



# **ADDRESSING COMMON CHALLENGES WITH FISCAL ACCOUNTABILITY REQUIREMENTS IN 1915(c) WAIVER APPLICATIONS**

**Division of Long-Term Services and Supports**

**Disabled and Elderly Health Programs Group**

**Center for Medicaid & CHIP Services**

# Training Objectives

- Provide an overview of 1915(c) Home and Community-Based Services (HCBS) waiver programs, fiscal integrity, cost neutrality, and rate determination.
- Review federal requirements for addressing key fiscal accountability appendices (I and J) of the 1915(c) waiver application.
- Discuss common challenges with completing the fiscal accountability portions of the waiver application and highlight key elements for states to consider when completing these appendices.
- Review current events impacting 1915(c) waiver programs and discuss strategies for updating waiver appendices to capture program changes.

# Overview of 1915(c) Waiver Programs & Fiscal Accountability

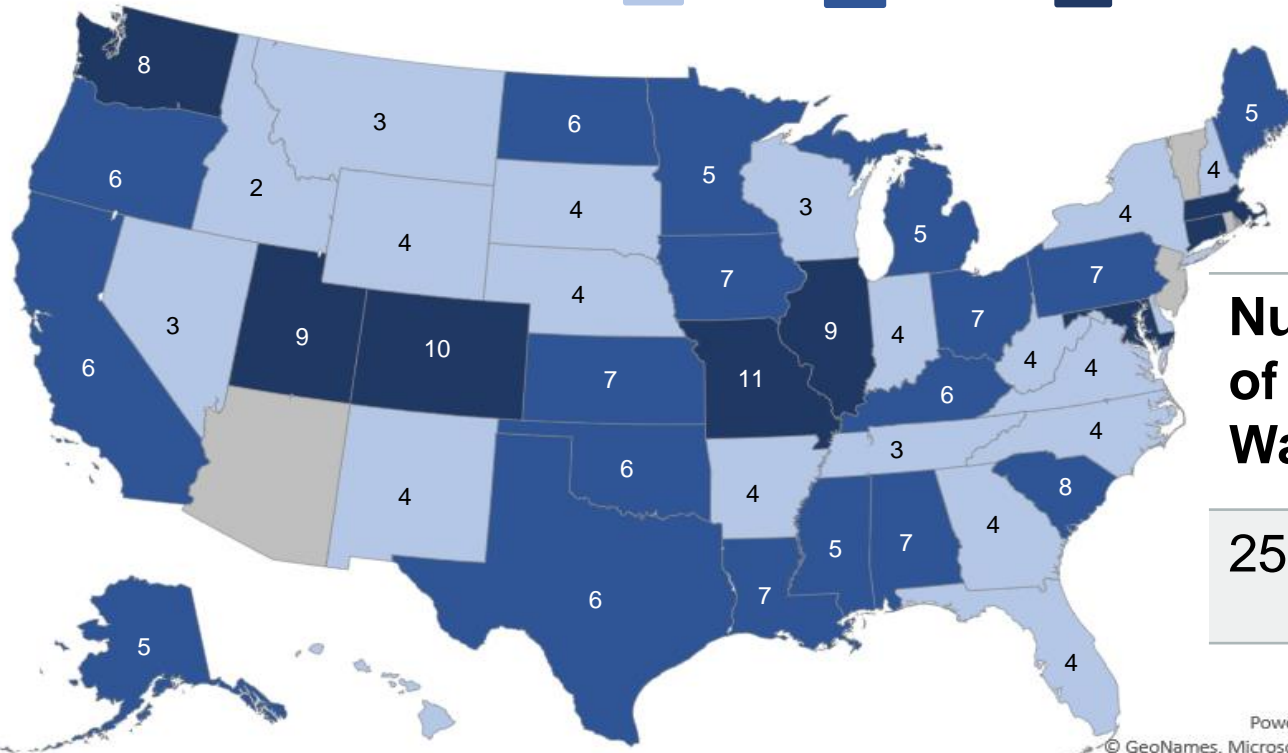
# 1915(c) HCBS Waiver Programs

- States administer Medicaid waiver programs authorized under §1915(c) of the Social Security Act (the Act) to meet the needs of individuals who prefer to receive services and supports in their community, rather than in an institutional setting.
- States determine 1915(c) waiver program goals, target populations, and waiver services based on the unique needs of Medicaid beneficiaries eligible for services.
- Most states operate multiple waivers with broad discretion to design programs most appropriate to address the needs of their target populations.

