

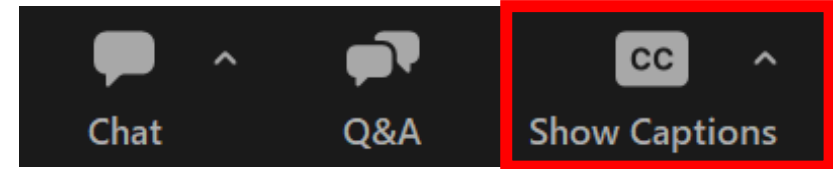
1915(c) HCBS Waiver Payments and Financing Trends

November 12, 2025

Closed Captioning and Asking Questions

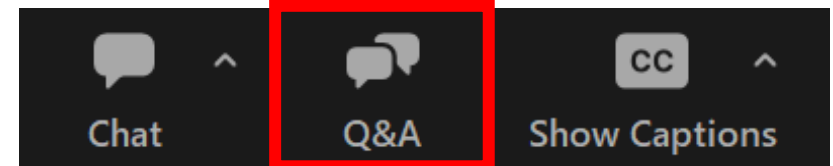
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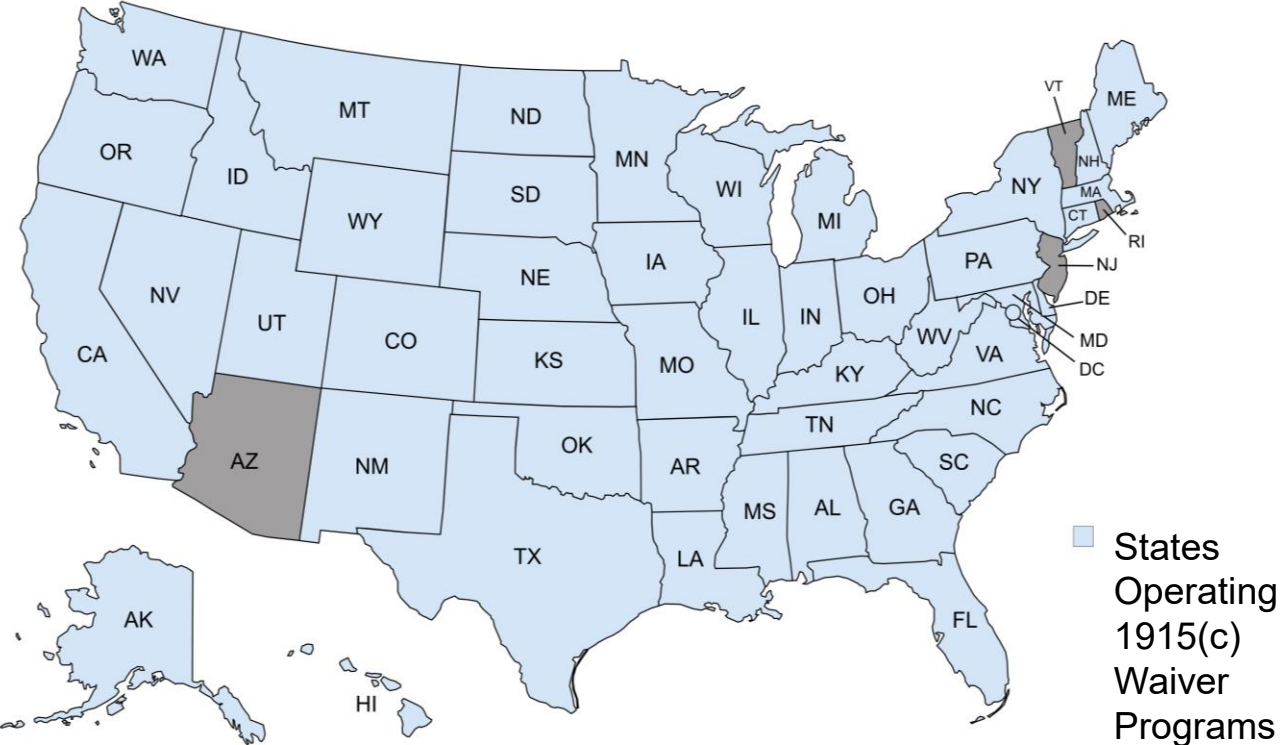
Training Objectives

- Provide an overview of active 1915(c) waiver programs, waiver financing, and the mechanisms and methodologies used to make payments in 1915(c) waiver programs.
- Review non-federal share financing methods for 1915(c) waiver programs, federal requirements, payments trends, and key examples of unique waiver program financing methods.
- Review 1915(c) waiver financing and payments data and trends including state examples and recent developments.

Overview of 1915(c) Waiver Programs

Active 1915(c) Waiver Programs

- Section 1915(c) of the Social Security Act permits states to furnish Home and Community Based Services (HCBS) in community-based settings.
- Forty-six states and the District of Columbia (referred to collectively as “states”) currently operate one or more 1915(c) waiver programs.
- Many states operate multiple waiver programs and have significant flexibility to tailor these programs to best meet the needs of their target populations.



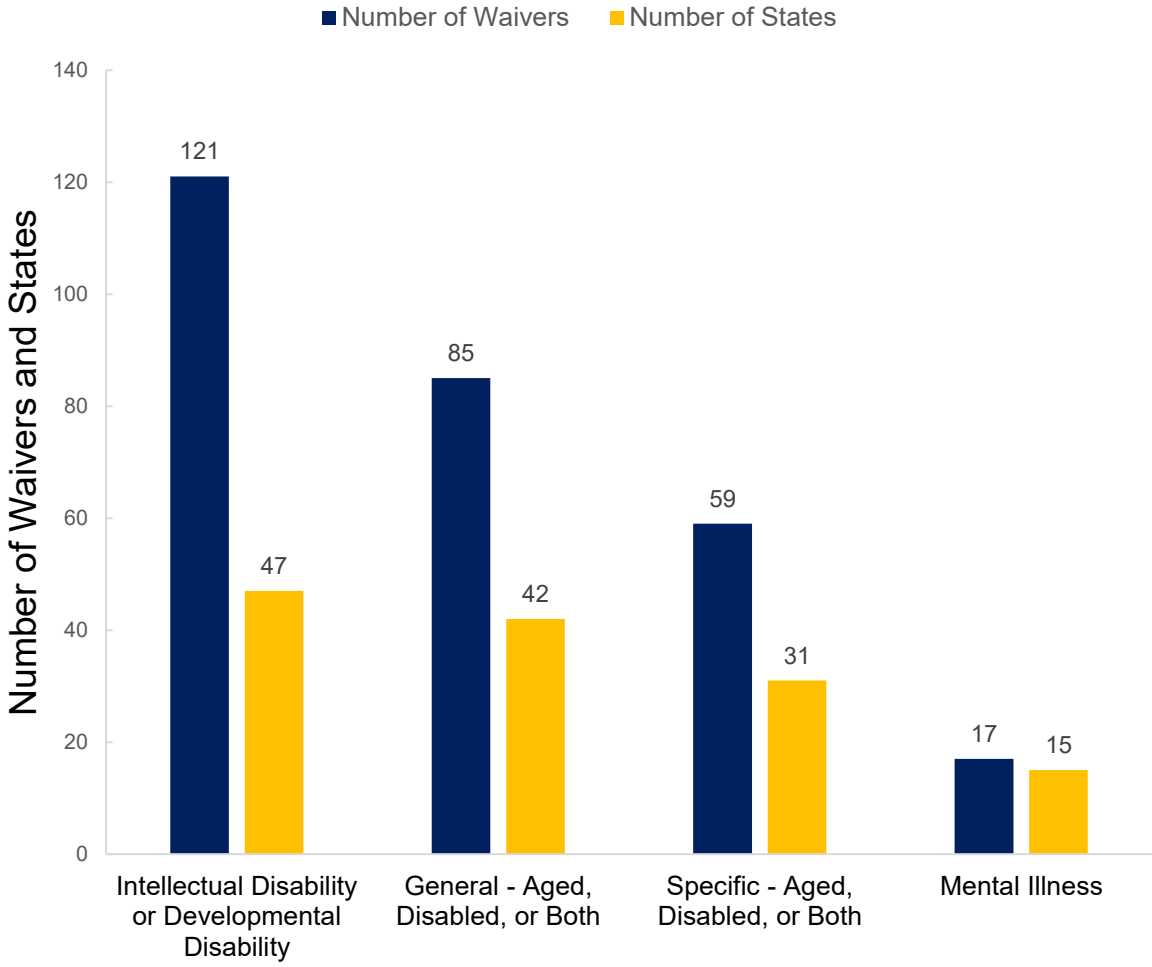
Number of Active Waivers	Number of States
261	47

