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1915(c) HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FINANCING AND PAYMENT TRENDS

Division of Long Term Services and Supports

Disabled and Elderly Health Programs Group

Center for Medicaid and CHIP Services

Training Objectives

- Provide an overview of active 1915(c) programs including populations served, projected expenditures, and active waivers operating under concurrent authorities.
- Review financial accountability and fiscal integrity trends reported in all 253 active 1915(c) waiver programs spanning 47 states as of June 30, 2020.*
- Explore 1915(c) financial accountability requirements, non-federal share financing for 1915(c) waiver expenditures, and rate setting methodologies used to establish waiver service payment rates.
- Discuss national trends and strategies employed by states to address payment processes and other financial elements within HCBS waiver operations.
- Review new financial accountability and fiscal integrity trends prompted by the COVID-19 Public Health Emergency (PHE).

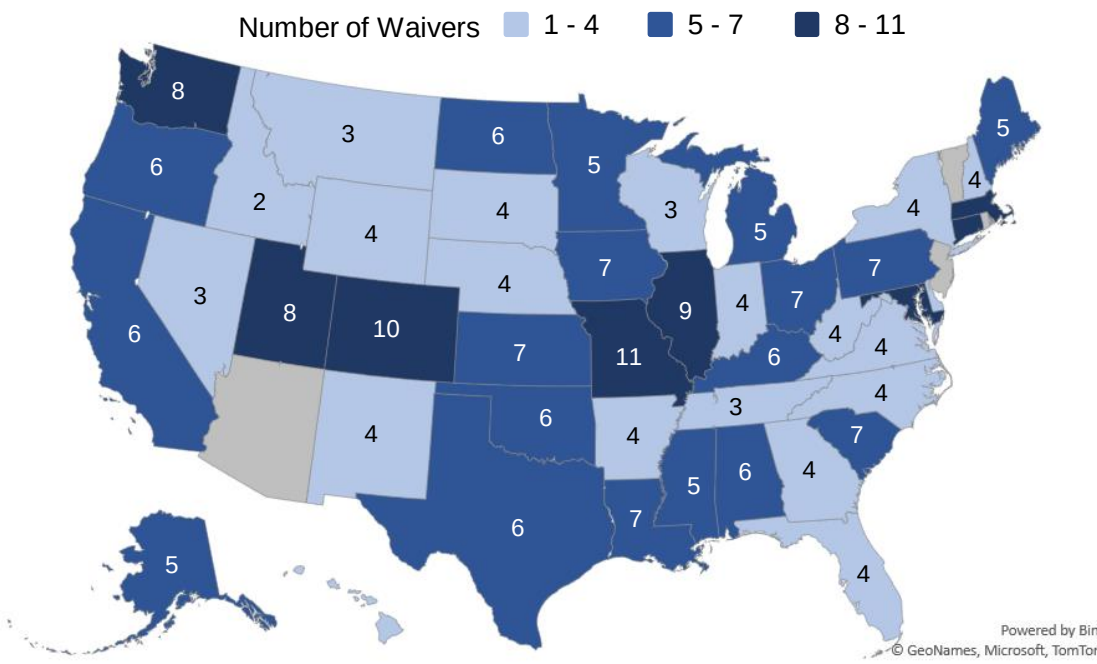
*Note: Number of states includes the District of Columbia (DC)

Overview of 1915(c) Waiver Programs

Active 1915(c) Waiver Programs as of June 30, 2020

- The Medicaid HCBS waiver program is authorized under §1915(c) of the Social Security Act.
  - Permits a state to furnish an array of HCBS that ensure community living for Medicaid beneficiaries who would otherwise be institutionalized.
- Most states operate multiple waivers with broad discretion to design programs most appropriate to address the needs of their target population.

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



Number of Active Waivers	Number of States
253	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 6/30/20. Waiver programs operated by states are included in Appendix A: State Waiver List.

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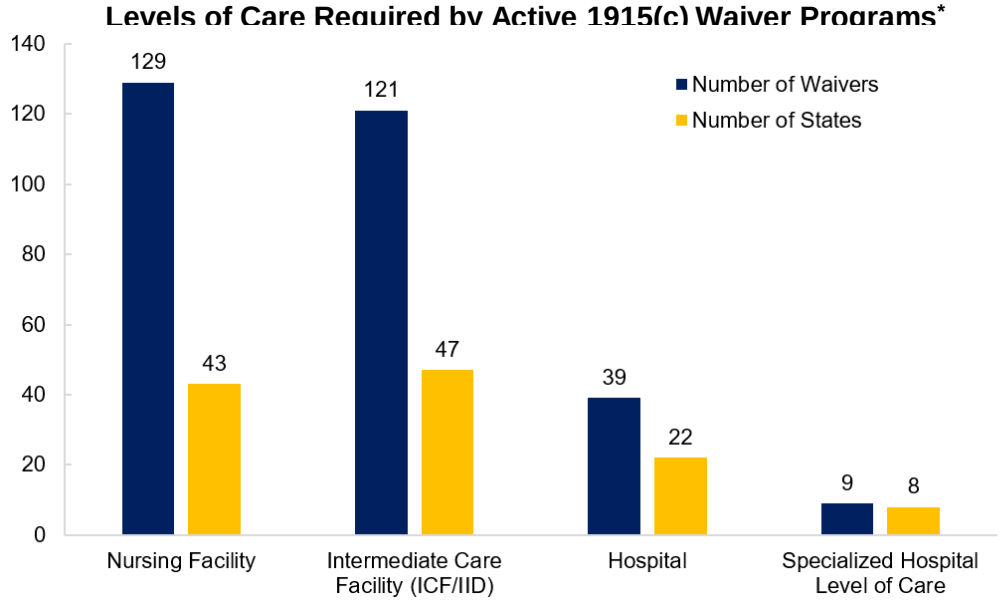
1915(c) Waiver Program Level of Care Requirements

States determine 1915(c) waiver program target populations based on the unique needs of Medicaid beneficiaries eligible for services.

- Waiver services may only be furnished to individuals who are determined to require the level of care furnished in, **a nursing facility**, **intermediate care facility (ICF/IID), hospital, and/or specialized hospital**
- Most active waiver programs require nursing facility and/or intermediate care facility levels of care (129 of 253 waivers (51%), and 121 of 253 waivers (48%), respectively)



*Note: States may operate waiver programs that serve multiple levels of care. As a result, total counts do not sum up to 253 waivers and 47 states.

Comparing 1915(c) Cost Neutrality

States are required to estimate the per capita costs for both 1915(c) waiver program participants and institutional settings serving a similar target group.

- Consistent with the statutory requirement of providing a cost-effective alternative to institutional costs, nationally, states project Medicaid 1915(c) waiver costs to be on average 62 percent less than institutional costs.