# Current Landscape of 1915(c) Waiver Programs

## Number of 1915(c) Waiver Programs Operated by the States\*

Number of Waivers     1- 4     5 - 7     8 - 11



Number of Active Waivers	Number of States
257	47

Powered by Bing  
© GeoNames, Microsoft, TomTom

\*Note: Number of Waivers – CT: 10, DE: 1, DC: 3, HI: 1, MD: 8, MA: 10. Grey states (AZ, NJ, and VT) do not operate programs under the 1915(c) HCBS waiver authority. All data current as of 3/31/22.



# Financial Integrity and Accountability in 1915(c) Waiver Programs

- States must assure the integrity of payments made for waiver services.
  - States are responsible for monitoring waiver service delivery to verify that billed services were actually rendered and to protect against fraud, waste, and abuse.
- States must have established processes and methods for ensuring the integrity of payments made for waiver services.
  - States are required to detail post-payment review and monitoring processes including the scope, methods, and frequency of such reviews in Appendix I-1 of the 1915(c) waiver application.
- States adding new services, modifying services to allow for remote delivery, or allowing for delivery of care by family caregivers must ensure that there are monitoring processes in place that align with the state's method for conducting post-payment reviews.

# Cost Neutrality

- §1915(c)(2)(D) of the Act requires that the state assure that the average per capita expenditures under the waiver during each waiver year do not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in a hospital, nursing facility, or ICF/IID under the state plan had the waiver not been granted.
- For a 1915(c) waiver to be approved, the state must demonstrate, as part of the waiver review process, that the waiver is cost neutral during each year that the waiver is in effect.
  - Appendix J-1 provides a composite overview of the cost neutrality formula.
  - Appendix J-2 contains the basis of estimates and waiver program cost estimates.

# 1915(c) Waiver Service Rate Determination

- States must describe the methods employed to establish provider payment rates for waiver services and the entity or entities responsible for rate determination.
  - States must specify if rate setting methodologies vary among waiver service offerings.
  - States' changes to rate setting methodologies must be prospective and are subject to public notice and comment in accordance with 42 CFR § 447.205 and 42 CFR § 441.304(d)(1)(2).
  - States must have a rate review process to ensure that payment rates remain in compliance with §1902(a)(30)(A) of the Act (“payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers...”).



# Common Challenges When Completing 1915(c) Waiver Applications

- Over the past 5 years, CMS has identified common fiscal accountability topics in which additional information was needed from states as part of the 1915(c) waiver application submission process.
- Omission of details relating to post-payment review methods, rate documentation, and the basis of states' cost neutrality calculation led to commonly asked questions in the following areas:

## Most Commonly Requested Information

Appendix I-1	Appendix I-2-a	Appendix J-2-c
<ul style="list-style-type: none"> <li>• Independent audit of financial statements requirements</li> </ul>	<ul style="list-style-type: none"> <li>• Rate determination methods</li> </ul>	<ul style="list-style-type: none"> <li>• The basis of Factor D, D', G, and G' estimates</li> </ul>
<ul style="list-style-type: none"> <li>• Post-payment review methods, scope, and frequency</li> </ul>	<ul style="list-style-type: none"> <li>• Public comment requirements</li> </ul>	<ul style="list-style-type: none"> <li>• Documenting and applying the growth trend to Factor estimates</li> </ul>

# Technical Guidance, Requirements, and Key Elements for Completing Appendix I-1

# Appendix I: Financial Integrity and Accountability

- Appendix I-1 of the 1915(c) waiver application requires states to complete a text field with information relating to the integrity of payments made for waiver services.
- **The state must describe its process to ensure fiscal integrity in the waiver, including:**
  - A post-payment review program description, including the methods, scope, and frequency of reviews that are conducted.
  - Financial statement audit requirement.
  - The agency (or agencies) responsible for conducting the periodic independent audit of the waiver program as required by the Single Audit Act.

# Appendix I-1 Audit and Review Requirements

**States must submit information relating to three separate review and audit requirements in Appendix I-1 of the waiver application.**

## Appendix I-1 Audit Requirements

Audit/Review Requirement	Requirement Details
Financial Statement Audit Confirmation	States must confirm whether providers are required to secure a financial statement audit.
Post-Payment Review Description	States must provide a description that includes methods, scope, and frequency of review activities to detect and prevent fraud, waste, and abuse.
Entity Responsible for Performing the Single Audit Act	A <b>Single Audit</b> , previously known as the OMB Circular A-133 audit, is an audit of organization-wide financial statements and federal awards for a non-federal entity that expends \$750,000 or more in federal funds in one year. States must confirm who is responsible for conducting the audit.

