Unwinding COVID – Waivers Granted Under the PHE and Implementation of Permanent Changes

Disabled and Elderly Health Programs Group
Medicaid and CHIP Operations Group
Center for Medicaid and CHIP Services
Purpose

• Summarize state utilization of flexibilities provided through the 1915(c) Appendix K and 1115 Attachment K, the COVID Addendum, HCBS-related 1135 requests, new Public Health Emergency (PHE) 1115s, and 1915(i) and 1915(k) Disaster Relief SPAs to support COVID-19 pandemic responses.
• Identify commonalities and distinctions across the states.
• Discuss post-pandemic planning and opportunities to consider lessons learned for future waiver amendment possibilities.
• Provide guidance to states on the best approach and time frames required for transitioning from pandemic to post-pandemic operations.
Supporting State Response Efforts

• Even prior to declaration of public health emergency (PHE), CMCS deployed our Disaster Relief Toolkit and began technical assistance to help states ready their response efforts.

• To streamline state response efforts, CMS developed tools and checklists to speed up the review of state applications and approvals for various flexibilities specific to the pandemic:
  – 1135 Waiver Checklist,
  – Medicaid Disaster State Plan Amendment (SPA) Template,
  – 1115 Demonstration State Medicaid Director Letter and Checklist,
  – Pre-populated Appendix K (tailored to state needs during COVID-19 PHE), and
  – Pre-populated 438.6(c) Templates for Managed Care Directed Payments.
Emergency Amendments and Flexibilities (1 of 2)

• Appendix K: Provides temporary or emergency-specific amendment(s) to an approved 1915(c) waiver. The state may specify the duration of the amendment(s). Historically Appendix Ks have been approved for up to a one year period.

• Appendix K Addendum: COVID-19 Pandemic Response (the COVID Addendum): A CMCS prepopulated section of the Appendix K based on the common needs that states have identified during their response to the COVID-19 PHE.

• Attachment K: Provides temporary and/or emergency-specific amendment(s) to an approved 1115 demonstration’s home and community-based services. The state may specify the duration of the amendment(s).
Emergency Amendments and Flexibilities (2 of 2)

- **1135 Waiver**: Allows the HHS Secretary to take actions under Section 1135 of the Social Security Act to waive certain statutes and implementing regulations. The state may specify the duration of the request, not to exceed the PHE declaration timeframe.

- **Disaster Relief SPA**: Assists states in responding to COVID-19 through multiple, time-limited options to revise the Medicaid state plan. The state may specify the duration of the request, not to exceed the PHE declaration timeframe.

- **COVID-19 Section 1115 Demonstration**: Provides opportunities for states to make available a number of authorities and flexibilities to assist states in enrolling and serving beneficiaries in Medicaid and to focus state operations on addressing the COVID-19 pandemic. The demonstration will expire no later than 60 days from the end of the PHE declaration.
HCBS Related 1135 Waiver Flexibilities

- Allow verbal agreement as a signature for the PCP: 25 states
- Waiver of HCBS Settings requirements: 25 states
- Allow payment to legally responsible relative 1905(a) PCS: 13 states
- Waive 1915(c) LOC timeline: 7 states
- Waive Conflict of Interest: 6 states
- Waive 1915(i) eligibility timeline: 5 states
- Waive CFC 1915(k) eligibility timeline: 4 states
State Approvals as of November 3, 2020

✓ 132 1135 Waivers
✓ 154 1915 Appendix Ks
✓ 139 Medicaid Disaster SPAs
✓ 33 1115 Demonstration Actions
<table>
<thead>
<tr>
<th>Option</th>
<th>Number of States Selecting Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modify services</td>
<td>49</td>
</tr>
<tr>
<td>Modify provider qualifications</td>
<td>47</td>
</tr>
<tr>
<td>Other (e.g. disenrollment policy, delay reports)</td>
<td>41</td>
</tr>
<tr>
<td>Allow retainer payments</td>
<td>38</td>
</tr>
<tr>
<td>Modify person-centered planning</td>
<td>38</td>
</tr>
<tr>
<td>Allow payment for HCBS in institutional settings</td>
<td>34</td>
</tr>
<tr>
<td>Allow virtual LOC determinations</td>
<td>34</td>
</tr>
<tr>
<td>Changes to participant safeguards</td>
<td>33</td>
</tr>
<tr>
<td>Modify payment rates</td>
<td>33</td>
</tr>
<tr>
<td>Extend dates for LOC determinations</td>
<td>31</td>
</tr>
<tr>
<td>Allow payment for family caregivers</td>
<td>28</td>
</tr>
</tbody>
</table>
Appendix K Start Dates