National Average Medicaid Annual Per Capita Cost Estimates for All Active 1915(c) Waiver Programs as of June 30, 2020*

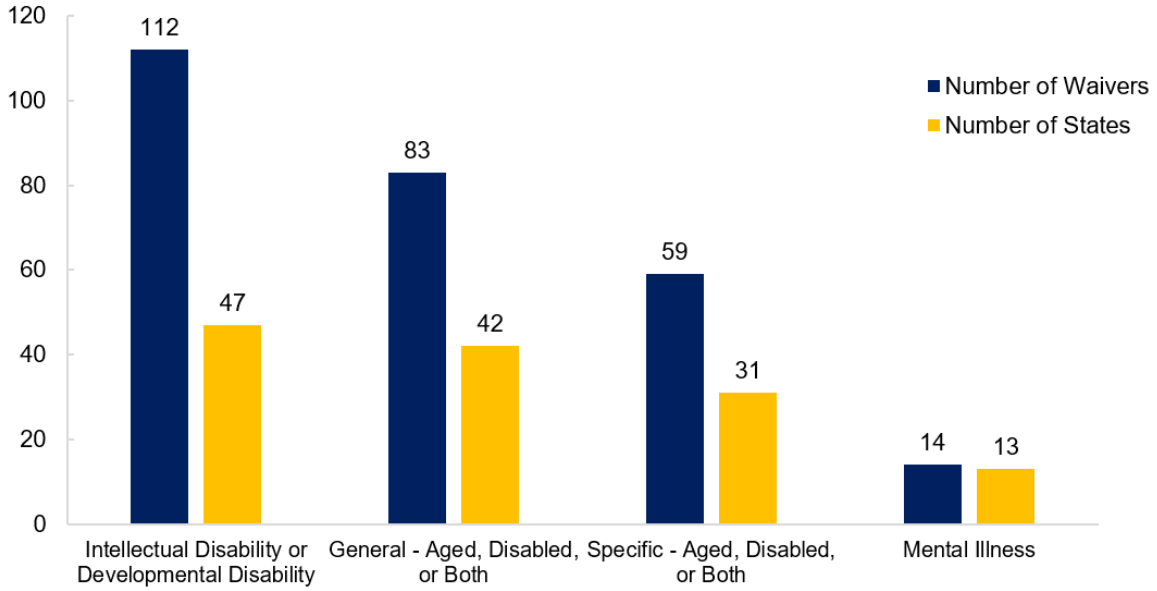
National Average Medicaid Per Capita Cost Estimates	Year 1 Per Capita Estimate	Year 2 Per Capita Estimate	Year 3 Per Capita Estimate	Year 4 Per Capita Estimate	Year 5 Per Capita Estimate
Waiver Costs (E.g., Cost of HCBS waiver program services)	$54,232	$56,003	$56,576	$58,038	$59,488
Institutional Costs (E.g., Cost of care in a nursing facility)	$141,503	$145,920	$149,903	$154,669	$159,448

*Note: Waiver program cost estimates account for the cost of 1915(c) home and community-based services and all other services provided to individuals in 1915(c) waiver programs (Factors D and D'); The estimated cost of institutional care and other Medicaid costs for waiver population individuals served, were the waivers not granted (Factors G and G').

Target Groups Served by Waiver Programs

State 1915(c) waiver programs serve the following target groups: **Intellectual or Developmental Disabilities, or Both (~~-~~General Aged, Disabled or Both (adults with physical disability and older adults); Specific Aged, Disabled or Both (brain injury, HIV/AIDS, medically fragile, technology dependent); Mental Illness (serious emotional disturbance)**.

- Over three-quarters of active 1915(c) waivers serve individuals with intellectual or developmental disabilities and/or older adults and adults with physical disabilities (112 of 253 waivers (44%), and 83 of 253 waivers (33%), respectively).



*Note: States may operate waivers that serve multiple target groups. As a result, total counts do not sum up to 253 waivers and 47 states.

Concurrent Authorities

Thirty-one of 47 states (66%) operate 1915(c) HCBS waiver programs concurrently with programs approved under other authorities in the Social Security Act.

- For example, three waiver programs for individuals with intellectual and developmental disabilities are implemented via both the 1915(b) managed care waiver authority and the 1915(c) HCBS waiver authority.

Waiver Authorities Concurrent with the 1915(c) Waiver Authority

Concurrent Authorities	Number of States Operating at least one 1915(c) Concurrent Waiver
1915(b): Waiver Authority: Managed Care Delivery System	24 (51%)
1115: Demonstration Authority	9 (19%)
1915(a)(1)(a): Waiver Authority: Voluntary Managed Care Programs	5 (11%)
1915(j): State Plan Authority: Person-centered and Directed Planning (Self Direction)	4 (9%)
1932(a): State Plan Authority: Managed Care Delivery	3 (6%)

*Note: States may have waivers that are operated by multiple concurrent authorities. As a result, total counts do not sum up to 253 waivers and 47 states.

Trends in 1915(c) HCBS Waiver Program Financing

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1915(c) Federal and State Waiver Program Financing

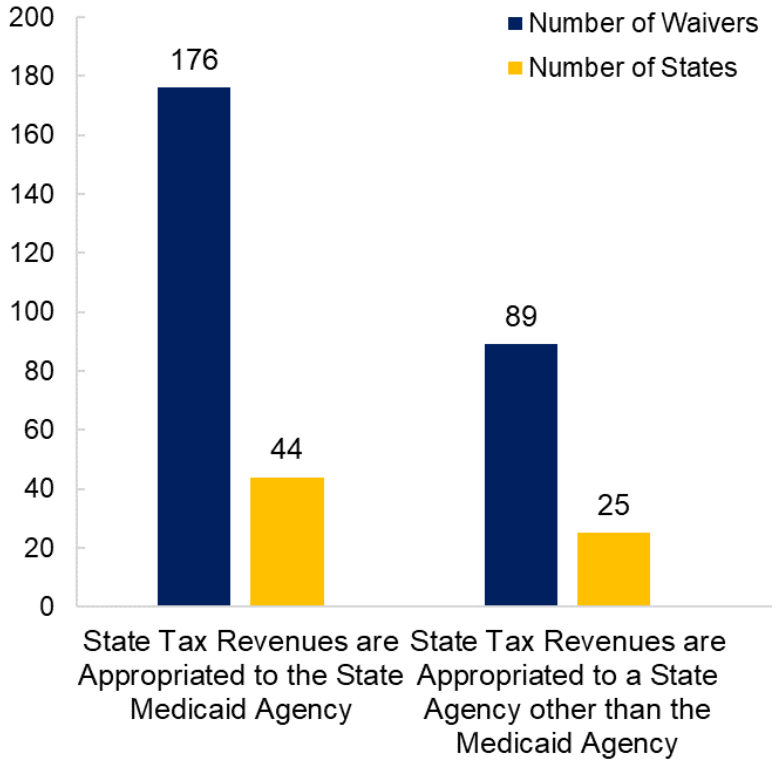
- States finance their portion of 1915(c) waiver programs through a variety of arrangements including:
  - State appropriated funds from the legislature to the Medicaid agency
  - Intergovernmental transfers derived from state or local tax revenues transferred from a state or local government unit (including State teaching hospitals or Native American tribal entities)
  - Certified Public Expenditures, funds expended by a state or local government that represent actual expenditures and account for the state share of Medicaid payments
  - Through cost sharing arrangements with waiver participants (e.g., copayments)
- The federal government provides a Federal Medical Assistance Percentage (FMAP) to cover the federal portion of Medicaid expenditures for services that fall within the scope of approved waiver services.
  - FMAP is the federal Medicaid matching rate for medical assistance furnished under that state's Medicaid program

State Government Sources of the Non-Federal Share of Waiver Costs

All 47 states use state tax revenues to fund the non-federal share of 1915(c) waiver costs.

