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Medicaid Section 1915(c) Home- and Community-Based Services Waivers

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SUMMARY

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April 29, 2025

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Medicaid is a means-tested individual entitlement program that finances the delivery of health care and long-term services and supports (LTSS) to certain low-income individuals. The federal government and the states jointly finance the Medicaid program. States have primary responsibility for administering their Medicaid program within broad federal guidelines. Home- and community-based services (HCBS) are a type of noninstitutional LTSS that support older adults; individuals with intellectual, developmental, or physical disabilities; and individuals with mental health and substance use disorders, among other populations with LTSS needs. HCBS are covered by state Medicaid programs under different federal statutory authorities, including waiver program authorities that states can choose to offer under Section 1915(c) of the Social Security Act (SSA). Over the past four decades, HCBS, covered by state Medicaid programs under state plan and waiver authorities, have accounted for a growing share of Medicaid-covered LTSS (from 1.1% of total Medicaid LTSS expenditures in 1981 to 64.6% in 2022).

Section 1915(c) of the SSA authorizes the Secretary of Health and Human Services to waive certain requirements of federal 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 LTSS needs. These waived requirements include "statewideness" (thus allowing states to offer HCBS in a limited geographic area) and "comparability" (thus allowing states to limit the amount, duration, or scope of HCBS for individuals in particular eligibility categories).

Section 1915(c) waivers are designed to expand opportunities for states to provide HCBS to additional groups of persons with 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. As a result, states use Section 1915(c) waivers to provide specific kinds of services (e.g., case management, homemaker/home health aide, personal care, adult day health, habilitation, rehabilitation, respite care) to targeted populations (i.e., aged or disabled individuals, or both; intellectually or developmentally disabled individuals, or both; or individuals with mental illness). States may use the Section 1915(c) waiver to cap enrollment. Because the demand for HCBS is often greater 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*, p*lanning lists*, and *registries*) when their program slots are filled or when state legislatures do not fund the maximum number of waiver slots under the CMS-approved waiver program.

For each Section 1915(c) waiver, states must submit a waiver application to the Centers for Medicare & Medicaid Services (CMS) for review and approval. Unlike Medicaid state plan benefit coverage, Medicaid Section 1915(c) waivers are time limited (e.g., three or five years) and the state must renew them subject to CMS approval. Section 1915(c) waiver approvals are subject to reporting and evaluation requirements. CMS-approved Section 1915(c) waivers must also meet a cost-neutrality test, whereby average Medicaid expenditures for waiver participants cannot exceed institutional care expenditures that would have been incurred absent the waiver. Historically, states have not been required to submit information on waiting lists and their programs' organization. However, in 2024, CMS issued a final rule that requires states to report annually on how they maintain lists of individuals waiting to enroll in waiver programs. If they cap enrollment on such programs, states must report whether they screen for eligibility prior to adding individuals to the waiting lists; whether they periodically rescreen individuals; and, if so, how often.

This report begins with an overview of Medicaid, followed by a discussion of Section 1915(c) waivers and relevant topics: target populations, eligibility criteria, covered services, enrollment limits, waiver waiting lists, and administration. The **Appendix** provides a table describing policies concerning waiver applications and amendments.

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Home- and community-based services (HCBS) are nonmedical, social, and supportive services that allow individuals to live independently in the community. HCBS support older adults; individuals with intellectual, developmental, or physical disabilities; individuals with mental health and substance use disorders; and other populations that need long-term services and supports (LTSS). Medicaid plays a key role in covering LTSS to eligible aged and disabled individuals. As the largest single payer of LTSS in the United States, Medicaid LTSS spending (federal and state) in CY2023 totaled $257.0 billion and accounted for 45.6% of all LTSS expenditures ($563.7 billion).[1]

HCBS are covered by state Medicaid programs under state plan and waiver authorities, specifically Section 1115 (research and demonstration waivers) and Section 1915(c) (HCBS-specific waivers) of the Social Security Act (SSA). Section 1115 of the SSA allows the Secretary of Health and Human Services (HHS) to waive certain Medicaid requirements to allow states to pursue "experimental, pilot, or demonstration" projects.[2] This report focuses on the HCBS waiver authority under Section 1915(c), which is the most common waiver authority states use to provide HCBS to Medicaid beneficiaries. Over time, Congress has provided state Medicaid programs with additional authority and federal payment incentives to expand their HCBS offerings.[3] Section 1915(c) waiver programs and policy in the broader context of Medicaid financing and coverage for LTSS likely will continue to be of interest to federal and state policymakers.

Section 1915(c) authorizes the HHS Secretary to waive certain requirements of Medicaid law, thereby allowing states to cover a broad range of HCBS for certain populations with LTSS needs. These waivers are designed to expand opportunities for states to provide home- and community-based care while containing Medicaid costs. Under this authority, states may provide HCBS to persons who, without these services, would require Medicaid-covered institutional care. States may use the Section 1915(c) waiver authority to cap enrollment on the number of individuals served. The Section 1915(c) waiver is time limited, and waiver approvals are subject to reporting and evaluation requirements. State-approved Section 1915(c) waivers also must meet a cost-neutrality test, whereby average Medicaid expenditures for waiver participants cannot exceed institutional care expenditures that would have been incurred absent the waiver. In calendar year (CY) 2022, nearly 1.8 million Medicaid enrollees received services under Section 1915(c) HCBS waiver programs, accounting for approximately 22% of all Medicaid-covered HCBS recipients. It is common for Section 1915(c) waiver recipients to also receive Medicaid-covered HCBS through other means, such as state plan personal care, home health, or rehabilitative services. However, Medicaid expenditures under Section 1915(c) waivers account for nearly half of all Medicaid-covered HCBS expenditures, totaling $62.4 billion in CY2022.[4]

Forty-six states and the District of Columbia (DC) offer at least one Section 1915(c) HCBS waiver program, for a total of 267 Centers for Medicare & Medicaid Services (CMS) approved

[1] CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 2023.

