Chapter 3:

Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

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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.

Key Points

- States cover home- and community-based services (HCBS) primarily through Section 1915(c) waivers. In 2024, 46 states and the District of Columbia operated more than 250 Section 1915(c) waivers. States can also cover HCBS in their Medicaid state plans through Section 1915(i), Section 1915(j), and Section 1915(k) in Title XIX of the Social Security Act.
- States consider a number of factors in selecting which federal authorities to use to design their HCBS programs, including state capacity to implement a new authority, which populations they want to cover, and the ability to waive certain federal design flexibilities such as statewideness, comparability of services, and community income rules.
- Most states operate multiple HCBS programs. The administrative complexity in federal statute, regulation, and subregulatory guidance can mean that states must dedicate substantial time and resources to meeting the requirements associated with operating Medicaid HCBS programs.
- Federal requirements under Section 1915 can be grouped into five categories: (1) application, approval, and renewal processes; (2) cost neutrality; (3) public input; (4) conflict of interest; and (5) reporting, monitoring, and quality improvement. Our findings focused on state experience adhering to requirements in these five categories and include feedback from interviewees on challenges and potential opportunities to streamline.
- The Commission considered policy changes in two areas: cost neutrality and renewals. Although states meet the cost neutrality requirement, we did not hear consensus on eliminating the requirement. Instead, feedback was mixed, with some describing it as administratively burdensome and others finding it useful for demonstrating that HCBS cost less than institutional care.
- Section 1915(c) waivers and Section 1915(i) state plan amendments that restrict eligibility to specific populations must be renewed every five years. Renewals help ensure that HCBS programs comply with federal law and provide an opportunity for public input. They are a resource-intensive process for the Centers for Medicare & Medicaid Services (CMS) and for states, with unpredictable timelines for approval from CMS. Experts we talked to supported changing the policy to extend the renewal period from 5 years to 10 years. This change aligns with past CMS practice when select Section 1115 demonstrations were renewed for 10 years and with the standard 10-year window that is part of the congressional budget process.

CHAPTER 3: Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

Medicaid home- and community-based services (HCBS) are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or in a home-like setting in the community. Medicaid HCBS encompass a wide range of services, such as personal care services, day services, caregiver support, supported employment, and home-delivered meals. Though nearly all HCBS are optional benefits for state Medicaid programs, all states choose to cover HCBS to some extent.[1] The way in which they do so reflects the availability of multiple federal Medicaid authorities in the Social Security Act (the Act) that states can use to design and administer HCBS programs, including waiver and state plan authorities.[2]

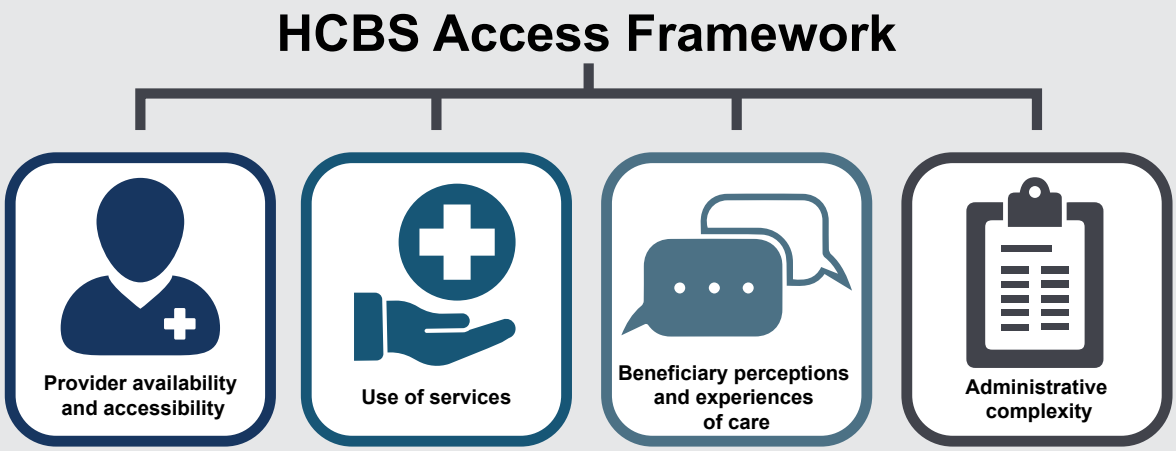
The primary way in which states cover HCBS is through Section 1915(c) waivers. States can operate multiple waivers under the same authority, and in 2024, 46 states and the District of Columbia used Section 1915(c) to operate more than 250 waivers (CMS 2024a, MACPAC 2024). Section 1915(c) gives states the flexibility to waive a number of different Medicaid requirements, allowing states to design their HCBS programs based on their policy goals and needs. States can also cover HCBS in their Medicaid state plans through Sections 1915(i), 1915(j), and 1915(k) in Title XIX of the Act. These authorities generally require that HCBS be made available statewide to all Medicaid enrollees who meet the eligibility criteria established for each of these programs.

Access to HCBS depends on a number of factors, including availability of providers and federal and state budgetary constraints. MACPAC uses an access monitoring framework to analyze access to HCBS (Figure 3-1). It has four key domains: provider availability and accessibility, use of services, beneficiary perceptions and experiences of care, and administrative complexity. In the first domain, provider availability and accessibility measures capture potential access to providers and services, regardless of whether the services are used. In the second domain, we measure realized access by examining use of services and, in some cases, use of specific providers or settings. The third domain in MACPAC's access framework, beneficiary perceptions and experiences, is focused on barriers to accessing care, experiences with care, and beneficiaries' knowledge and understanding of available benefits. The fourth domain in MACPAC's HCBS access framework, administrative complexity, examines state and federal burden in administering multiple HCBS programs often under different federal authorities, constraints on state capacity and resources, and the implications of system complexity for beneficiaries.

In MACPAC's June 2023 report to Congress, we analyzed barriers for beneficiaries trying to access HCBS and the challenges states face in managing HCBS programs (MACPAC 2023a). In our interviews with state Medicaid officials and other experts, administrative complexity emerged as a particular challenge. We heard that administrative complexity in federal statute, regulation, and subregulatory guidance can mean that states must dedicate substantial time and resources to meeting the requirements associated with operating Medicaid HCBS programs. The variation in requirements across federal authorities may create challenges for states administering multiple HCBS programs under various authorities, which most states do, and create confusion for beneficiaries and providers. The federal authorities that states use to administer their HCBS programs and potential opportunities to streamline are the subject of this chapter.

To better understand the administrative complexity of the Section 1915 authorities that states primarily use to operate HCBS programs, we reviewed the requirements under each authority and looked for opportunities to simplify or align them across authorities. We also interviewed stakeholders to obtain their insights about the complexity of administering these programs. Through these interviews, we identified three potential areas for streamlining: technical guidance for states using Section 1915(i), federal renewal requirements for Sections 1915(c) and 1915(i), and the statutory cost neutrality requirement

FIGURE 3-1. Home- and Community-Based Services Access Monitoring Framework



Notes: HCBS is home- and community-based services.

