



FACTORS TO BE CONSIDERED IN DETERMINING RATE SUFFICIENCY FOR 1915(c) HCBS WAIVERS

**Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services**

Agenda

- Explore rate setting methodologies used to establish 1915(c) waiver service payment rates.
- Discuss national trends and strategies employed by states to address payment processes and other financial elements within HCBS waiver operations.
- Highlight strategies employed by states to respond to the COVID-19 PHE, assess rate sufficiency, monitor access to services, and maintain a qualified provider pool.

Trends in 1915(c) HCBS Waiver Program Payments

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.
 - **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.

Frequency of Updating Rates (cont.)

- 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.
 - Supplemental and enhanced payments in the 1915(c) waiver are only allowable for FFS. If the waiver operates concurrently with a managed care authority, the state would not use 1915(c) waivers to effectuate such payments.

Supplemental or Enhanced Payments (cont.)

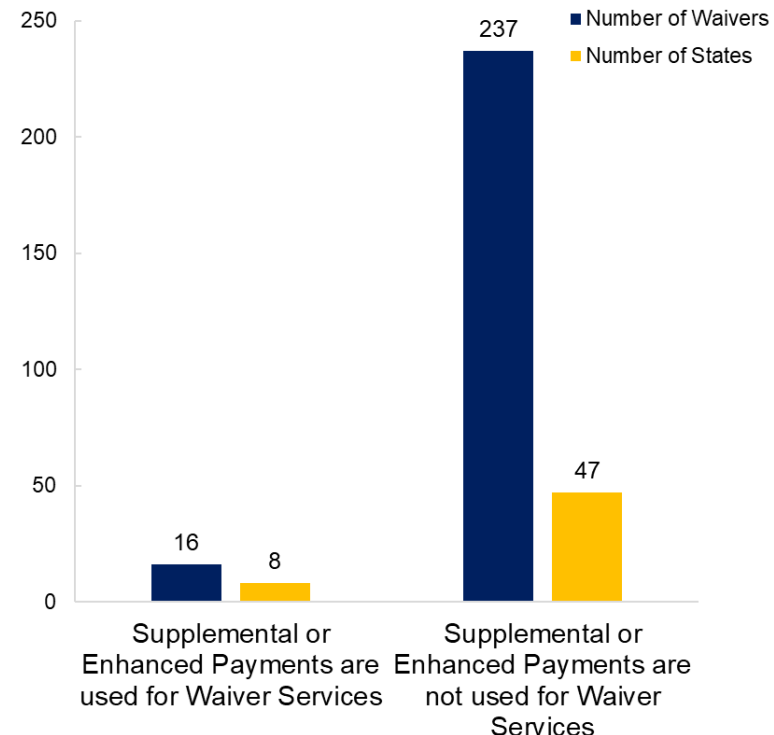
- States must provide the following information when offering supplemental or enhanced payments for waiver services:
 - The nature of the payments, the waiver services for which payments are made, and the types of providers that are eligible to receive payments.
 - The basis of and the circumstances 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.

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 ongoing 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 waiver expenditures claimed to CMS.
 - 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 for Rent and Food Expenses

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

- Federal funding is provided to compensate for additional costs incurred by the participant for rent and food for unrelated live-in caregivers. 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.