- Forty-four of the forty-seven (94%) states allocated state tax revenues to the State Medicaid Agency (SMA).
- Twenty-five of the forty-seven (53%) states allocated state tax revenues to agencies other than the SMA. In such cases, states specify the following in waiver applications:
  - State agencies to which the appropriation is made
  - Revenue sources of the funds that are allocated
  - Mechanisms that are utilized to transfer the funds to the SMA

State Level Sources of Non-Federal Funds for 1915(c) Waiver Programs*



*Note: States may have waivers that appropriate taxes to the SMA and to other state agencies. As a result, total counts do not sum up to 253 waivers and 47 states.

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State Tax Revenues Appropriated to Other State Agencies

States that allocate state tax revenues to an agency other than the SMA reported the types of state funds that support HCBS and the agencies that receive those funds in the 1915(c) waiver applications.

- State operating agencies most commonly receive the non-federal share through general revenue funds.
- Other tax-based state funds include the following:
  - Health Care-Related Taxes
  - Education trust funds
  - Mental health trust funds
  - Drug rebates
  - Tobacco Taxes

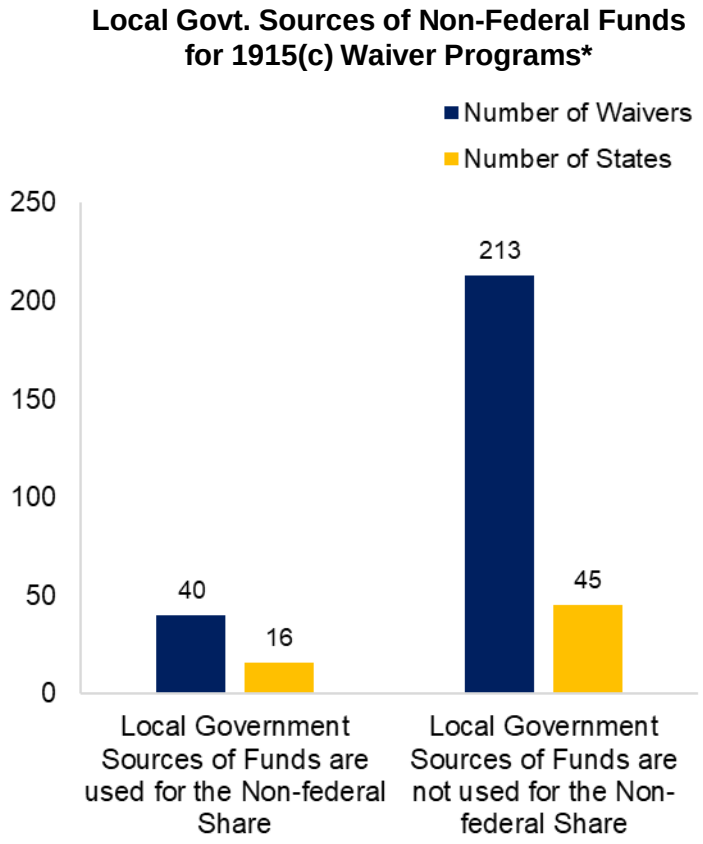
State Health Care Taxes and Fees

- Healthcare related taxes or fees in accordance with 42 CFR 433.56 can be used to fund portions of the non-federal share.
  - Healthcare taxes and fees must be broad-based and uniform across similar services unless waived by the state under CMS approval.
  - Imposed on a permissible class of health care services and providers.
- A few states reported using healthcare-related taxes or fees to source the non-federal share of funds. Some examples include the following:
  - Broad-based taxes that apply to all Medicaid, non-Medicaid, and/or private providers within hospitals, nursing facilities, and home health agencies
  - Nursing Facility Franchise Fees

Local Government Sources of the Non-Federal Share of Waiver Costs

Sixteen of 47 states (34%) cited the utilization of local government sources for the non-federal waiver funds.

- Local government units transfer funds to the SMA to support 1915(c) HCBS services.
- Common local government funding sources include:
  - General county taxes and revenue
  - Healthcare Reimbursement Accounts
  - Property tax
  - Lottery revenue
  - Tobacco tax



*Note: States may have waivers that both utilize and do not utilize local government funds. As a result, total counts do not sum up to 253 waivers and 47 states.

State and Local Contributions for Sources of Non-Federal Funds

States use two mechanisms to transfer or certify the non-federal share of funds to the SMA.

Intergovernmental Transfer (IGT) refer to **funds derived from state or local tax revenue transferred from another state or local government unit to the SMA** to be used as the non-federal share. If local government units are obligated to provide all or a portion of the non-federal share, they may meet this obligation by transferring funds to the SMA.

Certified Public Expenditure (CPE) are used when a state or local government unit expends funds and submits the total amount expended to the SMA. CPEs do not involve the transfer of money to the SMA. Instead, the **local government certifies that government funds were used to pay for the cost of providing Medicaid services.**

Transfer Mechanisms: Intergovernmental Transfer (IGT)

Intergovernmental Transfer (IGT)

- Most states use IGT to transfer allocated funds from state units (e.g., operating agency, provider agency) or local government units (county-based units, local county boards) to the SMA.
  - One state's Department of Mental Health transfers the non-federal share of waiver payments to the SMA through an IGT process. The funds transferred to the SMA from the Department of Mental Health are sourced from two tax-based funds including an education trust fund and a mental health trust fund.
  - Another state utilizes state tax revenues or general funds that are allocated to the state's operating agency by the state legislature. The state operating agency in turn transfers the funds to the SMA via an intergovernmental transfer.

Certified Public Expenditure (CPE)

Certified Public Expenditure (CPE)

- States that use CPEs receive federal matching funds for total computable costs for waiver services incurred by state or local government agencies.
- CPEs represent total costs incurred/payments made by the state or local government agency with FFP available as a percentage of total costs.
- States must verify that CPEs are used only for waiver services offered by 1915(c) waiver programs.
  - Twenty-six of 253 waivers (10%) spanning eight states report that state or local government agencies certify expenditures for waiver services.
    - Twenty waivers (77%) spanning six states identified that state public agencies directly expend funds for the cost of waiver services.
    - Six waiver applications (23%) spanning two states cited local government agencies.

1915(c) Cost Sharing Requirements

- States may choose to establish cost sharing arrangements including copayments, coinsurance, deductibles, and/or premiums.
  - Copayments are fixed amounts paid by waiver participants to providers for services delivered.
  - Coinsurance is a fixed percentage of the cost of a specific waiver service that must be paid by the participant. Under Medicaid, co-insurance amounts may not generally exceed 10 percent of the cost of the service.
  - Deductible is a specified dollar amount that the participant must incur before Medicaid pays for waiver services.
  - Premium is an enrollment fee or regularly paid specified dollar amount that a Medicaid beneficiary must pay by virtue of enrollment in the Medicaid program.
- States must establish cost sharing and premium amounts for 1915(c) waiver services based on income levels relative to the Federal Poverty Line (FPL).*
  - The amount of the co-payment charge may not exceed the allowable charges contained in 42 CFR §447.51-54 that establishes maximum charges based on the cost of a service.

Cost Sharing Arrangements with Waiver Participants

- When cost sharing arrangements are imposed, the payment amount must be deducted from the state's claim submitted to CMS for federal funding. This deduction occurs regardless of whether the individual has made the payment.
- States that use such cost arrangements must specify the type, amount, and basis of charges as well as the services and target groups that are subject to the charge in the 1915(c) waiver applications.
  - For example, one state imposes a co-payment for prescription drugs provided under the 1915(c) waiver authority.