Source: MACPAC 2023a.

for Section 1915(c). The Commission reviewed a number of policy options in each of these areas that were intended to reduce administrative burden for states. Based on this review, the Commission recommends that Congress make the following statutory change:

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 HCBS programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years.

To provide context for this recommendation, the chapter begins with background on Medicaid HCBS, the federal authorities under Section 1915 that states use to administer HCBS programs, and the variation in the applicable requirements. It then describes our analysis, including the purpose of our work and the approach we used. Then the chapter describes our key findings on administrative complexity across HCBS authorities, including opportunities to simplify and align adminstrative requirements. The chapter concludes with a discussion of the rationale for MACPAC's recommendation and next steps for the Commission's work in this area.

Background

Medicaid beneficiaries who use HCBS need LTSS but can live in the community. They are a diverse group, spanning a range of ages with different types of complex conditions and service needs, including physical disabilities, developmental disabilities, and behavioral health needs. They often receive services and supports for many years, with some beneficiaries receiving services throughout their lives. The types and intensity of services they require vary, both across and within population subgroups.

Medicaid is the primary payer for HCBS, a benefit that Medicare generally does not cover. In calendar year 2021, total federal and state Medicaid spending on HCBS was $82.5 billion, accounting for 55 percent of all Medicaid spending on LTSS and about 18 percent of all Medicaid expenditures.[3] In Fiscal Year 2019, in 29 states and the District of Columbia, HCBS made up 50 percent or more of total LTSS spending (Murray et al. 2021). Over 2.5 million people used Medicaid HCBS in calendar year 2021, representing about 2.6 percent of Medicaid enrollees.

States can choose to operate one or multiple HCBS programs under several authorities simultaneously, which gives them the flexibility to serve diverse

populations or to provide different service delivery options to beneficiaries. Nearly all states use Section 1915(c) waivers to comprehensively serve the needs of specific populations. Some states also choose state plan options that may allow them to serve a larger number of individuals with a select set of services. States weigh factors, such as requirements for statewide coverage or use of enrollment caps, when deciding which Medicaid authorities to use to develop their HCBS systems. States also consider the level of effort required to establish and maintain a new federal authority as well as the time frame within which the new authority can be obtained.

Section 1915 HCBS authorities

Section 1915 of the Act offers states several options for operating an HCBS program (Table 3-1). States most commonly use a waiver under Section 1915(c), but they can also choose to operate HCBS under an amendment to their state plan through Sections 1915(i), 1915(j), or 1915(k) (MACPAC 2023a).[4] As of February 2024, 46 states and the District of Columbia had one or more 1915(c) waivers, 16 states and the District of Columbia had a Section 1915(i) state plan benefit, and 8 states had a Section 1915(k) Community First Choice program (MACPAC 2024). In 2022, a prior environmental scan we conducted found that 8 states used Section 1915(j) in tandem with another authority, most often a Section 1915(c) waiver (MACPAC 2023a).[5]

Analytic approach

MACPAC contracted with Mathematica to better understand the federal administrative requirements for Section 1915 authorities. They reviewed federal statute, regulations, subregulatory guidance, and other technical assistance resources such as the HCBS authority comparison chart to describe the requirements and flexibilities of these authorities (CMS 2024b).

In addition to the federal policy scan, Mathematica conducted 17 interviews with officials in 5 states, federal officials, and policy experts to better understand the purpose of and potential administrative burden associated with each of these requirements.[6] After Mathematica concluded its interviews, MACPAC staff conducted an additional 10 interviews in summer 2024 with officials from the Centers for Medicare & Medicaid Services (CMS) and with policy experts to discuss the evidence gathered and considerations for simplifying or aligning administrative requirements for HCBS authorities.[7]

MACPAC staff analyzed CMS-372 data for Section 1915(c) waivers that were active over three years (2019–2021) to determine how often waivers met the cost neutrality requirement. After standardizing the data, we reviewed 169 Section 1915(c) waivers in 37 states and the District of Columbia for our analysis. The findings are discussed in the cost neutrality section later in this chapter.

State Considerations in Selecting HCBS Authorities

States consider a number of factors in selecting which federal authorities to use to design their HCBS programs: state capacity, target populations, design flexibilities in federal statute, state policy goals, and responses to legal action.

State capacity and resources

We heard through interviews that the initial and ongoing financial investment required to implement a new authority, as well as the capacity to manage and implement the policy and operational changes, are important considerations for states. One policy expert noted that states consider the availability of state funding when deciding whether to move forward with a new authority. Another policy expert shared a state's experience when implementing their Section 1915(k) program. Specific challenges, some of which had financial implications, included balancing direction from both the state legislature and external stakeholders; ensuring that services could be delivered to all eligible individuals; and making necessary policy, information technology, and operational changes.

TABLE 3-1. Section 1915 Authorities for Home- and Community-Based Services

Section 1915 authority	Enacting legislation	Description
Section 1915(c)	Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35)	Allows states to offer a broad array of HCBS to individuals who meet an institutional level of care. States may also choose to expand financial eligibility for waiver services through optional eligibility pathways such as the medically needy pathway or the special income-level pathway.[1]
Section 1915(i)	Deficit Reduction Act of 2005 (P.L. 109-171)	Allows states to offer HCBS under the state plan to people who need less than an institutional level of care, the typical standard for Medicaid coverage of HCBS. Individuals must be eligible for Medicaid under the state plan with income levels up to 150 percent of the federal poverty level.[2] States can also establish other specific criteria for people to receive services under this authority.
Section 1915(j)	Deficit Reduction Act of 2005 (P.L. 109-171)	Gives authority for self-directed personal assistance services (PAS), providing beneficiaries with the ability to hire and direct their own PAS attendant. States may also give beneficiaries the authority to manage their own individual service budget. This authority is used in conjunction with state plan PAS or other HCBS authorities, and financial eligibility criteria are linked to the corresponding HCBS authority under which self-direction is permitted.
Section 1915(k)	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)	Known as "Community First Choice," this option provides states with a 6 percentage point increase in the federal medical assistance percentage (FMAP) for HCBS attendant services provided under the state plan. Individuals eligible for Community First Choice must meet an institutional level of care and either (1) be eligible for Medicaid in an eligibility category that includes access to the nursing facility benefit or (2) be eligible for a Medicaid category that does not include access to the nursing facility benefit and have an income below 150 percent of the federal poverty level.

Notes: HCBS is home- and community-based services.

[1] Under the medically needy pathway, individuals whose incomes are too high to qualify for Medicaid can spend down to a state-specified medically needy income level by incurring medical expenses. Under the special income level pathway, states may cover individuals who meet level of care criteria for certain institutions and have incomes up to 300 percent of the Supplemental Security Income federal benefit rate (MACPAC 2023a).

[2] Section 1915(i) authority also gives states the option to serve individuals with incomes up to 300 percent of the Supplemental Security Income federal benefit rate.

Sources: Sections 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act; 42 CFR 441.715(b); CMS 2024b.

