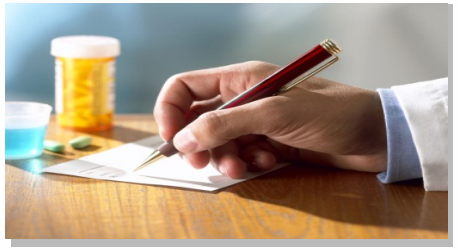
Innovations in Medicaid: State Home and Community Based Services (HCBS) Pandemic Response and Unwinding COVID-Related Waivers



Division of Long-Term Services and Supports
Division of Benefits and Coverage
Disabled and Elderly Health Programs 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).

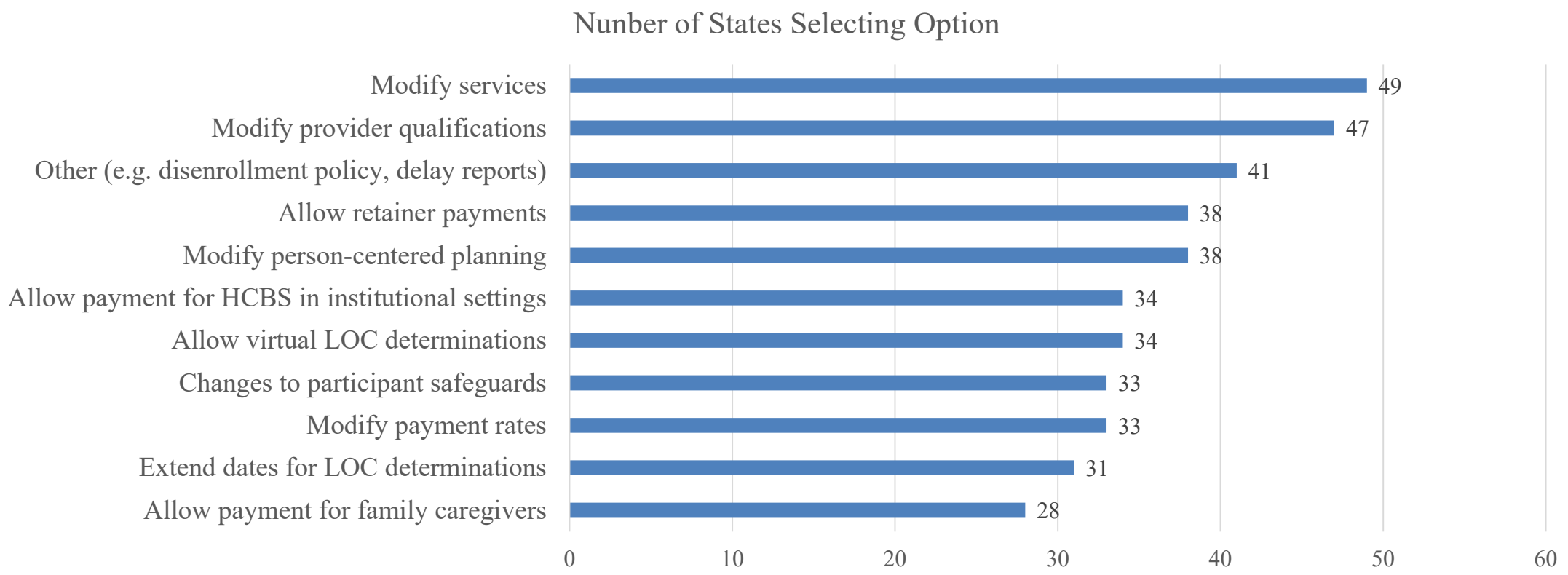
Emergency Amendments and Flexibilities (2 of 2)

- 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.

State Approvals as of November 3, 2020

- ✓ **132** 1135 Waivers
- ✓ **154** 1915 Appendix Ks
- ✓ **139** Medicaid Disaster SPAs
- ✓ **33** 1115 Demonstration Actions

Most Selected Options by States Using Appendix K



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.

