National
MLTSS
Health Plan Association

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Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Comments on New 1915(c)(11) Waiver Option

The National MLTSS Health Plan Association (MLTSS Association) writes to offer comments on the implementation of Section 71121 of the Working Families Tax Cut (WFTC), which establishes a new standalone 1915(c)(11) waiver option allowing states to extend Home and Community Based Services (HCBS) to individuals who do not yet meet an institutional level of care (LOC) standard. We appreciate that CMS issued an initial Informational Bulletin on November 18, 2025, providing early guidance to states, and we welcome the opportunity to share our perspectives as CMS continues to develop implementing guidance.[1]

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.[2] Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live independently. Our members cover the majority of enrollees in MLTSS plans nationwide, including national, regional, and community-based plans.

Our member plans are uniquely positioned to inform this process. MLTSS plans already deliver HCBS to people with complex and specialized healthcare needs under existing 1915 and 1115 frameworks, manage care coordination across the full continuum of LTSS, and possess the data infrastructure and population health capabilities needed to support states in operationalizing this new authority. We offer these comments with a strong belief that the new waiver option, if implemented thoughtfully, can advance prevention, promote independence and aging in place, and align with the administration's goals of improving care coordination and reducing unnecessary institutionalization.

Key Recommendations for CMS

Consider Lessons Learned and Best Practices from 1915(i) Authority

1915(i) authority allows states to provide Medicaid state plan HCBS to identified populations with functional needs that are less than an institutional LOC.[3] Because of the similarities between 1915(i)

[1] CMCS Informational Bulletin
[2] Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, LA Care, Lakeland Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, and UPMC Community Health Choices
[3] 1915(i) One Pager.pdf

authority and this new 1915(c)(11) waiver authority, CMS should draw deliberately on the experience states have accumulated under 1915(i) as it develops implementing guidance. Specifically, CMS should consider the following:

1. **Cost Neutrality and Oversight Requirements:** The cost neutrality and oversight requirements, coupled with administrative complexity, may limit how broadly states can or will pursue this new option. CMS should provide actuarial guidance and technical assistance to help states develop realistic cost projections, particularly given that the pre-institutional population may be larger and more heterogeneous than individuals served under existing waivers.
2. **Creation of Technical Guides and Tools:** Research from the Medicaid and CHIP Payment and Access Commission (MACPAC) found that 1915(i) authority lacked accompanying technical guides, and states reported that this absence creates ambiguity about reporting requirements.[4] CMS should issue clear technical guides, model eligibility frameworks, and validated assessment tools appropriate for the pre-institutional population. Specifically, CMS should issue guidance on eligibility criteria to ensure that states are using evidence-based criteria and assessment tools to appropriately target the desired population.

The MLTSS Association stands ready to convene subject matter experts, states, and managed care plans to surface lessons learned from 1915(i) implementation that can inform CMS guidance and technical assistance for this new waiver authority.

Managed Care Integration: MLTSS Plans as Implementation Partners

CMS should issue clear guidance affirming that states may and are encouraged to deliver services under new 1915(c)(11) waivers through MLTSS managed care arrangements. Many states have chosen MLTSS as their primary vehicle for delivering HCBS precisely because managed care offers the infrastructure, care coordination capacity, budget predictability, and accountability mechanisms necessary to serve people with complex and specialized healthcare needs efficiently.

Allowing MLTSS plans to serve the new pre-institutional population would:

1. Leverage existing care coordination infrastructure without requiring states to build parallel administrative systems
2. Enable seamless transitions when a beneficiary's needs escalate to institutional LOC (a common trajectory as individuals age)
3. Facilitate whole-person integration of physical health, behavioral health, and LTSS, which is especially important for the at-risk population the new waiver is designed to serve
4. Create economies of scale that improve the sustainability of the program

[4] Medicaid Home- and Community-Based Services: Comparing Requirements for States

CMS should also clarify how states and MCOs can meet the conflict-of-interest requirements in areas with limited provider capacity.

Quality Measurement and Annual Reporting

The statute requires states to report annually on cost, utilization, and quality metrics. The Association strongly supports robust quality measurement and outcome reporting and urges CMS to develop a quality framework that reflects the unique goals and characteristics of the pre-institutional waiver population.

Quality measures for this population should emphasize prevention and independence — metrics such as reduced readmissions, maintenance of functional status, and beneficiary-reported quality of life. Traditional acute care quality metrics are unlikely to be appropriate or meaningful for this population. For example, measures such as the percentage of beneficiaries who remain in a community setting after 90 and 365 days would be well-suited to tracking whether the waiver is achieving its core goal of delaying or preventing institutionalization. Similarly, functional status measures such as maintenance or improvement in activities of daily living (ADL) scores would capture whether services are supporting independence and wellbeing over time.

CMS should leverage the existing HCBS Quality Measure Set (QMS) rather than developing a separate core measure set for the 1915(c)(11) population and require reporting, where feasible, by waiver or program authority. This avoids the duplicative reporting and administrative burden a new framework would create. CMS should also encourage states to include a standardized indicator for 1915(c)(11) enrollment to support accurate attribution and reporting.

Implementation Timeline and State Readiness

The July 1, 2028, effective date for new waiver approvals provides meaningful lead time, but states will require significant preparation including waiver design, systems modifications, assessment tool development, and managed care contract amendments. CMS should use the period between now and 2028 to actively support state readiness.

CMS should issue detailed waiver application instructions no later than the end of 2026 to allow states sufficient time to design and submit applications. Also, CMS should offer technical assistance to states, particularly smaller states with limited waiver administration capacity. CMS should clarify whether states may begin planning and pre-implementation activities (e.g., systems development, actuarial analysis) using the $50 million in FY 2026 implementation funding. A pre-submission consultation process through which states and their plan partners can discuss waiver design questions with CMS staff before formal application would also be helpful.

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Conclusion

The National MLTSS Health Plan Association appreciates the opportunity to provide these recommendations as CMS develops guidance for the new 1915(c)(11) waiver authority. This new waiver option has significant potential to help delay or prevent institutionalization and support the independence of older adults and people with disabilities in their homes and communities. At the same time, the extent to which states pursue this option will depend on the availability of clear guidance, state administrative capacity, and alignment with states' broader Medicaid program and fiscal priorities. The MLTSS Association urges CMS to issue timely and comprehensive guidance, invest in state readiness, and affirm the role of managed care in delivering services under this new authority. We welcome the opportunity to serve as a partner to CMS throughout this process.

If you have any questions or would like to follow up on these comments, please contact me at mkaschak@mltss.org.

Sincerely,

Mary Kaschak
Chief Executive Officer