[2] For more information on Section 1115 waivers, see the "Medicaid Program Waivers" section of CRS Report R43357, *Medicaid: An Overview*.

[3] In addition to waiver authorities, states may use state plan authorities to cover home- and community-based services (HCBS); see the web pages on Social Security Act (SSA) §§1915(i), 1915(j), and 1915(k) on Medicaid's website, accessible at the "Home & Community Based Services Authorities" page at https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities.

[4] Cara Stepanczuk et al., *Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2022*, Medicaid, August 29, 2024, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2022.pdf.

waivers.[5] States generally offer multiple waiver programs (Section 1915(c) and Section 1115) targeting HCBS to different groups of eligible Medicaid participants.

Over the past four decades, HCBS have accounted for a growing share of Medicaid-covered LTSS (from 1.1% of total Medicaid LTSS expenditures in 1981 to 64.6% in 2022),[6] with HCBS recipients and expenditures increasing at a faster rate compared to institutional LTSS recipients and expenditures. The number of enrollees covered under these waivers is also growing faster (5.1% increase from 2021 to 2022) than the number of Medicaid institutional care users (0.8% increase from 2021 to 2022)[7] as a part of a larger trend of rebalancing Medicaid LTSS away from institutional care and toward HCBS.[8] These legislative and administrative activities were prompted, in part, by the U.S. Supreme Court decision in *Olmstead v. L.C.*, which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA).[9]

This report first provides background on Medicaid and various statutory authorities that allow states to cover LTSS, including HCBS. It then describes target populations, eligibility criteria, covered services, enrollment, waiting lists and other administrative and policy issues for the Section 1915(c) waiver program.

Background

Established under Title XIX of the SSA, Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services and LTSS to certain low-income individuals. The federal government and the states jointly finance the Medicaid program. States have primary responsibility for administering their Medicaid program within broad federal guidelines.[10] The federal share of most Medicaid expenditures is determined by the *federal medical assistance percentage* (FMAP). FMAP rates are based on a formula that provides higher federal reimbursement to states with lower per capita income relative to the national average (and vice versa).[11] Historically, to qualify for Medicaid, individuals must meet certain categorical and financial eligibility requirements.[12] To qualify for Medicaid-covered LTSS, individuals must also

[5] The four states that do not offer HCBS through Section 1915(c) waivers are Arizona, New Jersey, Rhode Island, and Vermont. Medicaid, "State Waivers List," accessed March 10, 2025, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

[6] These figures include HCBS expenditures from Section 1915(c) waiver authorities and other state plan authorities. Caitlin Murray et al., *Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid LTSS Users and Expenditures, 2022*, Medicaid, August 29, 2024, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2022.pdf.

[7] The increase from 2021 to 2022 is, in part, a result of the additional support for Medicaid HCBS provided by Section 9817 of the American Rescue Plan Act of 2021 (P.L. 117-2). Section 9817 increased the federal medical assistance percentage (FMAP) rate of Medicaid expenditures for certain HCBS by 10 percentage points for states that met certain requirements during the program-improvement period (April 1, 2021, through March 31, 2022). Cara Stepanczuk et al., *Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2022*, Medicaid, August 29, 2024, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2022.pdf. For more information, see CRS Report R46777, *American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions*.

[8] Medicaid, *Long-Term Services and Supports Rebalancing Toolkit*, November 2020, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.

[9] Olmstead v. L.C., 27 U.S. 581.

[10] For more information on Medicaid, see CRS Report R43357, *Medicaid: An Overview*.

[11] For further information, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[12] For further information, see CRS Report R46111, *Medicaid Eligibility: Older Adults and Individuals with Disabilities*.

meet functional eligibility criteria; that is, they have to demonstrate an extended need for long-term care. In general, functional criteria are state defined and often measure functional need, such as an individual's ability to perform certain self-care activities, and/or clinical need for care, such as a diagnosis of chronic illness or a disabling condition.

Title XIX and other SSA provisions contain several state plan and waiver authorities that permit states to offer LTSS, including HCBS, to individuals in need of such services. The *Medicaid state plan* is the agreement between a state and the federal government that describes how that state will administer its Medicaid program. Services provided under the Medicaid state plan are generally required to meet the following criteria:

- Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity or functional eligibility.
- Within a state, services available to certain groups of enrollees must be equal in amount, duration, and scope. This requirement is referred to as the "comparability" requirement.
- With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, also known as the "statewideness" requirement.
- With certain exceptions, beneficiaries must have "freedom of choice" among health care providers or managed-care entities participating in Medicaid.[13]

The SSA also 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 used because states may request that the HHS Secretary waive certain statutory requirements that normally would apply to services covered under Medicaid state plans. Under Section 1915(c) waivers, the HHS Secretary has the authority to waive Medicaid's statewideness requirement to allow states to offer HCBS in a limited geographic area. The HHS Secretary also may waive the comparability requirement that services be comparable in amount, duration, or scope for individuals in particular eligibility categories. In addition, states may apply the same income-counting rules that apply to individuals who qualify for Medicaid in institutional settings; this allows persons in HCBS waivers to count only their personal and not family income (i.e., spouse's or parent's income).[14] Expenditures under these waivers are matched at the state's regular FMAP rate.

For each waiver, states must submit a waiver application to CMS for review and approval. Unlike Medicaid state plan benefit coverage, which is in place until the state requests and CMS approves

[13] In general, states deliver Medicaid services through either fee-for-service or managed-care delivery systems. Under a managed-care delivery system, Medicaid enrollees receive services through an organization under contract with the state. For more information on Medicaid managed care, see the "Service Delivery Systems" section of CRS Report R43357, *Medicaid: An Overview*. Under the SSA, states can implement managed-care delivery systems using (1) a state plan authority under Section 1932(a), (2) a waiver authority under Sections 1915(a) and 1915(b), or (3) a waiver authority under Section 1115.

