



ACCOUNTING FOR THE PUBLIC HEALTH EMERGENCY, ECONOMIC TRENDS, AND THE IMPACT OF THE AMERICAN RESCUE PLAN IN 1915(C) WAIVER PROGRAMS

Division of Long-Term Services and Supports

Disabled and Elderly Health Programs Group

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Training Objectives

- Provide an overview of Medicaid Home and Community-Based Services (HCBS) 1915(c) waiver programs and highlight program responses to the COVID-19 Public Health Emergency (PHE).
- Discuss state Appendix K submissions, American Rescue Plan (ARP) spending plans and other state updates to 1915(c) HCBS waiver programs.
- Review relevant federal financial integrity and accountability requirements for 1915(c) waiver programs.
- Highlight state fiscal integrity and financial accountability considerations for states modifying waiver services and payment rates.
- Provide examples and review strategies for projecting waiver service utilization and factoring program updates into waiver estimates during the PHE and beyond.

Overview of 1915(c) Waiver Programs

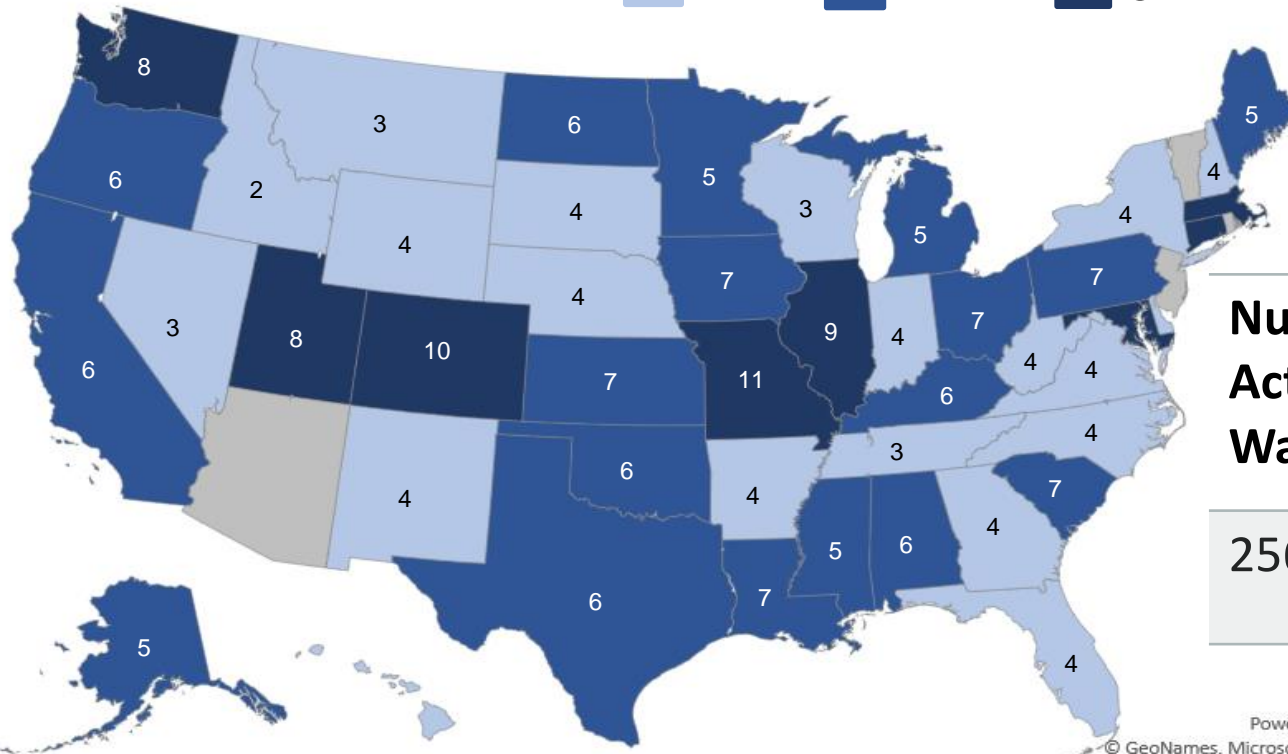
1915(c) HCBS Waiver Programs

- States administer Medicaid Home- and Community-Based Services (HCBS) 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 target populations-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
256	47

*Note: Number of Waivers – CT: 10, DE: 1, 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 11/30/21.

