or months. On the other hand, Medicaid payment to a nursing facility can be effective starting on the person's first day in the facility, even if Medicaid coverage isn't approved until weeks or even months later. In other words, Medicaid nursing facility payment can be retroactive back to the first day of services. The same is not true for HCBS.

What does this mean as a practical matter? A nursing facility will be willing to admit the person immediately, knowing that the facility eventually will receive payment for care provided, starting from the person's first day in the facility. An HCBS provider, however, will NOT be willing to provide services immediately, because they never will be paid for the initial days or weeks of service. So, as a result of this policy discrepancy, the person is forced to move to the nursing facility in order to receive necessary care.

The current situation is a lose-lose. The person needing care is forced into a nursing facility, rather than being able to receive necessary assistance at home. And the state unnecessarily pays the substantially higher cost of a nursing facility.

A Policy Solution: State Medicaid Program Uses Provisional Service Plans

Developing a full HCBS service plan takes time. Under HCBS regulations, the plan must be person-centered, and the planning process must include various steps to facilitate that person-centeredness.

But the federal Centers for Medicare & Medicaid Services (CMS) allows states to use provisional service plans to start payment expeditiously. CMS guidance states that these provisional plans "identif[y] 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." (Olmstead Letter No. 3, Attachment 3-a) A March 2025 report from the the Medicaid and CHIP Payment and Access Commission (MACPAC) shows that 24 states use provisional service plans, across 59 separate HCBS waiver programs. MACPAC recommends greater use of provisional service plans in order to reduce barriers to use of HCBS. (See chapter 2 of the report.)

[YOUR STATE] can use provisional service plans to address the current problem, so that persons needing personal care assistance on short notice can make a fair choice between nursing facility care and HCBS. If a person prefers HCBS, they will be able to use a provisional service plan to initiate prompt care at home (or another HCBS setting), rather than be forced into unwanted and unduly expensive nursing facility care.

RESOURCES

Note that these resources use different terms to refer to what the memorandum refers to as a "provisional service plan."

- Olmstead Letter No. 3, Attachment 3-a (federal guidance authorizing use of provisional service plans to initiate prompt coverage of HCBS; uses the term "provisional written plan of care")
- Medicaid and CHIP Payment and Access Commission (MACPAC), March 2025 Report to Congress on Medicaid and CHIP, ch. 2 (March 2025)
- Technical Guide for HCBS waivers (comprehensive federal guide on administrating HCBS waivers; see pages 194-95 for discussion of "temporary interim service plan")
- Person-Centered Service Planning in HCBS: Requirements and Best Practices (CMS 2024 webinar slides, including discussion of "provisional written plan of care" on slide #18)
- Section 1396n(c) of Title 42 of the United States Code, also known as Section 1915(c) of the Social Security Act (authorizing statute for HCBS waivers; according to CMS, requires that service plan be in place prior to first day of HCBS coverage)
- Price v. Medicaid Director, 838 F. 3d 739 (6th Circuit 2016) (federal appellate case rejecting challenge to CMS's interpretation that HCBS payment cannot begin until service plan is in place)
- Section 441.301(c)(1), (2) of Title 42 of the Code of Federal Regulations (federal requirements for comprehensive service planning in HCBS waivers)

QUESTIONS AND ANSWERS

Is the problem limited to individuals wanting to remain living at home?

No. The problem may also occur in residential facilities which can accept HCBS funding (such as, in most states, assisted living facilities). In those facilities, a coverage delay can result in the resident being unable to pay the facility for the weeks or months between the HCBS application date (when the resident has spent down to Medicaid eligibility levels) and the date on which HCBS coverage begins.

Does the "no HCBS payment without in-place service plan" problem apply to all HCBS programs, or only to HCBS programs authorized under HCBS waivers? In other words, does the problem also occur in HCBS funded under (for example) a Medicaid state plan, the Community First Choice option, or a Medicaid demonstration waiver?

This problem is found nationwide in almost all HCBS programs, even though CMS has only cited the HCBS waiver law (i.e., law governing 1915(c) waivers) for a statutory requirement that service plan approval precede the effective day of HCBS coverage.

As an example, consider Medicaid demonstration waivers (i.e., Section 1115 waivers). Nothing in the demonstration waiver statute sets any specific requirements regarding service plans but, as a practical matter, demonstration waivers generally are designed and implemented to make coverage effective only after a comprehensive service plan is in place. A state could address this problem by modifying the

demonstration waiver policy to allow for HCBS coverage to be initiated ASAP by a basic service plan (whether called "provisional" or something else), with continued coverage being contingent upon a comprehensive service plan being completed subsequently within a specified period of time.

At root, it usually doesn't matter *why* a state is requiring comprehensive service plans prior to the HCBS effective date. Whatever the reason, the state likely can solve the problem by authorizing *all* HCBS coverage to become effective upon development of a basic service plan, with the comprehensive plan being developed subsequently.

Is a provisional service plan the same thing as presumptive eligibility?

No, although both can be useful in improving access to HCBS, as discussed in the March 2025 MACPAC report.

Some states use presumptive eligibility to address the delay in determining financial eligibility for HCBS. As discussed above, determining financial eligibility routinely requires weeks or even months. As a result, a provider runs a risk by providing services while Medicaid eligibility is pending. If financial eligibility ultimately is granted for non-HCBS services, all is well — the Medicaid program can pay retroactively. But if eligibility is denied, the provider receives no Medicaid payment for services already provided.

Presumptive eligibility can eliminate the financial risk to the provider. Under presumptive eligibility, the Medicaid program grants eligibility immediately and reimburses providers while the application is pending. If Medicaid ultimately denies the application, that denial will be prospective-only, and will not affect payments for the services covered under presumptive eligibility.

Presumptive eligibility can be used together with provisional service plans to expedite HCBS coverage. The HCBS coverage could begin almost immediately, even though the Medicaid eligibility determination and comprehensive service plan would not be finalized until weeks or months later.

Further information about presumptive eligibility for HCBS is available in the 2025 MACPAC report (ch. 2) and a 2021 AARP issue brief.

Are all HCBS application delays caused by service plan requirements?

No, a state's HCBS application process certainly may have some other processes that unduly delay HCBS coverage. Advocates are encouraged to seek reform of any provisions that cause unnecessary delay.

Is the "no HCBS payment without in-place service plan" problem related to HCBS waitlists?

HCBS wait lists are a separate problem. Some states have limited HCBS slots for their 1915(c) waivers. In these states, HCBS applicants may have to wait months or years for their name to rise to the top of the waitlist. Arguing against enrollee caps and waitlists is an important facet of HCBS advocacy, in addition to urging use of provisional service plans and presumptive eligibility.