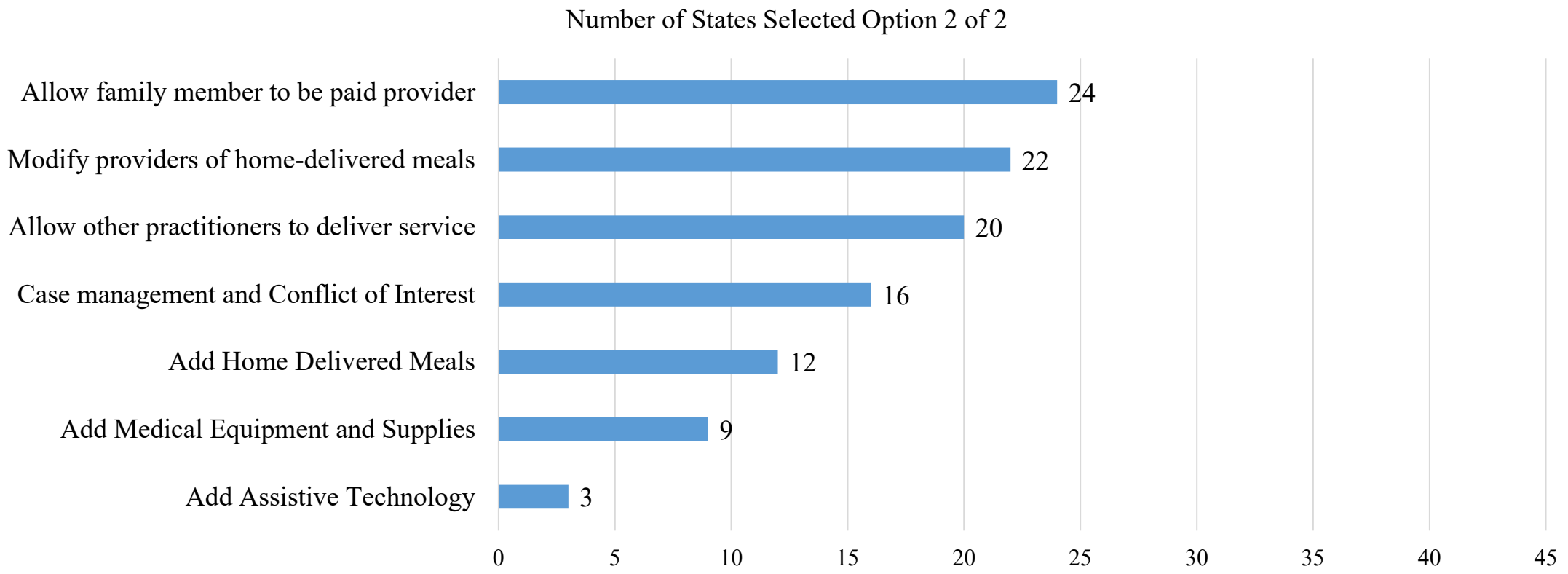
Use of the Appendix K COVID-19 Addendum (1 of 2)

- 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.

Use of the Appendix K COVID-19 Addendum (2 of 2)

- 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 (2 of 2)



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.

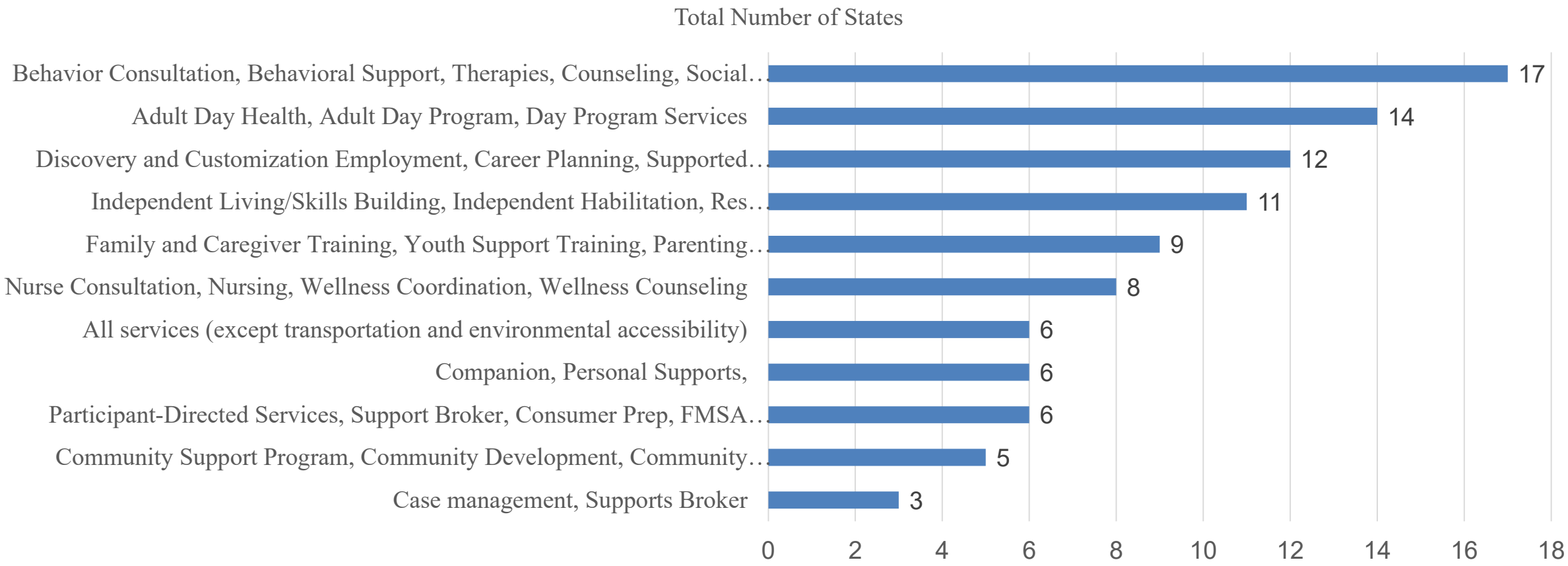
Telehealth Toolkit

- 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

Option	# and percentage of states (of 42)	# of HCBS Programs
Case management	36 (86%)	171
Personal care	30 (71%)	121
In-home habilitation	27 (64%)	98
Monthly monitoring	34 (81%)	161

Appendix K Electronic Service Delivery Requests Added (1 of 2)