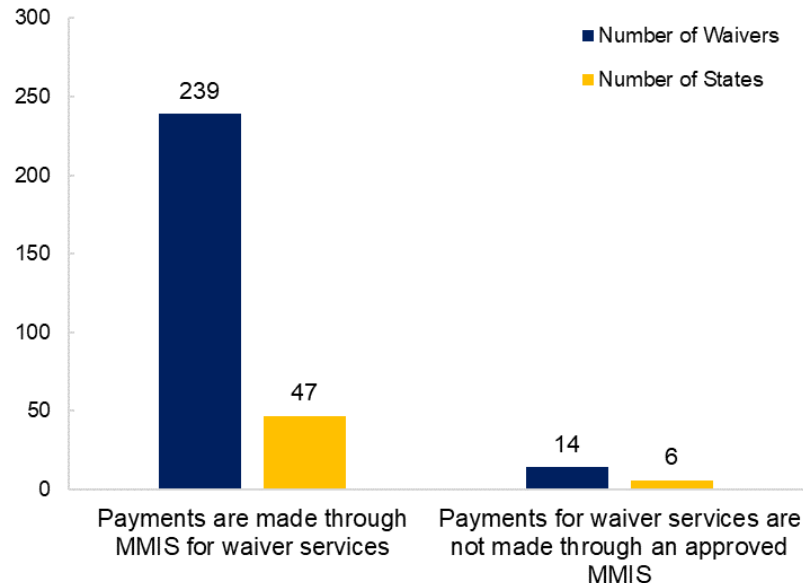
- The system controls Medicaid waiver program functions, such as:
 - Administrative program and cost control;
 - Operations of claims control; and
 - Management reporting for planning and control.
- States must have an MMIS/MES to be eligible for federal funding.

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.

- 239 of 253 1915(c) waiver programs (94%) spanning all 47 states reported using an MMIS/MES.
- 14 of 253 waiver programs (6%) currently use alternative claims processing systems that have similar functionalities to an MMIS/MES.

Medicaid Management Information Systems or Medicaid Enterprise System in 1915(c) Waiver Programs*



*Note: States may have waivers that use both MMIS and other systems. As a result, total state counts do not sum to 47 states.

Organized Healthcare Delivery System (OHCDS)

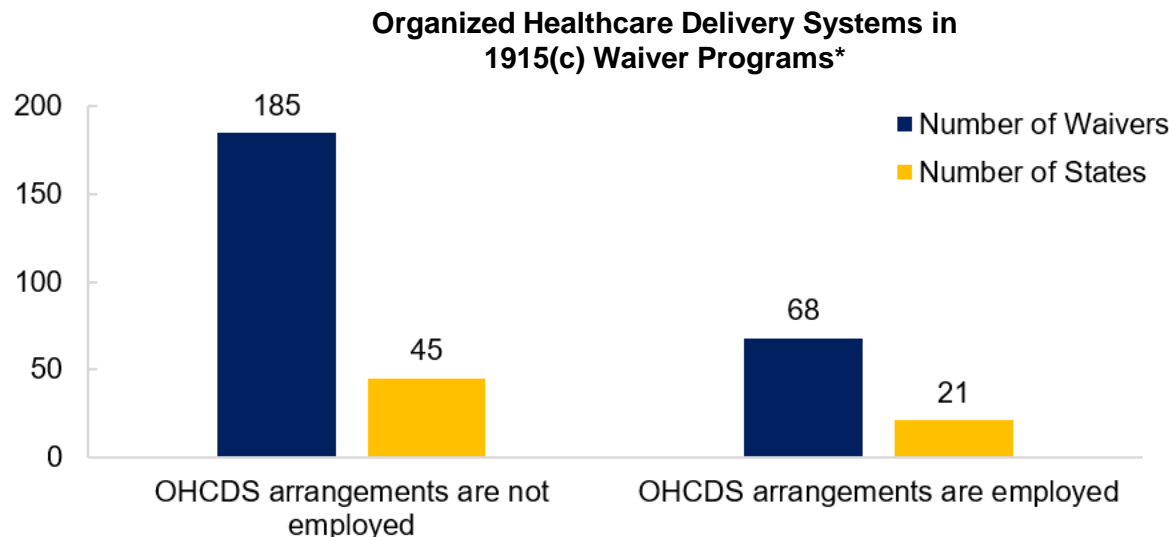
An Organized Health Care Delivery System (OHCDS) is an arrangement through which an agency may contract with qualified providers to furnish waiver services if the agency also provides at least one Medicaid waiver service directly to participants.

- 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.