• 24 states submitted 28 approved requests with an effective date between January 27 – February 29, 2020.
• 31 states submitted 37 approved requests with an effective date in March 2020.
• 6 states submitted 10 approved requests with an effective date in April 2020.
• 2 states submitted 2 approved requests with an effective date in May 2020.
• 1 state submitted one approved request with an effective date on June 1, 2020.
Appendix K End Dates at the Beginning of the Pandemic

• 14 states requested end dates for all or some HCBS programs prior to December 31, 2020.
• 25 states set an expiration date in January 2021.
• 16 states set an expiration date in February 2021.
• 14 states set an expiration date in March 2021.
• 42 out of 50 states with an approved Appendix K or Attachment K (84%) completed an Appendix K COVID-19 Addendum.
• 213 1915(c) waivers and seven (7) 1115 waivers are covered through the COVID-19 Addendum.
• 16 states (38%) requested different flexibilities and/or additional authorities for different waivers, or completed a COVID-19 Addendum for some but not all waivers.
The 16 states with different requests across waiver programs in the state likely had separate agencies prepare submissions, had different authorities in the base waivers, or tailored authorities by service population target group:

- The main difference occurring between waivers serving older adults and individuals with physical disabilities, versus waivers serving individuals with intellectual or development disabilities.
- Additional variability noted between children’s and adult’s programs.
- Variation occurred primarily in adding home delivered meals, justifying a conflict of interest exception, allowing spouses and parents of minor children to provide services, allowing family members to provide services and allowing other practitioners to deliver services.
**State Use of the Appendix or Attachment K COVID-19 Addendum by Frequency of Selection**

<table>
<thead>
<tr>
<th>Option</th>
<th>Number of States Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allow family member to be paid provider</td>
<td>24</td>
</tr>
<tr>
<td>Modify providers of home-delivered meals</td>
<td>22</td>
</tr>
<tr>
<td>Allow other practitioners to deliver service</td>
<td>20</td>
</tr>
<tr>
<td>Case management and Conflict of Interest</td>
<td>16</td>
</tr>
<tr>
<td>Add Home Delivered Meals</td>
<td>12</td>
</tr>
<tr>
<td>Add Medical Equipment and Supplies</td>
<td>9</td>
</tr>
<tr>
<td>Add Assistive Technology</td>
<td>3</td>
</tr>
</tbody>
</table>
State Use of COVID-19 Addendum Options

• One state chose all available options in the COVID-19 Addendum for all HCBS programs.
• 10 states (21%) selected all options available to alter provider qualifications.
• 6 states (14%) selected all provider qualification options except for adding additional home-delivered meal providers.
• 29 states (69%) selected all options available to alter processes.
Allowing Spouses and Parents or Family Members as Service Providers

- 34 states added authority to use spouses and parents of minor children as paid providers through the COVID-19 Addendum or the Appendix K impacting 112 HCBS waivers.
- 33 states added family members as eligible providers through the COVID-19 Addendum or the Appendix K impacting 113 HCBS waivers.
- Reflects mitigation strategies to limit exposure to COVID-19 in the family home, a way to provide support for individuals who returned from congregate settings to family settings to avoid the risk of transmission, and/or respond to the direct support workforce challenges exasperated even further as a result of COVID-19.
Telehealth

- Telehealth, in short, is described as using technology to deliver services.
- Many services covered in Medicaid can be delivered using telehealth.
- Examples of technologies are asynchronous store and forward, two-way real time audio/visual communication, telephone, etc.
- Medicaid coverage of services delivered via telehealth is not dependent on Medicare rules, but subject to Office of Civil Rights/HIPAA rules.
Telehealth

• State flexibility when covering telehealth:
  – What services to authorize via telehealth?
  – What practitioners to authorize to deliver services via telehealth?
  – What types of technology to use?
  – Where in the state will telehealth delivery be permitted?
  – How will services delivered via telehealth be reimbursed?