# Appendix I-1: Challenges in Documenting Post-Payment Review Program

- **States must include the methods, scope, and frequency of post-payment reviews:**
  - **Methods:** Methods for validating payments and addressing findings, including reviewing claims data, confirming services are documented, and verifying provider qualifications.
    - Examples: Record reviews, desk reviews, utilization reviews, review of financial management services (FMS) entity, etc.
  - **Scope:** Description of the sample for post-payment reviews and elements included in review.
    - Example: A state notes a statistically representative sample of provider claims are reviewed with a 95% confidence interval
  - **Frequency:** Specifies how often post-payment activities are conducted.
    - Example: Reviews are conducted quarterly.

# Appendix I-1: Key Elements

States should consider the following items when reviewing or updating Appendix I-1.

Element	Description
Timeframe and Frequency of Review <i>(Post-payment review)</i>	Time (year of data reviewed and length of time) of data in scope of review and how often reviews are conducted
Scope/Data Selection <i>(Post-payment review)</i>	Description of the sample for post-payment reviews and elements included in review.
Method of Review <i>(Post-payment review)</i>	Detail post-payment review methods
Electronic Visit Verification <i>(Post-payment review)</i>	Description of role of EVV in waiver service oversight and review if the state offers personal care services and/or home health care services
Post-Payment Review Results <i>(Post-payment review)</i>	Identification of how results are communicated to providers

# Appendix I-1: Key Elements (Cont.)

States should consider the following items when reviewing or updating Appendix I-1.

Element	Description
Corrective Action Plans <i>(Post-payment review)</i>	Discussion of how corrective plans are delivered and enforced
Financial Audit <i>(Financial Statement Audit)</i>	A statement confirming whether providers are required to secure a financial statement audit
Independent Audit of Waiver Program <i>(Single Audit Act)</i>	Identification of entity responsible for conducting periodic independent audit in accordance with the Single Audit Act

# **Technical Guidance, Requirements, and Key Elements For Completing Appendix I-2-a**



# Appendix I-2-a: Rate Determination Methods

- Appendix I-2-a requires states to detail waiver service rate determination methods. Rate setting is the process for determining a payment amount that a payer reimburses a provider for the provision of a waiver service.
- **The state must describe the rate determination methodology including:**
  - Rate setting methods for *each* waiver service.
    - Common methods include: fee schedule, negotiated market rate, tiered rates, bundled rates, and cost reconciliation rates.
  - Entities responsible for rate determinations.
  - The year rates were set and the year they were last reviewed.
  - How public comments are solicited.
  - How payment rates are made available to individuals.
  - Rate review methods and process.

# Appendix I-2-a: Rate Determination Methods (Cont.)

- States determine the payment amount providers will receive for delivering services under the waiver authority.
- Details of the rate methodology must include inputs regarding cost assumptions and data that were used to establish the rate.
- Proper rate setting enables the state to:
  - Establish deliberate approaches for how each service is paid.
  - Develop methods to ensure proper post-payment review.
  - Develop means for monitoring service utilization.

# Appendix I-2-a Review Criteria

- **States must include a rate setting methodology description for each waiver service.**
  - States are required to have a rate setting methodology for each waiver service and each service must be included in the state's Appendix I-2-a description.
  - States must update Appendix I-2-a when adding new services to capture the rate setting methodology used to establish payment rates.
  - States should include the requisite detail needed for CMS and stakeholders to clearly understand how the state sets and reviews rates for each waiver service.

# Appendix I-2-a: Review Criteria (Cont.)

- **States must address the following when describing the rate methodology.**
  - Provide a rate setting methodology description for each waiver service.
  - Indicate when current rates were set and/or when they will be rebased.
  - Document how the Medicaid agency solicits public comments on rate determination methods.
  - Document what cost factors were used to develop the rate and how the final rate was calculated.

# Appendix I-2-a: Key Elements

States should consider the following items when reviewing or updating Appendix I-2-a.

