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

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Medicaid and CHIP Payment and Access Commission

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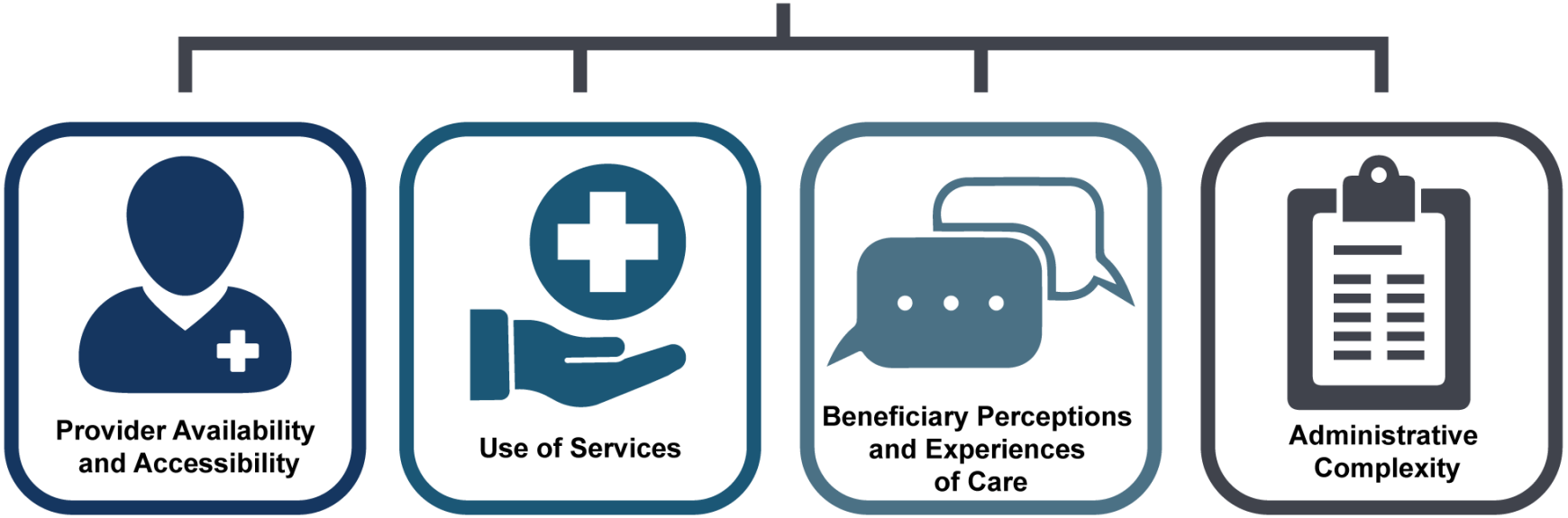
Overview

- Background
  - Home- and community-based services (HCBS) authorities
  - State considerations in selecting HCBS authorities
  - Methods
- Key findings
- Next steps

HCBS Access Framework



Background

HCBS Authorities

- Section 1915(i): state plan option for people who need less than an institutional level of care
- Section 1915(j): state plan option for self-directed personal assistance services
- Section 1915(k): state plan option, also known as Community First Choice (CFC), that provides a 6 percentage point increase in the federal medical assistance percentage (FMAP) for attendant services
- Section 1915(c): waiver authority that allows for a broad array of services and design flexibilities, for individuals with an institutional level of care

State Considerations in Selecting HCBS Authorities

- Design flexibilities and the ability to waive various requirements, including:
  - Statewideness: state Medicaid programs cannot exclude enrollees or providers because of where they live or work in the state
  - Comparability of services: Medicaid-covered benefits generally must be provided in the same amount, duration, and scope to all enrollees
  - Community income rules: Medicaid applicants' family income includes the spouse's income unless the applicant is institutionalized
- Additional flexibilities including limits on the number served, waiting lists, and caps on individual resource allocations or budgets

State Considerations in Selecting HCBS Authorities, cont.

- State resources and capacity to operate HCBS programs
- Needs of different HCBS populations
- State policy goals and legislative direction
- Lawsuits

Methods

- MACPAC contracted with Mathematica to explore the complexity associated with federal administrative requirements across HCBS Section 1915 authorities in the following categories:
  1. Reporting, monitoring, and quality improvement
  2. Application, approval, and renewal
  3. Public input
  4. Cost neutrality
  5. Conflict of interest
- Mathematica conducted 17 interviews with state officials in 5 states, federal officials, and policy experts

Key Findings

Requirements: Reporting, Monitoring, and Quality Improvement

- **Annual reports.** All authorities have annual reporting requirements, but the reporting elements and guidance available differ considerably
  - Section 1915(c) waivers have a technical guide and are the most prescriptive
  - Sections 1915(i) and 1915(j) have no accompanying technical guides
  - Section 1915(k) has a technical guide that lacks detail for reporting data
- **Evidence-based review.** Sections 1915(c) and 1915(i) require states to demonstrate compliance with federal requirements prior to renewal
- **Quality improvement.** All HCBS authorities require states to implement quality assurance and improvement systems, but demonstrating compliance varies by authority
  - Sections 1915(i), 1915(j), and 1915(k) have limited information on what states should measure and report
  - Section 1915(c) waivers must demonstrate that performance measures meet or exceed 86 percent compliance in their CMS-372 reports