**Data as of November 2024.*

Populations Served by 1915(c) Waiver Programs

- The 1915(c) waiver programs serve the following target groups:
 - Intellectual or Developmental Disabilities, or Both;
 - General Aged, Disabled, or Both;
 - Specific Aged, Disabled, or Both; and
 - Mental Illness.
- All 47 states that operate 1915(c) waiver programs serve Intellectual or Developmental Disability populations and over half serve the General and Specific Aged, Disabled, or Both populations.

Target Groups Served by 1915(c) Waiver Programs

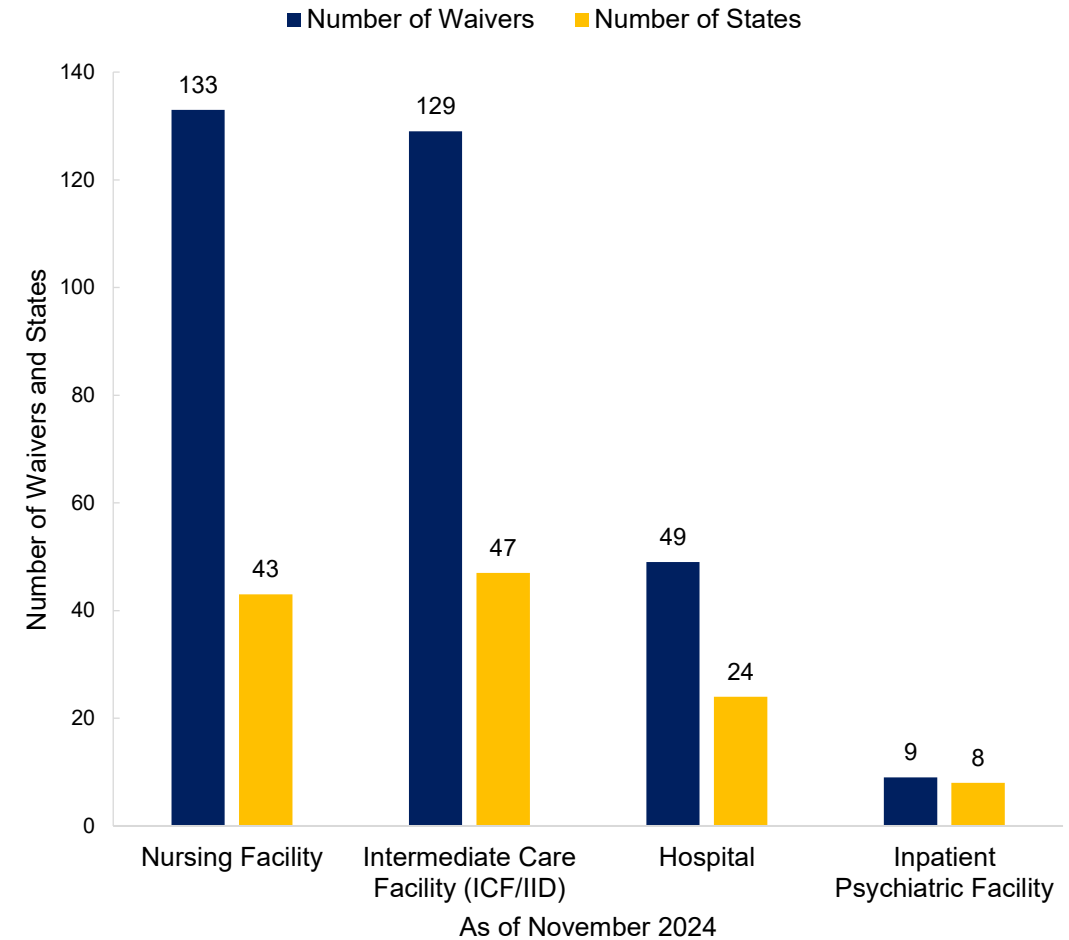


As of November 2024

Levels of Care Required by 1915(c) Waiver Programs

- Currently, participants must meet the minimum level of eligibility requirements for services in an institutional setting to qualify for HCBS.
 - Waiver services are available to individuals that require the level of care provided in a nursing facility, intermediate care facility (ICF/IID), hospital, and/or inpatient psychiatric facility.
- Most active waiver programs require the level of care provided in a nursing facility (133 of 261 waivers) and/or ICF/IID (129 of 261 waivers).

Levels of Care Required by 1915(c) Waiver Programs



1915(c) Waiver Program Cost Estimates

- States must demonstrate cost neutrality by confirming the average per capita expenditures under the waiver during each waiver year does not exceed 100 percent of the average per capita expenditures for services provided in a nursing facility, ICF/IID, hospital, or inpatient psychiatric facility.
- All 1915(c) waiver programs must be cost neutral, and states must demonstrate cost neutrality in the 1915(c) waiver application using the formula highlighted below:

$$D + D' \leq G + G'$$

- $D + D'$ represents the estimated annual average per capita Medicaid cost for HCBS and other services for individuals in the waiver program.
- $G + G'$ represents the estimated annual average per capita Medicaid cost for nursing facility, ICF/IID, hospital, or inpatient psychiatric facility care that would be incurred for individuals served in the waiver for HCBS and other services, were the waiver not granted.

