July 3, 2020

Seema Verma, Administrator   
Centers for Medicaid and Medicare   
The Hubert H. Humphery Building  
200 Independence Ave., S.W.  
Washington, DC 20001

RE: NACDD Recommendations for Unwinding of Medicaid Emergency Waivers in the States.

Dear Administrator Verma,

On behalf of the National Association of Councils on Developmental Disabilities, we would like to share our recommendations to ensure provisions of 1115 and 1915 (c) Appendix K waivers that benefit states and people with intellectual and developmental disabilities are not lost when the federal emergency declaration ends emergency waivers granted during the COVID-19 crisis unwind.

Approved Medicaid emergency authorities to address the COVID-19 Coronavirus emergency, including Medicaid Disaster Relief State Plan Amendments (SPAs); Section 1115 Waivers; Section 1135 Waivers; and 1915 (c) Waiver Appendix K strategies, ensured critical supports and services continued and provided relief for people with I/DD and their families. As state and local governments reopen, it is extremely important that CMS provide guidance on the best ways for states to transition from these temporary Medicaid emergency waiver services, to a better system of Medicaid service delivery customized to fit the needs of their state.

Recommendation #1: Automatic extension and reinstatement of approved emergency waivers.

We recommend that CMS provide guidance to reassure states that waivers approved under 1915 (c) Waiver Appendix K will be automatically extended for the remainder of the pandemic without the need to reapply should their original waiver expire before then. Alternatively, CMS should establish a simple renewal form instead of requiring a new application.

We also recommend that CMS justify the current position that Appendix K flexibilities must end no later than one year from the date of the President’s declaration of an emergency instead of allowing states to determine the end of their own state’s emergency. In past emergencies, CMS has allowed states to determine when the emergency has ended and thus when the Appendix K needs to end. COVID-19 is different in each state and therefore we believe the Appendix K flexibilities should be tied to the state emergency and expire when the state determines.

States are still in “crisis mode” dealing with a pandemic with an uncertain end date. Additionally, we are concerned about states that are seeing an increase in COVID-19 cases and the real possibility of a second wave before the first wave has ended. Therefore, we need to come up with unwinding solutions that provide certainty to states that should the incidence of COVID-19 spike there will not be any delay. Continued Appendix K authority based on the state’s emergency timeline would allow for that.

Recommendation #2: CMS should consider allowing states to permanently continue certain services included in many states’ approved 1915 (c) Waiver Appendix K.

Although K waivers are by nature specific to each state, common themes have arisen which could provide certainty and cost savings to states and CMS. Early during the pandemic, CMS provided a list to states of 1135 waiver elements that would receive approval under the 1135 waiver authority. This strategy facilitated the speed of getting Medicaid waiver services directly to the states and prompted states to consider them as “best practices” to adopt for their state. The result was a success.

We recommend that CMS work with NACDD and other stakeholders to develop common elements and requirements for services in approved K waivers that improve service delivery, are cost effective, and do not negatively impact the rights of people using HCBS or the ability to live in the community, and provide assurance to states that if they apply for those waivers they will be granted. States should be able to get assurance that they will be approved for these types of waivers to avoid the cost and time involved in the current 1915 (c) Waiver Appendix K application process. Areas that should be considered include:

* Telehealth with safeguards to protect against social isolation;
* Virtual Services where desired by the participant and as appropriate;
* Remote support technology (both remote services and supports and providing access to technology to access virtual services)
* Assistive Technology
* Overtime and hazard pay for Direct Care workers;
* Personal Protective Equipment and medical supplies
* Family members paid as support (especially for adults who self-direct their services) so long as appropriate restrictions and requirements are in place to protect the self-determination of the person using HCBS services and the services comply with current State Medicaid Manual Section 4442.3 (B)2 and 42 CFR 440.167 provision regarding legally responsible individuals;
* Support to set up and use technology, including connecting to the internet and training and support to use the technology.

Additionally, we recommend that CMS require states to provide public comment options as states move from the Appendix K and 1135 waiver authorities into their standard waiver authorities. Public comment is a critical piece of Medicaid policymaking that ensures Medicaid dollars are being used most effectively and it must be continued in these circumstances.

Recommendation #3: CMS should incentivize rebalancing initiatives.

COVID-19 has demonstrated the enhanced risks of congregant settings. Community based services that do not rely on settings that concentrate high-risk individuals in the same space offer a safer approach; research supports that people with greater levels of community engagement are safer. People with Intellectual and Developmental Disabilities want to live in the community, not institutional settings.

NAACD would like to discuss strategies CMS could use with states to prioritize and shift towards Home and Community Based Services.

Sincerely,

Kristen Britton

Tamara Jackson

Rachel London

[Add sign ons]