• Services must be provided within practitioners’ scope of practice.
• If the service is not covered statewide or by all providers of the service, the state must still cover the service delivered face-to-face.
Telehealth

• States are not required to submit a (separate) SPA for coverage or reimbursement of services delivered via telehealth, if the states reimburse for services in the same way/amount that they pay for face-to-face services/visits/consultations.

• States must submit a (separate) reimbursement (attachment 4.19-B) SPA if they want to provide reimbursement for services delivered via telehealth differently from reimbursement for face-to-face services.
Telehealth Toolkit

• Provides states with statutory and regulatory infrastructure issues to consider as they evaluate the need to expand their telehealth capabilities and coverage policies. As such, the toolkit describes each of the following areas and the considerations they require, including:
  – Populations eligible for telehealth,
  – Coverage and reimbursement policies,
  – Providers and practitioners eligible to provider telehealth,
  – Technology requirements, and
  – Pediatric considerations.
## COVID-19 Addendum Electronic Service Delivery Options Selected

<table>
<thead>
<tr>
<th>Option</th>
<th># and percentage of states (of 42)</th>
<th># of HCBS Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management</td>
<td>36 (86%)</td>
<td>171</td>
</tr>
<tr>
<td>Personal care</td>
<td>30 (71%)</td>
<td>121</td>
</tr>
<tr>
<td>In-home habilitation</td>
<td>27 (64%)</td>
<td>98</td>
</tr>
<tr>
<td>Monthly monitoring</td>
<td>34 (81%)</td>
<td>161</td>
</tr>
</tbody>
</table>
Appendix K Electronic Service Delivery Requests Added
(1 of 2)

Total Number of States

- Behavior Consultation, Behavioral Support, Therapies, Counseling, Social...
- Adult Day Health, Adult Day Program, Day Program Services
- Discovery and Customization Employment, Career Planning, Supported...
- Independent Living/Skills Building, Independent Habilitation, Res...
- Family and Caregiver Training, Youth Support Training, Parenting...
- Nurse Consultation, Nursing, Wellness Coordination, Wellness Counseling
- All services (except transportation and environmental accessibility)
- Companion, Personal Supports,
- Participant-Directed Services, Support Broker, Consumer Prep, FMSA...
- Community Support Program, Community Development, Community...
- Case management, Supports Broker

17
14
12
11
9
8
6
6
6
5
3
• One state requested electronic service delivery for 22 additional services offered in at least one of their waiver programs.
• Additional services requested by only one state:
  – Substance abuse services,
  – Assistive technology,
  – Personal care and respite supervisory visits,
  – Extended services,
  – Interpreter services, and
  – Recovery assistant and life coach services.
Modifications to Services

- Forty-nine (49) out of 50 states modified services in the Appendix K.
- Forty (40) states (80%) requested to exceed service limits or waive/modify prior authorization requirements, affecting 168 HCBS waiver programs.
- Twenty-eight (28) out of the 50 states (56%) made requests to modify service scope or coverage, affecting 117 HCBS waiver programs.
- Twelve (12) states (24%) submitted more than one Appendix K to make additional changes to services.
Modified Service Scope or Coverage in the Appendix K

Number of States

- Exceed service limits: 36
- Add telehealth and remote service delivery options: 27
- Allow services to be provided out of state: 15
- Add or allow additional Home Delivered Meals: 12
- Add or expand covered services in SMES including PPE and remote: 10
- Increase permitted occupancy in residential settings: 5
- Change minimum staffing requirements: 4
- Expand access to certain services previously not available to select: 4
- Suspend day services and replace with in-home support: 2
### Appendix K Exceeding Service Limits by Service Types