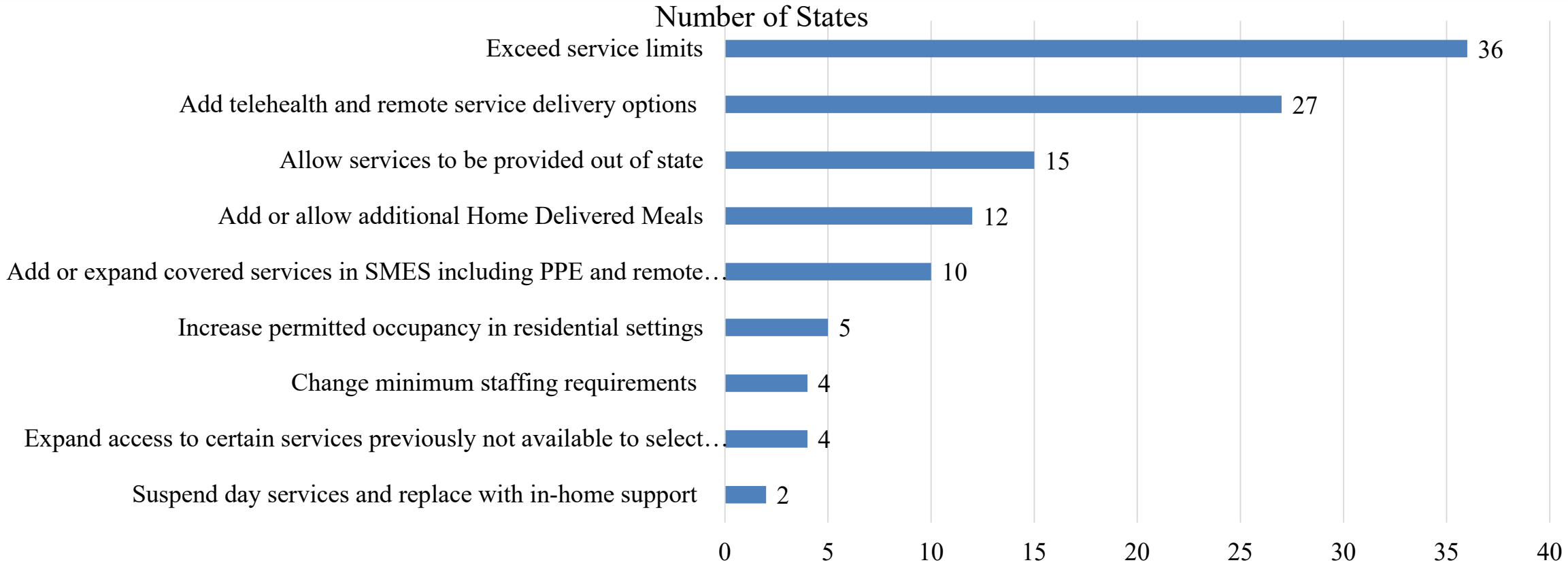
Appendix K Electronic Service Delivery Requests Added (2 of 2)

- 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.