Interviewees also shared states' experiences when expanding access to HCBS, which can place a burden on state resources because of the administrative complexity. For example, we heard that some challenges for states operating Section 1915(c) waivers include the high administrative burden associated with applications, renewals, and amendments; low perceived benefit of annual Section 1915(c) reporting; and demonstration of cost neutrality. We also heard that typically a limited number of state staff have this type of expertise, and staff turnover can lead to loss of programmatic and policy expertise, affecting states' ability to implement new programs. Additionally, experts shared that some states perceive the administrative requirements of a Section 1915(k) state plan amendment (SPA), such as the need to create a development and implementation council, to be burdensome. Interviewees shared that states often consider whether they will need to build out new infrastructure to effectively operate a program under the authority and meet the requirements.

Populations covered

States evaluate the populations that they want to serve and the types of services that they would like to offer. HCBS provided under Section 1915(c), 1915(i), and 1915(j) may be targeted to specific populations; Section 1915(k) services may not. For example, we heard that one state chose Section 1915(i) authority to create an entitlement program for individuals with developmental disabilities, as Section 1915(k) authority would not allow them to limit eligibility to a particular group. Limiting program enrollment to individuals with a certain disability type also allows states to design programs with service packages and service definitions that are developed to meet the specific needs of that group.

Federal design flexibilities

Medicaid HCBS authorities under Section 1915 vary in eligibility requirements and allow states to waive a combination of Medicaid program requirements found in Section 1902 of the Act (Table 3-2).

States may consider other flexibilities when developing their HCBS systems, such as the ability under Section 1915(c) authority to limit the number of HCBS program enrollees to better predict and manage costs (Hayes et al. 2021, ASPE 2016). Although enrollment caps allow states to manage costs, previous interviews with federal officials, national experts, and beneficiary advocates noted that when those caps result in waiting lists, it restricts access to HCBS for some individuals (MACPAC 2023a). States may also consider differences across waiver and state plan authorities in terms of their ability to set program limits on the amount that can be spent on participants; Section 1915(c) is the only authority that allows states to cap individual resource allocations or budgets (Appendix 3A).

State policy goals

State policy goals also influence which authorities states choose to use when designing and implementing an HCBS program. States shared that the enhanced federal medical assistance percentage (FMAP) available via a Section 1915(k) SPA was an incentive to transition some or all personal care services from a state plan benefit under Section 1905(a)(24) to Section 1915(k). States may also select particular authorities based on legislative direction. For example, one state's legislature directed the state to implement a Section 1915(k) SPA using existing state infrastructure. To do so, the state requested a Section 1915(b)(4) waiver—which permits a state to selectively contract by limiting choice of providers—to allow participants to keep their waiver providers as they transitioned to the Section 1915(k) SPA.[8]

Legal action

States also make choices in response to lawsuits. After enactment of the Americans with Disabilities Act of 1990 (P.L. 101-336), which required states to provide services to individuals with disabilities in the most integrated setting, and the 1999 *Olmstead v. L.C.* case, states experienced increased litigation related to institutionalization of individuals with disabilities who could be served in the community (CMS 2020a, Butler 2000).[9] Through technical assistance, CMS indicates that the *Olmstead* ruling requires that a state provide coverage in the community to people with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account

TABLE 3-2. Design Flexibilities Allowed under Section 1915 Authorities for Home- and Community-Based Services

Medicaid statutory provisions that can be waived under Section 1915	Section 1915 authority under which provisions can be waived	Description
Statewideness (§ 1902(a)(1) of the Social Security Act)	Sections 1915(c) and 1915(j)	Under the statewideness provision, a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state. Waiving statewideness allows states to target authorities to areas of the state where there is need or where certain types of providers are available.
Comparability of services (§ 1902(a)(10)(B) of the Social Security Act)	Sections 1915(c), 1915(i), and 1915(j)	Under the comparability of services provision, a Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. Waiving comparability of services permits states to make HCBS available only to certain groups of people who are at risk of institutionalization, such as older adults or adults with intellectual or developmental disabilities. States using an HCBS authority that waives comparability of services might also design their programs to serve an HCBS population subgroup or those with a particular diagnosis or condition (e.g., traumatic brain injury).
Community income rules for medically needy population (§ 1902(a)(10)(C)(i)(III) of the Social Security Act)	Section 1915(c), 1915(i), and 1915(k)	Under community income rules, a Medicaid applicant's family income includes the spouse's income unless the applicant is institutionalized. Waiving community income rules allows states to provide Medicaid HCBS to individuals who would otherwise be eligible only in an institutional setting, often because of a spouse's or parent's income and resources.

Note: HCBS is home- and community-based services.

Sources: MACPAC analysis of Section 1902 and Section 1915 of the Social Security Act; CMS 2024b.

the resources available to the entity and the needs of others who are receiving disability services from the entity (CMS 2020a).

A common component of litigation alleging violations of the Americans with Disabilities Act and *Olmstead v. L.C.* is the pace at which individuals are transitioning from waiting lists to receiving Medicaid HCBS (ADA 2019). For example, one state we interviewed told us that it set priorities for transitioning nursing home residents to waiver services because of an *Olmstead*-related settlement agreement (MACPAC 2020). In 2001, because of a legal settlement, Oregon created a new Medicaid HCBS program for individuals with intellectual or developmental disabilities with no waiting list. Additionally, in 2005 Mississippi expanded enrollment in existing HCBS programs in response to legal settlements with individuals in need of services (GAO 2018).

Administrative Requirements and Key Findings

For purposes of our analysis, we grouped federal administrative requirements for Section 1915 authorities into five categories:

- application, approval, and renewal processes;
- cost neutrality;
- public input;
- conflict of interest; and
- reporting, monitoring, and quality improvement.

Our findings are focused on states' experiences adhering to requirements in these five categories and include feedback from interviewees on challenges and potential opportunities to streamline the process.

Application, approval, and renewal processes

Requirements for states vary by Section 1915 authority for purposes of applying for, approving, and renewing a waiver or state plan. All four HCBS authorities require states to submit applications, either through a web-based portal for waivers or preprints submitted via a different portal for state plan options. CMS has made application templates publicly available for each authority. HCBS authorities differ in application length, time to complete, and availability of a technical guide (Table 3-3). In general, Section 1915(c) waivers have the most time-intensive requirements.

Approval time and renewal requirements also differ by authority. Section 1915(c) waivers have an initial approval period of three years (or five years if the waiver serves individuals dually eligible for Medicaid and Medicare), after which a renewal is required every five years. Sections 1915(j) and 1915(k) SPAs have one-time approvals, are not subject to renewal, and can continue indefinitely. Section 1915(i) has a one-time approval after which the program can continue indefinitely unless a state chooses to exercise the flexibility to restrict eligibility for services to specific populations, in which case they must be renewed every five years (42 CFR 441.745(a)(2)(vi)(A)). Nearly all states with a Section 1915(i) SPA target one or more populations (MACPC 2024). Outside of renewal, states may make changes to their HCBS programs under any of the four Section 1915 authorities by submitting an amendment to CMS, such as for changes to services offered, qualifications of providers, rates, or eligible populations.

