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Section 1915 Home- and Community-Based Services Authorities

Revisiting Policy Options

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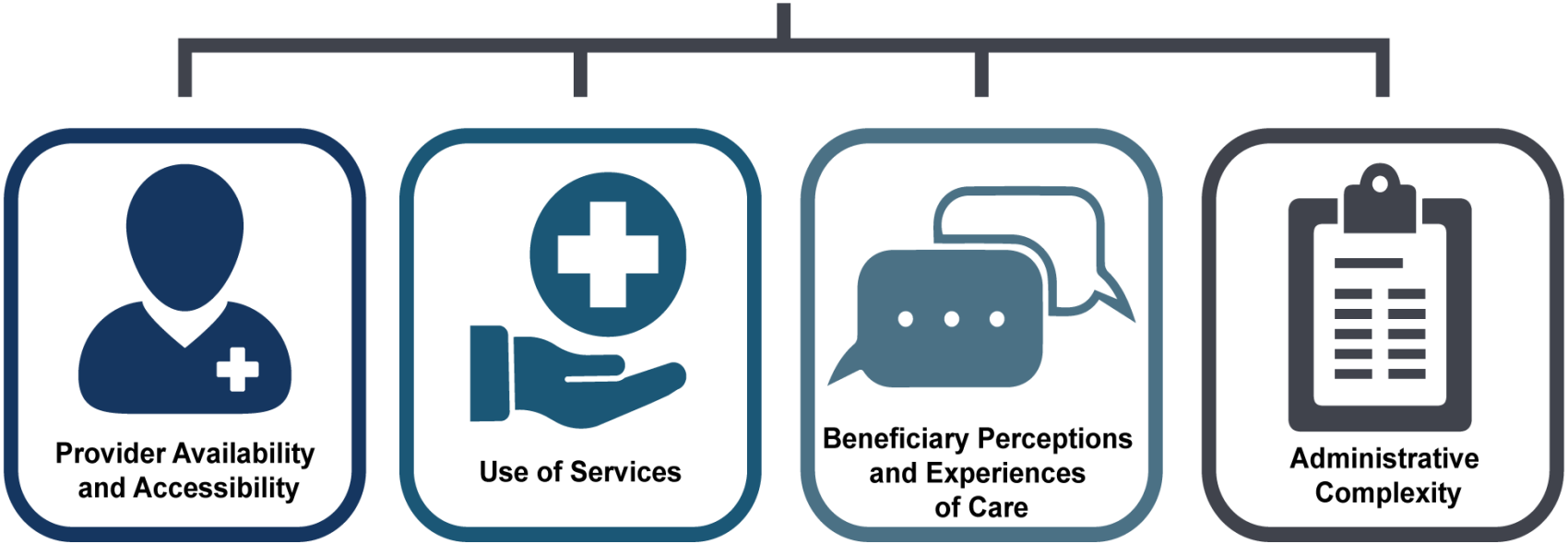
Overview

- 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

Methods

- Contracted with Mathematica to better understand administrative requirements for Section 1915 authorities
  - conducted a federal policy scan which identified five categories of administrative requirements
    1. Reporting, monitoring, and quality improvement
    2. Application, approval, and renewal
    3. Public input
    4. Cost neutrality
    5. Conflict of interest
  - interviewed stakeholders including state and federal officials and policy experts
  - presented preliminary findings at November 2023 Commission meeting

Methods, cont.

- Additional interviews in spring 2024 focused on three specific areas: technical guides, renewal requirements, and cost neutrality
  - Presented findings and policy options at March 2024 Commission meeting
- Based on feedback from Commissioners, staff conducted additional outreach to stakeholders including state associations to better understand the implications of the policy options under consideration

Key Findings

Application Processes

- In general, Section 1915(c) waivers have the most complex and time intensive requirements for completing an application
  - States spend 160 hours, on average, completing a Section 1915(c) waiver application
- States must include information on institutional spending in Appendix J (Cost Neutrality Demonstration) of the Section 1915(c) waiver application
- Calculating the costs of institutional care to demonstrate cost neutrality in Section 1915(c) waivers can be time consuming
  - For example, CMS can ask questions any time a state's annual reporting shows a greater than 10 percent variance from state projections in Appendix J of the application

Application Processes for 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 Processes

- Section 1915(c) waivers have an initial approval period of three or 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
- Renewals are important for oversight and evaluation of program performance, and allow for public input on the entire waiver
- Processes are time- and labor-intensive

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
  - Only applies to Section 1915(c)
- States must demonstrate compliance with cost neutrality requirements through submission of annual CMS-372 reports for each waiver they administer
- Interviewees generally agreed that states typically 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

Cost Neutrality, cont.

- We heard mixed feedback from interviewees 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 state officials 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

MACPAC Analysis of CMS-372 Data

- MACPAC analyzed CMS-372 data for Section 1915(c) waivers to assess waiver expenditures as a percentage of institutional spending
- We reviewed 169 waivers in 37 states and the District of Columbia over a three-year period from 2019 to 2021 and found that states generally meet the cost neutrality requirement
  - Of 169 waivers, 1 waiver in 2021 failed to meet the cost neutrality requirement
  - The remaining 168 waivers all showed some level of savings over institutional care
  - In each of the three years we reviewed, 60 percent or more of waivers had average per capita expenditures that were less than 50 percent of institutional spending

CMS-372 Data, 2019-2021

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

Policy Option 1 – Increase Renewal Period for Section 1915(c) Waivers from 5 to 10 Years

- Reduces frequency of renewals, easing burden on state and federal officials
- Maintains oversight and public comment opportunities critical to program management
- Based on Commissioner feedback, revised this option to specify 10 years
  - 10 year timeframe aligns with select Section 1115 demonstrations renewed for 10 years under the Trump Administration and with the standard 10-year period for budget projections and cost estimates used in the Congressional budget process
- The Congressional Budget Office (CBO) indicated that this policy option could decrease state administrative burden, but it is not possible to estimate changes in direct spending without additional detail

Policy Option 2 – Remove Requirement that States Meet Cost Neutrality Test and Direct the Secretary of Health & Human Services to Publish Annual Report

- Eases state burden by amending Section 1915(c) to remove requirement to fill out Appendix J (Cost Neutrality Demonstration) of the waiver application
- Maintains state data collection and reporting requirements for purposes of CMS-372 reporting

Policy Option 2, cont.

- Adds an annual report from the Secretary of HHS that states can rely on to demonstrate HCBS cost effectiveness relative to institutional care, based on feedback from Commissioners
- CBO estimated that this option would increase federal direct spending by about $1 billion over 10 years

Next Steps and Questions

Next Steps

- Commissioner feedback on policy options
  - Options are independent of one another and not considered a package
- Return at a future meeting for a possible vote
- Describe our findings on administrative burden in the March 2025 report to Congress

Questions

- Are there outstanding questions that staff can answer?
- In the Commission's assessment, does the evidence support either or both policy options moving to a vote during a future meeting?

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