Financial Integrity and Accountability Requirements for 1915(c) Waiver Programs

Financial Integrity in 1915(c) Waiver Programs

- 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 the 1915(c) waiver application.
- States adding new services or modifying services to allow for remote delivery must ensure that there are monitoring processes in place that align with the state's post-payment review program.

Appendix I: Financial Integrity and Accountability

- In addition to providing post-payment review details, states must also include a fiscal integrity summary description that specifies:
 - A statement that assures independent financial audit requirements are conducted for provider agencies.
 - A post-payment review program description, including the methods, scope and frequency of reviews that are conducted.
 - The agency (or agencies) responsible for conducting the periodic independent audit of the waiver program as required by the Single Audit Act.

Rate Determination Methods

- 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 amongst 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...”).
- States must also submit for approval an amendment or a renewal for any rate modification, including to a rate methodology, that includes a rate setting explanation for rate modifications or a rate methodology for new services.

Appendix J: Cost Neutrality Demonstration

- States must demonstrate the cost neutrality of the waiver in Appendix J.
 - §1915(c)(2)(D) of the Act requires that the state assure that the average per capita expenditure under the waiver during each waiver year 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.
- 42 CFR §441.302(e) requires that the expenditures upon which the cost neutrality demonstration are based be reasonably estimated and well documented and that the estimate must be annualized and cover each year of the waiver period.

Appendix J: Factor D

- Factor D represents the estimated annual average per capita Medicaid cost for 1915(c) HCBS for individuals in the waiver program.
- Factor D is calculated by dividing total annual program expenditures by the number of unduplicated participants in a waiver year.
- States must describe the basis and methodology used to calculate waiver program estimates for various components that comprise Factor D including:
 - The estimated number of waiver participants who use a service
 - The average units per user per waiver service
 - The average cost per unit for waiver services

Amending or Updating Waiver Programs

- States seeking, through an amendment or waiver renewal, to add new services, modify existing services, add waiver capacity, and/or make other changes that could impact service delivery and demand must account for fiscal integrity and financial accountability requirements highlighted on previous slides.
 - For example, a state that adds a new waiver service must establish and report a rate setting methodology, develop monitoring processes, and project estimated service utilization.
- States modifying payment rate methodologies previously not accounted for in the Appendix J estimates, must describe the basis for such changes in Appendix I and estimate the impacts of these modifications in Appendix J.

1915(c) Waiver Programs, Appendix K, American Rescue Plan Act, and the COVID-19 Public Health Emergency

1915(c) Program Response and the COVID-19 PHE

- As described on the Medicaid.gov American Rescue Plan Act of 2021 Section 9817 landing [page](#), *“The COVID-19 PHE laid bare the risks of institutional and congregate settings for older adults and people with disabilities, underscoring the urgent need to reduce the reliance on institutional services and expand access to high-quality home and community-based services (HCBS) to improve outcomes for people with long-term services and supports (LTSS) needs.”*
 - *“On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS beginning April 1, 2021, and ending March 31, 2022.”*

Emergency Preparedness and Response for HCBS 1915(c) Waivers – Appendix K

- States utilized Appendix K applications during the PHE to request temporary time-limited amendments to their approved 1915(c) waivers to make emergency related changes to waiver programs to better respond to the public health emergency.
- States made changes to 1915(c) programs with an aim to protect participant health and welfare, expand service access, and maintain adequate provider networks as states address challenges associated with the COVID-19 pandemic.
- Appendix K submissions include four main sections:
 - **Appendix K-1:** General Information
 - **Appendix K-2:** Temporary or Emergency-Specific Amendment to Approved Waiver
 - **Section A:** Services to be Added/Modified During an Emergency
 - **Appendix K Addendum:** COVID-19 Pandemic Response

Appendix K Submissions

- As of November 30, 2021, all 47 states submitted at least one Appendix K document in response to the COVID-19 PHE.
- The below table represents common Appendix K submission changes.