Interviewees shared that the statutory requirement to renew programs operating under Sections 1915(c) and 1915(i) exists to ensure that they are compliant with federal law but that the renewal process can be resource intensive. In particular, interviewees described the application and renewal processes for Section 1915(c) waivers, the most widely used HCBS authority, as time- and labor-intensive activities that can involve months of consultation with CMS. They said the renewal process depletes resources—such as quality improvement or designing approaches to meet the needs of beneficiaries in a person-centered way—that could be allocated to other activities. State officials we spoke with also noted that, although CMS is required to approve or deny Section 1915(c) waivers within 90 days of submission, the timelines for approval are unpredictable for states because this 90-day clock can be stopped to allow CMS to request additional information from states. They said that the questions they receive from CMS during the request for additional information can be extensive,

time consuming, and duplicative both within and across waiver programs. For example, officials in one state shared that they renewed four waivers at once, and they received more than 800 total questions from CMS on these four renewals, many of which were duplicative across the waivers. The high volume of questions can cause delays in state responses and, in turn, the implementation of the waiver. Some state officials questioned the need for a renewal process because CMS has the opportunity to review any portion of the waiver whenever a state requests an amendment, something that occurs with some frequency. In 2024, 72 percent of waivers had amendments approved (CMS 2025). CMS can use a waiver amendment to gather information about the service delivery system at that time.

Federal officials at CMS and policy experts said that renewals are critical to ensure that HCBS programs comply with federal law, to ensure overall program integrity, and to provide an opportunity for public input. Unlike amendments that may make only small changes to the waiver and thus prompt only a targeted review, CMS officials shared that renewals support a comprehensive review of the entire Section 1915(c) waiver at the federal and state levels. CMS officials noted that renewals help with program oversight, ensuring that states are compliant with federal requirements and that programs are being operated as approved. Furthermore, they present an opening for states to revisit their estimates for their cost neutrality calculations to ensure they are current. We also heard that renewals allow the public to provide input on the entire waiver, in contrast to amendments for which only substantive changes trigger an opportunity for public comment that is specific to a pending change.[10] One policy expert pointed to renewals as a mechanism to assess quality, outcomes, and beneficiary access.

Policy experts and state officials supported changes to the renewal requirement but differed on whether the change should be an increase in the renewal time period or the elimination of renewals altogether. One state suggested that for established programs, the renewal period should be longer, perhaps 10 years rather than 5 years. Several policy experts supported increasing the renewal time period, with one interviewee suggesting that 10 years may be the highest renewal time frame that Congress would consider. Another offered to give states the option to select a renewal time period of either 5 or 10 years. We heard from interviewees that a renewal period should not extend beyond 10 years but did not hear consensus around a specific time frame. A few interviewees indicated support for eliminating the renewal requirement, but one policy expert expressed concern that doing so could mean that states would be less inclined to scrutinize their spending under the waiver.

Cost neutrality

Section 1915(c) waivers are unique because they are the only Section 1915 HCBS authority that must comply with a cost neutrality requirement (42 CFR 441.303(f), Section 1915(c)(2)(D)).[11] However, other Medicaid authorities have similar requirements such as budget neutrality in Section 1115. The cost neutrality requirement dictates that the average per-person cost of Medicaid services provided to individuals enrolled in a Section 1915(c) waiver should not be greater than

TABLE 3-3. Summary of Differences in Application Requirements across Section 1915 HCBS Authorities

Requirement	Section 1915(c)	Section 1915(i)	Section 1915(j)	Section 1915(k)
Page length (blank application)	129 pages	19 pages	18 pages	27 pages
Estimated time to complete	163 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 2024c, 2024d, 2017, 2007, n.d.

the average cost of Medicaid services to individuals receiving comparable services in an institution, determined on a per capita basis or in the aggregate (ASPE 2010). States demonstrate compliance with the cost neutrality requirement as part of their annual CMS-372 reports.

Before Section 1915(c) waiver authority was enacted in 1981, there was no statutory pathway for states to provide coverage of LTSS in the community.[12] Interviewees suggested that the statutory requirement for cost neutrality was likely included in the new authority because of concerns about a "woodwork" effect, in which a large number of individuals already eligible for the program would enroll in the program as soon as services were made available (Kaye 2012). We also heard that the requirement was intended to manage spending, given the lack of available data at the time on how costs of providing care in the community would compare to institutional care. Several interviewees considered these concerns outdated because of the now widespread availability of data comparing HCBS costs to institutional care and the prevalence of HCBS programs across the country. Many interviewees shared that states generally meet the cost neutrality requirement, and some interviewees, when asked about the requirement that states demonstrate cost neutrality, supported eliminating the requirement as a way of reducing administrative burden on states.

Because CMS-372 reports are the vehicle that states must use to demonstrate compliance with cost neutrality, we set out to analyze these reports over several years to investigate state success or failure in meeting the requirement. After standardizing the CMS-372 data for comparability purposes, we reviewed 169 Section 1915(c) waivers in 37 states and the District of Columbia. Based on our analysis of three years of data, from 2019 to 2021, all states except one met the cost neutrality requirement in each year across all their Section 1915(c) waivers. One waiver in 2021 did not meet the cost neutrality requirement according to the formula in regulation (42 CFR 441.303(f)(1)).[13] The remaining 168 waivers all showed some level of savings over institutional care. We found that states often had waiver spending that was substantially less than institutional spending. 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 (Table 3-4).

TABLE 3-4. Section 1915(c) HCBS Waiver Expenditures as a Percentage of Institutional Spending, 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: The cost neutrality requirement is met based on the formula D + D′ ≤ G + G′, which is found in 42 CFR 441.303(f)(1). *G* is the estimated annual average per capita Medicaid cost for care in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities that would be incurred for individuals served in the waiver, were the waiver not approved. *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 approved. *D* is the estimated annual average per capita Medicaid cost for home- and community-based services for individuals in the waiver program. *D'* is the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. A total of 169 waivers were included in the analysis.

Source: MACPAC analysis of CMS-372 data, 2023.

Our findings from the analysis of CMS-372 data were further substantiated by interviews with stakeholders. We heard general consensus around states' ability to successfully meet cost neutrality requirements. Federal officials said that although states generally do not encounter challenges with this requirement, if problems arise they are typically related to mistakes such as calculation errors. Some interviewees shared that despite meeting the cost neutrality requirement, some states experienced challenges demonstrating cost neutrality. For example, two states with waivers for beneficiaries with intellectual or developmental disabilities had no ability to demonstrate a comparison to institutional costs within their state since they did not have intermediate care facilities enrolled in the Medicaid program. Those states worked with CMS to identify an approach that would allow them to demonstrate cost neutrality using other states' intermediate care facility costs, meaning that their demonstration of cost neutrality depends on factors outside their control.

As stated previously, the average time for states to complete a Section 1915(c) waiver application is 163 hours (Table 3-3) (CMS 2024d). Eliminating the cost neutrality requirement could reduce administrative burden for states and CMS because information required in Appendix J of applications and renewals demonstrating the lower level of spending on HCBS would no longer be required. We heard that calculating the costs of institutional care to demonstrate cost neutrality in Section 1915(c) waivers can be time consuming. We also heard how reporting cost neutrality data in CMS-372 reports might be burdensome; 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 waiver application, even if that variance does not impact cost neutrality.