Element	Description
Rate Setting Methodology	Methodology used (e.g., fee schedule, negotiated market price, etc.) for each waiver service
Data Sources	Sources used to determine rates
Cost Factors and Cost Assumptions	If applicable, the factors and assumptions used to determine rates
Tiered Rate: Cost Assumptions	If tiered rates are used, the difference in cost assumptions made for each respective tier
Differences between Agency and Self-Directed	Identification of differences between agency and self-directed services rate setting, if any
Rate Methodology Timeline	Identification of when the methodology was set
Last Reviewed	Identification of when the rates were last reviewed
Rate Review Methods	Description of rate review methods used at least every 5 years

# **Technical Guidance, Requirements, and Key Elements for Completing Appendix J-2-c**

# Appendix J-2-c: Derivation of Estimates of Each Factor

- Appendix J-2-c provides the derivation of estimates for each Factor in the cost-neutrality formula. States are to describe trend factors, data sources, and justification for using sources outside of CMS-372 reports.
  - **Factor D:** Estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.
  - **Factor D’:** Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.
  - **Factor G:** Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/IID care that would be incurred for individuals served in the waiver, were the waiver not granted.
  - **Factor G’:** 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.
  - **Cost Neutrality Formula:**  $D+D' \leq G+G'$ .

# Appendix J-2-c: Cost Neutrality Factors

- **States must demonstrate the cost neutrality of the waiver in Appendix J-2-c by including:**
  - The basis and methodology for determining Factor D, D', G, and G'.
  - If Factor D' is not greater than or equal to Factor G', an explanation for the difference.
  - If Factor D' is developed through sampling a comparable population, information on the process used and how Factor D' was derived.
  - The projected first year Factor D, D', G, and G' value(s) does not deviate substantially from historical data or CMS-372(S).
  - Explanations of deviations from CMS-372(S) reports.
  - The basis or source of growth rate calculations for Factors D, D', G, and G'.



# Appendix J-2-c: Review Criteria

- **States must provide sufficient information for all Factors. States should:**
  - Provide a detailed description of the basis for estimates.
  - Explain growth rate data sources used to trend forward estimates for Factors D', G, and G'.
  - Describe discrepancies between CMS-372(S) reports and Factor estimates.
  - Verify that the basis described in Appendix J-2-c matches Factor estimates reported in Appendix J-1 and/or service estimates detailed in Appendix J-2-d.

# Appendix J-2-c: Review Criteria (Cont.)

- **States must provide adequate detail to describe the basis of waiver service and program estimates (Factor D).**
  - States must detail the basis for waiver service estimates including a description that includes how the state estimated the number of users, average units per user, and average cost per unit for each waiver service.

# Appendix J-2-c: Key Elements for Documenting Factor Estimates Basis

States should consider the following items when reviewing or updating Appendix J-2-c.

Element	Description
Sources of the Baseline (WY1) Estimate Value	<ul style="list-style-type: none"><li>• The source for the baseline for each Factor</li></ul>
Data Source and Growth Rate Percentage	<ul style="list-style-type: none"><li>• Description of the data source and growth percentage used to trend baseline and annual estimates</li></ul>
Factor D	<ul style="list-style-type: none"><li>• Basis and/or data source used to calculate Factor D estimate (number of units, units per user, average cost, and average length of stay)</li><li>• Factor derivation (Appendix J-2-c) aligns with estimates in Appendix J-2-d</li></ul>

# Appendix J-2-c: Key Elements for Documenting Factor Estimates Basis, Continued

States should consider the following items when reviewing or updating Appendix J-2-c.

Element	Description
Factor D'	<ul style="list-style-type: none"><li>• Growth rate and Factor derivation (Appendix J-2-c) must align with Appendix J-1</li><li>• Detail the process, basis, and data sources for calculating estimates</li></ul>
Factors G and G'	<ul style="list-style-type: none"><li>• Growth rate and Factor derivation (Appendix J-2-c) must align with Appendix J-1</li><li>• Description of cost neutrality formula must be for a comparable population</li><li>• A description when Factor G' is greater than or equal to Factor D'</li></ul>

**COVID-19 Public Health Emergency (PHE),  
Appendix K, the American Rescue Plan  
(ARP), and Their Impact on the Fiscal  
Accountability of 1915(c) Waivers**

# The American Rescue Plan Act of 2021

- The American Rescue Plan Act of 2021 was passed in March 2021 and contained Medicaid HCBS provisions intended to increase coverage, expand benefits, and provide additional federal funding to support HCBS.
- States are required to submit a proposal and quarterly spending plans detailing how the state plans to enhance, strengthen, and expand HCBS and estimate projected expenditures for ARP related activities.
- States expanding HCBS and maintaining eligibility and maintenance of effort requirements are eligible for a 10% increase in federal matching funds.
  - States must use additional funding to supplement, not supplant state level HCBS funding.
  - States shall implement one or more activities which enhance, expand, or strengthen HCBS programs.