[14] SSA, §1902(a)(10)(A)(ii)(VI); Letter from Daniel Tsai, Deputy Administrator and Director of the Center for Medicaid and CHIP Services, to state Medicaid directors, "RE: State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services," December 7, 2021, https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21004.pdf.

an amendment, Medicaid waiver benefit coverage is limited to the duration of the waiver (i.e., three or five years). Subject to CMS approval, Medicaid waivers must be renewed by the state, and states may also seek CMS approval for amendments to an approved waiver program. Eligible enrollees can receive services under both the Medicaid state plan and a waiver program at the same time.

Section 1915(c) HCBS Waiver Authority

This section first discusses the populations states target under Section 1915(c) HCBS waivers and eligibility criteria for waiver enrollees, including financial and function eligibility criteria. It then discusses HCBS covered under Section 1915(c) waivers, limits on enrollment under waiver programs, and waiting lists for waiver services. Finally, this section discusses the administrative aspects of Section 1915(c) waivers, including the process for waiver application, review, and amendment, and requirements after waiver approval.

Target Populations

The SSA requires states to target a Section 1915(c) waiver to specific populations, and regulations require that waivers be limited to certain target groups (i.e., aged or disabled individuals, or both; intellectually or developmentally disabled individuals, or both; or individuals with mental illness) or related subgroups.[15] Common subgroups include individuals with specific conditions who may require services related to that condition or individuals with specific needs. Subgroups are often defined by states and can vary. For example, "aged" generally refers to persons 65 and older as defined in Section 1905(a)(iii) of the SSA, but a state has the option to designate a different age. Additionally, states have the option to combine target groups within one waiver program. 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.[16]

Target Groups (and Common Subgroups) of Section 1915(c) Waivers

The following are the target population groups (with specifically recognized subgroups) of Section 1915(c) waivers, but states have flexibility to define other subgroups.

- Aged, disabled, or both (brain injury, HIV/AIDS, medically fragile, technology dependent)
- Intellectual disability, developmental disability, or both (autism)
- Mental illness (serious emotional disturbance)

Source: Disabled and Elderly Health Programs Group et al., *Application for a 1915(c) Home and Community-Based Waiver: Instructions, Technical Guide and Review Criteria*, Version 3.5, January 2015.

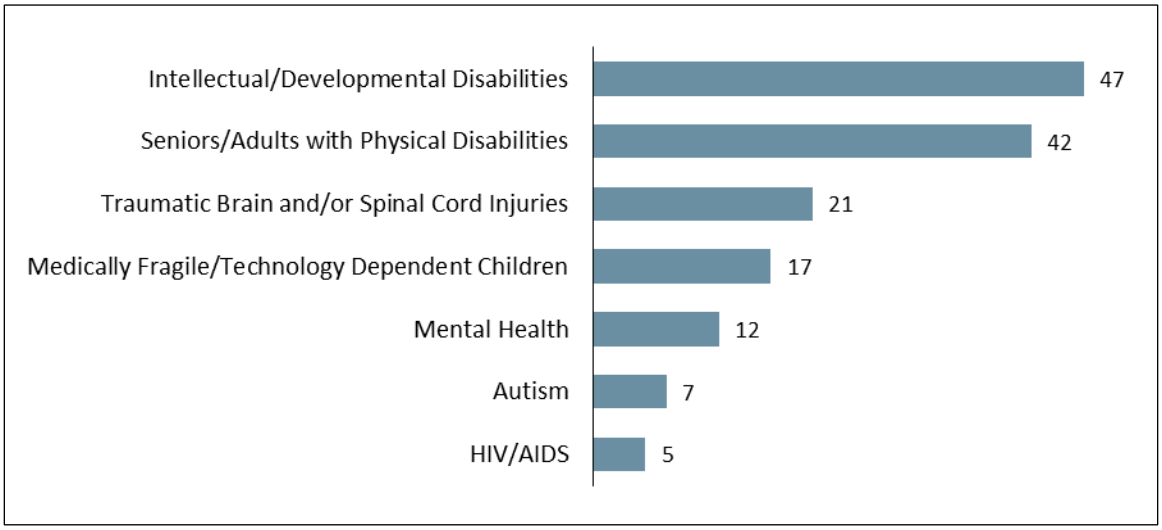
[15] 42 C.F.R. §441.301(b)(6).

[16] States have the option to combine target groups within one waiver program; see Department of Health and Human Services, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers," final rule, 79 *Federal Register* 2948, January 16, 2014. Prior to this regulatory 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.

As shown in **Figure 1**, in FY2023, 46 states and DC had at least one Section 1915(c) waiver, according to a survey by KFF.[17] Moreover, of the 258 Section 1915(c) HCBS waivers across all surveyed jurisdictions, 46 states and DC had at least one waiver for populations with intellectual and/or developmental disabilities; 41 states and DC had at least one waiver targeting seniors or adults with physical disabilities; and 21 states had waivers targeting individuals with traumatic brain injury/spinal cord injury. Additional populations served by Section 1915(c) waivers were medically fragile/technology dependent children (17 states) and individuals with mental health conditions (12 states), autism (7 states), and HIV/AIDS (5 states).[18]

Figure 1. Number of States with Section 1915(c) Waivers for Specific Target Populations

(FY2023)



Source: Alice Burns et al., "Payment Rates for Medicaid Home and Community-Based Services: States' Responses to Workforce Challenges," KFF, October 24, 2023, https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/.