Findings: Reporting, Monitoring, and Quality Improvement

- **Quality improvement.** Some states use the data required by CMS for their own quality improvement purposes
  - Recent CMS proposed rulemaking on ensuring access to Medicaid services (CMS-2442-P) may have implications for quality reporting
- **Operational challenges.** Interviewees cited challenges with CMS's waiver management system (WMS) and reporting templates
- **Unclear or inconsistent guidance.** States told us that guidance from CMS on Section 1915(k) requirements and the absence of technical guides for Sections 1915(i) and 1915(j) create ambiguity about reporting requirements

Requirements: Application, Approval, and Renewal

Applications. HCBS waiver and state plan options differ in application length and completion time, as well as availability of technical guides

	1915(c)	1915(i)	1915(j)	1915(k)
Page length (blank application)	125 pages	19 pages	18 pages	27 pages
Estimated time to complete	160 hours	114 hours	20 hours	10 hours
Format	Web-based portal	Preprint	Preprint	Preprint
Technical guide	Yes	No	No	Yes

Note: Average estimated time to complete each application is listed on the document, in accordance with the Paperwork Reduction Act of 1995 (P.L. 104-13). This average includes the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collected.
Sources: CMS 2022, 2019a, 2017, 2016b, 2016c, 2007a.

Requirements: Application, Approval, and Renewal, cont.

- **Approval and renewal timeline.** Waivers have the shortest approval timeline with the option for renewal, while state plan options have one-time approvals
  - Section 1915(c) waivers have an initial approval period of three to five years, after which they must be renewed every five years
  - Sections 1915(i), 1915(j) and 1915(k) have one-time approvals and do not require renewal
    - **Exception:** If a state chooses to restrict eligibility for services to specific populations under its Section 1915(i) state plan option, then it must be renewed every five years
  - Outside of renewal, states may submit changes to CMS via the amendment process for both waivers and state plan options

Findings: Application, Approval, and Renewal

- **State staff time and resources.** The Section 1915(c) application and renewal process is time- and labor-intensive, consuming resources that could otherwise be spent on quality improvement or serving beneficiaries

- **Renewal timeline.** Some states questioned the need for a renewal process for waivers, or suggested a different renewal frequency

- **Operational challenges.** Interviewees noted that the WMS is not user-friendly, citing challenges with amendment submissions

Requirements: Public Input

- All HCBS authorities must comply with federal regulations requiring states to issue a public notice of proposed changes in its methods and standards for setting Medicaid payment rates
  - With the exception of Section 1915(j), each authority has specific requirements
- Section 1915(c) requires a public comment process for new waivers and amendments, a state must:
  - Share the entire waiver with the public
  - Have two statements of public notice and public comment (web-based and non-electronic)
  - Establish a public notice and comment period of 30 days, prior to waiver submission
- Section 1915(i) requires states to provide a minimum of 60 days' notice before modifying the needs-based criteria
- Section 1915(k) requires states to consult and collaborate with a Development and Implementation Council to establish a CFC program

Findings: Public Input

- **Enhancing transparency.** Public input requirements were cited as being critical in enhancing transparency among states, community partners, and HCBS participants
- **Development and Implementation Council.** Interviewees had mixed feedback regarding the Section 1915(k) Development and Implementation Council
  - Respondents discussed the benefits of the council in providing feedback and standing up new programs, while some noted challenges meeting the requirement
- **Lengthy timelines.** We heard that the public input process can lengthen the timeline for implementation of waiver renewals as well as amendments

Requirements & Findings: Cost neutrality

- Section 1915(c) is the only HCBS authority which must comply with cost neutrality requirements
- Section 1915(c) waivers must be cost neutral, meaning the cost of waiver services cannot exceed the cost of care in institutional settings
- States use their annual CMS-372 report submission to demonstrate compliance with cost neutrality requirements

- **Meeting and demonstrating cost neutrality.** States generally expressed no difficulties meeting cost neutrality prerequisites for their Section 1915(c) waivers, noting that institutional costs are often high compared to waiver services
  - Interviewees shared that calculating the costs of institutional care to demonstrate cost neutrality can be complex (e.g., states with no intermediate care facilities)

Requirements: Conflict of Interest

- All HCBS authorities must ensure conflict-free case management services
- Section 1915(j) mandates that safeguards are in place to ensure the disclosure of a provider's role and to prevent a conflict of interest when providers are also involved in developing the person-centered service plan (PCSP)
- Section 1915(c) mandates that HCBS providers cannot provide case management or develop the PCSP
- Sections 1915(i) and 1915(k) dictate that those who conduct eligibility determinations, level of care assessments, and develop PCSPs cannot be related or financially responsible for the individual, nor have any ties to the HCBS provider

Exception: If only one entity is available in a geographic area to provide case management, assessments, develop PCSPs, and HCBS, the state must put in place conflict of interest protections

Findings: Conflict of Interest

- **Program integrity.** Interviewees recognized the importance of conflict of interest requirements to ensure that HCBS programs operate with integrity

- **Geographic challenges.** In rural areas and tribal communities where provider availability is limited, we learned that conflict of interest requirements may limit provider options for beneficiaries

- **Managed care organizations.** Some interviewees described a lack of clarity around compliance with conflict of interest requirements for managed care organizations

Takeaways

- Administrative complexity can cause states to dedicate a substantial share of their time and resources to meeting requirements, potentially reducing their capacity to focus on other program areas (e.g., quality improvement)

- Identifying opportunities to simplify administrative requirements may help decrease state administrative burden

Next Steps

- Much of the findings reflect the perspective of states, we plan to follow-up with CMS to place state input into context relative to CMS's policy goals and compliance obligations
- Staff would appreciate Commissioner feedback on areas to explore further to address administrative complexity
- Return in January with policy options for your consideration

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