Trends in 1915(c) HCBS Waiver Program Payments

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Rate Determination Methods

- States have the flexibility to select a rate methodology most appropriate for the respective waiver programs and service offerings. States establish payment rates for waiver services using one or more of seven rate determination methods:
  - **Fee Schedule**: Providers receive a fixed, pre-determined rate for a single service for a specified unit of time. This is the most common payment method, with prevalence in 45 of 47 states (96%).
  - **Negotiated Market Price**: Providers receive the current market or negotiated price for an individual service or good. Negotiated Market Price is the second most common rate methodology with prevalence in 41 of 47 states (87%).
  - **Tiered Rate Payment:** Providers receive payments for a service in which the rate varies by an identified characteristic of the individual, the provider, or some combination of both. For instance, providers may be eligible for a higher rate when serving high acuity participants. Thirty of 47 states (64%) utilize a tiered rate methodology.

Rate Determination Methods (cont.)

- The following rate determination methods are less commonly used.
  - **Capitated Payments**: In accordance with 42 CFR 438.2, states make periodical payments to a managed care plan on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services. Providers are then reimbursed via a Per Member Per Month (PMPM) rate methodology. Managed care capitation payments can vary by factors including acuity, level of care, and utilization. Twenty of 47 of states (43%) use capitated payment arrangements.
  - **Cost Reconciliation**: States use claims history or other information to set interim rates for waiver services with a reconciliation process at the end of the fiscal year to align payment rates with actual provider costs. Eight of 47 states (17%) use a cost reconciliation methodology to establish payments.
  - **Outcome-based Payment**: Providers receive a performance-related or incentive payment contingent on a designated outcome. Only four of 47 states (9%) use outcome-based payments.
  - **Bundled Rates**: Providers receive a fixed, pre-determined rate for a pre-determined amount of time that includes the delivery of multiple distinct services. Only a small portion of states (4 states) use bundled rates.

Frequency of Updating Rates

- States must review waiver service payment methodologies and rates, at minimum, every five years to ensure that rates are sufficient to maintain an adequate provider base qualified to deliver services.
- More than half of states (26 of 47) reported annual or biennial payment rate updates.
- States often identify the growth trends basis – i.e., the basis on which rates are subject to increase, as part of the rate setting process.
  - States most often noted that rate increases were contingent on **legislative action**. Thirty-one of 47 states (66%) reported legislative action as the basis for waiver rate growth.
- States can use a variety of growth trends and inflation indices to trend or apply cost of living adjustments to existing payment rates.
  - For example, states can use the **Consumer Price Index for all Urban Users (CPI-U)** which measures the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services as a basis for rate increases. Nine of 47 states (19%) reported CPI-U as the basis for rate increases.

Supplemental or Enhanced Payments

States have the option to make supplemental or enhanced payments for 1915(c) waiver services in addition to the base payment or the amount billed by the provider.

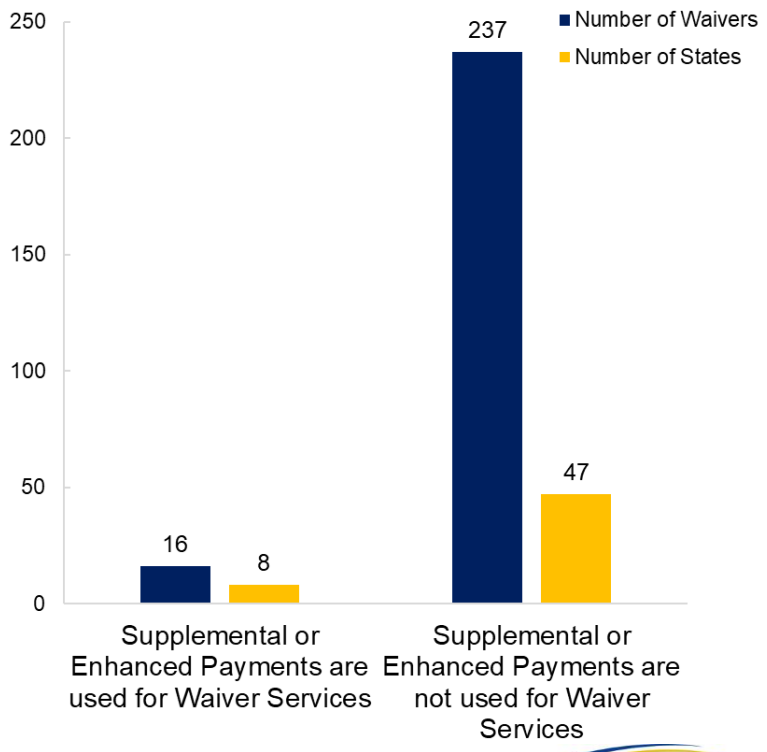
- Supplemental payments are lump sum payments that are frequently used to further state quality initiatives such as caregiver retention efforts.
- States must provide the following information when offering supplemental or enhanced payments for waiver services:
  - The nature of the payments, the waiver services for which payments are made, and the types of providers that are eligible to receive payments.
  - The basis of and the circumstances triggering such payments.
  - Source of the non-federal share of the supplemental or enhanced payments.
    - Providers must be able to maintain 100 percent of the expenditure claimed by the SMA to CMS.

1915(c) Supplemental or Enhanced Payments

Eight of 47 states (17%) reported using supplemental (enhanced payments) for one or more 1915(c) waiver services.

- Providers most commonly receive supplemental payments for direct support services including homemaker, personal care, care management, employment assistance, community attendant, habilitation and supported employment services.
- States offer supplemental payments for a variety of reasons including furthering waiver program goals and incentivizing providers. Examples include:
  - One state includes a competency payment for homemaker providers with two years of experience and 60 hours of accredited competency-based training.
  - One state makes supplemental payments to providers rendering services to individuals with complex medical or behavioral needs to prevent institutionalization.

Supplemental or Enhanced Payments in 1915(c) Waiver Programs*



*Note: State counts are not mutually exclusive as Supplemental or Enhanced Payments are specific to the waiver program and may vary by waiver. As a result, total counts do not sum up to 47 states.

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Payments in Residential Settings: Room and Board

All 47 states furnish waiver services in residential settings other than the personal home of waiver participants, across many 1915(c) waivers.

Exclusion of Payment for Room and Board in Residential Settings:

- Federal Medicaid funding is not available to pay for room and board expenses for services rendered in residential settings, with exceptions noted on the following slide.
- "Room" expenses include property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative fees
  - "Board" refers to three meals a day or any other full nutritional regimen
- States are required to demonstrate how room and board costs are excluded from federal financial participation.
  - States most commonly reported that the rate structure for services delivered in residential settings is based solely on the cost of delivering the service and therefore does not include room and board costs.

Payments in Residential Settings: Rent and Food Expenses

Inclusion of Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver in Residential Settings:

- Federal funding is provided to compensate for additional costs incurred by the participant for rent and food for unrelated live-in caregivers in residential settings. Unrelated live-in caregivers must be unrelated to participants by blood or marriage and provide covered waiver services to meet participant physical, social, or emotional needs.
  - Fourteen of 47 states (30%) operating 23 of 253 waivers claim federal funds for rent and food expenses for unrelated live-in personal caregivers.
- Methods for determining reimbursement for rent and food expenses related to a live-in caregiver vary from state to state. Common methods include:
  - Equally apportioning costs among all persons residing in the home;
  - Calculating the proportionate share of the household's housing and food expenses
  - Using regional and population-based Department of Housing and Urban Development (HUD) Fair Market Rent and United States Department of Agriculture (USDA) average moderate food cost data.

