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Waiting Lists in Medicaid Section 1915(c) Waivers

Background

The Social Security Act (SSA) authorizes several waiver and demonstration authorities that give states flexibility in operating their Medicaid programs. Each waiver authority has a distinct purpose and specific requirements. Medicaid waivers provide states the opportunity to try new or different approaches to the delivery of health care services or to adapt programs to the special needs of particular geographic areas or groups of Medicaid enrollees. For example, waiver programs allow states to extend benefits that are, among other things, neither comparable across groups nor statewide.

The term Medicaid "waiver" is so-named because states may request that the Secretary of the Department of Health and Human Services (HHS) waive certain statutory requirements that would normally apply to services covered under Medicaid state plans. For each waiver, states must submit a waiver application for review and approval by the Centers for Medicare & Medicaid Services (CMS). Unlike Medicaid state plan benefit coverage, Medicaid waiver benefit coverage is time-limited for the duration of the waiver (e.g., three or five years) and must be renewed by the state subject to CMS approval.

Section 1915(c) Home and Community-Based Services (HCBS) Waiver authority authorizes the Secretary of HHS to waive certain requirements of Medicaid law, thereby allowing states to cover a broad range of HCBS (including services not available under the Medicaid state plan) for certain persons with long-term care needs. Specifically, under SSA Section 1915(c) states may waive rules regarding "statewideness" and "comparability" of services. States may also apply certain income-counting rules to persons in HCBS waivers that allow an individual to be eligible for Medicaid who might not otherwise qualify. For FY2014, Medicaid expenditures for Section 1915(c) HCBS waivers were $41.5 billion.

Section 1915(c) Waivers

Section 1915(c) waivers are designed to expand opportunities for states to provide home and community-based care to additional groups of persons with long-term services and supports (LTSS) needs while containing Medicaid costs. Under this authority, states with approved applications may provide home and community-based care to persons who, without these services, would require Medicaid-covered institutional care. Section 1915(c) waivers permit states to cover services beyond the medical and medically related benefits that have been the principal focus of the Medicaid program. Under this authority, states can cover a wide variety of nonmedical, social, and supportive services that allow individuals to live independently in the community.

Covered Services

The Medicaid statute specifies a broad range of services that states may provide to waiver participants. These services include case management, homemaker/home health aide, personal care, adult day health, habilitation, rehabilitation, and respite care. States also have flexibility to offer additional services, when approved by the HHS Secretary. For individuals with chronic mental illness, states may cover day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) under a waiver. Section 1915(c) waivers may not cover room and board in a community-based setting, such as an assisted living facility.

Target Population

States must target a Section 1915(c) waiver to a specific population, such as individuals under age 65 with physical disabilities, individuals with intellectual or developmental disabilities, individuals aged 65 and older, or individuals with mental illness. As a result, states typically have more than one approved Section 1915(c) waiver, with each waiver program offering a specialized package of HCBS to a specific population. A CMS final rule published in 2014 gives states the option to combine target groups within one waiver program. Prior to this change, a Section 1915(c) waiver could serve only one of the following three target groups: (1) older adults, individuals with disabilities, or both; (2) individuals with intellectual disabilities, developmental disabilities, or both; or (3) individuals with mental illness. Eligible waiver participants must meet certain financial requirements (including income and resource requirements) and state-defined level-of-care criteria that demonstrate the need for LTSS. That is, individuals must have a level of need for LTSS that would otherwise be covered under a Medicaid institutional benefit, such as nursing facility care, Intermediate Care Facility for people with Intellectual Disability (ICF/ID), or hospital care.

Waiting List Requirements

There are no statutory or regulatory requirements that define or describe waiting lists for Medicaid Section 1915(c) waiver programs. Under the Section1915(c) waiver authority, states may cap the number of individuals served in a waiver program by setting a numerical limit (no less than 200) on the number of individuals participating in the waiver. Such limitations must be specified in the state's application for a Section 1915(c) waiver, which is subject to CMS approval. Because state Medicaid programs often have greater demand for HCBS than the number of available waiver "slots" for a given program, limiting the number of individuals receiving HCBS is one way for states to contain costs. As a result, many states maintain waiting lists (sometimes referred to as interest lists, planning lists,

and registries) when their program slots are filled or when state legislatures do not fully fund the maximum number of waiver slots under the CMS-approved waiver program. According to CMS technical guidance for the Section 1915(c) waiver:

> The state's limit on the number of individuals who participate in a waiver may result in a waiting list for waiver services (e.g., entrance to the waiver of otherwise eligible applicants must be deferred until capacity becomes available as a result of turnover or the appropriation of additional funding by the legislature). Entrance to the waiver may not be deferred when there is unused waiver capacity (except when a state has established a point-in-time limit, reserved capacity or made entrance subject to a phase-in schedule). If it is necessary to defer the entrance of individuals to the waiver, the state must have policies that govern the selection of individuals for entrance to the waiver when capacity becomes available. These policies should be based on objective criteria and applied consistently in all geographic areas served by the waiver.

State Use of Waiting Lists

The most recent data for Medicaid Section 1915(c) waiver program waiting lists is from analyses by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and the University of California, San Francisco, from a Section 1915(c) Waiver Policy Survey that collected data for 2015. These data were published by KCMU in an October 2016 report. **Table 1** provides data on Section 1915(c) waiver program waiting lists across all states and the District of Columbia (DC) by waiver target population group.

In summary, 47 states and DC had at least one Section 1915(c) waiver program in 2015, for a total of 293 programs. Thirty-five states reported having waiting lists; 12 states and DC reported no such lists. Among the 35 states with waiting lists, there were an estimated 640,841 wait-listed individuals across 131 Section 1915(c) waiver programs. The average wait time across all programs was just over two years (27 months); however, the average length of time an individual may spend on a waiting list varies by target population and ranged from 4 months for HIV/AIDS waivers to 43 months for individuals with Intellectual/Developmental Disabilities (I/DD) waivers.

Of waiver programs with wait lists, 70% prioritized certain clients. In addition, two-thirds of waiver programs with wait lists screened individuals for Medicaid eligibility (67%). Thus, since not all waiver programs with wait lists screened individuals, the total number of persons on wait lists may be an overestimate of the number of individuals who are eligible for Section 1915(c) waiver services. The majority of waiver programs with wait lists (92%) provided non-waiver services to Medicaid-eligible individuals who are also on the wait list for a waiver slot.

Table 1. Data on Waiting Lists for Medicaid Section 1915(c) Waiver Programs, by Target Population
(Data for 2015)

	I/DD	Aged/ Disabled	Children (<18)	Disabled Only	Aged Only	TBI/ SCI	HIV/ AIDS	Mental Health	Total
Number of Waiver Programs	103	54	51	24	18	27	11	5	293
Number of Program Waiting Lists	56	19	23	12	4	15	1	1	131
Number of Persons on Waiting Lists	428,151	117,693	51,606	11,744	27,731	3,823	65	28	640,841
Average Waiting Period (months)	43	18	25	17	25	16	4	5	27
Number (%) of Waiting Lists that Screen for Eligibility	34 (61%)	14 (74%)	18 (78%)	7 (58%)	3 (75%)	10 (67%)	1 (100%)	1 (100%)	10 (67%)
Number (%) of Waiting Lists that Prioritize Clients	39 (70%)	16 (84%)	12 (52%)	8 (67%)	3 (75%)	12 (67%)	1 (100%)	1 (100%)	12 (67%)
Number (%) of Waiting Lists that Provide Non-Waiver Services	52 (93%)	18 (95%)	20 (87%)	11 (92%)	4 (100%)	13 (87%)	1 (100%)	1 (100%)	13 (87%)

Source: Terrance Ng, Charlene Harrington, MaryBeth Musumeci, et al. *Medicaid Home and Community-Based Services Programs: 2013 Data Update*, KCMU, October 2016, see Tables 5, 13, and 14, pp. 45-46.

Notes: I/DD = Intellectual/Developmental Disability; Aged/Disabled = Individuals with physical disabilities/Individuals Aged 65+; Children (< 18) = children under age 18 who are medically fragile or technology-dependent; Disabled Only = Individuals with physical disabilities; Aged Only = Individuals aged 65+; TBI/SCI = Traumatic Brain Injury/Spinal Cord Injury; HIV/AIDS = Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome; and Mental Health = Individuals with mental or behavioral health conditions.

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