Common Change in Appendix K	State Example
Modified Payment Rates and Methods	States temporarily increased rates for situations in which the participant or someone in the participant’s household was quarantined because of COVID-19, to account for operational and cleaning costs associated with home-based services.
Modified Cost Limits	States temporarily modified program cost limits to allow for increased utilization of services, as needed to account for temporary increases in demand for services.

Most Common Appendix K Changes (Cont.)

Common Change in Appendix K	State Example
Utilized Retainer Payments	States offered retainer payments to support day services, habilitation services, and supported living services and provider networks.
Added New Waiver Services or Modified Scope and Coverage of Existing Services	States updated service specifications to allow for remote delivery of therapy and supported employment services.
Altered Provider Qualifications	States modified provider qualifications to allow for relatives/family members to render paid supports.

American Rescue Plan Act of 2021 (ARP)

- A 10-percentage point increase for HCBS of FMAP is available through Section 9817 of the ARP when they meet the following criterion:
 - 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.
 - 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.

ARP FMAP Increase

- Total FMAP is capped at 95% inclusive of the increase available under Section 9817.
- The ARP FMAP increase began on April 1, 2021 and lasted through March 31, 2022.
- Currently, states are expected to expend these funds by March 21, 2024.
- Additional information relating to the application of the ARP FMAP increase can be at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>

ARP Spending Plans

- As part of the ARP requirements, states were required to submit an initial HCBS spending plan which included an estimate of the total amount of funds attributable to the increase in FMAP and an initial HCBS spending narrative that provides information on the state's Section 9817 activities.
- States must also report quarterly HCBS spending plans and narratives to CMS until all Section 9817 funds are expended.
- Initial and quarterly HCBS spending plan and narrative requirements do not supersede 1915(c) authorization requirements.
 - States must follow all applicable rules, including financial integrity and accountability requirements, when making changes to 1915(c) programs and intending to use funds attributable to the increased FMAP to pay the state share of costs associated with such changes.

Expanding and Enhancing 1915(c) Waiver Programs under ARP

ARP Spending Plan Goals & Requirements

- CMS strongly encourages states to use the funds to implement structural changes to:
 - Expand eligibility and increase access to HCBS for all Medicaid beneficiaries including those on waiting lists for HCBS waiver programs, children with disabilities, and people with behavioral health conditions.
 - Strengthen the direct service workforce, including by increasing the pay and benefits of direct support professionals.
 - Support compliance with the home and community-based settings regulatory criteria and promote community integration.
 - Offer a broader range of community-based services, particularly for people with behavioral health conditions.

ARP Spending Plan Goals & Requirements (Cont.)

- CMS strongly encourages states to use the funds to implement structural changes to (cont.):
 - Make long term investments in HCBS infrastructure, including capital investments to expand access to non-disability specific settings as part of a state's implementation of the home and community-based settings regulation.
 - Address social determinants of health and improve equity for older adults and people with disabilities.

Common Initiatives to Enhance, Expand, and Strengthen HCBS

The table below includes common actions proposed by states in the ARP spending plans.

Initiatives in Spending Plans	Description of Initiative	State Example
Workforce retention and Bonus Payments	States proposed to offer additional payments through retention bonuses, referral payments, as well as one-time grants.	A state offered a one-time bonus to nursing staff, who serve individuals receiving HCBS, to improve employee retention.
Increase Waiver Slots	States proposed to increase the number of waiver slots.	A state proposed to add slots to its waiver serving older adults and individuals with a physical disability to increase capacity for the program.
Add New Services or Expand Scope of Existing Services	States added services to expand HCBS opportunities and to better address program participant needs.	A state proposed adding a transition service to facilitate the discharge or transition from an institution to HCBS.

Common Initiatives to Enhance, Expand, and Strengthen HCBS (Cont.)