# Section 9817 and Maintenance of Effort (MOE)

- A 10-percentage point FMAP increase for HCBS is made available through section 9817 of the ARP for states maintaining and preserving HCBS in accordance with the following maintenance of effort criteria:
  - States cannot impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than those in place as of April 1, 2021.
  - States must preserve covered HCBS, including the amount, duration, and scope of services, in effect as of April 1, 2021.
  - States must maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

# Payment Modifications & Maintenance of Effort (MOE)

- States cannot reduce rates or restrict access to HCBS in order to qualify for the increased FMAP.
  - For example, a state may not increase rates for all home-based services but reduce waiver slots and decrease existing service limits.
  - States consolidating or tiering service rates must demonstrate that the consolidation does not decrease payment rates in the aggregate.
  - States implementing rate increases to agency-based services must also implement proportional increases for individual budget amounts and service limits for participants who chose to self-direct to preserve access to service.
- States must evaluate proposed rate modifications or increases to assess impact on:
  - Other target groups receiving similar services within the state
  - Participant services authorized in the person-centered service plan
  - Program participants who self-direct services



# Appendix K and the Public Health Emergency (PHE)

- In response to the PHE, states submitted Appendix K applications to make time-limited changes to waiver programs in response to the COVID-19 PHE.
  - Appendix K submissions provided states with the flexibility to make programmatic changes such as adding services, expanding waiver capacity, and modifying service delivery methods to better respond to the PHE.
  - Common changes implemented as part of Appendix K often had fiscal accountability and fiscal integrity impacts that must be accounted for in upcoming amendments and renewals as the waiver matures, PHE expires, and states extend new flexibilities.
  - States also used Appendix K to effectuate changes proposed in ARP spending plans.

# Waiver Updates through Appendix K & ARP

States are now planning and implementing permanent new initiatives based on temporary flexibilities exercised using Appendix K and ARP funds which will impact Appendices 1-1, I-2-a, and J-2-c. Common changes include:

## Common Changes in Appendix K & ARP Spending Plans

Modified Payment Rates and Methods

Modified Cost Limits

Additional Waiver Services

Increased Waiver Slots

Expanded Scope of Services

Telehealth and Remote Delivery

# Modified Payment Rates and Methods

- Throughout the COVID-19 PHE, states submitted Appendix K submissions and ARP spending plan proposals to propose or implement payment modifications, new payment initiatives, and/or rate increases to support provider networks and expand access to HCBS.
  - For example, states proposed a variety of payment proposals to support direct support workers including workforce retention payments, provider sign-on bonuses, vaccination incentives, and other initiatives to strengthen and expand provider networks.
- States may not effectuate changes in payment rate methods unless they are a component of the approved rate methodology.
- States amending waivers to extend or make permanent rate changes must update Appendix I-2-a and Appendix J-2-c.

# Modified Payment Rates and Methods (Cont.)

- States' changes to rate setting methodologies must be prospective and are subject to public notice and comment in accordance with 42 CFR § 447.205 and 42 CFR § 441.304(d)(1)(2).
- Rate changes proposed as part of Appendix K or 1915(c) waiver amendment or renewal can only be effectuated in fee for service (FFS) payment models and cannot be implemented for managed care.
- States are required to review waiver service payment methodologies and rates, at a minimum, every five years to ensure that rates are sufficient to maintain an adequate provider base qualified to deliver services.