Concurrent Operation with Other Programs

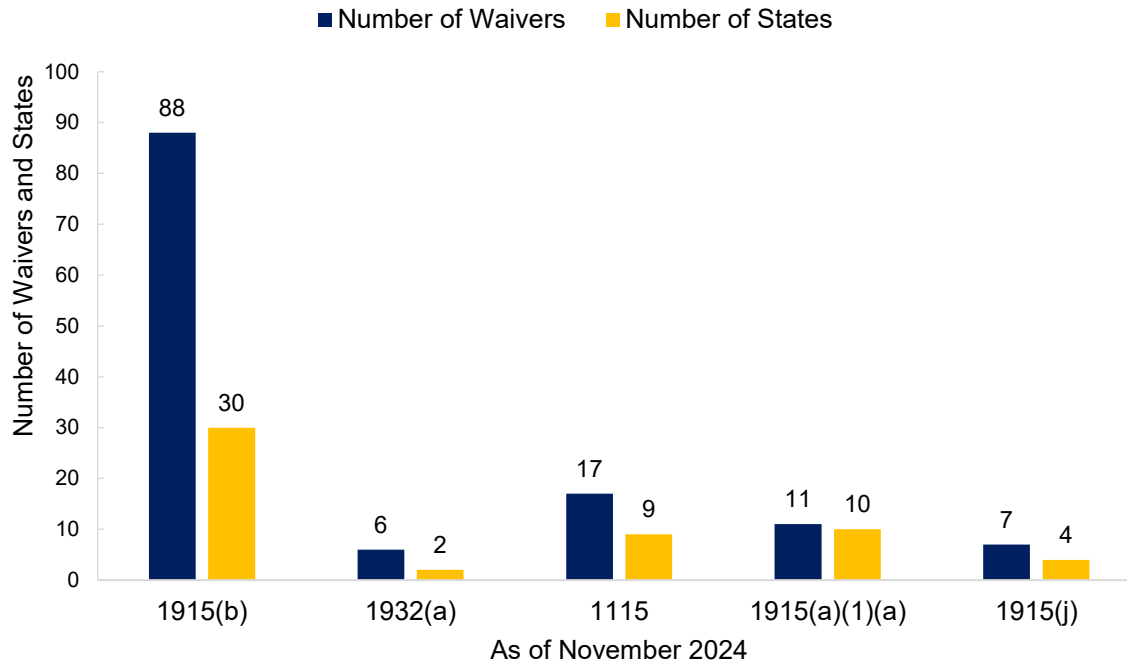
- The Social Security Act allows states to provide services simultaneously under multiple Medicaid authorities.
- States can use concurrent programs to combine the delivery of 1915(c) HCBS with the provision of other state plan services through a managed-care service delivery system.

Concurrent Operation with Other Programs	
1915(b)(1-4)	<ul style="list-style-type: none"> • (1) Freedom of Choice • (2) Enrollment Broker • (3) Non-Medicaid Services Waiver • (4) Selective Contracting Waiver
1115	Section 1115 Demonstration - Research & Demonstration Projects, Major Health and Welfare Programs
1915(a)(1)(a)	Services furnished by a managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) organization
1915(j)	Self-Directed Personal Assistant Services
1932(a)	State Plan Amendment for Managed Care Delivery

Concurrent Operation with Other Programs, cont.

- Many states operate concurrent programs. Almost half (129 of 261 waivers) of 1915(c) HCBS waiver programs operate concurrently with programs approved under other authorities.

Concurrent Operation with Other Programs



Concurrent Operation Example

- One State operates a 1915(c) children's waiver concurrently with 1915(b) and 1115 programs.
 - 1915(c):** Provides home health care management to children with disabilities.
 - 1915(b):** Permits service delivery from providers selectively contracted with financial management services.
 - 1115:** Provides a streamlined model of care for children and youth under 21 years of age with behavioral health and HCBS needs.

Trends in 1915(c) HCBS Waiver Program Financing

Overview of Waiver Financing Methods

- Per 42 CFR §433.51, states can finance waiver programs through public funds that are appropriated directly to the State Medicaid Agency, transferred from other public agencies (i.e., Intergovernmental Transfers), or expenditures certified by a contributing public agency (i.e., Certified Public Expenditures).
- States must specify all sources of the non-federal share of computable waiver costs in the 1915(c) waiver application.
- The federal share of computable waiver costs is provided by the Federal Medical Assistance Percentage (FMAP), which is the federal Medicaid matching rate for medical assistance furnished under the state plan.
 - States may receive 100% FMAP for providing eligible Medicaid services to American Indian and Alaska Native individuals.
- Most states finance waiver programs using state general funds and tax revenue.

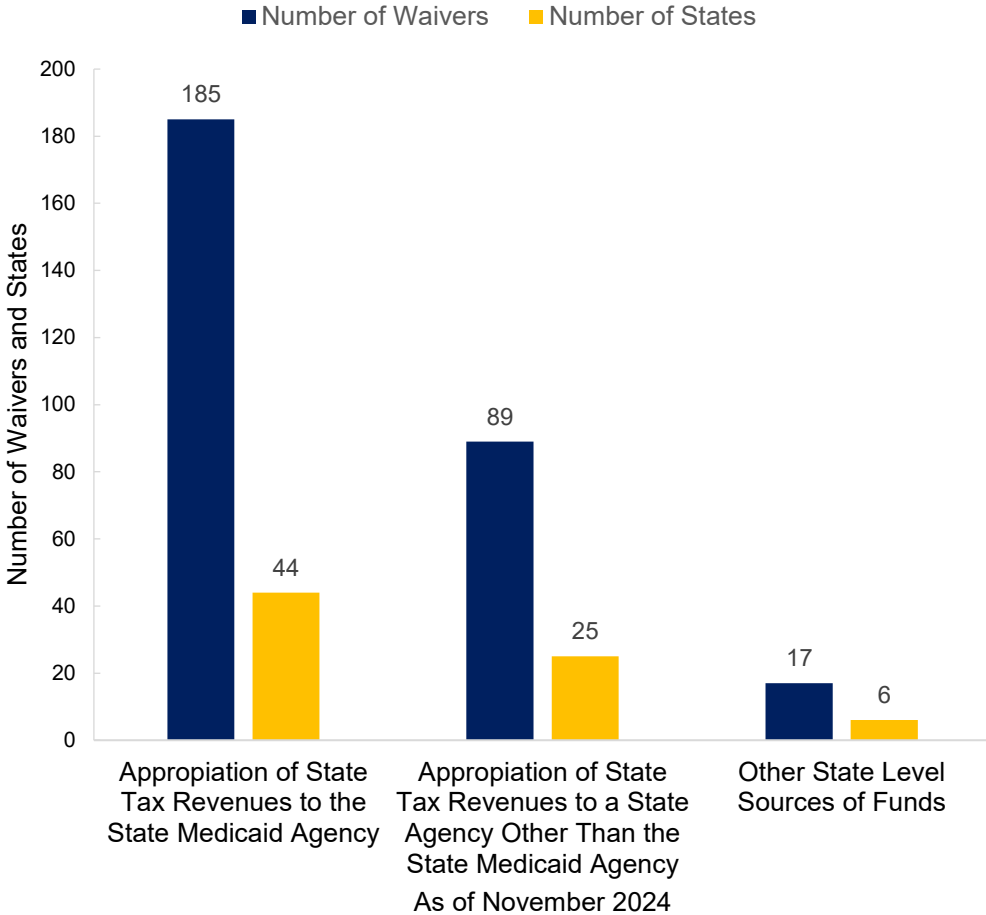
Methods for 1915(c) Waiver Program Financing

- States can finance waiver programs through a variety of methods including:
 - Direct funding from the state government using state funds and taxes;
 - Allocation through local government sources, including local funds and taxes; and
 - Cost-sharing arrangements with waiver participants (e.g., copayments).
- States must indicate the source of the non-federal funding share and describe the reimbursement mechanisms in waiver programs.

State Level Funding Sources

- All 47 states that operate 1915(c) waiver programs use state tax revenues as the source of the non-federal share to either the State Medicaid Agency or another state agency.
- Over half of states (25 of 47 states) allocate state tax revenues to agencies other than the State Medicaid Agency.
- Other tax-based state funds include the following:
 - Health care trust funds for provider taxes*;
 - Education trust funds;
 - Mental health trust funds; and
 - Drug rebates.