Provider Reimbursement Mechanisms

Providers are reimbursed either directly by the SMA or through alternate entities in the state.

Direct Payments

- All 47 states use direct payments that are made from the SMA to providers of waiver services.
- SMAs must retain the capability to make direct payments.

Additional Reimbursement Mechanisms

- Thirty-three of 47 states (72%) use additional reimbursement mechanisms. Payments to providers are made by other government agencies or organizations that contract independently with providers on behalf of the SMA.
- The SMA maintains oversight responsibility for other entities or agencies making payments.

Medicaid Management Information System or Medicaid Enterprise System

Direct payments to providers are usually made through a Medicaid Management Information System (MMIS) or Medicaid Enterprise System (MES). An MMIS/MES is a mechanized claims processing and information retrieval system that state programs can use to process claims and support program integrity activities.

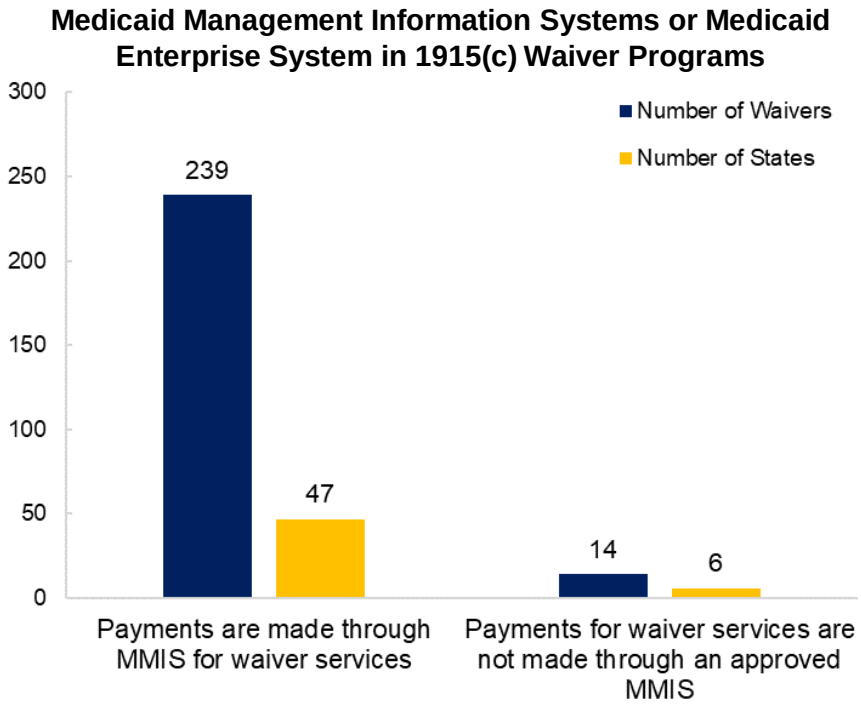
- The system controls Medicaid waiver program functions, such as:[2]
  - Administrative program and cost control;
  - Participant and provider inquiries and services;
  - Operations of claims control; and
  - Management reporting for planning and control.
- States must have an MMIS/MES to be eligible for federal funding.

Centers for Medicare & Medicaid Services, *Medicaid Management Information System Snapshot* Available online: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-medicaidmanage-infosystem.pdf

Medicaid Management Information System or Medicaid Enterprise System (cont.)

A majority of 1915(c) waivers spanning all 47 states reported using a Medicaid Management Information System or Medicaid Enterprise System.

- Two-hundred and thirty-nine of 253 1915(c) waivers programs (94%) spanning all 47 states reported using an MMIS/MES.
- Fourteen of 253 waiver programs (6%) currently use alternative claims processing systems that have similar functionalities to an MMIS/MES.



Organized Healthcare Delivery System (OHCDS)

An Organized Health Care Delivery System (OHCDS) is an arrangement through which an agency may contract with qualified providers to furnish waiver services if the agency also provides at least one Medicaid waiver service directly to participants.

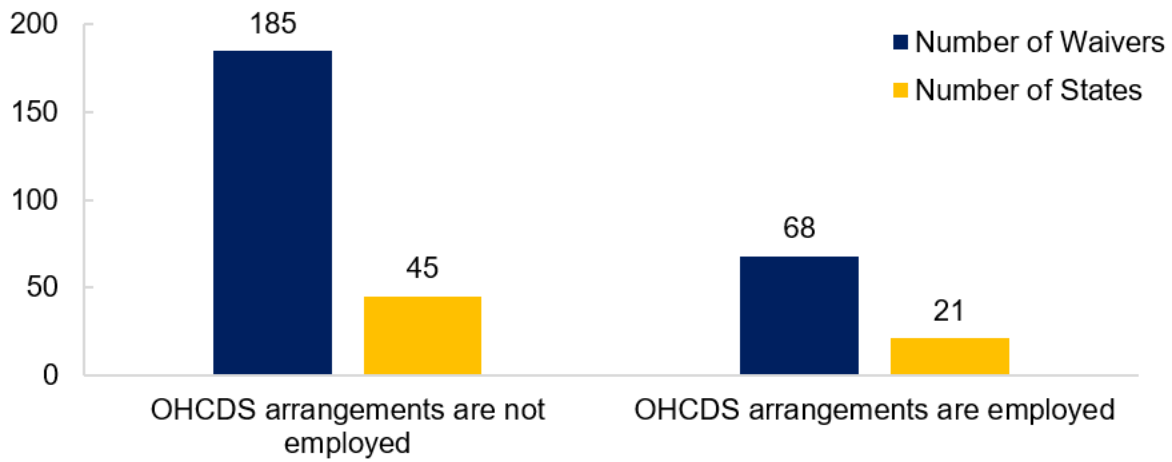
- States may employ an OHCDS to serve as a provider of Medicaid waiver services.
  - Providers may voluntarily contract with the OHCDS and the OHCDS contracts with the SMAs. Payments are made directly to the OHCDS, which then reimburses its subcontracting providers.
  - Providers may also choose to contract directly with the state as waiver providers. Therefore, states must offer and make providers aware of a direct payment option.
- Participants can secure services both through an OHCDS and directly from the state's providers.
- States must specify the following when OHCDS arrangements are employed:
  - Types of entities and methods of designating agencies which function as an OHCDS
  - Safeguards to ensure appropriate financial accountability and free choice of providers for participants
  - Certification and qualification requirements for contracted providers

Organized Healthcare Delivery System (OHCDS) Arrangements

Twenty-one of 47 states (47%) use OHCDS arrangements for some waivers to deliver 1915(c) waiver services.

- Local county governments, community-based organizations or regional area agencies most commonly function as an OHCDS to provide coordinated care to individuals in their catchment areas.
- OHCDS arrangements are often used to expand service access in rural areas, frontier regions or other low access areas.
- Eight of twenty-one states (38%) employ OHCDS arrangements that provide financial management and support services for participants who opt for participant direction.

Organized Healthcare Delivery Systems in 1915(c) Waiver Programs*



*Note: State counts are not mutually exclusive as OHCDS arrangements are specific to the waiver program and may vary by waiver. As a result, total counts do not sum up to 47 states.