Notes: Based on data from the 2023 KFF Medicaid home- and community-based services (HCBS) survey, including 46 states and DC. At the time of data collection, four states (Arizona, New Jersey, Rhode Island, and Vermont) provided HCBS only through Section 1115 waivers and did not have Section 1915(c) waivers.

Eligibility Criteria

Eligible waiver participants must meet certain financial requirements (including income and resource/asset requirements) and state-defined level-of-care criteria that demonstrate the functional need for LTSS (functional eligibility criteria). That is, individuals must have a level of need for LTSS that would otherwise be covered under Medicaid institutional care services, such as nursing facility care, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or hospital care. The following describes these eligibility requirements in more detail.

[17] Four states (Arizona, New Jersey, Rhode Island, and Vermont) provide HCBS through Section 1115 waivers. Alice Burns et al., "Payment Rates for Medicaid Home- and Community-Based Services: States' Responses to Workforce Challenges," KFF, October 24, 2023, https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/.

[18] Alice Burns et al., "Payment Rates for Medicaid Home and Community-Based Services: States' Responses to Workforce Challenges," KFF, October 24, 2023, https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/.

Eligibility Groups and Financial Eligibility

In an approved waiver application, states must identify the Medicaid eligibility groups (e.g., Supplemental Security Income [SSI] recipients) to which waiver services will be provided. These groups must be eligibility groups already covered under the Medicaid state plan and may include both mandatory and optional eligibility groups. In general, Medicaid eligibility groups included in Section 1915(c) HCBS waiver programs have both income and resource (asset) requirements.

To align with Medicaid financial eligibility rules that apply to institutionalized individuals, states have the option to apply more generous income and resource requirements to their HCBS waiver program participants who live in the community under the "special HCBS waiver group," also known as the "217 group," in reference to the specific regulatory section for this group.[19] States offering this option use the highest income and resource limit of a separate eligibility group covered by the state plan under which an individual would otherwise qualify for Medicaid if institutionalized.[20] For example, states can extend eligibility to waiver program participants with income up to 300% of the SSI federal benefit rate (about $2,901 per month for an individual in 2025), which is the same income limit allowed under the Special Income Level eligibility pathway that applies to individuals eligible for nursing facility care. States must apply to the 217 group the same income- and resource-counting methodologies used to determine eligibility for the separately referenced eligibility group. States may also apply more liberal income-counting rules to the 217 group.[21]

In addition to being in an eligibility group that is covered under the waiver program, Medicaid waiver participants must also meet state-defined functional eligibility criteria or level-of-care criteria that demonstrate the need for institutional 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, ICF/IID, or hospital care.

Functional Eligibility Criteria

Under Section 1915(c) waiver authority, states can provide HCBS to persons who, without these services, would require Medicaid-covered institutional care. In general, states determine an eligible individual's need for Medicaid-covered LTSS, both institutional and HCBS. The level of needed care defines the LTSS that a given enrollee is entitled to. To define functional eligibility criteria, sometimes referred to as "level-of-care criteria," states may use factors such as an individual's ability to perform certain *self-care activities*, often referred to as "activities of daily living" (ADLs; e.g., eating, bathing, dressing, and walking). Functional eligibility criteria also include the ability to perform certain *household activities*, often referred to as "instrumental activities of daily living" (IADLs; e.g., shopping, housework, and meal preparation), that allow an individual to live independently in the community. Along with functional eligibility criteria, states may also use clinical criteria such as diagnosis of an illness, injury, disability or other

[19] 42 C.F.R. §435.217.

[20] There are additional requirements for covering medically needy eligibility groups under Section 1915(c) HCBS waivers. States that limit coverage of medically needy by eligibility group (e.g., children, adults, aged, disabled) can cover only those medically needy groups that already are covered in the state plan. In addition, if a state does not cover institutional LTSS for medically needy individuals, it cannot provide HCBS waiver services to medically needy individuals requiring an institutional level of care; Disabled and Elderly Health Programs Group et al., *Application for a 1915(c) Home and Community-Based Waiver: Instructions, Technical Guide and Review Criteria*, Version 3.5, January 2015. For more information about medically needy eligibility groups, see CRS Report R46111, *Medicaid Eligibility: Older Adults and Individuals with Disabilities*.

[21] SSA, §1902(r)(2); 42 C.F.R. §435.601(d).

medical condition, treatment and medications, and cognitive status, among other information (e.g., autism or intellectual disability, serious mental illness, traumatic brain injury).

The majority of Section 1915(c) waivers use the same state-defined functional eligibility criteria as required for nursing facility eligibility (i.e., institutional care). However, some states have waivers that use less restrictive eligibility criteria than those required for institutional care. Self-care needs are more often required to establish functional eligibility than household activity needs, and among Section 1915(c) waivers that require self-care needs for eligibility, most require individuals to need help with three or more activities.[22]

Covered Services

The Medicaid statute specifies a broad range of services that states may provide to waiver participants.[23] These include "case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care," and rehabilitation. 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.[24]

For a general description of the types of services covered under Section 1915(c) waivers, see **Table 1**. Note that states have the ability to name and define Section 1915(c) waiver services, as well as identify and define other services, subject to HHS Secretary approval. Thus, there is substantial state-to-state variation in naming conventions and service definitions across Section 1915(c) waiver programs.

Table 1. Covered Medicaid Services Under Section 1915(c) Home- and Community-Based Services (HCBS) Waiver Programs

Service	General Service Description
Adult day health	Services furnished on a regularly scheduled basis for four or more hours per day, one or more days per week in a noninstitutional, community-based setting that encompasses both health and social services needed to ensure the optimal functioning of the individual.
Case management	Services that assist individuals in gaining access to needed waiver and other state plan benefits, as well as needed medical, social, educational, and other services, regardless of the funding source.
Habilitation	Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary for individuals to reside successfully in home- and community-based settings. May include residential habilitation, day habilitation, certain prevocational services, certain educational services, and supportive employment services.