#### Number of States by Type of Service

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite</td>
<td>35</td>
</tr>
<tr>
<td>In-home or family support</td>
<td>30</td>
</tr>
<tr>
<td>Home Delivered Meals (HDM)</td>
<td>25</td>
</tr>
<tr>
<td>Consumer-directed support, Individual directed goods, and supplies</td>
<td>12</td>
</tr>
<tr>
<td>Community connector, Community day, Supported employment</td>
<td>9</td>
</tr>
<tr>
<td>Nursing, Respiratory therapist</td>
<td>9</td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies (SMES)</td>
<td>8</td>
</tr>
<tr>
<td>Residential (Group home, Supported living, Shared living, Host home)</td>
<td>8</td>
</tr>
<tr>
<td>Center-based day services</td>
<td>6</td>
</tr>
<tr>
<td>Case management, Support broker</td>
<td>6</td>
</tr>
<tr>
<td>Behavior support, Counseling, Expressive Therapy, Bereavement counseling</td>
<td>5</td>
</tr>
<tr>
<td>Non-medical transportation</td>
<td>5</td>
</tr>
<tr>
<td>Assistive technology</td>
<td>4</td>
</tr>
<tr>
<td>Family training, mentoring</td>
<td>4</td>
</tr>
<tr>
<td>Home accessibility and adaptation</td>
<td>3</td>
</tr>
<tr>
<td>Community transition service</td>
<td>3</td>
</tr>
<tr>
<td>Community connector, Community day</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix K Added Services and Expanded Settings Options

- Added services:
  - 24 states (48%) added new services, affecting 78 HCBS programs
  - 4 states added to the approved menu of self-directed services

- Expanded allowable service settings:
  - 48 states (96%) requested delivery of services in new settings
  - 15 states (30%) requested authority to deliver services in out of state settings
Appendix K Examples of Added Services

- Remote Support Services
- Live-in Caregiver
- Medical Respite
- Home Delivered Meals
- Companion
- Homemaker
- Intensive Personal Care
- Behavior Stabilization

- Wellness Monitoring
- Wellness Education
- Assistive Devices and Medical Supplies
- Emergency Quarantine Service
- Shift Nursing
- Attendant Care
- In-Home Support
## Service Types Selected for Use in Expanded Settings

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Total No. and Percentage of States (of 48)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Services</td>
<td>39 states (81%)</td>
</tr>
<tr>
<td>Residential Services</td>
<td>30 states (63%)</td>
</tr>
<tr>
<td>Respite</td>
<td>26 states (54%)</td>
</tr>
<tr>
<td>In-home Services, Including Individual and Family Support</td>
<td>19 states (40%)</td>
</tr>
<tr>
<td>Clinical and Therapeutic Services</td>
<td>16 states (33%)</td>
</tr>
<tr>
<td>Not Specified</td>
<td>8 states (17%)</td>
</tr>
</tbody>
</table>
Appendix K Expanded Settings Locations

- Allow direct support worker to move into participant’s home: 2
- Respite in congregate day facility: 2
- Expand residential facility bed capacity or reuse formally closed settings: 3
- HCBS Services in an ICF/IID: 6
- Respite and/or services in any alternative setting: 8
- Residential services in day settings or unlicensed setting: 10
- Out of state settings: 13
- Remote delivery: 13
- Day service provided in residential setting: 25
- Services in hotel/paid lodging, newly rented room, other emergency settings: 25
- Day services provided in private home: 33
Appendix K Requests to Modify Provider Qualifications
Overview (1 of 3)

• Forty-seven (47) out of the 50 states submitting Appendix Ks, or 94%, requested some waiver of provider qualifications through the Appendix K flexibility (including use of the COVID-19 Addendum).

• Some requests impact provider agency qualification, but most impact the qualification of individuals employed by the provider agency or working independently.

• Requests to allow the hiring of normally excluded family members were generally applied to participant-directed programs or services.
Appendix K Requests to Modify Provider Qualifications Overview (2 of 3)

• It was more common to delay or modify training requirements rather than waive them completely. The most common modification was to allow online trainings in place of in-person.

• It was also much more common to delay background check requirements rather than waive them completely.