OHCDS Safeguards to Ensure Financial Accountability and Fiscal Integrity

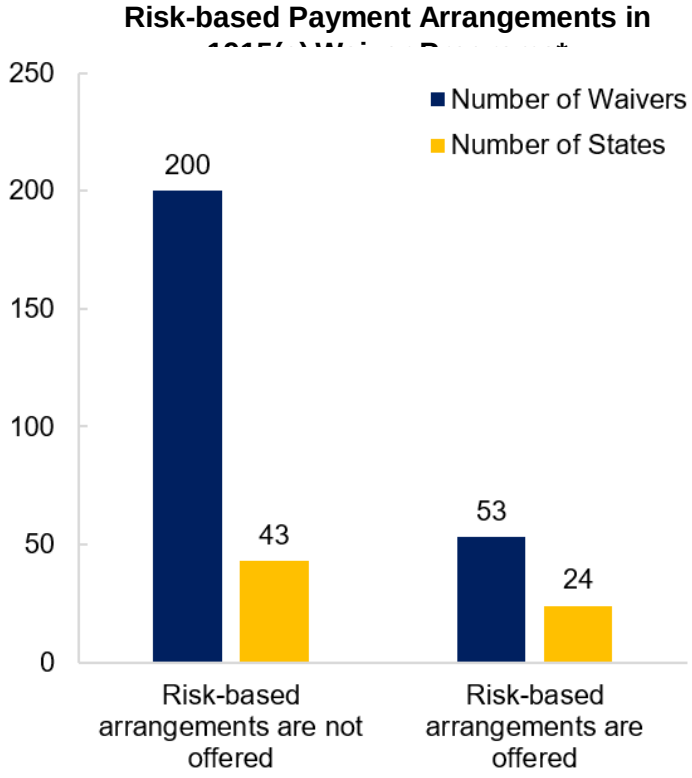
States ensure financial accountability and fiscal integrity of provider billings between the SMA, the OHCDS and its provider sub-contractors through one or more of the following processes:

- Service payments to sub-contracted providers are established based on budget methodologies that rely on historical reimbursement rates for similar services.
- Electronic systems are installed to verify contract information and service authorization information for service reporting.
- Periodic audit programs are conducted, and recoupments are made if service records are not adequate or accurate upon review.

Contracts with Managed Care and Health Plans

Twenty-four of 47 states (51%) establish risk-based and other payment arrangements with managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans to deliver waiver services.

- Of states that use risk- based arrangements, over half target specific geographic areas.
- Waiver services are usually furnished by contracted organizations with the exclusion of a few specialty services (e.g., developmental disability waiver services, dental services and non-emergency medical transportation services).



*Note: State counts are not mutually exclusive as risk-based and other payment arrangements are specific to the waiver program and may vary by waiver. As a result, total counts do not sum up to 47 states.

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Impacts on 1915(c) Waiver Program Policies & Trends due to the COVID-19 Public Health Emergency (PHE)

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COVID-19 PHE Impact: Families First Coronavirus Response Act (FFCRA)

Section 6008* of the Families First Coronavirus Response Act (FFCRA) provides for a temporary 6.2% increase in the Federal Medical Assistance Percentage (FMAP) for states that meet the four conditions described in section 6008(b).

- The four conditions for claiming the increased FMAP require that a state:
  - Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020;
  - Not charge premiums that exceed those that were in place as of January 1, 2020* or increase the premium charged to a given beneficiary;
  - Keep beneficiaries enrolled, if they were enrolled on or after March 18, 2020; and
  - Cover, without the imposition of cost sharing, testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.

*Section 3720 of the CARES Act added a new subsection (d) to section 6008 of the FFCRA in order to provide states which have increased premiums for any Medicaid beneficiaries above the amounts in effect on January 1, 2020, with a 30-day grace period, beginning March 18, 2020, to restore premiums to amounts no greater than those in effect as of January 1 without jeopardizing the state's eligibility for the temporary 6.2 percentage point FMAP increase.

COVID-19 PHE Impact: FFCRA FMAP Increase

- For additional information related to the FFCRA and maintenance of effort, please refer to the FAQ document https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.
- For additional information related to changes to continuous enrollment provisions, please refer to the IFC https://www.cms.gov/files/document/covid-vax-ifc-4.pdf.

Families First Coronavirus Response Act, *H.R.6201 – 116th Congress (2019-2020)* Available online: https://www.congress.gov/bill/116th-congress/house-bill/6201/text

COVID-19 PHE Impact: American Rescue Plan of 2021

Additional FMAP is available through Section 9817 of the American Rescue Plan (ARP) enacted on March 13, 2021.

- Section 9817 allows states to receive a **10 percentage point FMAP increase for HCBS** if they meet conditions outlined on the next slide.
- The ARP FMAP increase began on April 1, 2021 and will last through March 31, 2022.
- States can expend these funds through March 31, 2024.
- Additional information relating to the application of the ARP FMAP increase can be found at https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.

American Rescue Plan Act of 2021 Available online: https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-HF2D79E73283C4304A02CE9D819916324

COVID-19 PHE Impact: ARP FMAP Increase

States must adhere to the following criteria to receive the ARP FMAP increase:

- Additional funding must be used to supplement, not supplant state level HCBS funding.
- The state shall implement one or more activities which enhance, expand, or strengthen HCBS programs.
- Total FMAP is capped at 95% inclusive of the increase available under Section 9817.
- States cannot impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than those in place 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.

COVID-19 PHE Impact: Increased Waiver Service Payment Rates

Appendix K Emergency Preparedness and Response Amendments

- Appendix K is a standalone appendix utilized by states in response to an emergency and includes actions that states can take under existing 1915(c) waiver authorities.
  - Under a 1915(c) waiver authority, states have the flexibility to make a variety of waiver finance and policy related changes including **temporary modifications to payment processes and provider reimbursement** during the COVID-19 PHE.[5]
- Thirty-seven of forty-seven states (79%) as of June 2021 elected to temporarily increase payment rates to help promote the sustainability of the HCBS workforce and provider networks. Rate increases were based on several factors including:
  - Increased staffing
  - Personal protective equipment (PPE) costs
  - Other costs related to the COVID-19 PHE

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.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf

COVID-19 PHE Impact: Increased Waiver Service Payment Rates (cont.)

- States most often increased rates for the following services:
  - Personal Care Services
  - Adult Day Services
  - Therapeutic Services
  - Wellness and Behavioral Health Services
- Increased rates were determined on a case-by-case basis and the methodologies used to adjust rates depended on various factors including acuity of care, level of risk, required training for supervision, geographic regions and maximum state-imposed limits for reimbursement.
- In general, states opted to increase rates by an exact amount or maximum percentage increase. Waiver service rate increases could vary based on participant acuity, COVID-19 related expenses, and/or other factors.
  - For example, one state increased rates for situations in which the participant or someone in the participant's household was quarantined because of COVID-19 to account for additional operational and cleaning costs associated with various services.

Summary & Appendices

Summary

- States use a variety of state and local-level sources including general taxes and revenue, property tax, mental health funds, lottery revenue, tobacco tax and other revenue to finance 1915(c) waiver operations.
- Fee-for-service and negotiated market pricing methods are used by nearly all states to determine base payment rates. A few states also offer lump-sum enhanced payments to improve caregiver retention efforts and waiver participant experience.
- States use a variety of payment mechanisms and systems to directly or indirectly deliver waiver services to participants and reimburse providers.
- States may make temporary changes to protect participant health and welfare and maintain adequate provider networks, as states address challenges associated with the COVID-19 PHE.