A few interviewees noted the benefit of using the cost neutrality test to show that HCBS programs result in lower federal and state spending relative to institutional care. Federal officials shared that states generally meet the cost neutrality requirement and noted that the test can be useful in demonstrating the lower relative spending in HCBS to state leadership, such as when requesting additional funding for HCBS programs from state legislatures. In particular, they suggested that states should be able to use cost neutrality data as a tool to showcase savings from optional HCBS programs.

Although we heard some support for eliminating the cost neutrality requirement as a way of reducing administrative burden, we also heard concerns from CMS officials and others that doing so could increase HCBS spending to the extent that some states constrain their spending based on how it compares to institutional care. Interviewees raised concerns that if states could design their programs without consideration of their costs relative to institutional care, states would potentially increase HCBS expenditures, which would result in increases at both the state and federal levels because of the federal match on state Medicaid spending. However, potential increases in spending could be mitigated by states' ongoing need to operate within their budget parameters. Based on our review of 2019–2021 data, states are already managing their HCBS spending by keeping it below the cost neutrality ceiling. Because states consistently spend below that ceiling, the cost neutrality requirement does not appear to establish a meaningful cap on HCBS spending. Furthermore, states employ cost containment tools available through Section 1915(c) waivers, such as enrollment caps and caps on individual resource allocations to manage spending and enrollment. Section 1915(c) authority also permits states to waive the Medicaid comparability of services requirement and statewideness. These flexibilities, along with the cost containment tools discussed, provide some cost predictability for states (Hayes et al. 2021).

We also spoke with several state associations to get their insights on eliminating the cost neutrality requirement. The responses were mixed, with some states speaking in support of removing the requirement because of the administrative burden and because the purpose of the test is unclear when all states generally meet it. Other states spoke in support of keeping the requirement because of the usefulness of the test for purposes of demonstrating the cost effectiveness of their HCBS programs and, in at least one case, because they do not see the process as administratively burdensome. One policy expert commented that many states recognize that HCBS are more cost effective than providing services in institutional settings and would prefer that HCBS be the default choice for providing LTSS.

The Commission discussed an amendment to Section 1915(c)(2)(D) to eliminate the cost neutrality requirement but ultimately decided not to proceed with a recommendation because the evidence was not conclusively in favor of removing it. Commissioners agreed that the data show most states are meeting the test and that eliminating it could potentially reduce state administrative burden. However, they also found it compelling that the exercise of demonstrating cost neutrality produces a useful data point for states to show that HCBS cost less than care in an institution.

Public input

All Section 1915 HCBS authorities must comply with federal regulations requiring states to issue a public notice of proposed changes to methods and standards for setting Medicaid payment rates (42 CFR 447.205), and each authority also has specific public notice requirements, with the exception of Section 1915(j).

States and policy experts largely valued public input requirements and noted the benefits of stakeholder feedback on changes being made to waivers or SPAs. Interviewees cited public input requirements as being critical in enhancing transparency among states, community partners, and HCBS participants. One state gave an example of where a provider identified some discrepancies in the proposed rate changes in their SPA during the public comment period. The state agency used the feedback to update the rates before submitting the amendment to CMS.

Section 1915(c) authority requires that states establish and use a public comment process for new waivers or amendments consistent with the requirements in 42 CFR 441.304(f). To comply with the public notice requirements, states must (1) share the entire waiver with the public; (2) ensure that there are at least two statements of public notice and public comment, with at least one being web based and at least one being non-electronic; and (3) establish a public notice and comment period of 30 days, to be completed before submission of the waiver to CMS. However, states may choose to go beyond these minimum requirements. The state must share, in the final waiver application to CMS, a summary of responses to public comments and an indication of whether any modifications were made to the waiver as a result of the public comments. Section 1915(i) authority requires states to provide a minimum of 60 days' notice before modifying the needs-based criteria for the state plan option (42 CFR 441.715(c)(1)).

Several interviewees shared challenges encountered by states related to delays caused by the timing of public input requirements. The public input process can lengthen the timeline for implementation of waiver renewals, waiver amendments, and SPAs. Three states noted that the timeline of the public comment period could delay implementation of proposed changes. For example, one state was unable to include a change in a Section 1915(c) waiver renewal due to the length of the public comment period and had to include the change in a subsequent waiver amendment.

One state noted that the technical guidance provided by CMS, such as what constitutes a substantive change to a program, is sometimes insufficient to determine the necessity of a public comment period. This lack of sufficient guidance can impact state planning, as non-substantive changes to Section 1915(c) and 1915(i) authorities can be made retroactively, whereas substantive changes must be prospective. Substantive changes to Sections 1915(c) and 1915(i) authorities are defined in regulations (42 CFR 441.304(d)(1) and 441.745(a)(2)(v)). However, the state noted that the technical guidance is not always clear on when a waiver amendment is considered substantive and requires a public comment period, resulting in state officials having to confirm requirements with CMS. The extent to which other states experience similar challenges is something that could be explored further.

Section 1915(k) authority requires states to consult and collaborate with a development and implementation council, established by the state, in developing and implementing the SPA. The council must include a majority of members with disabilities, older adults, and their representatives (42 CFR 441.575; CMS n.d.). Interviewees had mixed feedback regarding the development and implementation council. Two states discussed the benefits of the council in providing feedback and implementing new programs. One state shared that the council was helpful in determining which optional services to include in their program as well as how to reinvest the enhanced FMAP into the state's HCBS programs. Another state said the council was involved in

discussions with the state regarding program design when the state was initially setting up its Section 1915(k) program. In contrast, some respondents noted challenges with the council. Policy experts explained that some states delayed or chose not to implement a Section 1915(k) SPA because of the requirement to establish a council. One state that operated a development and implementation council experienced difficulties meeting membership requirements and noted challenges with facilitation and encouraging members to participate.

Reporting, monitoring, and quality improvement

Federal requirements related to reporting, monitoring, and quality improvement vary across the four authorities in Section 1915 and may include sending annual reports to CMS, establishing quality improvement processes, and conducting evidence-based reviews. Sections 1915(c), 1915(i), 1915(j), and 1915(k) authorities all have annual reporting and quality improvement requirements, though the way in which states must demonstrate compliance with these requirements varies by authority. For Sections 1915(c) and the 1915(i) authorities that are subject to renewal, states must comply with an evidence-based review process, also referred to as "evidentiary reports," before renewal (CMS 2014).

Annual reports. All four Section 1915 authorities have annual reporting requirements, but the reporting elements and guidance available differ by authority. Reporting requirements for Section 1915(c) waivers are the most prescriptive, and CMS has published extensive technical guidance for states (CMS 2024c). States must complete the annual CMS-372 reports to submit cost, utilization, and performance measurement data for each waiver they administer (CMS 2024f).[14] Almost all states operate multiple Section 1915(c) waivers; the number of waivers by state ranges from 1 to 11, with an average of 5 per state (MACPAC 2024). CMS predicts that the time burden for states to complete one CMS-372 report is 44 hours (CMS 2024c). CMS provides detailed guidance on how to complete the reports and makes the specific reporting elements available publicly (CMS 2024c).