[22] Molly O'Malley Watts et al., *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, issue brief, KFF, March 2022, https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/.

[23] SSA, §1915(c)(4)(B).

[24] State Medicaid programs can choose to cover services in community-based settings, such as assisted living facilities, for certain eligible participants; however, Medicaid does not cover room and board. Essentially, federal Medicaid statute delineates that housing is separate from health and social services provided to an individual in a private home or residential setting; Section 1915(c)(1) of the SSA.

Service	General Service Description
Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage such activities.
Home health aide[a]	Services and supports defined in 42 C.F.R. §440.70 (e.g., nursing services, home health aide services, durable medical equipment) that are provided in addition to home health aide services furnished under the approved state plan or are provided when the latter are exhausted.
Personal care[b]	Services to assist with activities of daily living (ADLs) such as eating, bathing, dressing, and personal hygiene. May include assistance with preparation of meals but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores that are incidental to the care furnished or that are essential to the health and welfare of the individual.
Respite care	Services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care.
Mental health	Services include day treatment, psychosocial rehabilitation, and clinics, to provide mental health care spanning multiple settings. Mental health services covered under Section1915(c) waivers are not limited to waiver participants with primary diagnoses of chronic mental health conditions but may be offered to all eligible waiver participants.
Other (HHS Secretary approved)	Other specified services and supports under the waiver program may include home modifications, skilled nursing, nonmedical transportation, specialized medical equipment and supplies, personal emergency response systems, adult foster care, and assisted living.

Source: CRS analysis of Center for Medicaid and CHIP Services et al., *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, 2024, https://wms-mmdl.cms.gov/WMS/help/version_3.7_1915c_Waiver_Application_and_Accompanying_Materials.zip.

Notes: Covered services are listed in Social Security Act (SSA) §1915(c)(4)(B) (42 U.S.C. §1396n). HHS = Department of Health and Human Services.

a. Home health services are a mandatory state plan service. Home health aide services are a component of the state plan coverage. In a waiver, a state may furnish home health aide services that are different in their scope and nature than the services offered under the state plan.

b. Personal care services are an optional benefit that a state may furnish under its state plan, as provided in 42 C.F.R. §440.167. A state may offer personal care under a waiver when (1) it does not offer personal care under its state plan; (2) its coverage under the waiver differs in scope and nature from the coverage under the state plan; or (3) the state wishes to furnish personal care services in an amount, duration, or frequency that exceeds the limits in the state plan.

Enrollment Limits

Unlike Medicaid services under the state plan, which must be offered to all eligible enrollees, Section 1915(c) waiver programs allow states to limit the number of beneficiaries who can receive HCBS through the state's waiver program. This number of waiver participants (known as "Factor C") is determined by the state and must be no fewer than 200 individuals.[25] However, states may opt to implement other enrollment limits (see **Table 2**). States can implement some or all of these, and when they are reached, many states maintain waiting lists for services offered under a Section 1915(c) HCBS waiver (see "Waiver Waiting Lists").

[25] 42 U.S.C. §1396n(c)(10).

Table 2. Enrollment Limit Policies for Section 1915(c) HCBS Waivers

Policy	Description
Unduplicated number of participants ("Factor C")	States may specify this maximum limit, and until it is reached, states may not deny waiver services to eligible individuals unless there are other limits (see below). The unduplicated number of participants may be increased or decreased through a waiver amendment submitted to CMS. An amendment to increase the number of individuals served by a waiver is made effective at the start of a waiver year. An amendment to reduce the number of individuals served by a waiver must provide additional "information concerning the impact of the reduction on existing waiver participants" and is effective only as of the date of approval.[b]
Point-in-time enrollment limit	States may set a point-in-time enrollment limit, which is the maximum number of individuals served by a waiver at any given point in time during a waiver year. States may use point-in-time enrollment limits to account for turnover in the waiver program. For example, a point-in-time limit lower than the unduplicated number of participants prevents states from having to "freeze entrance to the waiver before the end of the waiver year."[b]
Phase-in or phase-out schedule	States may enroll waiver participants over a certain time frame by allowing the entrance of a specific number of individuals per month (i.e., phasing in) or transitioning waiver participants to other waivers (i.e., phasing out).
Reserve capacity	States may keep waiver slots open for specific individuals on a priority basis as "reserve capacity." For example, states may reserve capacity for individuals transitioning into the community, individuals transitioning from other waivers, or individuals in crisis. CMS guidance states that reserve capacity is intended for different individuals and not for different sets of services within a waiver (i.e., individuals are eligible for services under a waiver regardless of whether or not they enrolled via reserve capacity).[c]

Source: CRS analysis of Center for Medicaid and CHIP Services et al., *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application, 2024*, https://wms-mmdl.cms.gov/WMS/help/version_3.7_1915c_Waiver_Application_and_Accompanying_Materials.zip.

Notes: CMS = Centers for Medicare & Medicaid Services.

a. *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, p. 82.

b. *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, p. 83.

c. Letter from Timothy M. Westmoreland, Director of Center for Medicaid and State Operations, Maryland, to state Medicaid directors, January 10, 2001, https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd011001a.pdf.

Waiver Waiting Lists

Because states 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 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.[26]

Waiting lists are implemented differently across states and potentially across waiver programs within states. Notably, states differ in their screening processes prior to adding individuals to waiver waiting lists. For example, some states do not evaluate individuals' eligibility for waiver services prior to adding them to a waiting list, leading to overestimates of waiting list length.

[26] Center for Medicaid and CHIP Services et al., *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, 2024.