Initiatives in Spending Plans	Description of Initiative	State Example
Modify Payment Rates and Methodologies	States proposed to modify payment rates with a goal of increasing direct support worker pay and better aligning rate structures to provider costs.	A state proposed to pilot a new rate structure that would increase funding based on staffing patterns for waiver participants with complex needs.
Training Initiatives	States proposed training initiatives for direct support workers to incentivize retention, promote standardization of care, and enable workers to better serve waiver participants.	A state proposed a disability and cultural competency training for providers to ensure better access to appropriate care for HCBS participants.
Telehealth and Remote Delivery	States proposed changes to existing services to allow for new remote/telehealth delivery models to help support participant independence and continuity of services.	A state referenced improving access to technology for participants to support independent living such as medication reminders, live skills training, and other tasks.

Accounting for Inflation, Labor, and Other Economic Factors During and After the PHE

Accounting for Economic Factors

- States must account for state and local economic factors when establishing payment rate methodologies and projecting service estimates.
 - For example, a state may choose to adopt a higher rate in certain parts of the state to account for cost of living or other regional differences.
- The PHE brought about new economic factors and considerations that states needed to account for, such as increased staffing costs, PPE costs, and transition-related costs for participants transitioning from institutional supports.
- States should use current data that best represents the unique economic characteristics specific to their state to more accurately measure provider costs and project future program expenditures.

Waiver Program Growth Rate

- States are required to estimate waiver service utilization and program expenditures for the five-year waiver period (three years for new waivers).
- States apply a growth rate to waiver estimates to project inflation, cost of living increases, program growth, and other factors impacting program growth.
 - States most commonly use the CPI-U that tracks the average change over time in the prices paid by consumers for a market basket of consumer goods and services.
 - The 2021 CPI-U increased 7% before seasonal adjustment. This will impact state estimates using the CPI-U as a factor for program growth rates.

Labor, Personal Protective Equipment (PPE) and other Economic Factors

- States should account for provider costs and economic conditions when establishing payment rates.
 - Direct support worker shortages and access to care have been long-standing concerns in HCBS that were exacerbated by the PHE and have contributed to increased wage pressures for direct support workers.
 - States should have mechanisms and review processes in place to monitor provider costs and verify that rates are sufficient to maintain a qualified provider pool.
- States may also need to account for increased PPE costs relating to the delivery of services, particularly in congregate settings.

Economic Factors and Establishing Payment Rates

- States must consider economic factors such as labor rates, inflation, and cost of living when establishing payment rates sufficient to maintain a qualified provider pool.
 - States may consider administering provider cost surveys to assist with monitoring costs and reviewing year-to-year changes in provider costs.
 - States may also use wage surveys to gather data on direct support worker wages.
- States must review payment rates at least every 5 years to verify that payment rates reflect current economic conditions and that payment rates are sufficient to maintain access to a qualified provider pool.

Economic Factors and Estimating Service Utilization

- CMS recommends that States use data captured on the CMS-372 reports as a basis for waiver program estimates when appropriate. Otherwise, states are encouraged to use data that best represents future projections and expectations for program costs and growth.
 - States may need to consult or review alternate sources to best incorporate ARP section 9817 spending plans, inflation, and other factors that may not be captured in the CMS-372 reports.
- States will need to factor increased FMAP dollars into program cost neutrality, growth rates, and program expenditures.
 - For example, if the state rates increase by 10% commensurate with the ARP spending plan, the state should provide an explanation in Appendix J-2-c that details the rationale and methodology for estimates reported in Appendix J-2-d.

Ensuring Fiscal Integrity and Financial Accountability When Making Changes Through the Appendix K and American Rescue Plan

Waiver Program Changes

States must account for financial related changes implemented as part of Appendix K program extensions and/or ARP spending plan proposals in the 1915(c) waiver application. Common appendices subject to update include but are not limited to the following:

Appendix	Reason for Update:
Appendix I-1: Financial Integrity and Accountability	The state updates monitoring and/or post-payment review processes to account for new services or changes to existing services.
Appendix I-2-a: Rate Determination Methods	The state is implementing a rate increase or changing the rate setting methodology for a waiver service(s) not accounted for in the rate methodology.
Appendix I-3-c: Supplemental or Enhanced Payments	The state is implementing a waiver service payment that is in addition to the amount billed by the provider for a service.
Appendix J-2-c: Derivation of Estimates	The state is updating waiver cost estimates and must include an explanation detailing estimation methodology.
Appendix J-2-d: Estimate of Factor D	The state plans to update program estimates.