*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

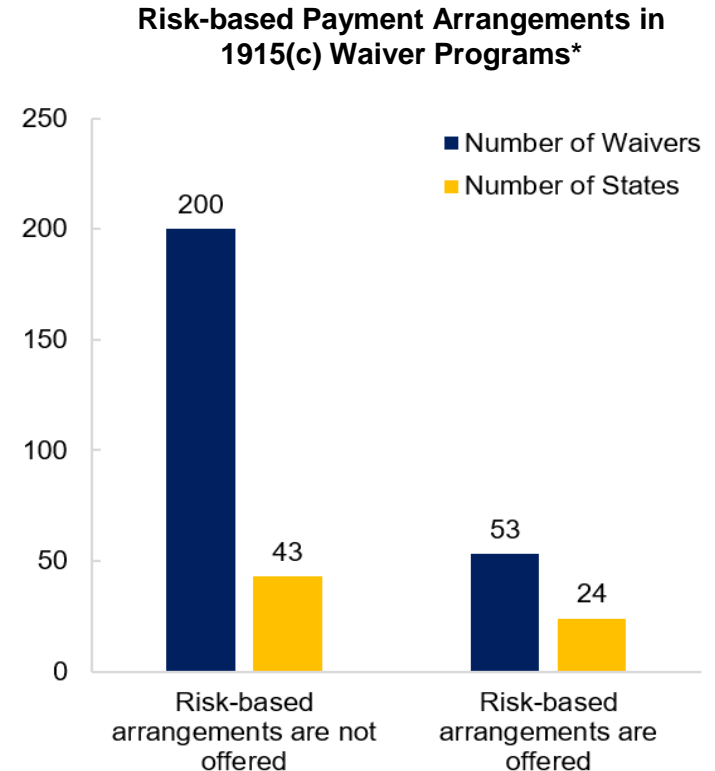
States ensure financial accountability and fiscal integrity of provider billings between the SMA, the OHCDs and its provider sub-contractors through one or more of the following processes:

- 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.
- States that use risk-based payment arrangements usually allow for waiver services to be furnished by contracted provider organizations.



*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.

**Expanding and Monitoring
Access to 1915(c) Waiver
Programs and Provider
Networks During the COVID-19
PHE**

Access in 1915(c) Waiver Programs

- States may encounter challenges with facilitating access to HCBS and expanding HCBS provider networks as part of operating 1915(c) waiver programs. Common challenges include:
 - Recruiting an adequate provider pool to serve varying levels of participant acuity, cultural competencies, and other participant needs
 - Identifying appropriate wages to attract, train, and retain providers while maintaining state-imposed limits for reimbursement
 - Defining career advancement opportunities for direct service providers to strengthen the direct care HCBS workforce
 - Providing services in rural and low-access regions
 - Managing participant waitlists due to demand for HCBS exceeding the availability of waiver resources
- Additionally, states continue to address challenges in 1915(c) programs accentuated by the COVID-19 PHE including high provider turnover, evolving participant needs, and increased service costs.
- CMS released a State Medicaid Director letter implementing the 10 percentage point FMAP increase authorized under the American Rescue Plan Act, providing options states can explore to enhance, expand and strengthen HCBS.

COVID-19 PHE Impact: American Rescue Plan of 2021

Additional FMAP is available through Section 9817 of the American Rescue Plan Act (ARP) enacted on March 11, 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.