• It was more common to delay, waive, or modify requirements for new hires than ongoing staff.

• Roughly a third of the states requesting to delay or waive background checks or initial training requirements were applying that change only to participant-directed programs/services.
Appendix K Requests to Modify Provider Qualifications Overview (3 of 3)

- Modification of certification requirements most often included waiving site visits as part of a new certification or a renewal.
- Modification of licensure requirements varied but could include waiving capacity limits or staffing ratios in settings, extending licensure expiration dates, and delaying survey visits.
Appendix K Requests on Provider Qualifications (1 of 2)

Percent of States Making Changes to Provider Qualifications

- Added Provider Type: 77%
- Delay Background Check Requirements: 65%
- Allow Hiring of Normally Excluded Family Members: 60%
- Modify Licensure Requirements: 60%
- Delay New Worker Training Requirements: 60%
- Modify Certification Requirements: 43%
- Delay Ongoing Training Requirements: 40%
Appendix K Requests on Provider Qualifications (2 of 2)

Percent of States Making Changes to Provider Qualifications Continued

- Modify Staffing Ratios: 30%
- Modify Training Requirement/Delivery: 30%
- Waive New Worker Education/Experience Requirements: 23%
- Other: 17%
- Waive New Worker Training Requirements: 9%
- Lower Age Requirements: 9%
- Waive Background Check Requirements: 6%
- Waive Ongoing Training Requirements: 4%
Appendix K Eligible Services for Percentage Rate Increase

Number of States That Chose to Increase Rates by Service Category

- Group residential: 25 states
- In-home supports: 22 states
- Day, vocational and community supports: 13 states
- Case management: 3 states
Appendix K Rate Increase Methods

- Supplemental payments
- Tiered payments based on acuity and positive COVID-19 diagnosis
- New rate for daily Adult Day Health delivered remotely
- New rate for increased occupancy in residential setting
- Percentage increase for hazard pay and Personal Protective Equipment costs
- Supplemental payments to direct support staff
- Increase wage cap in participant-directed services
- Defined new rate
• Eight (8) states increased rates by a set percentage. Percentage increases ranged from 8 – 50%.
• Sixteen (16) states increased rates by a percentage with an up to a maximum threshold ranging from 5-50%.
• One state will provide a supplemental payment for select services based on hours worked, and an additional tiered payment based on acuity of the beneficiary and hours worked for beneficiaries who tested positive for COVID-19.
• One state will also provide a per diem or unit add-on payment for residential services, personal assistance, and nursing if provided to a person with COVID-19.
Rate Increase Method Examples (2 of 2)

- One state will pay a higher rate, unspecified, to account for higher Direct Support Professional (DSP) costs if using a staffing agency, and for working in quarantine settings. The state also created a new rate for Adult Day Health Program (ADHP) services provided remotely (75% of the daily per diem).

- One state increased the wage cap for participant-directed services.

- One state’s Acquired Brain Injury (ABI) waivers will pay time and a half if a staff person works over 40 hours.

- One state created new rates for two or three persons to receive Shared Living services in the same setting in case beneficiaries had to be moved into different settings due to COVID-19.
Thirty-eight (38) states or 76% of the 50 states, with submissions impacting 195 HCBS programs, requested to use retainer payments. Retainer payments covered such services as:

- Center-based day services (37 states / 97%);
- Community-based day and employment services (32 states / 84%);
- In-home individual supports (27 states / 71%);
- Array of group residential supports (23 states / 61%); and,
- Therapeutic and supportive services (3 states / 8%).

Eleven states requested to permit retainer payments of three episodes of thirty consecutive days.
Appendix K Retainer Payments Continued

- Sixteen (16) states requested retainer payments for some but not all HCBS programs within the state (AL, CA, CT, FL, IL, MA, MD, ND, NE, NV, NY, OR, SD, TN, WA, and WV).
- Several states identified the requested service as Habilitation with a personal care component (AZ, CA, KY, IL, and NJ) or any service that includes a personal care component or direct care workers (NC and RI).
When were Retainer Payments Permitted?