# Modified Cost Limits

- States increased service cost and authorization limits, particularly for services with a negotiated market pricing methodology, to allow for higher service utilization and to account for changes in service scope.
  - For example, a state modified its assistive technology service to allow for additional device purchases to better facilitate remote delivery of services.
- States amending or renewing waivers to include modified cost limits should update:
  - Appendix I-2-a to document changes to the rate-setting methodology (if applicable)
  - Appendix J-2-c to document how the state factored the modified cost limits into program expenditure projections

# Additional Waiver Services

- Some states proposed new waiver services as part of their section 9817 spending plans to strengthen, enhance, and expand HCBS programs, such as transitional case management services, to facilitate the transition from institutions to HCBS.
  - States should evaluate rate methodologies for existing services to determine if one of the existing rate methodologies is appropriate for the new service(s). For example, if a state administers cost surveys to assess provider costs, the state should evaluate whether this approach is appropriate for the new service.
- States adding new waiver services must establish a rate setting methodology for the new service and must also provide an estimated methodology for projecting demand and service utilization.
  - States can review participant feedback, similar services in other waivers, and historical data for previously added services to help assess demand and project utilization estimates.

# Increased Waiver Slots

- Multiple states have proposed through their section 9817 spending plans increasing waiver capacity or slots to help alleviate waiting lists and expand access to HCBS.
- States expanding capacity or adding slots must account for increased demand in both the unduplicated participant counts (Appendix J-2-a) and waiver service utilization (Appendix J-2-d).
- States adding waiver participants must account for this addition in the Factor D estimate and Factor D derivation description in Appendix J-2-c.
- States must develop estimates that account for increases in waiver participants and must assess existing provider networks to determine service capacity and to estimate demand and utilization for services after new participants are onboarded.

# Expanded Scope of Services

- State ARP spending plans and Appendix K applications indicate that states are modifying service specifications to allow for more flexibility and adaptability to meet participant needs.
  - States proposed expanding self-direction opportunities to offer additional waiver services eligible for self-direction.
  - States expanded family caregiver programs to allow for more services and populations to be served by relatives and legal guardians.
- States should update rate setting methodologies (if applicable) to account for any changes or expansion in the scope of services.
- States must reflect any projected changes in demand for services in Appendix J-2-c and Appendix J-2-d.



# Telehealth and Remote Delivery

- Through lessons learned over the course of the COVID-19 PHE, states have proposed as part of their section 9817 spending plans to continue and/or implement new remote service delivery options.
- States expanded services to allow for more telehealth opportunities and remote delivery to promote flexibility, address safety concerns, and expand provider networks.
- States amending or renewing applications to include remote flexibilities and/or telehealth should update:
  - Appendix I-1 to detail the oversight processes for remote services
  - Appendix I-2-a to highlight rate methodology impacts
  - Appendix J-2-c to describe the basis for remote service estimates

# Summary & References

# Summary

- States must report on key fiscal accountability processes and strategies as part of the 1915(c) waiver application process.
- States must establish and clearly document financial statement audit requirements and post-payment review processes to assure the integrity of payments made for waiver services.
- States must detail a rate setting methodology, rate review methods, and growth rate expectations for each waiver service.
- States must include a detailed description of each of the cost neutrality factors including a breakdown of the waiver service estimate derivation and other factors that demonstrate 1915(c) waiver cost neutrality.
- Current events such as COVID-19 and other economic factors are impacting financial accountability and fiscal integrity processes which will require states to make updates to 1915(c) waiver programs and the waiver application.

# References

1. 1915(c) Home and Community-Based Waiver Instructions, *Technical Guide and Review Criteria (January 2019)*, Available online: [Instructions Technical Guide and Review Criteria \(cms.gov\)](#)
2. Centers for Medicare & Medicaid Services, *DLTSS Training: Appendix J Training: Documenting the Basis of Factors D', G, and G' in 1915(c) Waiver Applications* : <https://www.medicare.gov/sites/default/files/2019-12/documenting-basis-factors-d-prime-g-g-prime-1915c.pdf>
3. Centers for Medicare & Medicaid Services, *Documentation of Rate Setting Methodology*, Available online: <https://www.medicare.gov/sites/default/files/2019-12/hcbs-1b-transparent-documentation.pdf>
4. Centers for Medicare & Medicaid Services, *Financial Accountability*, Available online: <https://www.medicare.gov/sites/default/files/2019-12/hcbs-9-financial-accountability.pdf>

# References (Cont.)

5. Centers for Medicare & Medicaid Services, *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency*, Available online: <https://www.medicare.gov/federal-policy-guidance/downloads/smd21003.pdf>
6. Centers for Medicare & Medicaid Services, *Appendix K Instructions* Available online: <https://www.medicare.gov/state-resource-center/downloads/1915c-appendix-k-instructions.pdf>

# For Further Information

---

**For further information, contact:**

[HCBS@cms.hhs.gov](mailto:HCBS@cms.hhs.gov)