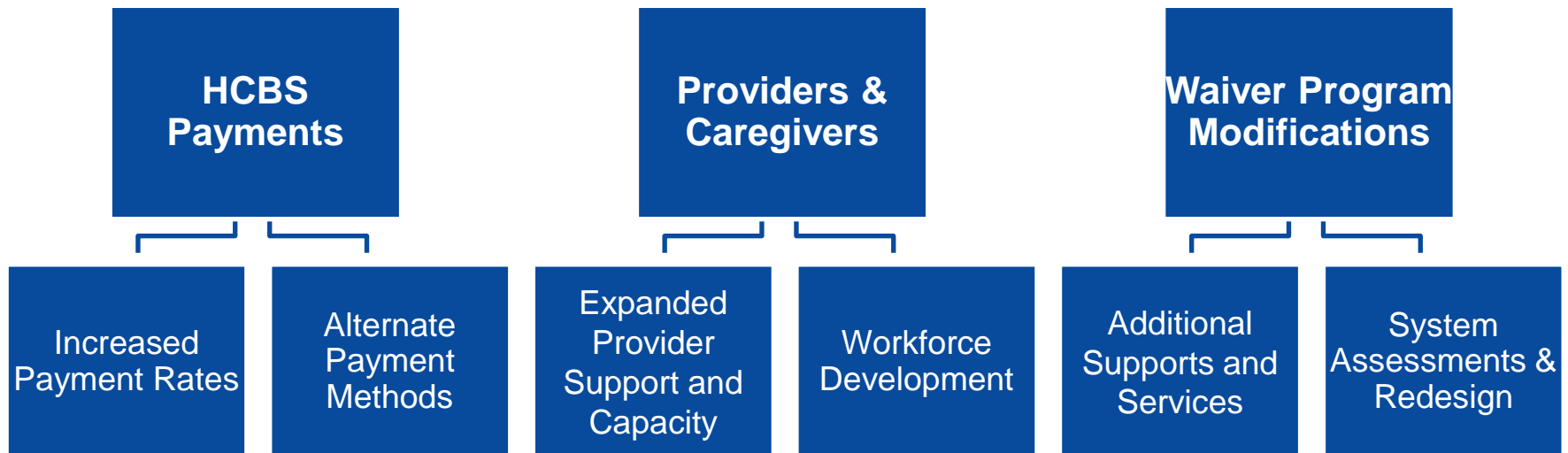
COVID-19 PHE Impact: ARP FMAP Increase

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.
- States must implement activities which enhance, expand, or strengthen HCBS programs.
- Total FMAP is capped at 95%, inclusive of the increase available under Section 9817 of the ARP.
- 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.

State Actions to Expand Access to HCBS

- States continue to take action to expand HCBS access and strengthen the direct care workforce.
- States submitted temporary Appendix K submissions and ARP spending plans detailing efforts to expand access to HCBS. The most common topic areas are highlighted below.



HCBS Payments

States increased payment rates and offered alternate payment methods to support providers and maintain the health and welfare of participants impacted by the COVID-19 PHE.

- **Increased Payment Rates:** States used funds to increase waiver service payment rates to support provider networks.
 - States most often opted to increase rates for personal care services, respite, day services, and habilitation services to support direct support professionals (DSPs).
 - One state 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 various services.
- **Alternate Payment Methods:** States offered additional payments through retention bonuses, referral payments as well as one-time grants to support providers and participants.
 - For example, some states offered one-time provider payments or retainer payments to support workforce retention and expansion efforts.

Providers & Caregivers

States expanded provider capacity and workforce development initiatives through training opportunities, recruitment efforts, and retention activities.

- **Expanded Provider Support and Capacity:** States supported provider and caregiver recruitment, onboarding, and capacity building efforts to widen the provider network for service delivery.
 - Many states are expanding provider pools to include family members, adult peers, high intensity staff, and case managers to aid in service delivery.
 - Some states proposed utilizing additional funds to expand HCBS in rural communities by assisting with broadband installation and equipment.
- **Workforce Development:** States expanded provider-centric initiatives including training and career development programs to assist the existing workforce.
 - States proposed career expansion and growth opportunities for DSPs by providing educational and credentialing programs, mental health and stress assessment supports, as well as additional resources to aid in service delivery.
 - Several states indicated offering additional training for providers on topics related to infection control, racial equity, shift care nursing, and wellness care.

Waiver Program Modifications

States assessed waiver programs to expand waiver slots, modify services and systems.