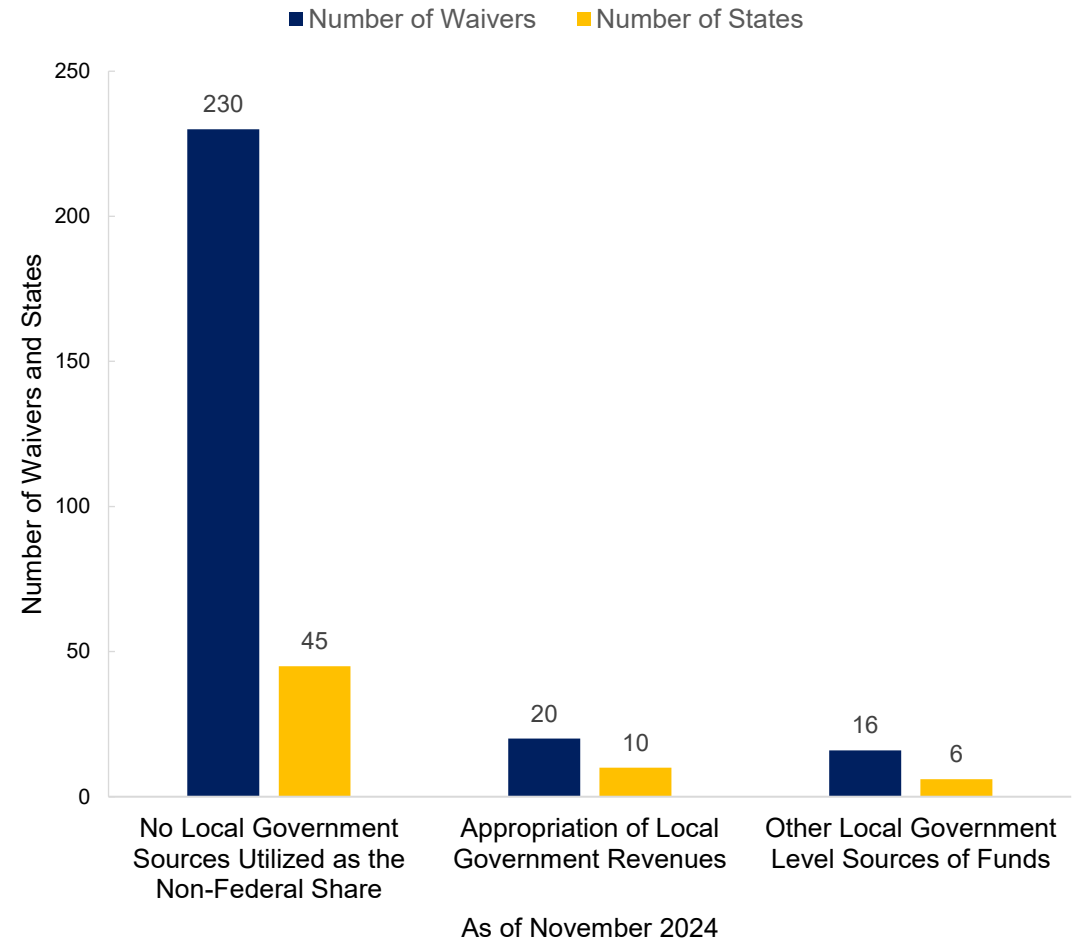
State Level Sources of the Non-Federal Share of Computable Waiver Costs



Local Government Funding Sources

- Local government agencies will reimburse State Medicaid Agencies to support 1915(c) waiver programs.
- Over one third of states (16 of 47 states) utilize local government funds as the non-federal share.
- Local government funding sources include:
 - General county taxes and revenue;
 - Healthcare reimbursement accounts;
 - Property tax;
 - Lottery revenue;
 - Tobacco tax; and
 - Miscellaneous special revenue funds.

Local Government or Other Sources of the Non-Federal Share of Computable Waiver Costs



Intergovernmental Transfer (IGT)

- IGTs occur when funds are transferred from another state agency or a local government entity to the Medicaid agency to be utilized as the non-federal share.
- If local government entities are obligated to provide all or a portion of the non-federal share, they may meet this obligation by transferring funds to the Medicaid agency.

Department of Aging

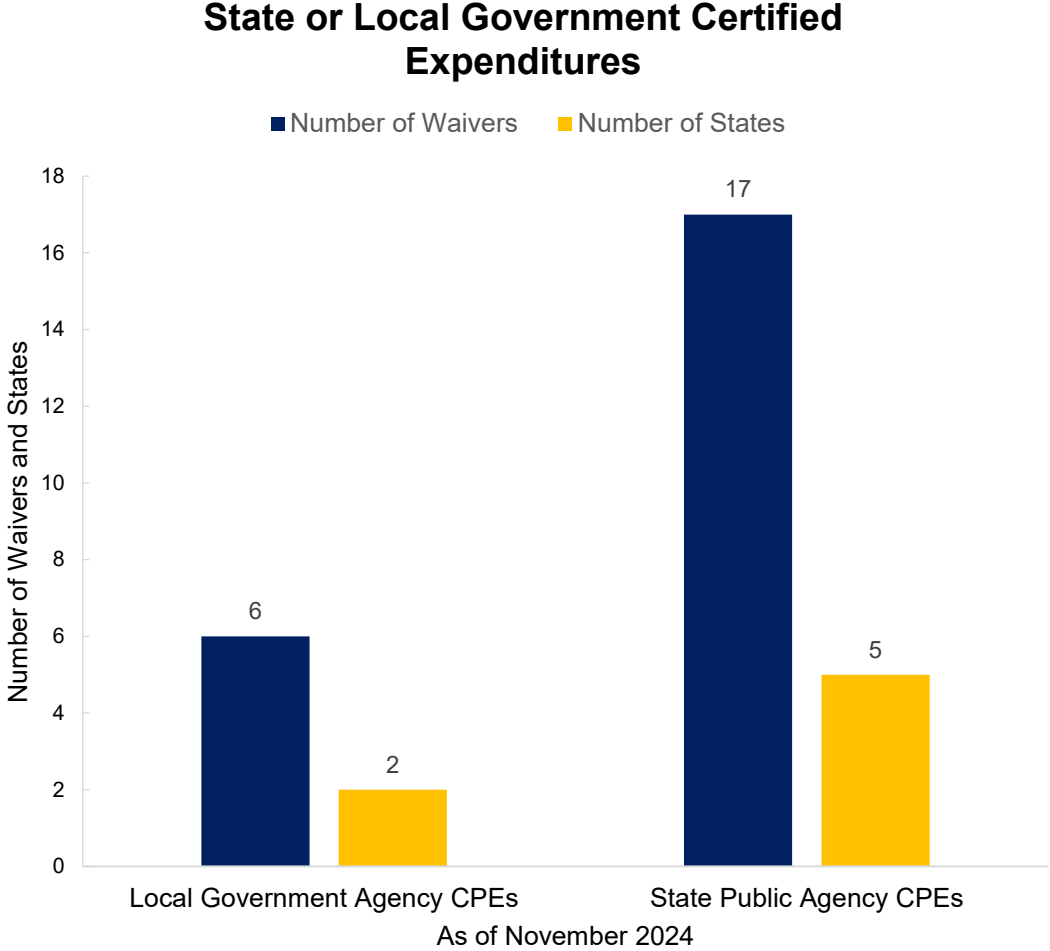
One State's non-federal share of waiver costs is transferred from state tax revenues appropriated to the Department for Aging and Independent Living and the Department for Public Health to the Medicaid agency through an IGT.

