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MACPAC Holds January 2025 Meeting

On January 23 and 24, the Medicaid and CHIP Payment and Access Commission (MACPAC) held a virtual public meeting, which included the following sessions:

- Timely Access to Home-and Community-Based Services,
- Home- and Community-Based Services Payment Policy Option, and
- Vote on Recommendations for the March Report to Congress.

The full agenda and presentations for the sessions are available here.

MACPAC DISCUSS TIMELY ACCESS TO HOME-AND COMMUNITY-BASED SERVICES

MACPAC staff reviewed challenges and opportunities related to improving timely access to home-and community-based services (HCBS) through strategies such as presumptive eligibility, expedited eligibility, and provisional plans of care. The presentation discussed findings from an analysis which included an environmental scan, stakeholder interviews, and waiver reviews, as well as proposed recommendations for improving access to HCBS for Medicaid beneficiaries. Staff also detailed key requirements to accessing HCBS, including the application, eligibility determination, and person-centered service plan.

There are several mechanisms used to streamline access to Medicaid services, but there are challenges associated with each mechanism. Presumptive eligibility allows individuals to receive Medicaid-covered services during the application process; however, states often limit its use to narrow populations due to administrative complexity and financial concerns. Expedited eligibility, while accelerating the determination process, does not ensure immediate access to services. Provisional plans of care, permitted under CMS guidance since 2000, offer essential HCBS for up to 60 days of waiver eligibility and are primarily used in emergency situations, but are underutilized due to limited awareness, state capacity, and administrative complexity.

MACPAC analysis identified key themes. States primarily use presumptive eligibility and expedited eligibility for older individuals and those with disabilities and they rely upon Section 1115 demonstrations to use presumptive eligibility for non-modified adjusted gross income (MAGI) populations, often in combination with provisional plans of care. Stakeholders expressed concern regarding the abrupt loss of services for

individuals found ineligible for Medicaid after receiving services under presumptive eligibility. Stakeholders further noted mixed feedback regarding the need for additional CMS guidance, but public comments emphasized the value of guidance in helping states navigate operational and administrative hurdles.

Recommendations

MACPAC staff proposed that the Secretary of the U.S. Department of Health and Human Services direct CMS to issue guidance on implementing provisional plans of care, including Sections 1915(c), 1915(i), 1915(k), and 1115 of the Social Security Act. Such guidance would aim to clarify policy considerations, address state operational questions, and ensure compliance with statutory and regulatory rules, ultimately facilitating more timely access to HCBS. Commissioners voted in favor of this recommendation in a subsequent session.

Commission Discussion

Commissioners broadly supported the recommendation, emphasizing the need to reduce administrative burdens on states and highlight HCBS's role in preventing institutionalization. Some commissioners underscored the institutional bias inherent in current regulatory frameworks, noting that individuals entering nursing facilities receive coverage more readily than those seeking HCBS, resulting in increased patient institutionalization. Others highlighted the importance of flexible options and minimal administrative processes to encourage state adoption of provisional plans.

Commissioners also discussed CMS's role in facilitating these plans, suggesting that CMS should provide states with pathways to incorporate provisional plans of care without requiring extensive waiver amendments. There was agreement on the importance of addressing presumptive eligibility and ensuring guidance applies to both MAGI and non-MAGI populations.

Future work will include exploring level-of-care assessments and person-centered planning processes for non-MAGI populations.

MACPAC DISCUSSES MEDICAID PAYMENT POLICIES TO SUPPORT HOME-AND COMMUNITY-BASED SERVICES WORKFORCE

During the January 2025 meeting, MACPAC staff presented an overview of Medicaid payment policies for Home-and Community-Based Services (HCBS) and their impact on workforce efficiency. The discussion focused on rate-setting approaches, payment principles, and developing a framework to support workforce sustainability.

Commission staff conducted a study with the following objectives:

- Understanding HCBS rate-setting approaches

- Identifying efficient payment principles
- Establishing a framework for equitable payment and access

The findings of the studies revealed two key principles: HCBS rates influence workforce participation, and limited wage data creates barriers to adequate rate-setting. Payment rates are a crucial tool for promoting the HCBS workforce, yet rates vary across various models and regions. Bureau of Labor Statistics (BLS) data is inconsistent, does not exclusively capture Medicaid-specific wages, and does not provide a single, reliable data source for states to utilize. Providing states with timely and accurate base wage data would improve efficiency and help with ensuring adequate rates.

MACPAC recommends that the HHS create a national public data source containing wage information for HCBS workers under high-cost Medicaid programs. This database should disaggregate data by Medicaid and non-Medicaid payment sources, state, job class, and state variations. It should include high-cost and high-volume services based on per capita costs. The database should utilize and build upon existing data collection methods. A centralized national public data source will allow CMS to provide more accurate Medicaid wage data, improving workforce retention and service quality.

Commissioners raised key concerns and recommendations with the policy including developing a clearer definition for setting wages and benefits, questioning tech infrastructure and resources constraints, and asking if the approach will solve and address the root causes of shortage. Regarding CMS data sources, commissioners recommend utilizing already existing data collection sources, but questioned feasibility, asking where CMS will retrieve the data. One commissioner suggested letting HHS determine where to find the data, and the possible need for states to collect data individually. Many commissioners have implementation concerns on state collected data based on past challenges.

Regarding workforce challenges and payment, commissioners expressed concern about wage differentiation across states, as many states struggle to calculate hourly wages due to resource constraints, which is traditionally the role of BLS. A few commissioners stressed interrogating the "why" behind wages, and how different financial resources impact wage levels. In terms of wage equity and benefits, some commissioners asked whether wage data would include information on benefits and worker demographics to better address workforce disparities.

Potential solutions to address workforce shortages include advising Congress to integrate Federal Medical Assistance Percentages (FMAP) into wage calculations and encouraging states to use American Rescue Plan Act (ARPA) funds to maintain and expand the workforce. MACPAC staff will incorporate feedback from this discussion

and refine its policy recommendation for consideration in the June Report to Congress meeting.

COMMISSION VOTES IN FAVOR OF RECOMMENDATIONS ON EXTERNAL QUALITY REVIEW AND HOME-AND COMMUNITY-BASED SERVICES FOR THE MARCH REPORT TO CONGRESS

In this session, Commission members voted on recommendations to include in the March 2025 Report to Congress. Recommendations related to external quality review and home- and community-based services (HCBS). Discussion of these recommendations was included in other sessions during the meeting and was not a part of this session.

External Quality Review Recommendations

The Commission voted in favor of three recommendations that aim to improve the external quality review (EQR) process by changing the goals of EQR activities from process and compliance to outcomes and actionable data.

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

All 16 commissioners voted in favor of the recommendation.

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

15 commissioners voted in favor of the recommendation with one commissioner voting against.

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

All 16 commissioners voted in favor of the recommendation.

HCBS Recommendation – Provisional Plans of Care

The Commission voted in favor of a recommendation focused on the use of provision plans of care.

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.*

All 16 commissioners voted in favor of the recommendation.

HCBS Recommendation – Reducing Administrative Burden for States Use of Section 1915 Authorities

The Commission voted in favor of a recommendation that aims to reduce the administrative burden for states using Section 1915 authorities.

Recommendation 3.1: *To reduce administrative burden for states and the federal government, Congress should amend Section 1915(c)(3) and Section 1915(f)(1)(C) of the Social Security Act to increase the renewal period for home- and community-based services programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.*

All 16 commissioners voted in favor of the recommendation.

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This Applied Policy® Summary was prepared by Emma Hammer with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at ehammer@appliedpolicy.com or at 202-558-5272.