Sections 1915(i) and 1915(j) reporting elements are defined in statute. Section 1915(i) requires annual reporting of the estimated number of enrollees and the count of enrollees from the prior year (42 CFR 441.745(a)(1)(i)). Reporting elements defined in statute for Section 1915(j) include the number of individuals served and total aggregated expenditures (42 CFR 441.464(e)). One factor that may complicate reporting is the absence of a technical guide for these two authorities. However, CMS has indicated that states can use the Section 1915(c) technical guide for Section 1915(i) programs.

Section 1915(k) annual reporting elements are defined in statute and include data on utilization, expenditures, and quality. Data on enrollees served must be stratified by type of disability, age, gender, education level, and employment status (42 CFR 441.580). Unlike Sections 1915(i) and 1915(j), Section 1915(k) has a technical guide; however, it is less comprehensive than the 1915(c) technical guide and does not specify a format or method for reporting data (CMS n.d.). For example, the technical guide includes this instruction to states: "States must collect the information annually and provide the information to CMS upon request. At this time CMS is not prescribing the format in which the information must be submitted" (CMS n.d.). This direction is in contrast to Section 1915(c) authority, for which an extensive technical guide can be referenced (CMS 2024c).

States told us that unclear guidance from CMS on Section 1915(k) authority requirements and the absence of technical guides for Sections 1915(i) and 1915(j) authorities creates ambiguity about reporting requirements across these authorities. In our review and through interviews, we found that written CMS guidance on Section 1915(k) annual reporting requirements is less detailed than that for Section 1915(c) HCBS waivers. However, a CMS official shared that when states express interest in Section 1915(k) authorities, CMS provides one-on-one technical assistance on the data elements that must be reported to comply with statutory requirements. States shared that, though they value technical assistance from CMS, more detailed, written direction could create efficiencies for both states and CMS by giving states clear guidance upfront, preventing the need for ad hoc engagement with CMS. A policy expert we spoke with recommended that CMS develop

technical guides for Section 1915(i) and Section 1915(j) authorities. Though federal and state officials acknowledged that the Section 1915(c) technical guide serves as a reference for Section 1915(i), reporting and monitoring requirements differ between these two authorities, and states may struggle to identify which requirements apply to Section 1915(i) programs (CMS 2024c). A federal official pointed to the lack of a Section 1915(i) technical guide as the "weakest link" in the availability of CMS technical assistance to support state compliance with reporting and monitoring requirements. We heard the same concern from a state official who noted that the absence of such a technical guide causes uncertainty about the authority's requirements. This could also introduce risk for CMS of increased administrative burden as agency staff interpret and reinterpret requirements, particularly as they experience staff turnover.

Evidence-based reviews. Both Sections 1915(c) and 1915(i) authorities require states to comply with an evidence-based review process, also referred to as "evidentiary reports," before renewal (CMS 2014). As part of this process, states submit evidence demonstrating compliance with federal requirements, and CMS completes a findings report; any items identified by CMS must be addressed by the state before the waiver or SPA can be renewed. Under both authorities, states must submit the results of their evidence-based review process to CMS approximately two years before the waiver or SPA expires (CMS 2016, 2014).

Much of the feedback from interviewees centered around challenges using CMS's reporting templates and waiver submission portal. State officials shared that they experience technological and administrative challenges with report templates in CMS's waiver management system, which is used to submit annual CMS-372 reports as well as Section 1915(c) waiver applications, renewals, and amendments. Interviewees also noted the administrative burden associated with preparing evidentiary reports, citing an "antiquated format" (i.e., a Word document), which can make it time consuming to enter the necessary data, and frequent changes to the evidentiary report templates. Even minor tweaks to reporting requirements can require training for staff and change the way data are captured.[15] A CMS official shared, however, that the agency is working to simplify the 1915(c) evidentiary report process by instead asking states to submit Section 1915(c) HCBS performance measurement data in the annual CMS-372 reports, eliminating the need for a lengthy evidentiary report submission from states.

Quality improvement. All Section 1915 HCBS authorities require states to implement quality assurance and improvement systems, though the way in which states must demonstrate compliance with these requirements varies. CMS has similar quality improvement processes, including creating a quality improvement strategy and addressing deficiencies for states operating Sections 1915(c), 1915(i), and 1915(k) authorities, but each authority also has slightly different requirements. For example, Section 1915(c) authority requires states to demonstrate that performance measures meet or exceed a specific threshold of 86 percent in their CMS-372 reports (CMS 2024e).[16] For the other authorities, information on what states should measure and report on quality is limited.

Several state officials shared that they use the reporting and quality monitoring data required by CMS for their own quality improvement purposes. For example, one state shared that it produces several reports for the state legislature and the Community First Choice Advisory Council on quality-based data collected for their Section 1915(k) program. However, interviewees described more challenges than benefits associated with meeting reporting and monitoring requirements, such as technological and administrative challenges with using CMS's reporting templates and waiver submission portal, and unclear or inconsistent guidance from CMS.

Many interviewees referenced the CMS final rule on ensuring access to Medicaid services, which was published on May 10, 2024, and became effective July 9, 2024, as having possible implications for administrative requirements (CMS 2024f). Some state officials, federal officials, and policy experts discussed the potential impacts of the final rule on reporting and monitoring requirements and generally agreed that the rule would standardize reporting and monitoring requirements by mandating state use of the CMS HCBS Quality Measure Set across Section 1915 HCBS authorities. The final rule aligns with policy experts' recommendations that CMS not only work to

standardize the quality measures across authorities but also streamline the types of measures that states need to report. MACPAC commented in support of the quality provisions in the notice of proposed rulemaking (MACPAC 2023b). The Commission noted that requiring the use of the HCBS Quality Measure Set in Section 1915(c) waiver programs would promote public transparency related to the administration of Medicaid-covered HCBS and would enable comparisons across states on quality performance and the calculation of national performance rates for quality of care. The Commission agreed with CMS that aligning quality metrics across HCBS programs could allow for more comparative data (MACPAC 2023b). MACPAC will monitor state efforts to comply with the quality provisions.

Conflict of interest

When the same individual or entity both provides a service and helps beneficiaries access that service, there is a potential for a conflict of interest. Federal requirements are designed to help prevent and mitigate potential conflicts of interest by separating duties and responsibilities, defining clear roles, and safeguarding conflicts of interest (CMS 2018). In particular, each Section 1915 HCBS authority has requirements in place to ensure that case management services are provided in a way that prevents a conflict of interest:

- Section 1915(c) mandates that HCBS providers, or those who have an interest in or are employed by an HCBS provider, cannot provide case management or develop the person-centered service plan (PCSP), except when the state demonstrates the only available entity in a geographic area to provide case management or develop PCSPs also provides HCBS. In such cases, the state must put in place conflict of interest protections (42 CFR 441.301(c)(1)(vi)).
- Sections 1915(i) and 1915(k) dictate that those who conduct eligibility determinations and level of care assessments and develop PCSPs cannot (1) be related by blood or marriage to the individual or paid caregiver, (2) be financially responsible for the individual, (3) be empowered to make financial or health-related decisions for the individual, or (4) have a financial interest in any entity paid to provide care (42 CFR 441.730(b), 441.555(c)). Similar to Section 1915(c), they cannot be providers of HCBS for the same individuals, except where there is only one entity available in a geographic area.
- Section 1915(j) mandates that when providers are also involved in developing PCSPs, the state must describe the safeguards that are in place to ensure that the provider's role is disclosed to the individual or their representative and that controls are in place to prevent a conflict of interest (42 CFR 441.468(d)).