Division of Developmental Disabilities

Another State utilizes funds appropriated to the Division of Developmental Disabilities which are then transferred via an IGT to the State Medicaid Agency.

Certified Public Expenditures (CPEs) in 1915(c) Waiver Programs

- CPEs are funds that a state or local government agency expends (i.e., pays providers for waiver services or directly incurs expenses for services furnished by the entity) and submits a certification of the total amount expended to the State Medicaid Agency.
- CPEs do not involve the transfer of money directly to the State Medicaid Agency. Instead, the local government certifies the government funds were used to pay for the cost of providing Medicaid services.
- Seven of 47 states utilize CPEs in 1915(c) waiver programs through local government agencies and state public agencies.



Certified Public Expenditures Examples

- States can use CPEs through both state and local government agencies.

State Agency

- One State's Department of Developmental Services operates a 1915(c) waiver program and incurs CPEs which are reimbursed by the State.
- Another State's Aging and Disability Services Division incurs CPEs and uses a cost allocation plan to demonstrate how costs are allocated to services provided by the division.

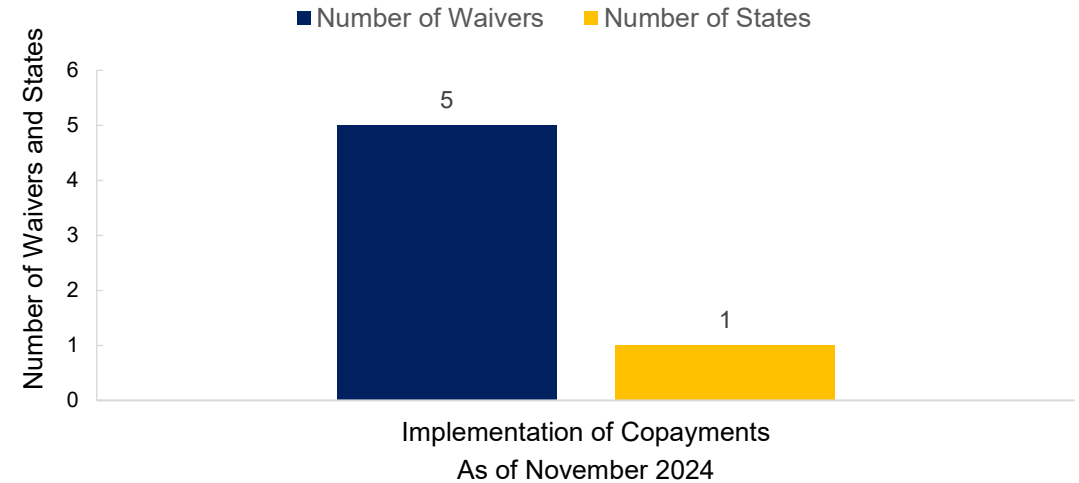
Local Agency

- In one State, CPEs are incurred when the county board of developmental disabilities delivers services, which the State will reimburse.
- In another State, Community Mental Health Services Programs, a local governmental entity, incurs CPEs for mental health service delivery which are reviewed and reimbursed by the State.

Cost Sharing Agreements

- States may establish cost sharing agreements, such as copayments, coinsurance, and deductibles, which require participants to pay a portion of the service costs.
- The payment amount from the cost sharing agreement must be deducted from the states' claim submitted to CMS for federal funding.
- One State that operates five of the 261 waivers includes a cost sharing agreement of a copayment.

State Imposes Copayments or Similar Charge Upon Participants for Waiver Services



Copayments

- One State implements copayments on prescription drugs and services provided in an assisted living facility for specific populations.

Trends in 1915(c) HCBS Waiver Program Payments

Overview of 1915(c) Payments

- As part of the 1915(c) waiver application process, states are required to respond to a variety of payment requirements that detail how the state administers payments and pays for waiver services.
 - **Waiver Service Payment Methodology:** States are required to provide rate determination methods to indicate how the state sets payment rates for each waiver service.
 - **Supplemental or Enhanced Payments:** States can make supplemental or enhanced payments to providers for 1915(c) waiver services in addition to the base payment to achieve overarching waiver program goals or program initiatives.
 - **Fiscal Intermediary or Agent:** States may use a fiscal intermediary or agent to facilitate payments and ensure payment accuracy for the provided waiver services.
 - **Payments to Specific Types of Providers:** States make payments to a diverse pool of qualified providers which may include government providers and live-in caregivers. The payment mechanism for the provider is dependent on the type of provider rendering services.

Statewide Rate Methodology Requirements

- States are required to describe waiver service rate determination methods and establish the entity or entities responsible for rate determination and oversight. States must include:
 - When rates were initially set and last reviewed;
 - How the state measures rate sufficiency and compliance;
 - The rate review method(s) used; and
 - The frequency of rate review activities.
- Rates may vary based on several factors including but not limited to type of service, level of care, geographic location, and provider type.

Rate Determination Methods

- Payment rates generally fall into the rate determination methods listed below.

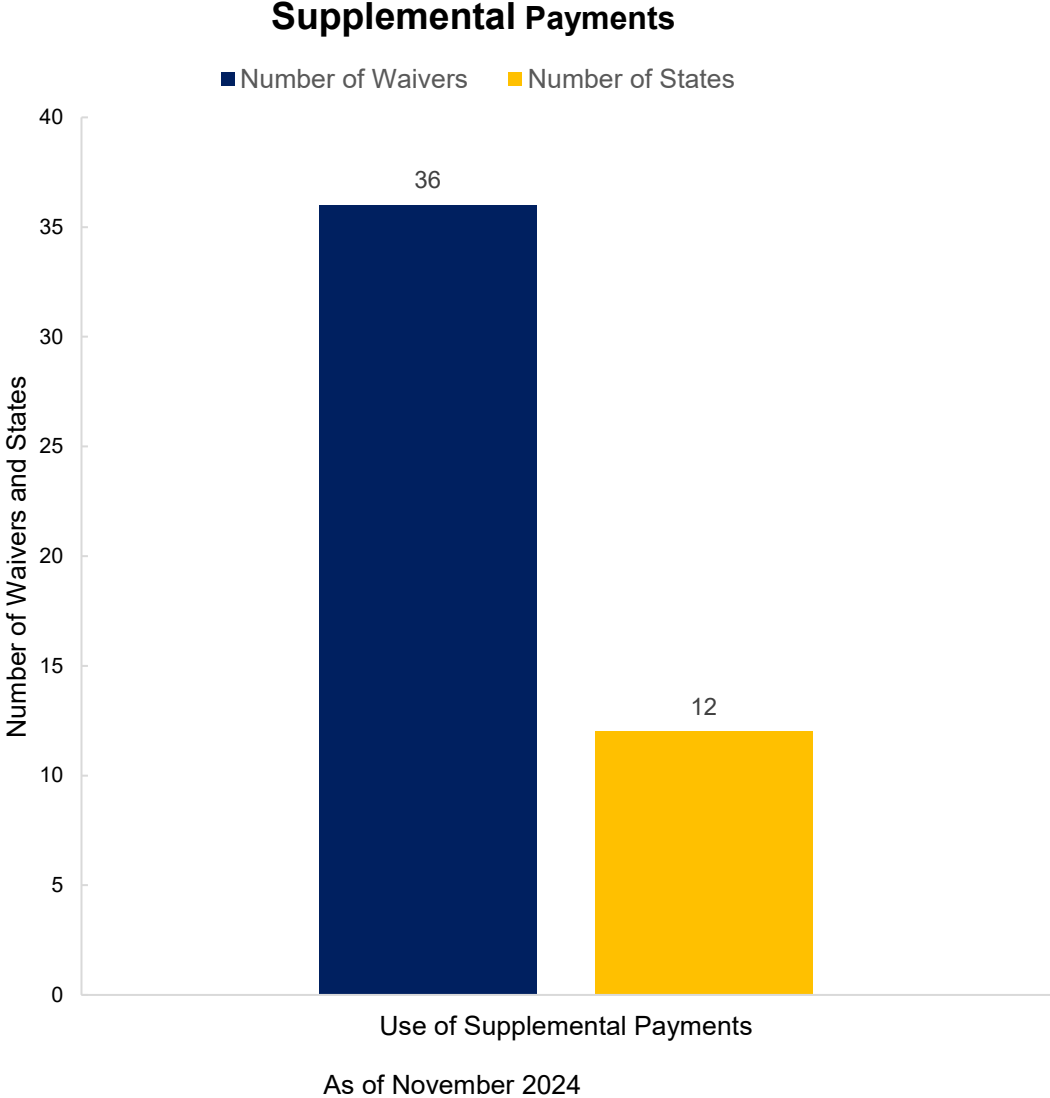
Method	Description
Fee Schedule (Fee-for-Service)	A fee schedule is used when a provider receives a fixed, pre-determined rate for a single service for a specified unit of time.
Negotiated Market Price	Payments for services are made using a negotiated market price when the provider receives the current market or negotiated price for an individual service or good.
Tiered Rate Payments	Tiered rates are fee-for-service or fee schedule payment rates in which the rate varies by an identified characteristic of the individual, the provider, or some combination of both.