Historically, states have not been required to submit information on waiting lists and their programs' organization. However, in 2024, CMS issued a final rule that requires states to report annually on how they maintain lists of individuals waiting to enroll in waiver programs.[27] If they cap enrollment on such programs, states must report whether they screen for eligibility prior to adding individuals to waiting lists; whether they periodically rescreen individuals; and, if so, how often.[28] If applicable, states must also report the number of people on the waiting list and the average time that individuals newly enrolled in the waiver program over the past 12 months were on the waiting list. States must begin compliance with these new reporting requirements by July 9, 2027 (i.e., three years from the effective date of the final rule).[29]

State Use of Waiting Lists

The most recent data for Medicaid Section 1915(c) waiver program waiting lists are from analyses by KFF, from survey results published in an October 2024 report. In 2024, 40 states reported having waiting lists for Section 1915(c) and Section 1115 HCBS waiver programs with an estimated 710,000 wait-listed individuals. Some states offer HCBS through Section 1115 waivers instead of, and sometimes in addition to, Section 1915(c) waivers. Similar to Section 1915(c) waivers, Section 1115 waivers can offer a variety of HCBS targeted at specific groups and must be "budget neutral."[30] In addition, states may have waiting lists for Section 1115 waivers. KFF's data on HCBS waiver waiting lists are not standardized and are collected via survey of state Medicaid programs, which means that waiting list counts for Section 1915(c) and Section 1115 waivers are often not reported separately. Individuals can receive Medicaid state plan services while on a waiting list for a waiver program, but state plan services may not include HCBS or may be limited in the amount, scope, or duration of HCBS coverage.

In 2024, the average time spent on a waiver waiting list was 40 months, but the average length of time an individual may spend on a waiting list varied by target population. Individuals with mental illness waited for 6 months on average, whereas children waited 44 months on average.[31] However, individuals with intellectual and developmental disabilities (I/DDs) waited the longest, at 50 months on average.

Additionally, more than half of wait-listed individuals were located in states that do not screen people for eligibility for a waiver program prior to adding them to a waiting list (see **Figure 2**). Therefore, this practice may inflate the total number of persons on waiting lists may and obscure the true level of unmet need among individuals who qualify for Section 1915(c) waiver services. The lack of standardized screening procedures across states complicates efforts to compare waiting list data.

Individuals with I/DDs account for 73% of the total waiting list population, especially in states that do not screen individuals for waiver eligibility prior to adding them to a waiting list. For example, in these states, individuals with I/DDs account for 89% of the waiting list population,

[27] Centers for Medicare & Medicaid Services (CMS), "Medicaid Program; Ensuring Access to Medicaid Services," 89 *Federal Register* 40542, May 10, 2024, https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

[28] CMS, "Medicaid Program; Ensuring Access to Medicaid Services," 89 *Federal Register* 40542, May 10, 2024.

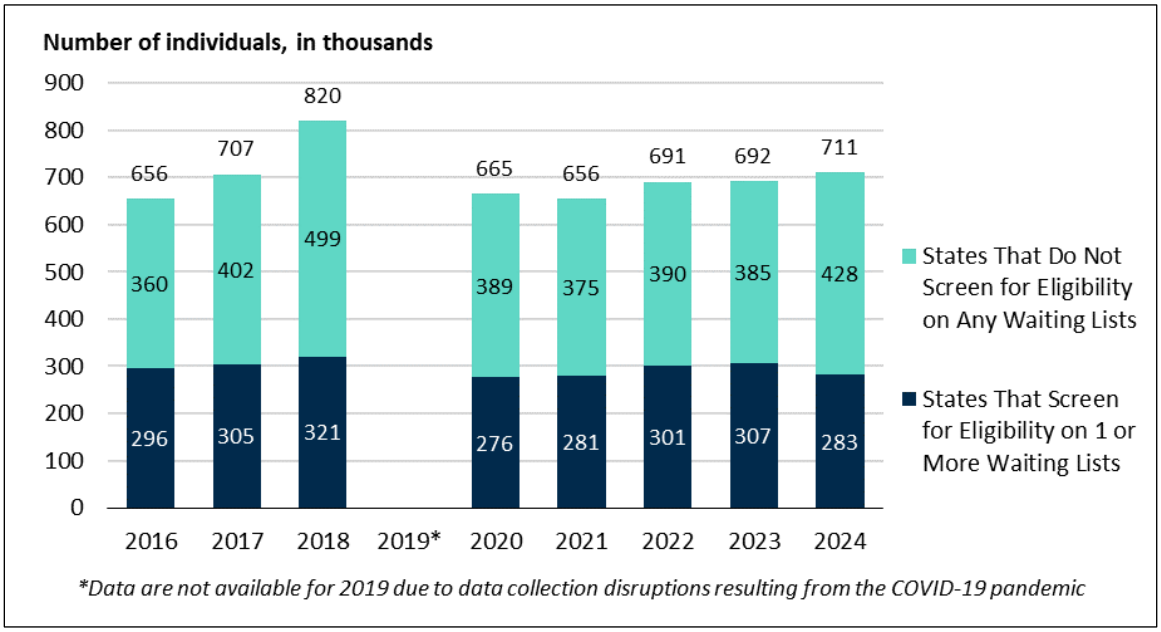
[29] Medicaid, "Ensuring Access to Medicaid Services (CMS-2442-F): Provisions and Relevant Timing Information and Dates," September 9, 2024, https://www.medicaid.gov/medicaid/access-care/downloads/applicability-date-chart-ac.pdf.

[30] *Budget neutrality* means that the estimated spending under the waiver cannot exceed the estimated cost of the state's Medicaid program without the waiver.