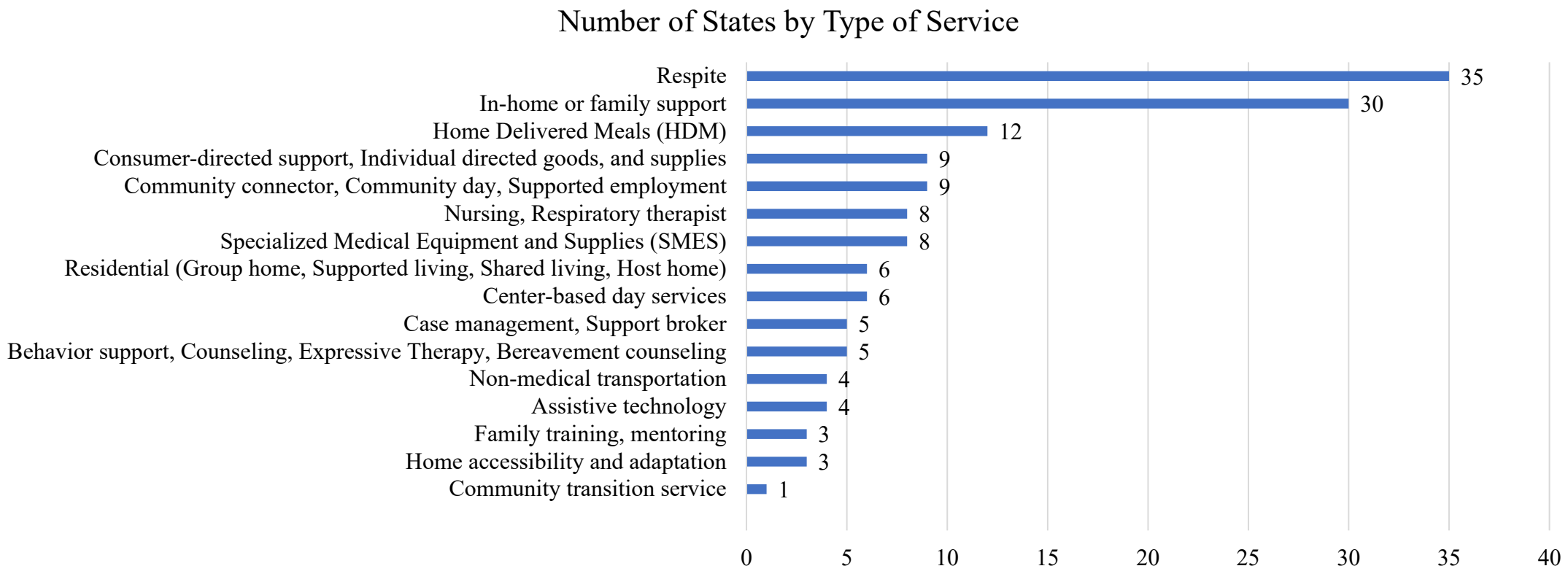
Modifications to Services

- 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



Appendix K Exceeding Service Limits by Service Types



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

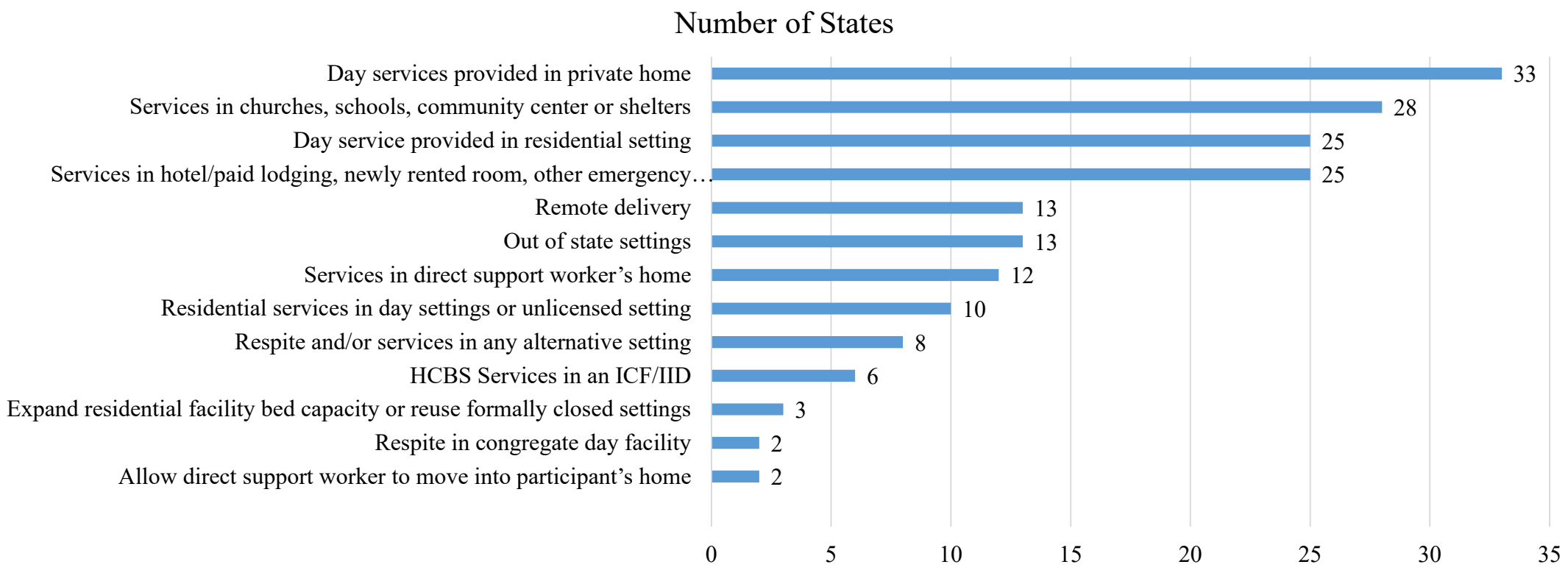
Appendix K Examples of Added Services

- 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

Type of Service	Total No. and Percentage of States (of 48)
Day Services	39 states (81%)
Residential Services	30 states (63%)
Respite	26 states (54%)
In-home Services, Including Individual and Family Support	19 states (40%)
Clinical and Therapeutic Services	16 states (33%)
Not Specified	8 states (17%)

Appendix K Expanded Settings Locations



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.

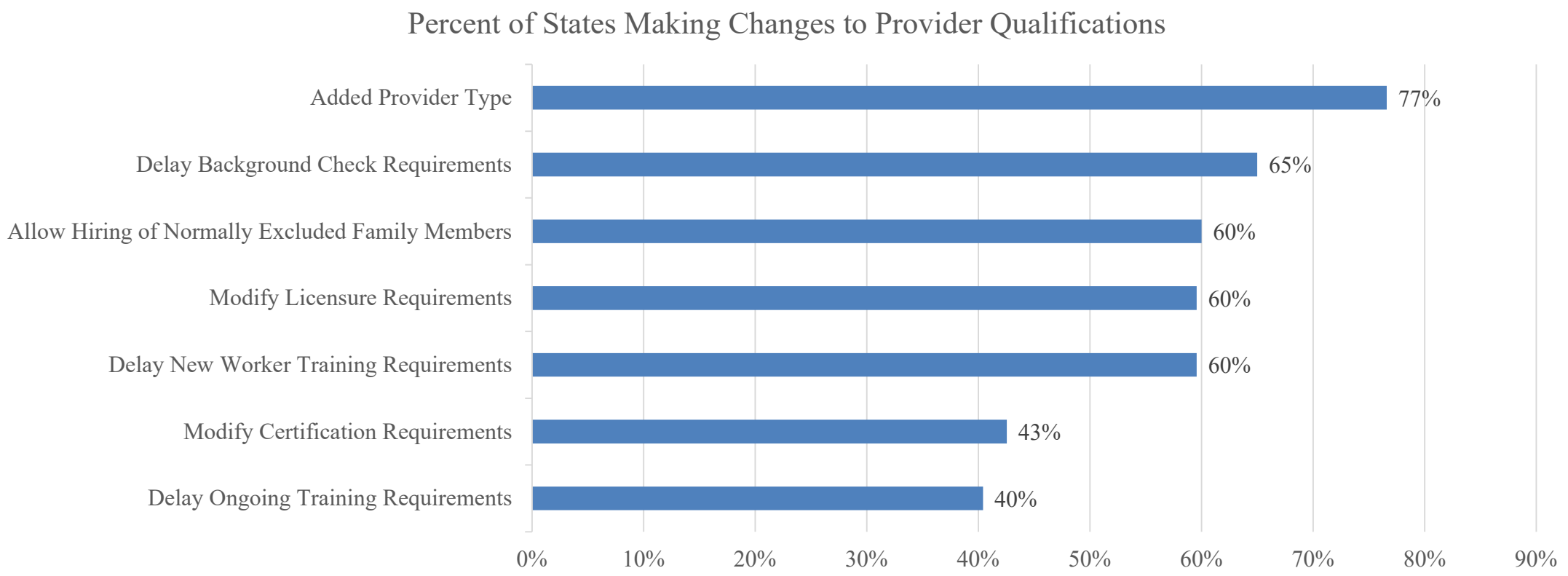
Appendix K Requests to Modify Provider Qualifications Overview (2 of 3)