Rate Determination Methods, cont.

Method	Description
Cost Reconciliation Payments	A type of rate setting where providers file cost reports or cost surveys that are created by the state. The state sets interim rates for waiver services and includes a reconciliation process at the end of the fiscal year to align payment rates with provider costs.
Capitated Payments	In a managed care payment system, services are reimbursed via a per member per month rate methodology. The managed care capitation payments can vary by factors including acuity, level of care, and risk of high utilization.
Outcome-Based Payments	An outcome-based payment is a performance-related or incentive-based reimbursement model contingent on a designated participant outcome.

Supplemental Payments

- Supplemental or enhanced payments are additional payments to providers that are separate from the base payments for services rendered.
- For example, states may use these payments to:
 - Incentivize providers based on service quality and participant satisfaction;
 - Promote training and continuing education;
 - Expand access to care; and
 - Address operational costs.
- Currently, 12 states across 36 waivers provide supplemental payments.



Supplemental Payment Examples

- States use supplemental payments to help meet waiver program goals, including efforts to strengthen and expand the workforce.

Prevention and Wellness

- In one State, supplemental payments are made to eligible residential providers who provide licensed/certified community living arrangement services for the completion of an annual survey. The survey collects data on individuals who received select preventative health services based on nationally recognized standards.

Workforce

- In one State, supplemental payments are used to strengthen and increase the pay of the direct support professional workforce. Payments will be disbursed to provider agencies in annual, lump sum allotments.
- One State provides supplemental payments to providers whose employees become certified or re-certified as trained specialists.

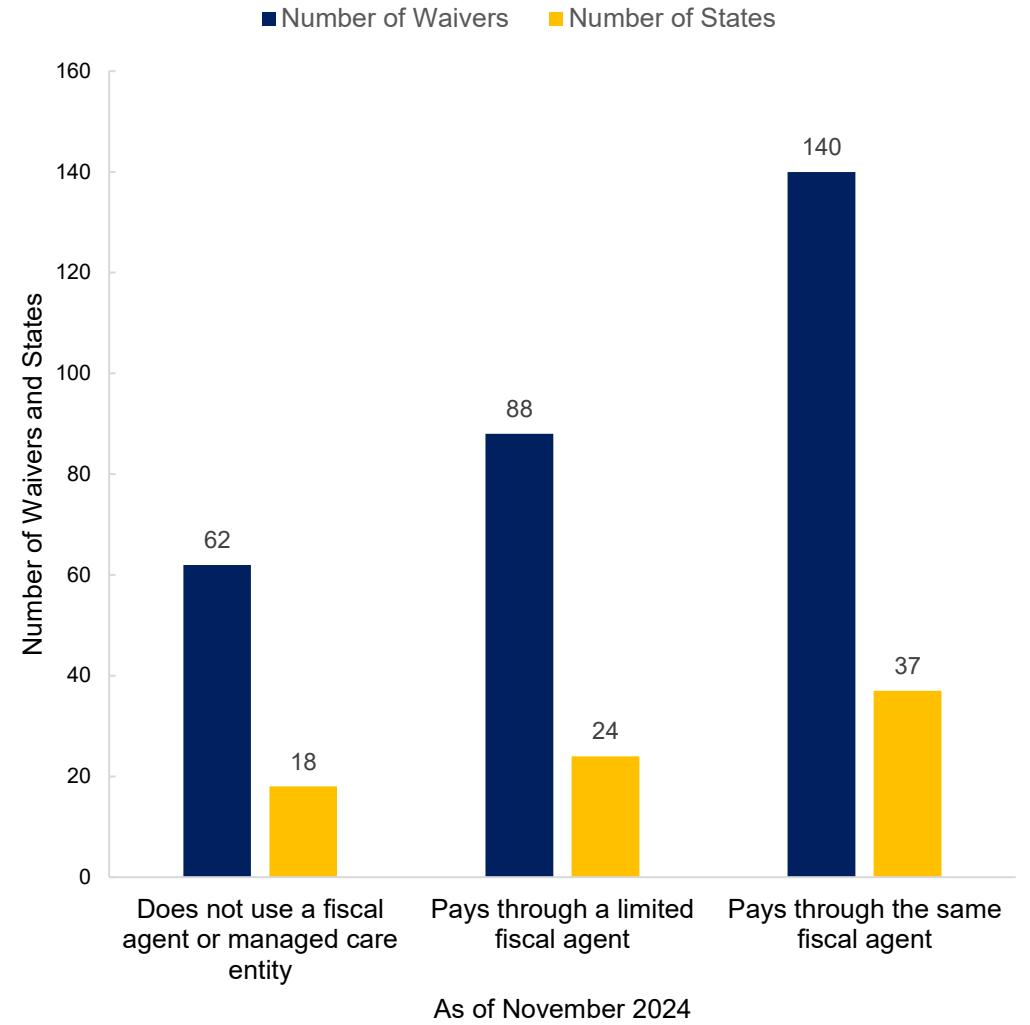
Training

- In another State, supplemental payments are provided by appropriated funds to providers across all services for the successful completion of direct service professional training and development courses.

Fiscal Intermediary or Agent

- Waiver providers do not need to submit claims directly to the State. States can use alternate arrangements, including fiscal intermediaries.
 - Fiscal agents may process invoices, verify eligibility, manage participant funds, execute Medicaid provider agreements, and ensure compliance with state regulations regarding HCBS service delivery.
 - Limited fiscal agents are contractors that processes claims, receives payments for approved claims, and disburses funds to providers.
- The State Medicaid Agency must have a process to screen fiscal agents, and, if used, the fiscal agent is subject to Medicaid agency oversight.
- Most states pay through a limited fiscal agent or through the same fiscal agent.

Fiscal Intermediary or Agent Use



Fiscal Intermediary or Agent Examples

- States can use fiscal intermediaries and agents to assist in billing, financial management, and other general payroll functions.