• 53% of the requested retainer payments are authorized when a participant is ill, hospitalized, or in quarantine and therefore not able to receive the service.
• 35% are for any general reduction in service utilization.
• 12% are authorized if the individual is ill or otherwise cannot receive services or the service provider must close due to local, state or federal requirements.
Person-Centered Plans and Verbal Consent under Appendix K Flexibility

Requested to Use Verbal Consent to Authorize Services Pending Receipt of Written Signature

- Yes, 30%
- No, 70%

Yes  No
Appendix K Requests for Verbal Consent on PCPs vs. Remote/Virtual PCP Meetings

• 49 states (98%) requested to allow for remote/virtual options for person-centered planning (PCP) meetings
• 31 states (62%) requested the use of verbal consent to initiate services in place of or pending written signature depending upon the authority used
• 19 states (38%) requested remote/virtual PCP meetings but did NOT request the use of verbal consent
• 48 states (96%) requested the use of electronic signatures for consent to the PCP
• States specified that changes to services in the PCP including amount, duration, and scope will be appended as soon as possible but no later than 30 days to ensure that the specific service is delineated accordingly to the date it began to be received.
Appendix K States Requesting to Hold PCP Meeting and Update Plan Without All Service Providers Represented

PCP Update Without Full Team

- Yes, 20%
- No, 80%

Yes | No
Appendix K Health and Welfare Safeguards

- 33 states (66%) submitted modifications to safeguards affecting 159 HCBS programs
- 27 states (54%) submitted modifications to incident management reporting
- 9 states (18%) will track COVID 19 infections
- 7 states (14%) requested some modification to medication administration requirements
- 11 states (22%) used the other category to request extension in 372 reporting or evidentiary packages
Appendix K Extension of 372 and Evidence Based Report (EBR) Reporting Timeframes

- Yes, 54%
- No, 46%
Appendix K Miscellaneous Requests (1 of 2)

- Pause waiver disenrollments of participants who are re-institutionalized beyond the 30-day limit.
- Permit substitution of lower level staff in a service plan, such as substituting a companion for a homemaker, when necessary and in order to maximize use of available staffing resources.
- Expand bed capacity in residential settings.
- Allow participants to receive less than one waiver service per month.
Appendix K Miscellaneous Requests (2 of 2)

- Delay enrollment of new providers.
- Extend deadlines for audits and fiscal reporting by providers.
- Delay state licensing and quality oversight activities.
- Change waiting list protocols.
- Waive physician orders for select services.
- Suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance; as a result the data will be unavailable for this pandemic specific time frame in ensuing reports.
## Number of Times States Submitted Requests

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>One Submission</th>
<th>Two Submissions</th>
<th>Three Submissions</th>
<th>Four or more Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Related 1135 Waiver</td>
<td>27 states</td>
<td>7 states</td>
<td>1 state</td>
<td></td>
</tr>
<tr>
<td>1915(c) Waiver Appendix K Amendment</td>
<td>15 states</td>
<td>12 states</td>
<td>6 states</td>
<td>13 states</td>
</tr>
<tr>
<td>1115 Waiver Attachment K Amendment</td>
<td>6 states</td>
<td></td>
<td>1 state</td>
<td></td>
</tr>
</tbody>
</table>
Why Did States Make Subsequent Appendix K Submissions?

• Responding to shrinking workforce.
  – Addition of new provider types, family members, raising staff ratios, increasing rates for services to include hazard pay, overtime, and Personal Protective Equipment
• Responding to lessons learned and/or increasing impact over time.
  – Addition of services eligible for electronic service delivery and other alternative settings.
  – Adding retainer payments to stabilize the provider network
• Responding to CMS guidance as found in COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies.
Level of Care (LOC) Flexibilities Across HCBS Authorities

- LOC Date and Virtual: 87%
- LOC Date Only: 7%
- LOC Virtual Only: 6%
- LOC None: 1%
## Disaster Relief State Plan Amendments and/or 1135 Waivers in the 1915(i) or 1915(k) benefit as of August 22, 2020