- 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.

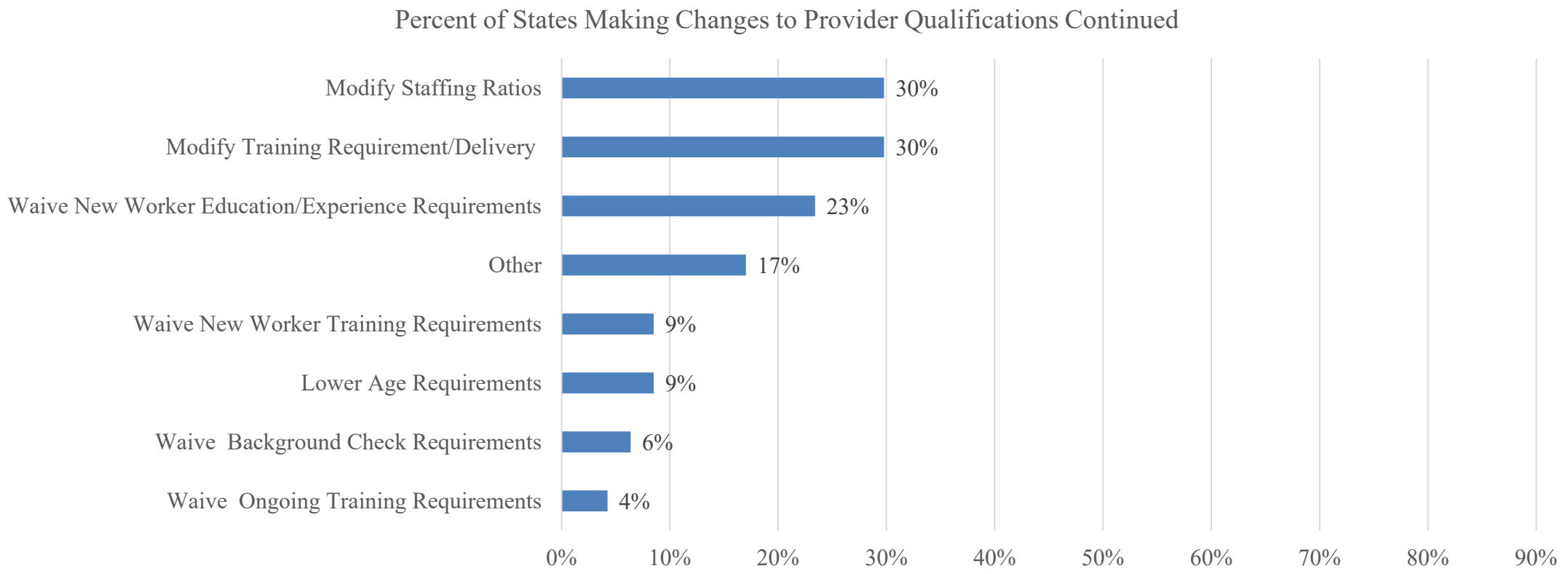
Appendix K Requests to Modify Provider Qualifications Overview (3 of 3)

- 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)



Appendix K Requests on Provider Qualifications (2 of 2)



