March 7, 2024

Medicaid Home- and Community-Based Services: Addressing Administrative Requirements

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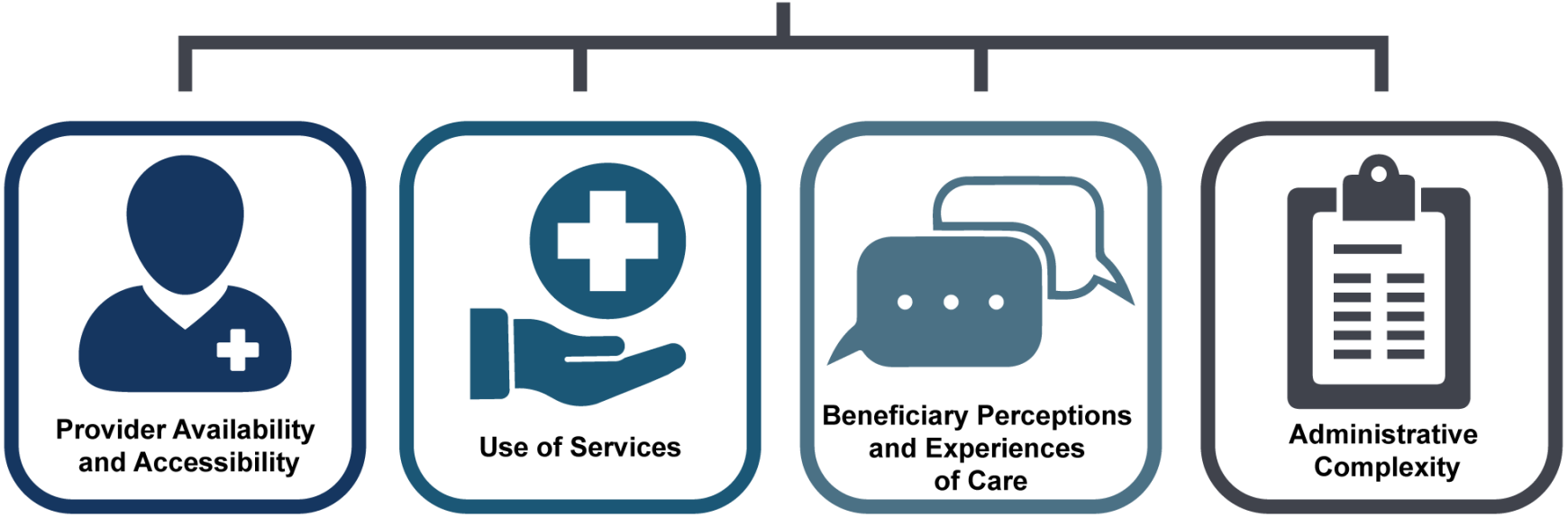
Overview

- Background
- Key findings
- Policy options
- Next steps

Background

HCBS Access Framework



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 who need an institutional level of care

Design Flexibilities

- States have the ability to waive various requirements in certain Section 1915 authorities, 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 include limits on the number of people served and caps on individual resource allocations or budgets

Notice of Proposed Rulemaking on Ensuring Access to Medicaid Services: Relevant Provisions

- New reporting requirements for Section 1915 authorities, such as a grievance system for fee-for-service beneficiaries for grievances not subject to fair hearing requirements
- Requires use of a nationally standardized HCBS quality measure set
  - Metrics will be updated every other year, with an opportunity for public comment
- Updates to incident management systems
- To improve transparency, states will have to have a website with information on HCBS program quality and performance
- Establishes Beneficiary Advisory Groups

Methods

- Contracted with Mathematica to conduct interviews with key stakeholders to explore complexity of federal administrative requirements across Section 1915 HCBS authorities
- Presented findings in November 2023
  - Review of requirements grouped by the following categories:
    1. Reporting, monitoring, and quality improvement
    2. Application, approval, and renewal
    3. Public input
    4. Cost neutrality
    5. Conflict of interest
  - Interviews with state officials in 5 states, federal officials, and policy experts
- Follow up interviews with 3 Centers for Medicare & Medicaid Services (CMS) divisions and 7 policy experts to dive deeper and better understand the implications of potential policy changes

Key Findings

Requirements: Reporting, Monitoring, and Quality Improvement

- **Annual reports:** All authorities require annual reporting, but the reporting elements and available guidance 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 but it lacks detail on data reporting
- **Evidence-based review:** Sections 1915(c) and 1915(i) require states to submit their evidence-based review process to CMS about two years before the waiver or state plan amendment (SPA) expires
- **Quality improvement:** All authorities require quality assurance and improvement systems, but demonstrating compliance varies by authority

Findings: Reporting, Monitoring, and Quality Improvement

- We heard that the absence of a technical guide for Section 1915(i) creates ambiguity about reporting requirements
  - There was general agreement about the value of a technical guide and some interviewees shared it could create consistency and transparency
- Federal officials indicated that CMS technical assistance (TA) and the SPA preprint support state use of Section 1915(i); other interviewees expressed challenges with the scope and availability of CMS TA
- Interviewees raised different considerations for developing a technical guide
  - CMS officials identified it as a low priority given limited resources, the volume of states using the SPA, and finalization of the access rule
  - Some cited possible pressure on CMS to develop technical guides for other non-HCBS SPAs
  - Policy experts indicated the usefulness of written guidance in maintaining institutional knowledge

Requirements: Application, Approval, and Renewal

- **Application:** HCBS authorities differ in page length, time to complete, and format

	1915(c)	1915(i)
Page length (blank application)	125 pages	19 pages
Estimated time to complete	160 hours	114 hours
Format	Web-based portal	Preprint

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.