Most interviewees recognized the importance of conflict of interest requirements to ensure that HCBS programs operate with integrity. Although states did not describe these requirements as burdensome, a few interviewees identified instances in which they can be difficult to adhere to. In some rural areas and tribal communities where provider availability is limited, conflict of interest requirements can further limit provider options for beneficiaries, and it is more likely that case management entities are also service providers. For example, one state cited a situation in which the case managers for its Section 1915(k) SPA are affiliated with the one hospital in the area that provides assisted living facility and personal emergency response units. To mitigate potential risks associated with this conflict of interest, the state requires an annual self-audit of the intake materials that are provided to all HCBS enrollees who have case managers affiliated with the hospital. Another state with tribal populations explained that conflict of interest requirements can be a barrier to culturally competent service delivery. Many of the tribal members in the state receiving HCBS prefer to have a provider from their community, which can increase the likelihood that the HCBS provider is also acting as the case management entity.

Some interviewees described a lack of clarity around compliance with conflict of interest requirements, particularly that CMS guidance is not clear on expectations regarding requirements for managed care organizations that provide case management services. Though CMS guidance indicates that conflict of interest requirements generally do not apply to managed care organizations because they

rarely provide services, a national expert shared that several states have indicated a considerable level of questions from CMS through the request for additional information process for Section 1915(c) waivers and Sections 1915(i) and 1915(k) SPAs (CMS n.d.).

Commission Recommendation

The Commission makes the following recommendation to reduce administrative burden associated with renewals under Sections 1915(c) and 1915(i).

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.

Rationale

The renewal process is resource intensive for states and for CMS, but renewals are critical for ensuring state compliance with current policy and overall HCBS program oversight. This policy change would reduce the frequency of renewals that a state is required to complete for Section 1915(c) waivers and Section 1915(i) SPAs, while also maintaining critical components of HCBS program management, such as oversight and public comment opportunities. This policy change is specific to the renewal period and does not change the frequency of other processes such as evidentiary reports.

The 10-year time frame specified in the Commission's recommendation aligns with past practice when select Section 1115 demonstrations were renewed for 10 years, such as the Healthy Indiana 2.0 waiver (CMS 2020b). That time frame also aligns with the Congressional Budget Office's standard 10-year period for budget projections and cost estimates used in the congressional budget process (CBO 2024, Guth et al. 2020). Also, we heard from interviewees that a waiver renewal period should not extend beyond 10 years.

Any potential loss of oversight opportunities as a result of a longer renewal period could be mitigated by other tools that CMS and states have to continually oversee their HCBS programs, such as the CMS-372 reports for Section 1915(c) waivers and CMS review of waiver amendments. In those reports, states share details about Section 1915(c) waiver service utilization and spending, describe deficiencies in performance measures, and propose remediations to address these deficiencies. Separately, the final rule on ensuring access to Medicaid services includes several changes to reporting requirements that are intended to improve monitoring of state compliance with statutory and regulatory requirements (CMS 2024f). The changes are designed to improve the health and welfare of beneficiaries, such as the establishment of a grievance system for services delivered via fee for service, changes to the compliance threshold for PCSPs, and changes to critical incident reporting.

Any lengthening of the renewal period should maintain meaningful opportunity for public engagement. Stakeholders are given an opportunity for public comment on the entire HCBS program at initial approval and at each subsequent renewal. Additionally, any modifications to Section 1915(c) and Section 1915(i) authority between renewals can also provide an opportunity for public input specific to the change, so long as it is considered a substantive change. States and policy experts largely valued public input requirements and noted the benefits of stakeholder feedback on changes being made to waivers or SPAs. Public input requirements were cited as being critical in enhancing transparency among states, community partners, and HCBS participants. The final rule on ensuring access to Medicaid services also includes changes that support public input and transparency (CMS 2024f). These requirements include (1) creating a new public engagement period biennially specific to HCBS quality measure set updates; (2) changing Medical Care Advisory Committees, renamed as "Medicaid Advisory Committees" under the final rule, which could serve as a resource for public engagement if the renewal time frame was extended; and (3) establishing a state website to publicly report

on HCBS program performance, which could be used by interested stakeholders.[17]

States frequently make changes outside of renewals to their Section 1915(c) and Section 1915(i) authorities by submitting an amendment to their program. Federal officials shared that it is uncommon for a state to reach the five-year mark without making an amendment to an HCBS program, and multiple state officials talked about amending their waivers. Finally, extending the renewal period also recognizes that many of these state programs are well established and known for their effectiveness in facilitating community integration for individuals with LTSS needs and supporting beneficiary preference to remain in the community.

Implications

Federal spending. This recommendation could result in decreased state administrative activities and the federal matching funds that states would otherwise claim for those activities, but the Congressional Budget Office could not estimate effects on direct spending without knowing the details of the potential regulatory changes that would result from this policy change.

States. This recommendation would result in decreased administrative burden for states as they would be required to renew their Section 1915(c) waivers and Section 1915(i) SPAs less frequently.

Enrollees. This recommendation would not have a direct effect on Medicaid enrollees. The public comment period associated with the waiver renewal will occur less frequently, every 10 years instead of every 5 years, so there will be fewer opportunities for public comment on the entire waiver, but enrollees can still make public comments when the amendments include substantive changes.

Plans. This recommendation would not have a direct effect on health plans.

Providers. This recommendation would not have a direct effect on providers. The public comment period associated with the waiver renewal will occur less frequently, every 10 years instead of every 5 years, so there will be fewer opportunities for public comment on the entire waiver, but providers can still make public comments when the amendments include substantive changes.

Next Steps

Our work presented in this chapter highlights that administering HCBS programs is complex and can be challenging to navigate for states. HCBS worker shortages and limited state staff capacity further exacerbate these challenges. Many states are administering multiple HCBS programs with limited resources and competing priorities for staff already juggling multiple responsibilities. Our findings show that policy and operational challenges persist.

In the coming years, the Commission will continue to monitor access to HCBS within each domain of our framework and explore ways to reduce administrative complexity for states. In particular, we will work to better understand use of services, taking into account costs, by exploring HCBS utilization and spending for different subpopulations, including HCBS users with intellectual or developmental disabilities and people who are age 65 or older. These data will enhance our knowledge of Medicaid HCBS utilization and spending and identify potential areas for further research.

Endnotes

[1] States are required to cover home health services under Section 1905(a)(7) of the Social Security Act; all other HCBS are optional for states.