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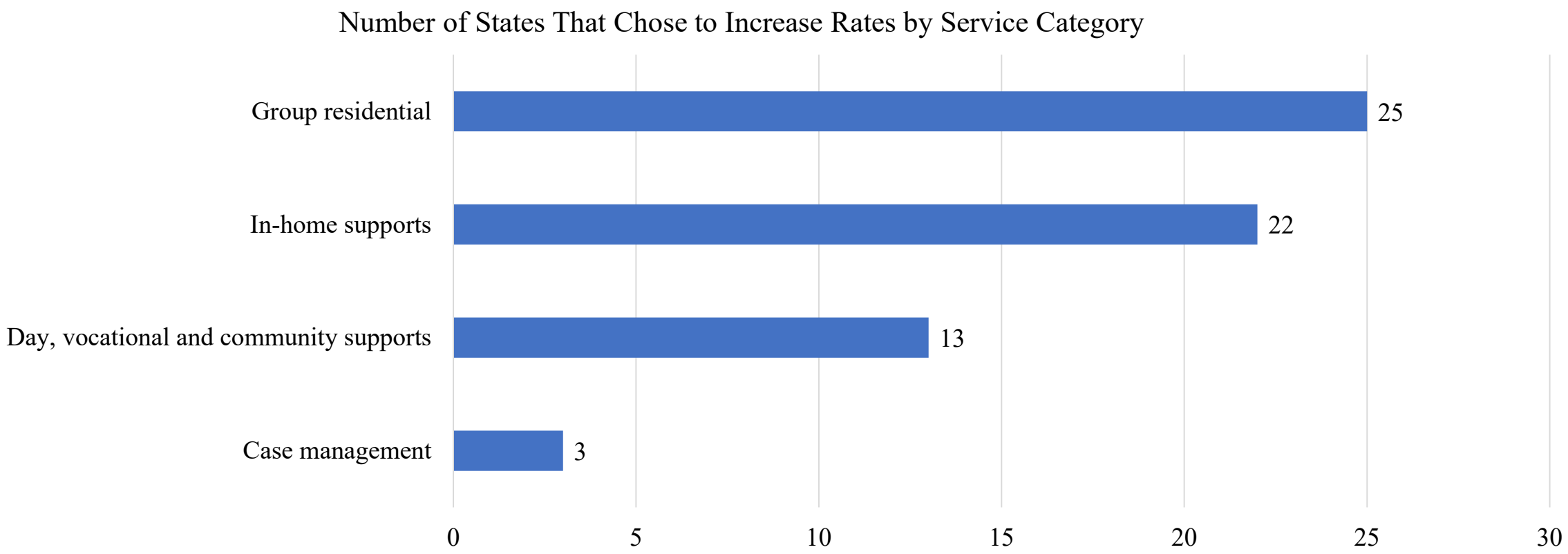
Appendix K Eligible Services for Percentage Rate Increase



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

Rate Increase Method Examples (1 of 2)

- 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.

Retainer Payments authorized through the Appendix K

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.

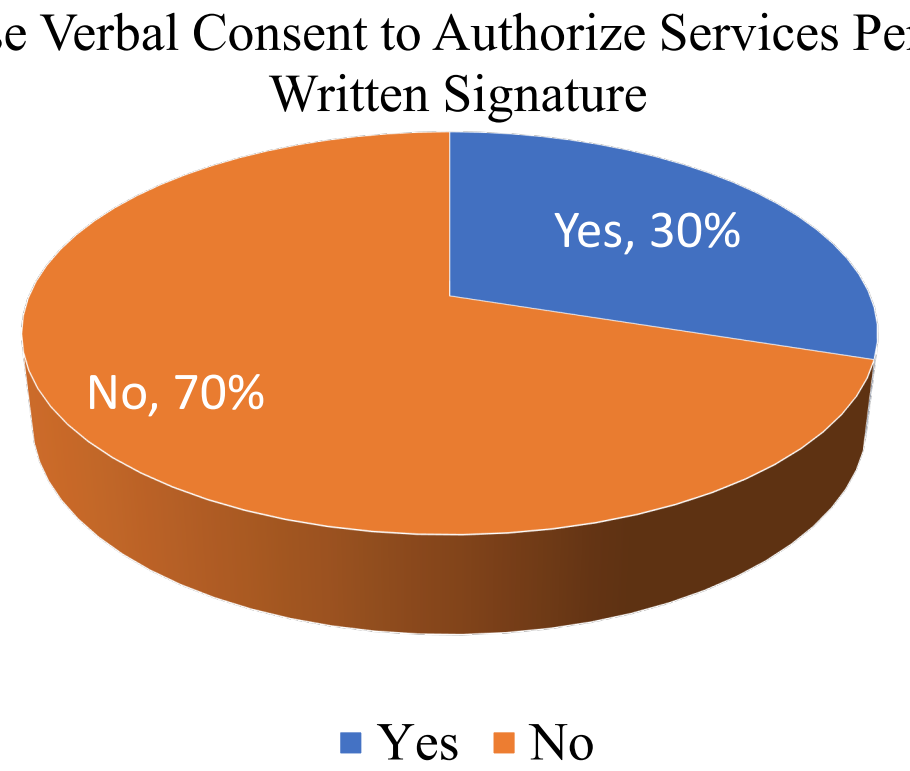
Appendix K Retainer Payments Continued

- 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.