- **Approval and renewal timeline:** Waivers have an initial approval period of three to five years, and can be renewed every five years. Section 1915(i) SPA has a one-time approval unless a state chooses to restrict eligibility for services to specific populations, then it must be renewed every five years

Findings: Application, Approval, and Renewal

- Application and renewal processes are time- and labor-intensive, consuming resources that could otherwise be spent on quality improvement or serving beneficiaries
- Federal officials, states, and policy experts noted that renewals are important for oversight and evaluation of program performance, and allow for public input on the entire waiver
- Interviewees had mixed feedback on changes to renewal requirements
  - CMS officials noted that renewals support a comprehensive review
  - Policy experts and state officials supported an increase in the renewal period, with several suggesting a time frame no longer than 10 years; a few suggested removing the renewal requirement

Requirements: Cost Neutrality

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

Findings: Cost Neutrality

- Interviewees generally agreed that states do not have difficulties meeting cost neutrality requirements for their Section 1915(c) waivers; some pointed to institutional costs as generally higher than waiver services
- We heard mixed feedback regarding eliminating cost neutrality
  - CMS officials shared that cost neutrality data can be useful in demonstrating that HCBS results in lower spending relative to institutional care
  - Some federal officials and policy experts indicated that eliminating it could lead to an increase in HCBS spending
  - Several policy experts and one state official expressed support for removing the requirement, with some citing that the initial trigger for the cost neutrality requirement in the 1980s related to concerns around uncontrolled spending are no longer relevant

Findings: Cost Neutrality, cont.

- MACPAC analyzed CMS-372 cost data for Section 1915(c) waivers from 2019 to 2021 to assess waiver expenditures as a percentage of institutional spending

2019		2020		2021	
Waiver Costs as Percentage of G+G'	Percent of Waivers	Waiver Costs as Percentage of G+G'	Percent of Waivers	Waiver Costs as Percentage of G+G'	Percent of Waivers
≥90%	2%	≥90%	3%	≥90%	2%
80-89	4	80-89	4	80-89	5
70-79	5	70-79	4	70-79	7
60-69	12	60-69	9	60-69	7
50-59	17	50-59	17	50-59	15
<50	60	<50	63	<50	63

Notes: G is the estimated annual average per capita Medicaid cost for hospital, nursing facility (NF), or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) care that would be incurred for individuals served in the waiver, were the waiver not granted. G′ is the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted. A total of 169 waivers in 37 states and DC that were active between 2019-2021 were included in the analysis.
Source: MACPAC analysis of CMS-372 data, 2023.

Policy Options

Challenges and Policy Options

Challenge	Policy Option
Lack of a technical guide for Section 1915(i) SPA creates ambiguity around requirements	1 CMS should develop an authority-specific guide for Section 1915(i) SPA
Renewal process for Section 1915(c) waivers and Section 1915(i) SPAs are resource intensive	2 Congress should increase the renewal period beyond five years
States are generally able to meet cost neutrality requirements for Section 1915(c) waivers	3 Congress should remove the cost neutrality requirement

Policy Option 1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop an authority-specific technical guide for Section 1915(i)

- Rationale
  - Interviewees shared that
    - lack of a technical guide creates challenges for states
    - availability of timely and consistent CMS TA varies
    - written guidance provides a definitive interpretation of requirements
  - Federal officials noted that a Section 1915(i) preprint guides states in completing the application; however, other Section 1915 HCBS authorities have a preprint and an accompanying technical guide
  - A technical guide would address complexities associated with managing several HCBS authorities

Policy Option 2

Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of Title XIX of the Social Security Act to increase the renewal period beyond five years

- Rationale
  - More time between renewals would reduce administrative burden for both CMS and states
  - Potential loss of oversight could be mitigated by
    - CMS-372 reports
    - Proposed changes in the access NPRM intended to improve compliance with requirements and the health and welfare of beneficiaries
  - Opportunity for public engagement that occurs at renewal can be maintained in other ways
    - Stakeholders are given an opportunity for public comment at initial program approval, renewal, and when a substantive change is made via an amendment
    - The access NPRM also includes proposed changes that support public input and transparency

Policy Option 3

Congress should amend Section 1915(c)(2)(D) of Title XIX of the Social Security Act to remove the cost neutrality requirement

- Rationale
  - Eliminates the cost neutrality test while maintaining data collection on waiver cost and utilization to assess waiver operations
  - There was widespread agreement regarding states' ability to avoid exceeding the cost neutrality limit, which is supported by MACPAC's analysis of CMS-372 cost data
  - Several states and policy experts found no practical utility in cost neutrality requirements
  - States have several cost containment tools for waivers to manage spending and enrollment, and they must operate within their state budget parameters, all of which would mitigate concerns related to possible increases in HCBS spending

Next Steps

- Commissioner discussion and feedback on policy options
- April meeting
  - Present draft chapter for the June 2024 report to Congress
  - Vote on recommendations

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