<table>
<thead>
<tr>
<th>Flexibilities and Authorities</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modify benefits including adding new services, telehealth options, removing limit caps and increasing home delivered meals</td>
<td>AR(i), CT (i), CT (k), DC(i), IA(i), OR (k)</td>
</tr>
<tr>
<td>Allow relatives and/or legally responsible persons to deliver service</td>
<td>CT (i), IA(i)</td>
</tr>
<tr>
<td>Allow virtual eligibility and independent assessments</td>
<td>DC(i), MI(i), OR (k)</td>
</tr>
<tr>
<td>Extend date for level of care re-evaluations</td>
<td>OR (k)</td>
</tr>
<tr>
<td>Person-centered planning modifications</td>
<td>CT(i), IA(i), MI(i), OR (k)</td>
</tr>
<tr>
<td>Modify provider qualifications and add provider types</td>
<td>CT(i), OR (k), OR (i)</td>
</tr>
<tr>
<td>Increase or modify payment rates</td>
<td>AR(i), DC(i), MI(i), OR (k)</td>
</tr>
<tr>
<td>Use retainer payments</td>
<td>OR (k)</td>
</tr>
<tr>
<td>Payment of HCBS in an acute care hospital setting</td>
<td>OR (k)</td>
</tr>
<tr>
<td>Expanded settings</td>
<td>IA(i), OR (i), OR (k)</td>
</tr>
<tr>
<td>Conflict of interest</td>
<td>IA(i)</td>
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<tr>
<td>Waive visitors requirement under Settings Rule</td>
<td>IA(i)</td>
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## New Public Health Emergency 1115(a) Demonstrations

<table>
<thead>
<tr>
<th>Flexibilities and Authorities</th>
<th>States</th>
</tr>
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<tbody>
<tr>
<td>Waiver for state-wideness</td>
<td>NC, WA</td>
</tr>
<tr>
<td>Expand access and eligibility and allow self-assessment of disability or Level of Care</td>
<td>NC, WA</td>
</tr>
<tr>
<td>Vary the amount, duration and scope of services based on population needs</td>
<td>NC, RI, WA</td>
</tr>
<tr>
<td>Modify initial and annual 1915(i)-like eligibility and assessment of need dates</td>
<td>HI</td>
</tr>
<tr>
<td>Modify initial and annual 1915(c) and 1915(c)-like Level of Care dates</td>
<td>HI</td>
</tr>
<tr>
<td>Allow 1915(c) like eligibility and Level of Care self-attestation and delay Level of Care for one year</td>
<td>NC, WA</td>
</tr>
<tr>
<td>Allow retainer payments</td>
<td>HI, NC, NH, RI, WA</td>
</tr>
<tr>
<td>Waive visitor requirements under Settings Rule</td>
<td>HI</td>
</tr>
<tr>
<td>Modify payment rates</td>
<td>WA</td>
</tr>
<tr>
<td>Modify functional assessment requirements</td>
<td>NC, WA</td>
</tr>
<tr>
<td>Allow payment for services even if the PCSP is not updated timely</td>
<td>NC, WA</td>
</tr>
</tbody>
</table>
Nursing Facility Reimbursement During PHE

• August 24, 2020 Informational Bulletin described reimbursement mechanisms to enhance payment to nursing facilities based on increased resident acuity or actions taken to mitigate COVID-19 infection spread.
• Provided examples of payment methodologies in both fee-for-service and managed care delivery systems.
• Described examples of payment enhancements already implemented by states.
• CMS remains available for technical assistance.
Life After COVID-19: Post-Pandemic HCBS Planning

- What is the state’s glide path to a post-pandemic era as restrictions imposed by the COVID-19 public health emergency are relaxed or eliminated?
- How can a state ensure that participants re-connect with their communities in ways that reflect individualized choices and preferences while taking into account the dignity of risk?
- What steps are being taken to provide individuals with the training and support needed to re-integrate into their community once there is no longer a PHE threat?
- How will the state ensure operational procedures are ready to resume without Appendix K or 1135 flexibilities?
What Does It Mean to “Unwind” COVID-19 Flexibilities?