[31] Alice Burns et al., "A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024," KFF, October 31, 2024, https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/.

compared to 49% of the waiting list population in states that do screen for eligibility. Additionally, seniors and adults with physical disabilities account for 24% of the total waiting list population. Notably, despite individuals with I/DD accounting for the majority of the waiting list population, less than half of individuals covered under a Section 1915(c) HCBS waiver program are in this population.[32]

Figure 2. Number of Individuals on HCBS Waiting Lists



Source: Alice Burns et al., "A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024," KFF, October 31, 2024, https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/.

Notes: Based on data from the FY2024 KFF Medicaid HCBS Waiver Program Survey. States reported the number of individuals on a "waiting list, referral list, interest list, or another term." Data include individuals on waiting lists for both Section 1915(c) and Section 1115 waivers. States that screen individuals for eligibility for one or more waiting lists may not do so for all waiting lists. Between 2018 and 2020, Ohio instituted an assessment of eligibility prior to adding individuals to waiting lists, accounting for nearly half the decline in number of individuals on waiting lists between those years. Other factors, including mortality among waiting list populations as a result of the COVID-19 pandemic and additional support for Medicaid HCBS provided by Section 9817 of the American Rescue Plan Act of 2021 (P.L. 117-2), also may have contributed to this decline.

Administration

State Medicaid agencies may operate waivers directly, or another state-designated agency (known as the "operating agency") may do so, as long as the state Medicaid agency has final authority.[33] At the federal level, the Center for Medicaid and CHIP Services, within CMS, administers HCBS waiver authority.

[32] Priya Chidambaram and Alice Burns, "10 Things About Long-Term Services and Supports," KFF, July 8, 2024, https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.

[33] 42 C.F.R. §431.10(b)(1).

Waiver Application, Review, and Amendment

To offer services under a Section 1915(c) HCBS waiver authority, states must submit an initial waiver application to CMS that meets applicable statutory, regulatory, and other requirements. Waiver applications include information on populations eligible for waiver services, services covered, and provider reimbursement rates.[34] As states design their waivers and work on the application, CMS provides relevant technical assistance.[35] CMS also provides a technical guide, updated periodically, that instructs states on how to draft waiver applications.[36]

The initial waiver is approved for a three-year period, after which states can continue waiver operation by submitting a waiver renewal request, which CMS generally approves for five-year increments. To be eligible for renewals, states must demonstrate that they have met waiver requirements by submitting annual waiver reports (see "After Waiver Approval"). Different waiver application types are subject to different policies (see **Table A-1**).

Cost Neutrality

CMS approval of a Section 1915(c) HCBS waiver is contingent on the state demonstrating in its waiver proposal that the waiver program is cost neutral during every year of operation. States use a formula that takes into account the cost of Medicaid-covered waiver services and other Medicaid-covered services provided to individuals in the waiver program, as well as the costs that would be incurred by the Medicaid program in the absence of the waiver program. Administrative costs are not included. States may use data specifically relevant to target groups served and may include services relevant to those target groups.

Certain special considerations for Section 1915(c) waivers are implemented concurrently with other authorities. For example, Section 1915(c) waiver services can be delivered with other state plan authorities (such as in Section 1915(j) or 1915(k) of the SSA), and states must indicate this in a waiver application. States may also deliver Section 1915(c) services concurrently with managed-care waiver programs under Section 1915(a) or (b) of the SSA. States can also modify approved waivers through the renewal process by splitting or combining waivers or by converting model waivers to regular waivers. For descriptions of policies concerning waiver applications and amendments, see **Table A-1**.

After Waiver Approval

After waiver approval and implementation, states are required to submit an annual report to CMS discussing the services offered, populations served, cost, and health impacts on waiver enrollees.[37] This annual reporting requirement is submitted as a CMS-372(S) form, or "372 report." This report includes figures on individuals served, expenditures (both for total waiver services and on a per capita basis), average days of coverage and "average length of stay on the waiver," as well as expenditures of non-waiver services (such as those covered under early and periodic screening, diagnostic, and treatment [EPSDT] services) for waiver participants.[38] These

[34] For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so covered benefits are available to Medicaid enrollees, at least to the same extent that they are available to the general population in the same geographic area. For more information, see the "Provider Payments" section of CRS Report R43357, *Medicaid: An Overview*.

[35] Medicaid, "Home & Community Based Services Technical Assistance for States," https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-technical-assistance-states/index.html.

[36] Center for Medicaid and CHIP Services et al., *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, 2024.

[37] 42 C.F.R. §441.302(h).

[38] Center for Medicaid and CHIP Services et al., *Instructions, Technical Guide and Review Criteria. Instructions:* (continued...)

reports also detail the "actual performance of a waiver against the prospective cost-neutrality demonstration" required of Section 1915(c) HCBS waivers.[39]

Concluding Observations

Medicaid Section 1915(c) waiver programs allow states to provide HCBS to targeted populations with specific health and LTSS needs. Nearly all states (except Arizona, New Jersey, Rhode Island, and Vermont) offer at least one Section 1915(c) waiver program, with many states providing care under multiple waiver programs. The administrative process to approve and renew hundreds of waiver programs is a significant effort for states and CMS. Recently, the Medicaid and CHIP Payment and Access Commission (MACPAC) recommended that the renewal period for Section 1915(c) waivers be extended from 5 years to 10 years.[40] State Medicaid programs have shown modest interest in implementing additional HCBS state plan authority (e.g., Section 1915(i), Section 1915(k)) with waiver-like features.[41] These state plan authorities generally do not allow states to cap enrollment and may not necessarily limit eligibility solely to enrollees requiring an institutional level of care.[42]

Demand for HCBS is often greater than supply, as evidenced by the sizeable waiting lists across states for Section 1915(c) waiver services,[43] which often have enrollment limits. A lack of standardized screening procedures across states complicates efforts to compare waiting list data, but the final rule released by CMS in May 2024 requires states to report on the sizes of these waiting lists and any requirements for screening individuals for waiver eligibility prior to wait-listing them. These new regulatory reporting requirements may help provide more consistent and transparent measures of demand for HCBS in state Medicaid programs, which could assist policymakers with planning and administration.