Billing Services

- In one State, payments for waiver services will be made either by the Medicaid Management Information System (MMIS) directly or the fiscal intermediary (FI) depending on the service. The FI serves as the billing agent for providers of waiver services and will submit claims on behalf of waiver service providers to the MMIS. The FI will ensure that claims for waiver services provided by individuals will be subject to the limitations established in the approved service plan and will request formal documentation (e.g., timesheets) from these individual providers.

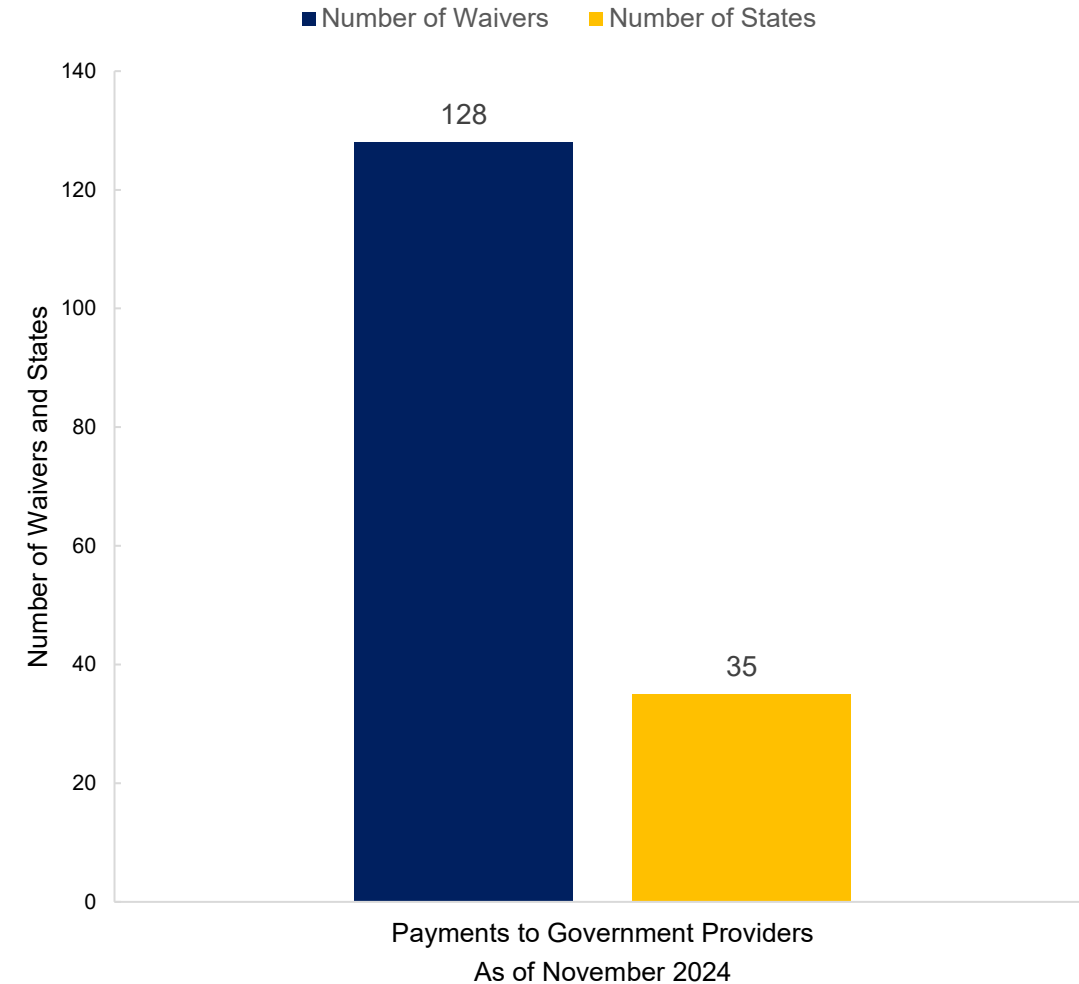
Self-Direction

- In one State, a financial management services entity is used to make payments for in-home services and respite delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. The entity cuts checks biweekly and transfers funds to workers by direct deposit.
- Another State contracts with a limited fiscal agent for self-directed waiver services. The limited fiscal agent performs general payroll functions, including withholding taxes.

Payments to Government Providers

- State or local government providers may provide certain waiver services if they meet the provider qualifications. However, states may not limit the provision of a service to only government providers.
- States must specify the state or local government providers that receive payments.
- Payments to state or local government providers may differ from payments to other providers when the payment is based on the reasonable costs that state or local government providers incur in furnishing the service.
- Currently, 35 states across 128 waivers make payments to government providers.

Payments to Government Providers



Payments to Government Providers Examples

- Many states make payments to government providers for waiver services rendered by local and state providers.

Operating Agency

- In one State, the State Department of Mental Health is the operating agency for the I/DD waiver and provides services such as day habilitation, employment support, personal care, respite, and more.
- In another State, some waiver provider agencies are local county governments and receive the same monthly comprehensive care management reimbursement rate as other agencies providing the same services.

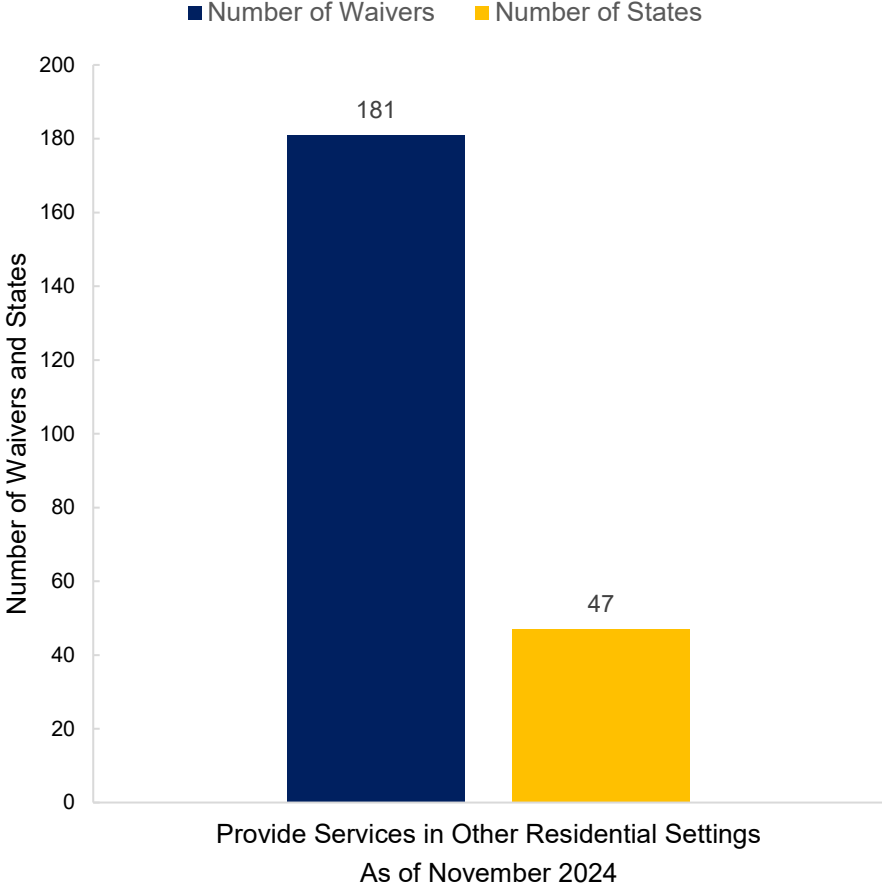
Local Services

- One State uses respite services provided by local health departments due to a lack of qualified providers in the area to meet the needs of participants.
- Another State has county owned hospitals and nursing facilities provide home delivered meals and respite care.