- **Additional Supports and Services:** States offered additional supports for participants to maintain service access. For instance, some states:
 - Proposed to increase the number of waiver slots while reducing and eliminating HCBS waitlists.
 - Worked with advocacy networks to communicate service changes, additional supports, and updates for individuals with intellectual and developmental disabilities
 - Modified or added HCBS including assistive technology, behavioral health, telehealth, personal care services, as well as housing supports and addiction treatment programs.
- **System Assessments and Redesign:** States proposed conducting organizational assessments, benefit designs, rate studies, and similar redesign and evaluation efforts.
 - For example, a few states mentioned equity analyses and participant surveys to evaluate participant satisfaction and service access, to identify areas for improvement.
 - Several states referenced new rate studies to gauge waiver spending and potential changes to waiver services and supports.

Considerations for Monitoring HCBS Access

- As states implement actions to widen access to HCBS programs and address challenges prompted by the COVID-19 PHE, states should monitor the following:
 - **Geographic Variation:** States should analyze local and economic factors to expand and maintain service access and provider networks in underserved areas.
 - States can utilize local data sources (e.g., county data) for benchmarking payment rates and evaluating direct service worker wages.
 - Bureau of Labor Statistics (BLS) regions are frequently used as the basis for rate setting inputs, cost estimation and inflation adjustments. States can utilize BLS regional metrics (e.g., occupation wages, CPI-U) to assist with evaluating wages, inflation, and other market factors.
 - **Participant Acuity:** States should monitor participants across all acuity levels to evaluate potential service gaps and align providers to participant needs.
 - For example, states may consider tiering service rates to offer higher rates for serving participants with more complex needs.

Considerations for Monitoring HCBS Access (cont.)

- **Qualifications within Provider Network:** Rate development processes should account for provider qualifications when determining rates.
 - In addition to establishing licensing, certification, training, age and education standards and requirements to allow providers to deliver services, these parameters should also be considered as part of the rate setting process.
 - State qualification standards and safeguards should be structured to protect waiver participant health and welfare. Family caregivers must meet the minimum qualifications established by the state. ~~to be necessary for delivery of the service.~~
- **Feedback from Providers and Participants:** States benefit from soliciting feedback on opportunities to strengthen provider networks and expand care.
 - States can conduct stakeholder engagement with participants, providers, caregivers, and state department representatives to receive feedback on existing service delivery processes as well as potential improvements.
 - States must complete Section 6-I, Public Input, in the 1915(c) waiver application to document public comments and verify that substantive waiver changes have been reviewed by stakeholders. This should include comments received on challenges accessing waiver services.

Considerations for Monitoring HCBS Access (cont.)

- **Rate Setting Methodologies:** Rate reviews must be conducted by states at least once every five years. The review process may include:
 - Reviewing the rate determination basis for each waiver service to evaluate whether existing payment rates are adequate to secure a qualified provider pool.
 - Identifying potential provider imbalances due to payment disparities for similar or like services:
 - For different waivers in the state
 - For similar services afforded under the state Plan
 - For different age groups

Considerations for Monitoring HCBS Access (cont.)

- **Service Delivery and Utilization:** To determine potential impacts on the financial accountability of waivers, states could consider monitoring and reporting service utilization and delivery information outlined below.
 - Changes in historic service-level utilization, including the number of participants utilizing an individual waiver service and service expenditure data in the CMS 372(s) reports, to identify trends that may impact service access and provider costs.
 - Performance measures that track whether services are delivered in accordance with the Person-Centered Service Plan (PCSP), including the type, scope, amount, duration and frequency specified in the PCSP.
 - Grievances and appeals data to determine whether participants experienced challenges with accessing services, locating providers, and/or receiving services in accordance with the type, scope, amount, duration and frequency specified in the PCSP.
 - Managed LTSS utilization data, when applicable, should be monitored to verify access and review utilization trends.

Summary & References

Summary

- 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 changes to address challenges related to the health and welfare of participants and adequacy of provider networks. Increased federal funding, including through the American Rescue Plan Act, allows states the opportunity to further identify strategies to expand and monitor access in 1915(c) waiver programs.
- It is important to remember that the Maintenance of Effort (MOE) for Section 9817 clarifies that the state must maintain and/or increase service rates until such a time as the MOE expires.

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For Further Information

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