Addition of New Waiver Services

- Some states proposed new waiver services 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 estimate 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.

Waiver Service Payment Rate Increases

- When updating payment rates, states should detail the results or provide a link to the rate study (if applicable) to help support new payment rates.
- As part of both Appendix K submissions and ARP spending plan proposals, states frequently proposed or implemented rate increases to support provider networks and expand access to HCBS.
 - States may not effectuate payment rate increases unless they are a component of the approved rate methodology, or the state is submitting a rate methodology to include the component that permits the rate increase.
- As part of the ARP, some states proposed to evaluate existing methodologies and payment rates to verify that payment rates remain appropriate to maintain a qualified provider pool.

Waiver Service Supplemental Payments

- Through the ARP spending plan, states proposed retention bonuses and other types of payments such as sign-on bonuses and recruitment bonuses.
- For states implementing supplemental payments, states must address the following in Appendix I-3-c of the waiver application:
 - The nature of such payments and the waiver services for which these payments are made.
 - The types of providers to which such payments are made.
 - The source of the non-federal share of the supplemental payment.
 - Confirmation that providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS.

Modified Waiver Services

- Through Appendix K and ARP spending plans, states modified or proposed to modify services to allow for more flexibility in the locations in which the services can be delivered and to also help modernize existing services to allow for remote delivery.
 - States must verify that existing oversight processes are sufficient to adequately review and verify the delivery of billed services.
 - States must also update rate setting methodologies (if applicable) to account for any differences in rates or methodologies resulting from a location or service delivery change.
 - For example, if a state elects to offer supported employment services remotely it must specify any changes to the rate setting methodology resulting from this change.

Payment Modifications and Maintenance of Effort (MOE)

- States must evaluate proposed rate modifications or increases to determine impact on other target groups receiving similar services within the state, impact on participant needs and services authorized in the person-centered service plan, and for program participants that self-direct services.
- As part of ARP Section 9817, 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 choose to self-direct to preserve access to service.

Increased Waiver Capacity

- States expanding capacity or adding slots must account for increased demand in both the program 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, which measures the per capita cost per waiver participant.
- 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.
 - Multiple states through the ARP spending plans have proposed increasing waiver capacity or slots to help alleviate waiting lists and expand access to HCBS. The requirements above must be met to effectuate this change.

Summary

Summary of Training

- Appendix K and Section 9817 of the ARP provided states with additional flexibility to respond to challenges presented by the COVID-19 PHE and strengthen, enhance, and expand HCBS.
- States responded to the COVID-19 PHE by modifying service specifications and locations, increasing payment rates, and by making a variety of programmatic changes.
- States amending or renewing waiver programs to implement Appendix K and/or ARP related changes must account for 1915(c) program requirements, particularly those related to the financial impact of such changes.
- States should factor current economic conditions and use data that best represents future expectations for program growth and utilization when calculating waiver program estimates.

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 \(cms.gov\)](https://www.cms.gov/1915c)
2. Centers for Medicare & Medicaid Services, *1915(c) Home and Community Based Services Waiver Instructions and Technical Guidance, Appendix K: Emergency Response and Preparedness*, Available online: <https://www.medicare.gov/medicaid/home-community-based-services/downloads/1915cappendix-k-instructions.pdf>
3. Centers for Medicare & Medicaid Services, *Strengthening and Investing in Home and Community Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817 Spending Plans and Narratives*, Available online: [Strengthening and Investing in Home and Community Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817 Spending Plans and Narratives | Medicaid](https://www.cms.gov/medicaid/section-9817)
4. Centers for Medicare & Medicaid Services, *SMD#21-0003 Implementation of ARP Act of 2021 Section 9817: Additional Support for Medicaid HCBS during the COVID-19 Emergency*, Available Online: [SMD# 21-003: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency.pdf](https://www.cms.gov/medicaid/section-9817)

For Further Information

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