Payments for Services Furnished in Other Residential Settings

- States may furnish waiver services in residential settings that are not the participant’s own private residence, but they must include how the cost of room and board are excluded in the methodology.
 - 42 CFR § 441.310(a)(2) prohibits making Medicaid payments for room and board (e.g., housing, food, and utility costs).
 - States may exclude the costs of room and board by separating room and board costs from service costs in determining payment rates or basing payments solely on service costs.
- Medicaid payments may only be used for the services provided.
- All 47 states that provide HCBS furnish waiver services in residential settings other than the private residence of the individual.

Services Furnished in Residential Settings Other than the Private Residence of the Individual



Excluding Room and Board State Examples

- States may use different methodologies to identify and exclude room and board costs from Medicaid payments for services delivered in residential settings.

Direct Cost of Services

Rates for community residential services and respite services exclude the costs related to room and board. These rates only include the cost of direct care services. No reimbursement of room and board costs occurs for any residential setting. Individuals contribute to room and board costs through earned and unearned income.

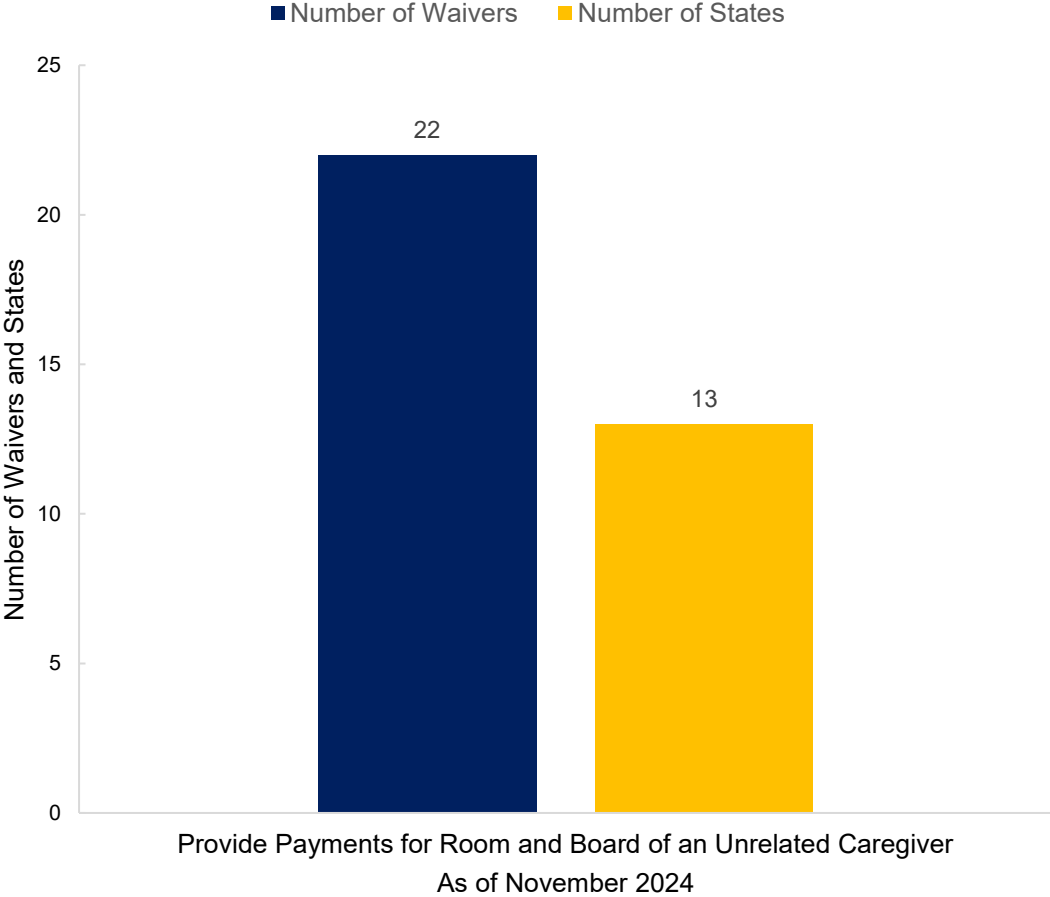
Other Funds

Room and board rates are determined based on the Supplemental Security Income (SSI) payments available for individuals and married couples and are separate from reimbursement by the Medicaid agency for waiver services. Room and board costs are paid directly to the supportive living program provider by the customer. These rates increase whenever SSI amounts increase.

Payments for Rent and Food Expenses of an Unrelated Live-In Caregiver

- The only exception to the room and board exclusion is when the participant is receiving respite outside of a private residence in an approved facility or when the participant requires an unrelated personal caregiver who resides in the same household.
- For this provision, “unrelated” is defined as someone who is unrelated by blood or marriage.
- A personal caregiver provides a covered waiver service to meet the participant’s physical, social, or emotional needs.
 - These services are not directly related to personal care giving (e.g., housekeeping or chore services).
- 13 states across 22 waivers provide payments for room and board of an unrelated caregiver.

Reimbursement for Room and Board of an Unrelated Live-In Caregiver



Payments for Rent and Food Expenses of an Unrelated Live-In Caregiver Examples

- States may use any reasonable method to apportion the cost of room and board of an unrelated live-in caregiver.

Maximum Payment

The maximum payment for the rent and food expenses of a live-in personal caregiver is the sum of: (a) one-half of the most-recent published federal housing and urban development fair market rent for a two-bedroom living unit in the geographic area where the participant resides and (b) the current United States Department of Agriculture maximum food stamp allowance for a single individual.

Methodology

The rent and food expenses of an unrelated live-in caregiver, who does not hold the lease or own the residence, will be determined by dividing total household rent and food expenses by the number of residents in the home, including the caregiver. The caregiver is considered a resident in the home, and food and rent expenses are apportioned equally among all persons residing in the home.

Summary

- States use a variety of funding sources (e.g., federal, state and local) and payment mechanisms to deliver waiver programs.
 - States may use state funds and taxes, allocate local government funds, and utilize cost-sharing agreements.
- States primarily use a standard approach for waiver payments and financing, although a few programs adopt a unique approach to meet the needs of their program and populations.
 - There are six widely used rate determination methods to set rates for services.
 - States may leverage supplemental payments and utilize fiscal agents to assist with billing processes as strategies to incentivize provider participation and improve waiver program service delivery.
- States can leverage a variety of payments and financing methods to successfully operate waiver programs.

References

- Center for Medicare and Medicaid Services. “1915(c) Home and Community Based Waiver Instructions, Technical Guide and Review Criteria Version 3.7.” https://wms-mmdl.cms.gov/WMS/help/version_3.7_1915c_Waiver_Application_and_Accompanying_Materials.zip
- Center for Medicare and Medicaid Services. “*State waivers list*” <https://www.medicare.gov/medicaid/section-1115-demo/demonstration-and-waiver-list>
- Center for Medicare and Medicaid Services. “Home and Community-Based Services Training Series – **Rates and Fiscal Integrity**.” Includes trainings on rate setting methodologies, fiscal audits, cost neutrality, and financial accountability in 1915(c) waiver programs. <https://www.medicare.gov/medicaid/home-community-based-services/home-community-based-services-training-series>