References

1. 1915(c) Home and Community-Based Waiver Instructions, *Technical Guide and Review Criteria (January 2019)* Available online: https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf

2. Centers for Medicare & Medicaid Services, *Medicaid Management Information System Snapshot* Available online: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-medicaidmanage-infosystem.pdf

3. Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127, *Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136, Frequently Asked Questions (April 13, 2020)* Available online: https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf

4. Families First Coronavirus Response Act, *H.R.6201 – 116th Congress (2019-2020)* Available online: https://www.congress.gov/bill/116th-congress/house-bill/6201/text

5. 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.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf

6. 42 CFR § 447.51-54, *Cost sharing for Medicaid Services* Available online: https://www.law.cornell.edu/cfr/text/42/447.51, https://www.law.cornell.edu/cfr/text/42/447.52, https://www.law.cornell.edu/cfr/text/42/447.53, https://www.law.cornell.edu/cfr/text/42/447.54

For Further Information

For further information, contact: HCBS@cms.hhs.gov

Appendix A: State Waiver List (AK-CO) as of June 30, 2020

State	Waiver Titles (Base Waivers)
AK	People with Intellectual and Developmental Disabilities (0260) Alaskans Living Independently (0261) Adults with Physical and Developmental Disabilities (0262) Children with Complex Medical Conditions (0263) Individualized Supports Waiver (1566)
AL	Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (0001) Alabama Home and Community-Based Waiver for the Elderly and Disabled Waiver (0068) SAIL Waiver (0241) Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities (0391) Technology Assisted Waiver- TA Waiver (0407) Alabama Community Transition Waiver (0878)
AR	Community and Employment Support Waiver (0188) ARChoices in Homecare (0195) Living Choices Assisted Living Waiver (0400) Autism Waiver (0936)
CA	Home and Community Based Alternatives Waiver (0139) Multipurpose Senior Services Program (0141) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) (0183) HCBS Waiver for Californians with Developmental Disabilities (0336) California Assisted Living Waiver (0431) California Self-Determination Program Waiver for Individuals with Developmental Disabilities (1166)
CO	Elderly, Blind and Disabled (HCBS-EBD) (0006), Developmental Disabilities (HCBS-DD) (0007), HCBS Waiver for Community Mental Health Supports (CMHS) (0268) Persons with Brain Injury (HCBS-BI) (0288) HCBS – Children's Habilitation Residential Program (0305) Colorado's Home and Community Based services Waiver for Children with Life-Limiting Illness (0450) Persons with Spinal Cord Injury (0961) Children's Home and Community Based Services (CHCBS) Waiver (4157) Children's Extensive Support (CES) Waiver (4180)

Appendix A: State Waiver List (CT-IA) as of June 30, 2020

State	Waiver Titles (Base Waivers)
CT	Home and Community Based Services Waiver for Elders (0140) Personal Care Assistance Waiver (0301) CT ABI Waiver (0302) Individual and Family Support Waiver (0426) Comprehensive Supports Waiver (0437) Mental Health Waiver (0653) Employment and Day Supports Waiver (0881) Home and Community Supports Waiver for Persons with Autism (0993) CY ABI Waiver II (1085) Katie Beckett Waiver (4110)
DC	People with Intellectual and Developmental Disabilities (IDD) Waiver (0307) Elderly & Persons With Physical Disabilities Waiver (0334)
DE	DDDS Lifespan Waiver (0009)
FL	Developmental Disabilities Individual Budgeting Waiver (0867) Florida Long-Term Care (0962) Model Waiver (40166)
GA	Elderly and Disabled Waiver (0112) New Options Waiver (NOW) (0175) Comprehensive Supports Waiver Program (0323) Independent Care Waiver Program (CWP) (4170)
HI	HCB Services for People with Intellectual and Developmental Disabilities (I/DD Waiver) (0013)
IA	Home and Community Based Services – AIDS/HIV (0213) Home and Community Based Services – Intellectual Disabilities (ID) Waiver (0242) Home and Community Based Services – Brain Injury (BI) (0299) Home and Community Based Services – Physical Disability Waiver (0345) The Children's Mental Health Waiver (0819) Home and Community Based Services – Health and Disability (HD) Waiver (4111) Home and Community Based Services – Elderly Waiver (4155)

Appendix A: State Waiver List (ID-KY) as of June 30, 2020

State	Waiver Titles (Base Waivers)
ID	Idaho Developmental Disabilities Waiver (0076) Aged and Disabled Waiver (1076)
IL	Persons with Disabilities (0142) HCBS Waiver for Persons who are Elderly (0143) HCBS Waiver for Persons with HIV or AIDS (0202) HCBS Waiver for Children who are Medically Fragile, Technology Dependent (0278) Illinois Supportive Living Program (0326) HCBS Waiver for Persons with Brain Injury (0329) HCBS Waiver for Adults with Developmental Disabilities (0350) Support Waiver for Children and Young Adults with Developmental Disabilities (0464) Residential Waiver for Children and Young Adults with Developmental Disabilities (0473)
IN	Aged & Disabled Waiver (0210) Community Integration and Habilitation Waiver (0378) Family Supports Waiver (0387) Traumatic Brain Injury Waiver (4197)
KS	Kansas – HCBS-I/DD Waiver (0224) Home and Community Based Services for the Frail Elderly (0303) Kansas Physical Disability Waiver (0304) Serious Emotional Disturbance (SED) Waiver (0320) Autism Waiver (0476) Technology Assisted Waiver (4165)
KY	Home and Community Based Waiver (0144) Supports for Community Based Waiver (0314) Acquired Brain Injury Waiver (0333) Michelle P. Waiver (0475) Acquired Brain Injury, Long Term Care (0477) Model Waiver II (40146)

Appendix A: State Waiver List (LA-ME) as of June 30, 2020

State	Waiver Titles (Base Waivers)
LA	Adult Day Health Care (ADHC) Waiver (0121) Children's Choice (CC) Waiver (0361) New Opportunities Waiver (NOW) (0401) Supports Waiver (0453) Residential Options Waiver (ROW) (0472) Community Choices (CC) Waiver (0866) Coordinated System of Care (CSoC) Severely Emotionally Disturbed (SED) Children's Waiver (0889)
MA	Frail Elder Waiver (0059) Traumatic Brain Injury Waiver (0359) Community Living Waiver (0826) Intensive Supports Waiver (0827) Adult Supports Waiver (0828) MFP Community Living (MFP-CL) (1027) MFP Residential Supports (MFP-RS) (1028) Children's Autism Spectrum Disorder Waiver (40207) Acquired Brain Injury with Residential Habilitation (ABI-RH) Waiver (40701) Acquired Brain Injury Non-Residential Habilitation (ABI-N) Waiver (40702)
MD	Community Pathways (0023) Home and Community Based Options Waiver (0265) Waiver for Children with Autism Spectrum Disorder (0339) Medical Day Care Services Waiver (0645) Family Supports Waiver (1466) Community Supports Waiver (1506) Model Waiver for Fragile Children (40118) Brain Injury Renewal Waiver (40198)
ME	Home and Community Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (0159) Elderly and Adults with Disabilities Waiver (0276) Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (0467) Home and Community Based Services for Adults with Other Related Conditions (0995) Home and Community Based Services for Members with Brain Injury (1082)