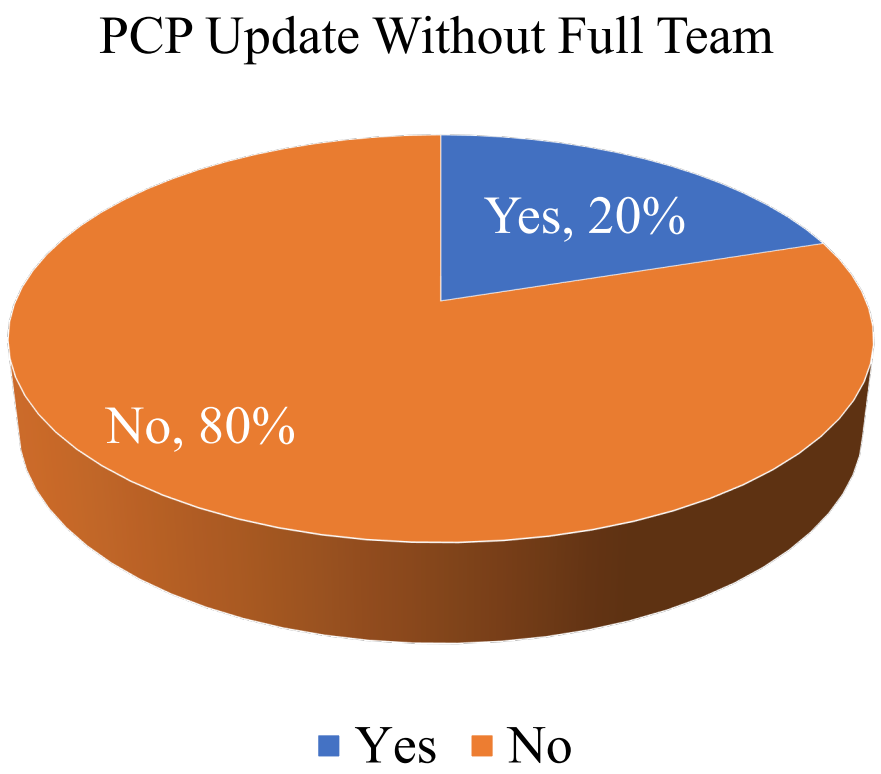
Person-Centered Plans and Verbal Consent under Appendix K Flexibility



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.

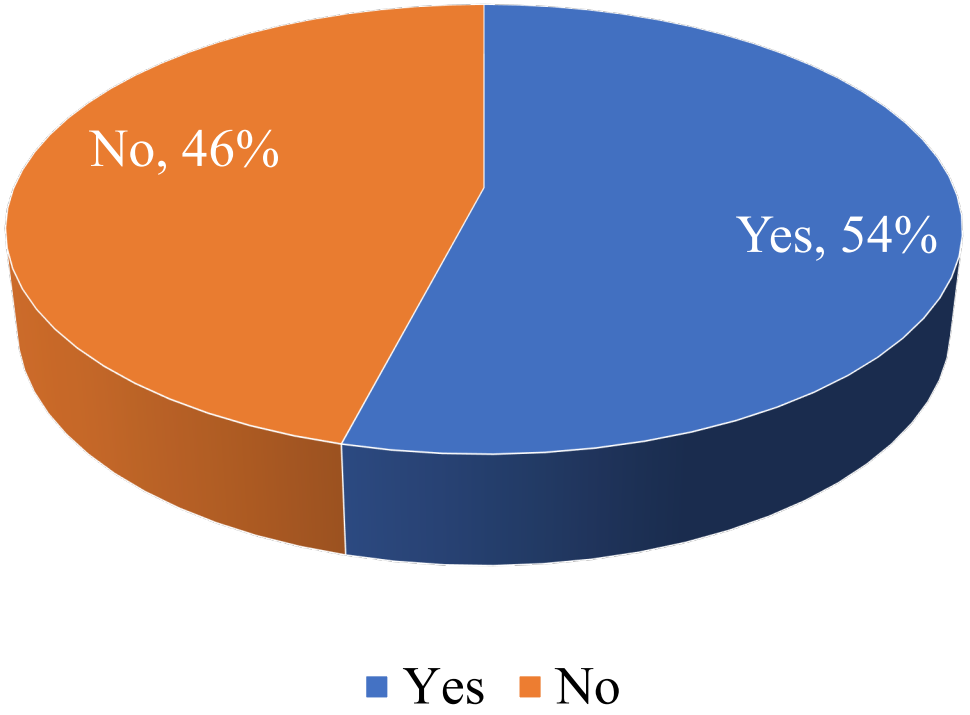
Appendix K States Requesting to Hold PCP Meeting and Update Plan Without All Service Providers Represented



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



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

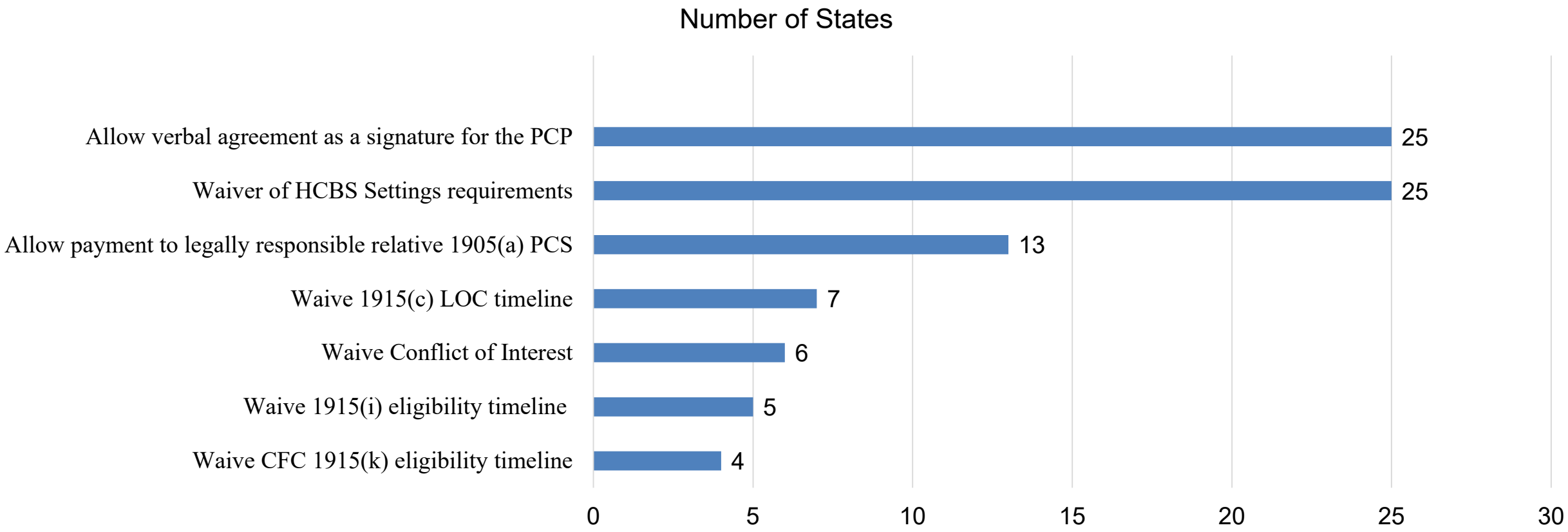
Number of Times States Submitted Requests