Version 3.7 HCBS Waiver Application, 2024; Early and periodic screening, diagnostic, and treatment (EPSDT) services are a required benefit for nearly all children (under the age of 21) who are enrolled in Medicaid. This benefit covers health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services. The screenings and services must be provided at regular intervals that meet "reasonable" medical or dental practice standards. States are required to provide all federally allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state's Medicaid plan.

[39] Center for Medicaid and CHIP Services et al., *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, 2024, p. 31.

[40] Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2025, https://www.macpac.gov/wp-content/uploads/2025/03/MACPAC_March-2025-WEB-Final-508.pdf.

[41] Molly O'Malley Watts et al., *State Policy Choices About Medicaid Home and Community-Based Services amid the Pandemic*, KFF, March 4, 2022, https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/.

[42] CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by Kirsten J. Colello.

[43] Alice Burns et al., "A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024," KFF, October 31, 2024, https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/.

Appendix. Policies Concerning Waiver Applications and Amendments

Table A-1 lists selected policies concerning Section 1915(c) waiver applications and amendments and brief descriptions of those policies, as well as citations to regulation and guidance where applicable.

Table A-1. Selected Policies Concerning Waiver Applications and Amendments

Waiver Application/Amendment Type	Description and/or Relevant Policies
New waiver application	States submit a new waiver application to CMS for review and approval. After submission, CMS has 90 calendar days to approve, deny, or issue a request for additional information (RAI).[a] This is known as the "90-day clock," and states are encouraged to submit applications 90 days in advance of the proposed waiver start date. While informal correspondence between states and CMS do not stop the 90-day clock, an RAI does, and a state's resubmission of an application begins a new 90-day clock. CMS issues only one RAI while reviewing waiver applications.
New waiver to replace approved waiver	States may elect to replace an approved waiver with a new waiver when substantial changes are needed to waiver services or operation. CMS may also ask states to submit a new waiver as a replacement after identifying issues in waiver operation. States must include transition plans when submitting new waiver applications in these circumstances.
Waiver renewal application	States must submit waiver renewal applications at least 90 days prior to a waiver expiration date (though CMS encourages doing so 180 days prior). Before approval of waiver renewal applications, CMS (1) assesses cost neutrality and quality after review of HCBS annual waiver and statistical reports and (2) evaluates whether the state operated the waiver "in accordance with the approved waiver, all applicable federal requirements, and the waiver assurances."[b]
Splitting a waiver	States may opt to split a single waiver into multiple waiver programs, particularly when that waiver may serve multiple target groups. In these situations, states must alter the approved waiver to focus on one target population and submit a new waiver application for others. This cannot be done with a waiver amendment (see below) prior to the waiver's expiration date.
Combining waivers	States may combine two approved waivers that serve similar target populations by submitting a renewal application for one of the waivers, combining target populations or services, and allowing the other to expire. If combining the waivers would result in the reduction of services, states may be required to develop a transition plan.
Reducing participant limits	States may request to lower the number of participants served by a waiver, but must notify CMS whether this reduction would have an impact on those currently being served by the waiver. This includes providing pathways for affected waiver participants to continue receiving HCBS through other alternatives. According to HCBS, "any loss of services would be subject to notice of Medicaid fair hearing rights."[c]

Waiver Application/Amendment Type	Description and/or Relevant Policies
Extending a waiver	Until CMS approves a waiver renewal, states may request 90-day waiver extensions beyond a waiver expiration date. CMS may grant waiver extensions to states in certain circumstances, such as (1) alignment of a waiver to a fiscal year, (2) combination of a waiver with another under review but not yet approved, (3) termination and phaseout of a waiver, (4) identification of major problems in a waiver from CMS, or (5) a state's need for additional time to resolve issues in a waiver after review.
Concurrent waivers	States can deliver Section 1915(c) waiver services through a Medicaid managed-care authority by delivering services concurrently with a 1915(b) waiver, which waives free choice of provider requirements in Section 1902(a)(23) of the Social Security Act. States must submit two waiver applications, and both must be approved by CMS. States may also choose to deliver Section 1915(c) services with a 1915(a) managed-care authority, although this is less common.
Waiver amendments	States can submit waiver amendments at any time, and the 90-day clock applies to CMS review of an amendment. A state may choose to retroactively apply an amendment to the beginning of the waiver period, but it cannot do so if the changes are substantive. Substantive changes include (1) alterations to services or the scope of services available under the waiver, (2) reduction in eligible populations, or (3) updates in rate methodology.[d] CMS may encourage a state to submit a waiver amendment if the waiver serves more individuals than approved, spending is substantially different from approved, or the services delivered under the waiver differ from those outlined in the approved waiver.
Waiver termination	States may terminate a waiver prior to expiration and must submit a waiver amendment along with a transition plan and/or phase-out schedule at least 30 days prior to ending waiver services.[e] Additionally, states must notify waiver participants at least 30 days prior to ending waiver services.[f]

Source: Center for Medicaid and CHIP Services et al., *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, 2024, https://wms-mmdl.cms.gov/WMS/help/version_3.7_1915c_Waiver_Application_and_Accompanying_Materials.zip.

Notes: CMS = Centers for Medicare & Medicaid Services; HCBS = home- and community-based services.

a. 42 C.F.R. §430.25(f)(3).

b. *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, p. 25.

c. *Instructions, Technical Guide and Review Criteria. Instructions: Version 3.7 HCBS Waiver Application*, p. 27.

d. 42 C.F.R. §441.304(d).

e. 42 C.F.R. §441.307.

f. 42 C.F.R. §431.210.

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