[2] States can also provide HCBS through Section 1115 demonstrations. Although Section 1115 demonstrations are subject to some of the same administrative requirements as Section 1915 authorities, Section 1115 is outside the scope of this analysis. Furthermore, federal officials we interviewed shared that they are working to support state HCBS goals via existing Section 1915 authorities; their view was that only when state policy goals cannot be achieved using that authority should Section 1115 demonstrations be considered.

[3] We analyzed calendar years 2019–2021 HCBS Transformed Medicaid Statistical Information System (T-MSIS) data. Total Medicaid spending data used to calculate the share of HCBS expenditures are from a MACPAC 2024 analysis of CMS-64 Financial Management Report net expenditure data as of November 20, 2024.

[4] States are required to cover home health care services under Section 1905(a)(7) and can choose to offer personal

care services as an optional state plan benefit under Section 1905(a)(24).

[5] In addition to Section 1915 authorities, 14 states choose to offer some HCBS via Section 1115 demonstration authority (MACPAC 2020). Under Section 1115, the Secretary of the U.S. Department of Health and Human Services can waive almost any Medicaid state plan requirement under Section 1902 to allow states to make changes to their Medicaid programs as long as the changes are likely to promote the objectives of the Medicaid program. These demonstrations can cover the entirety or a small portion of a state's Medicaid program. Medicaid spending under Section 1115 demonstrations must be budget neutral, meaning that federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (MACPAC 2021).

[6] Interviewees included officials from five states (California, Michigan, Montana, Texas, and Washington); CMS officials; and HCBS policy experts from the National Association of State Directors of Developmental Disabilities Services, ADvancing States, the National Association of Medicaid Directors, the George Washington University Milken Institute School of Public Health, and the U.S. Government Accountability Office.

[7] Interviewees included CMS officials with responsibility over Section 1915 and Section 1115 authorities as well as seven policy experts from academic institutions, think tanks, and independent HCBS consultants.

[8] Section 1915(b) of the Act, enacted in 1981 as part of the Omnibus Budget Reconciliation Act (P.L. 97-35), provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. States can implement managed care delivery using Section 1915(b)(4); states may use waivers to limit the number or type of providers who can provide specific Medicaid services—for example, for disease management or transportation. This includes selective contracting by states paying providers on a fee-for-service basis. Freedom of choice cannot be restricted for providers of family planning services and supplies.

[9] *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

[10] Substantive changes to Section 1915(c) waivers and Section 1915(i) state plan options are defined in regulations at 42 CFR 441.304(d)(1) and 42 CFR 441.745(a)(2)(v), respectively. Substantive changes for both authorities include revisions to services available under the benefit, such as elimination of or reduction in services; changes in the scope, amount, and duration of services; changes in the qualifications of service providers; changes in rate methodology; and changes in the eligible population.

[11] Cost neutrality is defined as "the annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the estimated annual average per capita expenditures of the cost of services in the absence of the waiver" (42 CFR 441.303(f)).

[12] States have been able to cover home health services since the establishment of the Medicaid program in 1965 under Section 1905(a)(7); the home health benefit became mandatory in 1970 (Social Security Amendments of 1967, P.L. 90-248).

[13] The equation set forth in 42 CFR §441.303(f)(1) specifies the components of the cost neutrality equation: $D + D' \leq G + G'$. The symbol "≤" means that the result of the left side of the equation must be less than or equal to the result of the right side of the equation. *D* is the estimated annual average per capita Medicaid cost for HCBS for individuals in the waiver program. *D′* is the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. *G* is the estimated annual average per capita Medicaid cost for care in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities 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.

[14] States must submit annual CMS-372 reports for all Section 1915(c) waivers that they operate. In CMS-372 reports, states report details about Section 1915(c) waiver service utilization and spending, calculate cost neutrality, describe deficiencies in performance measures, and share proposed remediations to address these deficiencies.

[15] As part of the evidence-based review process, CMS sends a letter requesting evidence from the state (based on performance measures that were included in the approved authority) demonstrating that the authority is operating in compliance with federal requirements. States must report evidence demonstrating that they complied with all assurances, using the results of performance measures included in their applications. The assurances include

administrative authority, level of care, qualified providers, service plan, health and welfare, and financial accountability.

[16] The CMS-372 reports aggregate statistics on enrollment and spending under HCBS waivers. The CMS final rule on ensuring access to Medicaid services increases the threshold from 86 percent to 90 percent, effective July 2027 (CMS 2024f).

[17] The final rule also expanded the scope of the topics to be covered by the Medicaid Advisory Committees to include policy development and effective program administration (CMS 2024f). The final rule also requires states to establish a corresponding Beneficiary Advisory Council, to be composed of beneficiaries and their families and caregivers.

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APPENDIX 3A: Comparing Section 1915 Authorities

TABLE 3A-1. Summary of Similarities and Differences in Flexibilities Allowed by Sections 1915(c), 1915(i), 1915(j), and 1915(k)

Flexibilities	Similarities	Differences
Requirements that may be waived or disregarded	• All four Section 1915 HCBS authorities allow states to waive at least one Medicaid program requirement from Section 1902 of the Social Security Act	• Section 1915(c) waivers allow states to waive statewideness, comparability of services, and community income rules for medically needy populations • Section 1915(i) state plan options can waive comparability of services and community income rules for medically needy populations • Section 1915(j) state plan options can waive statewideness and comparability of services • Section 1915(k) state plan options can waive community income rules for medically needy populations
Limits on number of enrollees served	• HCBS authorities vary on whether they allow limits on the number of individuals who receive HCBS • None of the HCBS authorities can place limitations on the numbers served by population subgroup	• Section 1915(c) and Section 1915(j) allow for limits on the number of enrollees (42 CFR 441.303(f)(6), 42 CFR 441.462(c)) • Section 1915(i) and Section 1915(k) authorities cannot limit enrollment, and services must be offered statewide[1]
Waiting lists	• No similarities	• States may establish waiting lists when demand exceeds the program's approved capacity for Section 1915(c) waivers and Section 1915(j) state plan options • States may not create waiting lists for Section 1915(i) and Section 1915(k) state plan services

TABLE 3A-1. (continued)

Flexibilities	Similarities	Differences
Caps on individual resource allocations or budgets	• Sections 1915(i), 1915(j), and 1915(k) state plan options do not allow caps on individual resource allocations but can determine the process for setting individual budgets for participant-directed services	• Section 1915(c) waivers are the only authority that allows caps on individual resource allocations or budgets

Notes: HCBS is home- and community-based services.

[1] Although states cannot limit enrollment in a Section 1915(i) state plan amendment like they can with a Section 1915(c) waiver, Section 1915(i) authority grants states the ability to restrict the needs-based eligibility criteria if enrollment in Section 1915(i) exceeds the estimated enrollment from the state plan amendment application.

Sources: 42 CFR 441.301(a)(2), 441.303(f)(6), 441.305(a), 441.462, 441.462(c), 441.472(a), 441.515, 441.560(b), 441.710(e), 441.745(a)(1)(ii), 441.745(a)(1)(ii)(C).

Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on January 24, 2025.

Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services

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.

3.1 voting result	#	Commissioner
Yes	16	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Nardone, Snyder
Vacancy	1	