Type of Request	One Submission	Two Submissions	Three Submissions	Four or more Submissions
HCBS Related 1135 Waiver	27 states	7 states	1 state	
1915(c) Waiver Appendix K Amendment	15 states	12 states	6 states	13 states
1115 Waiver Attachment K Amendment	6 states		1 state	

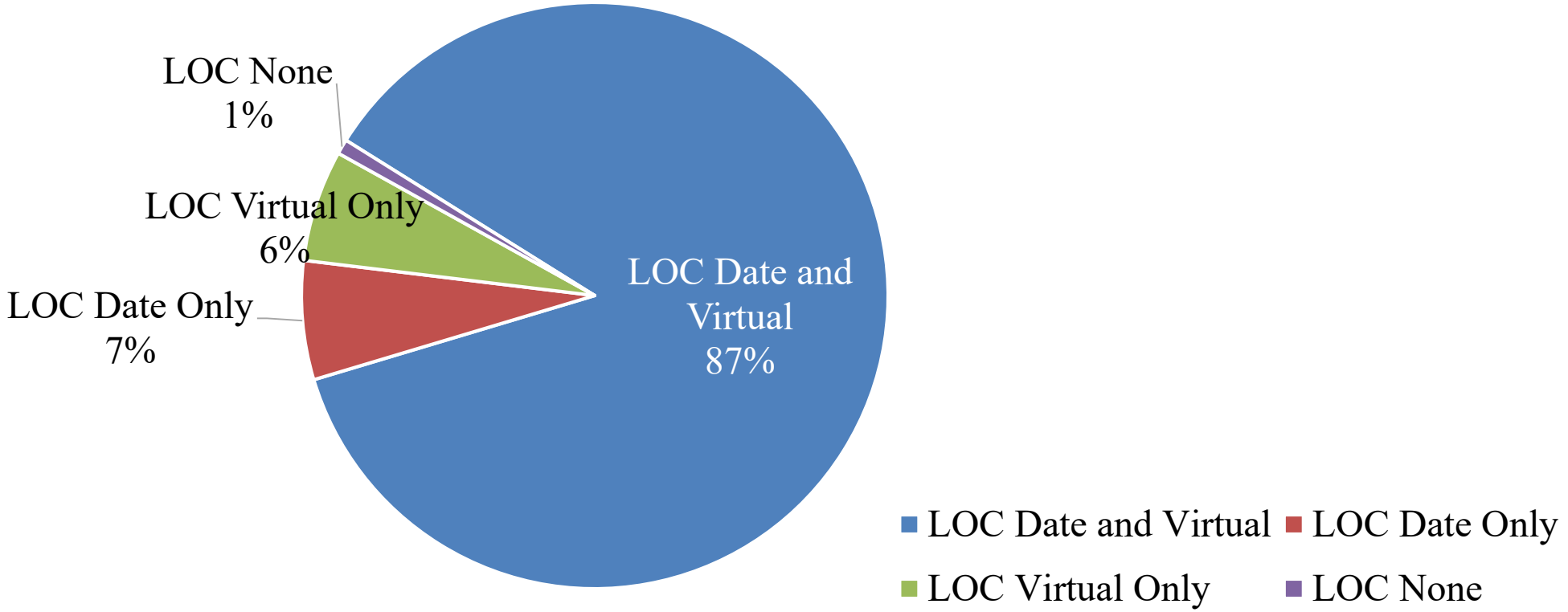
Why Did States Make Subsequent Appendix K Submissions?

- 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.

HCBS Related 1135 Waiver Flexibilities



Level of Care (LOC) Flexibilities Across HCBS Authorities



Disaster Relief State Plan Amendments and/or 1135 Waivers in the 1915(i) or 1915(k) benefit as of August 22, 2020

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

New Public Health Emergency 1115(a) Demonstrations

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

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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.

Which Flexibilities May Be the Most Functional For States in a Post-Pandemic Environment? (1 of 3)

- 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.

Looking Ahead

- 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.gov:

- **https://www.medicaid.gov/medicaid/home-community-based-services/index.html**

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

  https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf

Questions