Appendix A: State Waiver List (MI-MT) as of June 30, 2020

State	Waiver Titles (and Base Waivers)
MI	Habilitation Supports Waiver (0167) MI Choice Waiver (0233) Waiver for Children with Serious Emotional Disturbances (0438) MI Health Link HCBS (1126) Children's Waiver Program (4119)
MN	Elderly Waiver (EW) (0025) Developmental Disabilities (DD) Waiver (0061) Community Access for Disability Inclusion (CADI) (0166) Community Alternative Care (CAC) Waiver (4128) Minnesota Brain Injury Waiver (4169)
MO	Aged and Disabled Waiver (0026) DD Comprehensive Waiver (0178) AIDS Waiver (0197) Independent Living Waiver (0346) Division of DD Community Support Waiver (0404) Partnership for Hope (0841) Adult Day Care Waiver (1021) Brain Injury Waiver (1406) Structured Family Caregiving (1706) Medically Fragile Adult Waiver (40190) Missouri Children with Developmental Disabilities (MOCDD) Waiver (4185)
MS	Independent Living Waiver (0255) Elderly and Disabled (E&D) (0272) Intellectual Disabilities/Developmental Disabilities (ID/DD) (0282) Assisted Living Waiver (0355) Traumatic Brain Injury/Spinal Cord Injury Waiver (0366)
MT	Montana Big Sky (0148) Home and Community-Based Waiver for Individuals with Developmental Disabilities (0208) Severe and disabling Mental Illness Home and Community Based Services (0455)

Appendix A: State Waiver List (NC-NY) as of June 30, 2020

State	Waiver Titles (Base Waivers)
NC	CAP/DA Renewal (3.5) (0132) North Carolina Innovations (0423) TBI Waiver (1326) Community Alternatives Program for Children (4141)
ND	Traditional IID/DD Home and Community Based Services Waiver (0037) Medicaid Waiver for Home and Community Based Services (0273) North Dakota Medicaid Waiver for Medically Fragile Children (0568) Children's Hospice (0834q) Autism Spectrum Disorder (ASD) Birth through Thirteen (0842) Technology Dependent Medicaid Waiver (1266)
NE	HCBS Waiver for Aged and Adults with Children with Disabilities (0187) Developmental Disabilities Day Services Waiver for Adults (0394) Traumatic Brain Injury (40199) Comprehensive Developmental Disabilities Services Waiver (4154)
NH	NH Developmental Disabilities Waiver 2016-2021 (0053) Choices for Independence Waiver Renewal: 2017→2022 (0060) NH IN Home Supports Waiver for Children with Developmental Disabilities: 2016→ 2020 (0397) NH Acquired Brain Disorder Waiver 2016-2021 (4177)
NM	Developmental Disabilities Waiver Program (0173) Medically Fragile Waiver Amendment (0223) Mi Via – ICF/IFF Renewal Waiver (0448) Supports Waiver (1726)
NV	HCBS Waiver for Individuals with Intellectual and Developmental Disabilities (0125) Waiver for the Frail Elderly (0152) Home and Community Based Waiver for Persons with Physical Disabilities (4150)
NY	NYS OPWDD Comprehensive Renewal Waiver (0238) TBI Waiver Renewal (0269) Nursing Home Transition & Diversion Medicaid Waiver (0444) Children's Waiver (4125)

Appendix A: State Waiver List (OH-PA) as of June 30, 2020

State	Waiver Titles (Base Waivers)
OH	PASSPORT)Phase II Waiver Alignment (0198) IO Waiver (0231) Ohio Home Care Waiver (0337) Level One Waiver (0380) Assisted Living (0446) Self Empowered Life Funding (SELF) (0877) Integrated Care Delivery System (ICDS) Waiver (MyCare Ohio) (1035)
OK	Advantage (0256) In-Home Supports Waiver for Adults (0343) In-Home Supports Waiver for Children (0351) Homeward Bound Waiver (0399) Medically Fragile (0811)
OR	Children's HCBS Waiver (0117) Aged and Physically Disabled Waiver (0185) Adults' HCBS Waiver (0375) Medically Involved Children's Waiver (MICW) (0565) Medically Fragile (Hospital) Model (40193) Behavioral (ICF/IDD) Model Waiver (40194)
PA	Consolidated Waiver (0147) OBRA Waiver (0235) Medicaid Waiver for Infants, Toddlers and Families (0324) Person/Family Directed Support Waiver (P/FDS) (0354) Community HealthChoices (0386) Pennsylvania Adult Autism Waiver (0593) Community Living Waiver (1486)

Appendix A: State Waiver List (SC-UT) as of June 30, 2020

State	Waiver Titles (Base Waivers)
SC	HIV/AIDS Waiver (0186) Intellectually Disabled and Related Disabilities Waiver (ID/RD) (0237) Head and Spinal Cord Injury (HASCI) Waiver (0284) Community Choices (0405) Medically Complex Children (0675) Community Supports (CS) Waiver (0676) Palmetto Coordinated System of Care for Children (PCSC) Home and Community Based Waiver (1686) Mechanical Ventilator Dependent Waiver (40181)
SD	CHOICES (0044) Home and Community-Based Options and Person-Centered Excellence (HOPE) Waiver (0189) Assistive Daily Living Services Waiver (0264) South Dakota Family Support 360 Waiver (0338)
TN	Statewide Home and Community Based Services (or “Statewide”) Waiver (0128) Comprehensive Aggregate Cap Home and Community Based Services (or “CAC”) Waiver (0357) Tennessee Self-Determination Waiver Program (0427)
TX	Home and Community-Based Services (HCS) Program (0110) Medically Dependent Children Program (MDCP) (0181) Community Living Assistance and Support Services (CLASS) (0221) Deaf Blind with Multiple Disabilities (0281) Texas Home Living Program (0403) Youth Empowerment Services (YES) (0657)
UT	Community Supports Waiver for Individuals with Intellectual Disabilities & Other Related Conditions (0158) Waiver for Individuals Age 65 or Older (0247) Acquired Brain Injury (0292) Physical Disabilities Waiver (0331) New Choices Waiver (0439) Medically Complex Children’s Waiver (1246) Community Transitions Waiver (1666) Waiver for Technology Dependent, Medically Fragile Individuals (40183)

Appendix A: State Waiver List (VA-WY) as of June 30, 2020

State	Waiver Titles (Base Waivers)
VA	Commonwealth Coordinated Care Plus (0321) Family and Individual Support Waiver (0358) Community Living Waiver (0372) Building Independence Waiver (0430)
WA	COPES (0049) Basic Plus (0409) Core Waiver (0410) Community Protection Waiver (0411) New Freedom (0443) Residential Support Waiver (1086) Individual and Family Services (1186) Children's Intensive In-Home Behavioral Support (40669)
WI	Family Care Waiver (0367) Children's Long- Term Support Waiver Program (0414) IRIS (Include, Respect, I Self-Direct) Waiver (0484)
WV	Intellectual/Developmental Disability Waiver (0133) Aged and Disabled Waiver (0134) Traumatic Brain Injury (TBI) Waiver (0876) Children with Serious Emotional Disorder (1646)
WY	Community Choices Waiver (CCW) (0236) Children's Mental Health Waiver (0451) Supports Waiver (1060) Comprehensive Waiver (1061)