Unwinding:

• The assessment process that each state designs and implements to systematically determine how it will:
  – Either return its HCBS programs, services and supports to their pre-pandemic operation; and/or
  – Adapt techniques and strategies learned from the use of those flexibilities to re-configure the delivery of services to adjust to the changing needs of participants and providers through permanent amendments to the authority and/or program.
How Will a State Evaluate Which Flexibilities Should Be Retained or Expire?

• Communicate with key stakeholders—individuals, families, advocates, friends—to ensure that services align with post-pandemic needs and preferences;

• Build on person-centered thinking, planning, and practice to reassess how each individual will systematically and safely re-engage in community activities and identify how services should be designed to accommodate individualized re-integration strategies;

• Support providers to evaluate the current status of their services to determine the most viable course of action to meet the needs and preferences of their participants.
Now Where Do We Go From Here?

• Based on the results of each state’s evaluation of which flexibilities should expire or be retained, the state can make permanent changes to the structure and operation of its HCBS program(s) by submitting a 1915(c) or 1115 waiver renewal or amendment or a 1915(i) and (k) SPA to include any of the flexibilities noted for review by CMS.

• Flexibilities implemented via a Disaster SPA can be added permanently to the state plan. Flexibilities implemented via 1135 waivers may not be made permanently to the state plan or 1915(c) waiver. Many, but not all, of the flexibilities implemented in an Appendix K may be made permanently to the 1915(c) waiver.
• For ease of operation, states may consider the use of electronic signatures.
• Retainer payments for services that include a personal care component on a time-limited basis may be instrumental in assisting individuals to transition into community activities at their own pace. Be mindful of the non-disaster parameter that retainer payments cannot exceed the lesser of the state’s nursing facility bed-hold days or 30 days.
• Re-analysis of LOC determinations and assessment tools to determine if efficiencies have been identified that the state would like to continue.
Which Flexibilities May Be the Most Functional For States in a Post-Pandemic Environment? (2 of 3)

- Virtual/remote and/or assistive technology methods have been used by states for evaluation, assessment and monitoring due to stay-at-home orders, self-isolation and social distancing, which have prohibited on-site visits/reviews during the pandemic.
- Post-pandemic, states may need to re-institute on-site strategies, for the evaluation of individual’s access to community integration.
- Electronic service delivery may offer opportunities to reach participants in areas where provider capacity challenges remain. Services like career exploration and job coaching could continue to be effective.
Which Flexibilities May Be the Most Functional For States in a Post-Pandemic Environment? (3 of 3)

• States may also find it effective to continue to use assistive technology and/or to combine remote and in-person service delivery if there is continued social distancing to assist individuals to acclimate to community activities at their own pace with the goal of full community integration that may result in the fading of the remote service delivery component.

• In consideration of each individual’s preference in how to systematically and safely re-engage in community activities, states may consider using spouses, parents of minor children, and/or other family members to be paid providers of services.

• States may also allow other practitioners to deliver services and thereby expand the available provider network during the transition to a post-pandemic environment.

• Expand self-directed services to increase direct support worker options.
• CMS is committed to working with states through the PHE and beyond. To support these efforts, CMS plans to:
  – Provide guidance on state strategies and planning on unwinding COVID authorities once the public health emergency has ended,
  – Update the Medicaid and CHIP Disaster Relief Toolkit to reflect lessons learned and include elements specific to public health emergencies,
  – Update and integrate FAQs, checklists, and templates.
  – CMS will also be monitoring the impact of flexibilities adopted during the PHE and impact of the pandemic on beneficiaries.
Resources (1 of 2)

CMS Baltimore Contact---Division of Long-Term Services and Supports:

❖ HCBS@cms.hhs.gov

Medicaid and CHIP Operations Group Contact

❖ Reach out to your primary waiver analyst in the Division of HCBS Operations and Oversight

Medicaid.gov:


To request Technical Assistance:

❖ HCBSettingsTA@neweditions.net
Resources (2 of 2)

- Telemedicine in Medicaid
  https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html
- Telehealth Toolkit for States
  Medicaid & CHIP Telehealth Toolkit Checklist for states
- State Plan fee-for-service telehealth payments