1915(c) Home and Community-Based Waiver Application

Documenting Appendices I and J

This job aid offers promising practices for completing Appendices I and J of the 1915(c) waiver application, which focus on the financial management of waiver programs.[1] The job aid is optional for states and focuses on the sections of these appendices that most often result in Requests for Additional Information (RAI). Including sufficient detail in the waiver application before submitting it to CMS:

- Reduces the number of questions in an RAI;
- Reduces the amount of time required for the RAI; and
- Maximizes the information available for public comment.

Appendix I: Financial Accountability

Checklist for Documenting Appendix I-1 (Financial Integrity and Accountability):

Does the state's application:

- Specify whether the state requires waiver providers to secure an audit of their financial statements?
- Specify which state agency (or agencies) are responsible for conducting the independent financial audit of the waiver program in accordance with the Single Audit Act? [2]

If services are furnished on a fee-for-service basis, does the application:

- Describe how data is selected for review?
  - Data source (e.g., MMIS claims)?
  - Frequency (e.g., annually)?
  - Sampling methodology (e.g., random sample with 95% confidence level and +/- 5% margin of error)?
  - Time period (e.g., one year of claims data)?
- Indicate whether data selection differs by service?
- Indicate the method of the review (i.e., what the reviewer is validating)?
  - How the state determines whether to complete a desk or on-site review?
- Indicate whether review methods differ by service?
- Detail what state agency (or agencies) are responsible for conducting review activities?
  - Does the state use contractors? If so, what state agency is responsible for overseeing contractor performance?
- Detail how the results of reviews are communicated to providers?
- Indicate whether corrective action plans are required from providers?
  - How the state ensure corrective action plans are followed by providers?
- Describe how the state performs billing / post-payment reviews of claims processed by a FMS or OHCDS entity, if applicable?

If the state makes capitated payments to managed care entities (e.g., MCOs, PIHPs or PAHPs):

- Does the application include alternative methods used to ensure financial accountability?
  - For example, does the state validate member eligibility or require managed care entities to implement post-payment review activities?

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[1] This job aid focuses specifically on documenting a subset of Appendices I and J. For further guidance on applicable statutory, regulatory and other requirements, states should refer to the CMS Instructions, Technical Guidance and Review Criteria at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf. for §1915(c) waivers released in January 2015.

[2] HCBS waivers (like other Medicaid services) are subject to requirements of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146).

Checklist for Documenting Appendix I-2-a (Rate Determination Methods):

If services are furnished on a fee-for-service basis, does the application:

- Provide sufficient detail for an independent party to understand how rates were developed?
  - What is the rate setting methodology (e.g., fee schedule, negotiated market price, cost reconciliation, etc.)?
  - What data sources are used to determine rates (e.g., provider cost survey, wage data, etc.)?
  - If applicable, what cost factors (i.e., base wage, employee expenses, administrative expenses, program expenses, productivity adjustments, and inflation) and cost assumptions does the state use to determine rates?
  - If you have a tiered rate setting methodology, what differences in cost assumptions produce the tiered rates?
- Include rate setting information for each waiver service? Remember that the state may group services where the same method is employed.
- List differences between agency-directed and self-directed service rate setting, if any?
- Indicate when the rate methodology was set?
- Indicate when the rate was last reviewed?
- Indicate the frequency of rate review activities?
- Specify how the state measures whether rates are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers?[3]
- Describe how the state solicits public comments on rate determination methods?
- Describe how information about payment rates is made available to waiver individuals?

If the state makes capitated payments to managed care entities (e.g., MCOs, PIHPs or PAHPs):

- Does the application reference the §1915(b) waiver application and associated materials?

[3] This requirement is outlined in §1902(a)30(A) of the Social Security Act.

Appendix J: Cost Neutrality Demonstration

CMS expects that derivations of each factor will be the data the state has reported via the CMS-372(S) (referred to as “372” from this point) trended forward to reflect inflation adjustments. However, there are cases when an alternate basis may be appropriate. Use the following checklist as a guide for explaining and justifying departures from the 372 baseline.

Checklist for Determining if an Alternate Basis is Appropriate:

- Does your 372 data have outliers (e.g., abnormally large increases and decreases in participant counts, service utilization, service costs, etc.)?
- Are there new services that are not reflected in 372 data?
- Are there services that have been removed since the last 372?
- Has the waiver experienced changes in the scope or definition of services?
- Are there external reasons for service cost or utilization changes (e.g., the addition of a specific number of slots or legislative budgetary increase)?

Checklist for Documenting Appendix J-2-c (Derivation of Estimates of Each Factor):

- Does the state document the source of the baseline for Factors D, D', G and G'?
  - If this is not the 372, does the state include the baseline in the application?
- Does the state include the percentage used to trend the baseline?
- Does the state explain and justify every percentage in Appendix J-2-c?
  - If the percentage is based on inflation, does the state indicate the population, area, series title, and index base period for the inflation metric?

Special Considerations for Factor D

- Does the state describe the basis for calculating the elements used in Factor D estimation (i.e., estimated number of users, units per user, average cost per unit, and overall average length of stay)?
- If the application includes a new service, has the state included the basis of estimates?
- Is the basis of factor estimates described in Appendix J-2-c consistent with the growth trends in Appendix J-2-d?

Special Considerations for Factor D'

- If the state develops D' through sampling a comparable population, does the state provide information on the process used, including specific data sources?

Special Consideration for Factors G and G'

- Does the state's data only include the level(s) of care indicated in the waiver request?
- If Factor G' is greater than Factor D', does the state explain why?