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Medicaid Section 1915 Authorities for Home- and Community-Based Services: Analyzing Federal Administrative Requirements and Opportunities to Streamline

Review of recommendation and draft chapter for March report

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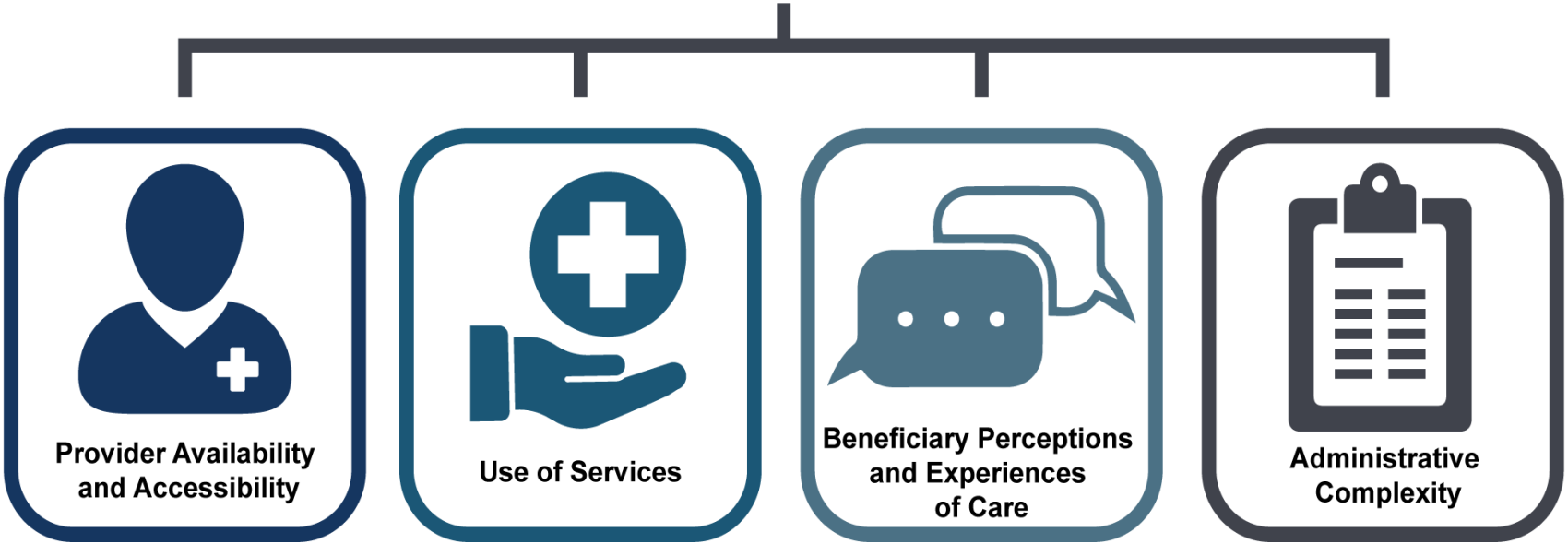
Overview

- Background
- State considerations in selecting home- and community-based services (HCBS) authorities
- Administrative requirements and key findings
- Commission recommendation
- Next steps

Background

HCBS Access Framework



Section 1915 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, that provides a 6 percentage point increase in the federal medical assistance percentage 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

Analytic Approach

- 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
- MACPAC staff conducted additional interviews on technical guides, renewal requirements, and cost neutrality, in order to better understand the implications of the policy options under consideration

State Considerations in Selecting HCBS Authorities

Federal 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

Additional State Considerations

- State capacity
  - Initial financial investment
  - Balancing direction from various stakeholders
  - Administrative complexity
- Coverage
  - Specific populations
  - Services
- State policy goals
- Legal action

Administrative Requirements and Key Findings

Reporting, Monitoring, and Quality Improvement

- Annual reports: All authorities require annual reporting, but the reporting elements and available guidance differ considerably
  - Section 1915(c) and 1915(k) have technical guides; Sections 1915(i) and 1915(j) do not
    - However, CMS advises states that the Section 1915(c) guide can generally be used for Section 1915(i) programs
- Evidence-based reviews: 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

Application, Approval, and Renewal Processes

- Requirements vary by Section 1915 authority for purposes of application, approval, and renewal of an HCBS waiver or state plan but all require states to submit applications through a web-based portal
  - In general, Section 1915(c) waivers have the most complex and time intensive requirements for completing an application
- CMS makes application templates available for each authority

	Section 1915(c)	Section 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

Public Input

- Federal regulations require states to issue public notice of proposed changes to methods and standards for setting Medicaid payment rates, and establish specific public notice requirements for each HCBS authority
- We heard that stakeholders value public input and view it as critical to enhancing transparency among states, community partners, and beneficiaries
- Section 1915(c) requires a public comment process for new waivers and amendments to waivers; states must:
  - share the entire waiver with the public
  - release at least two statements of public notice and public comment
  - establish a public notice and comment period of 30 days

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; unique requirement among HCBS authorities
- 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
- States must demonstrate cost neutrality through submission of annual CMS-372 reports
- Interviewees generally agreed that states do not have difficulty meeting cost neutrality requirements

Cost Neutrality, cont.

- We heard mixed feedback from interviewees on eliminating cost neutrality
  - Data can be useful in demonstrating that HCBS spending is lower than institutional care
  - Eliminating it could lead to an increase in HCBS spending
  - Some interviewees supported removing the requirement, with some citing that the original reasons for establishing the cost neutrality requirement are no longer relevant

Conflict of Interest

- Can occur when the same individual or entity provides a service and helps beneficiaries access that service
- Federal requirements separate duties and responsibilities, define clear roles, and safeguard conflict of interest
- Section 1915 authorities have requirements to prevent conflicts of interest
  - Section 1915(c) mandates that HCBS providers cannot provide case management or develop person-centered service plans (PCSPs) except in certain cases
  - Section 1915(i) and 1915(k) place limitations on individuals who conduct eligibility determinations, level of care assessments, and develop PCSPs
  - Section 1915(j) mandates that for providers involved in developing PCSPs, the state has to ensure the provider's role is disclosed to the beneficiary

Conflict of Interest, cont.

- States did not describe the requirements as burdensome
- Some interviewees said they can be tough to adhere to such as in rural areas or tribal communities where provider availability is limited
  - Conflict of interest requirements can further limit provider options for beneficiaries
  - Case management entities are more likely to also be service providers
  - Conflict of interest requirements can be barriers to culturally competent care to the extent that tribal members prefer to see a provider from their community

Recommendation

Rationale and implications

Recommendation 3.1

- To reduce administrative burden for states and the federal government, Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(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.

Recommendation 3.1: Rationale

- Renewal process is resource intensive for states and CMS
- At the same time, renewals are critical for ensuring state compliance with federal policy and HCBS program oversight
- Recommendation reduces frequency of renewals while maintaining critical components of HCBS program management such as oversight and public comment
- 10-year timeframe aligns with federal practice
  - Select Section 1115 demonstrations renewed for 10 years under the first Trump administration
  - Congressional budget process uses a 10-year budget window for projections and cost estimates

Recommendation 3.1: Implications

- Federal spending
  - Although this type of change could lead to reductions in spending, the Congressional Budget Office (CBO) indicated it could not estimate changes in direct spending without additional detail
- States
  - Decreased administrative burden
- Enrollees
  - No direct effect; extends the period between public comment
- Plans
  - No direct effect
- Providers
  - No direct effect

Next Steps

Next Steps

- Obtain Commissioner feedback and address questions ahead of the vote
- Publish chapter in March 2025 report to Congress

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