Unwinding Home and Community-Based Services (HCBS) Public Health Emergency (PHE) Flexibilities

February 8, 2023

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Webinar Overview

- CMS resources to support states in unwinding PHE flexibilities, including considerations for HCBS.
- Overview of HCBS-related PHE flexibilities to unwind, with a focus on the 1915(c) HCBS Appendix K authority.
- Overview of HCBS-related PHE flexibilities that can be made permanent in 1915(c) Waivers and the CMS approval process.
- Other considerations for HCBS programs when unwinding from the PHE.

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CMS Resources to Support States in Unwinding PHE Flexibilities

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Unwinding HCBS-Related Flexibilities Granted During the COVID-19 PHE

- For the purposes of this HCBS-specific presentation, the term "unwinding" refers to 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 flexibilities approved for use during the pandemic 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.

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Considerations for States in Planning for the Design of Post-Pandemic HCBS (1 of 3)

- Consider what mechanisms should be in place to analyze the status of each flexibility going forward.
- Consider what methods to use to evaluate successful transition and re-integration of individuals receiving HCBS into their communities as restrictions imposed by the pandemic continue to be relaxed or eliminated.
- Consider how to ensure that participants re-connect with their communities in ways that reflect individualized choices and preferences while taking into account the dignity of risk.

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Considerations for States in Planning for the Design of Post-Pandemic HCBS (2 of 3)

- Consider what changes will need to occur as the flexibilities approved for use during the pandemic begin to unwind.
- Consider how to unwind the flexibilities approved for use during the pandemic.
- Consider if any new techniques or strategies adopted to support individuals while operating within the restrictions of the pandemic proved to be particularly beneficial and should be included in a new design of service delivery going forward. For example, a day program without walls in the community.

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Considerations for States in Planning for the Design of Post-Pandemic HCBS (3 of 3)

- Determine if a specific flexibility had a positive impact on the way HCBS and supports are delivered and should be included in a waiver renewal/amendment or a State Plan Amendment for review by CMS.
- Prepare for how to ensure operational procedures are ready to resume without COVID-19 PHE flexibilities.
- Ensure steps are being taken to provide individuals with the training and support needed to re-integrate into their community once the PHE ends.
- Ensure steps are being taken to provide stakeholders with the training and support needed to adapt to the “new normal”.

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Overview of HCBS-Related PHE Flexibilities to Unwind

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HCBS-Related PHE Flexibilities

Authority / Provision	Effective Date	Termination Date
Appendix K of the 1915(c) HCBS Waiver Instructions and Technical Guidance	January 27, 2020 or any later date elected by state	For Appendix Ks in response to the COVID-19 PHE, the termination date will be no later than six months after the expiration of the PHE.
Medicaid Disaster Relief SPA for the COVID-19 PHE	March 1, 2020 or any later date elected by state	Expires at the end of PHE or any earlier approved date elected by state.
Medicaid & CHIP 1135 Waivers	March 1, 2020	Expires at the end of PHE.

States can find additional information on how to unwind Disaster Relief SPAs and 1135s at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

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Appendix K Flexibilities to Unwind

All states operating 1915(c) HCBS waiver programs requested flexibilities through multiple Appendix K submissions to CMS. The most frequently requested flexibilities were:

Options	Count of States	Number of HCBS Waivers N=258
Modify services	51 (100%)	229 (89%)
Modify provider qualifications	49 (96%)	205 (79%)
Modify payment rates	49 (96%)	231 (90%)
Other	45 (88%)	216 (84%)
Allow retainer payments	42 (82%)	175 (68%)
Modify person-centered planning	42 (82%)	183 (71%)
Allow virtual Level of Care determinations	36 (71%)	141 (55%)
Allow payment for HCBS in institutional settings	35 (69%)	135 (52%)
Changes to participant safeguards	33 (65%)	146 (57%)
Extend dates for Level of Care determinations	32 (63%)	124 (48%)
Allow payment to family caregivers	29 (57%)	107 (41%)
Modify access and/or eligibility	23 (45%)	63 (24%)

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Appendix K Flexibilities to Unwind: COVID Addendum

States also used the Appendix K COVID Addendum to request flexibilities, some of which duplicated initial state Appendix K requests:

Option	Count of States / D=43	Number of HCBS Waivers
Waive visitors settings criterion	42 (98%)	186
Allow extension for reassessments and reevaluations	41 (95%)	183
Allow virtual/remote evaluations, assessments, and person-centered service planning	41 (95%)	180
Add electronic method of signing off on required documents	41 (95%)	180
Add electronic service delivery	40 (93%)	197
Adjust prior approval/prior authorization elements approved in the waiver	37 (86%)	158
Adjust assessment requirements	35 (81%)	150
Allow spouses and parents of minor children to be paid providers	29 (67%)	96
Allow family member to be paid provider	25 (58%)	92
Modify providers of home-delivered meals	22 (51%)	76
Allow other practitioners to deliver service	21 (49%)	68
Case management and Conflict of Interest provisions	18 (42%)	59

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Disaster Relief SPA Flexibilities to Unwind

Eleven states requested flexibilities to modify 1915(i) state plan HCBS benefits.

Option	Number of States
Modify payment rates.	9
Modify benefits including adding new services, telehealth options, removing limit caps and/or increasing home delivered meals.	7
Modify provider qualifications and/or added provider types.	7
Modify person-centered planning modifications.	4
Expand settings where services may be delivered.	4
Allow virtual eligibility and independent assessments.	3
Allow retainer payments.	3
Allow relatives and/or legally responsible persons to deliver service.	2
Modify conflict of interest requirements.	1
Add self-direction options.	1

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Flexibilities Provided through 1135 Waivers

Many states used the 1135 waiver to modify HCBS program elements, with some states duplicating requests across disaster response methods.

Requests	Number of States
States requesting to waive written person-centered planning (PCP) requirements.	29
States requesting waiver of HCBS Settings requirements.	27
States requesting to waive 1915(c) LOC timeline.	8
States requesting to waive Conflict of Interest requirements.	7
States requesting to waive 1915(i) eligibility timeline.	4

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CMS Guidance: 1915(c) Appendix K Flexibilities That Are Not Approvable in a Standard 1915(c) Waiver Application

- Provision of waiver services in institutional settings (excluding respite and services provided in accordance with section 3715 of the CARES Act);
- Extension of timeframes for level of care (re)evaluations;
- Suspension of quality improvement system activities;
- Flexibility with the HCBS settings requirements at 42 CFR Section 441.301(c)(4)(vi)(D) stating that individuals are able to have visitors of their own choosing at any time;

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CMS Guidance: 1915(c) Appendix K Flexibilities That Are Not Approvable in a Standard 1915(c) Waiver Application (cont.)

- Authorization of case management entities to serve as the only willing and qualified provider under 42 CFR Section 441.301(c)(1)(vi) due to the PHE (i.e., waiving conflict of interest requirements due to the PHE personnel crisis);
- Extension of due dates for CMS-372s and evidentiary reports; and
- Changes approved via section 1135 waiver authority including, but not limited to, extensions of person-centered service plan (PCSP) re-certifications, verbal signatures for PCSPs, and waiving settings requirements.

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Planning for Flexibilities That Cannot or Will Not Be Extended or Made Permanent (1 of 2)

State considerations include:

- Does the state have sufficient personnel to resume level of care re-determinations, prior authorization and service authorization review requirements, service reduction notifications, incident management reporting and investigation timelines, quality assurance and reporting and other post-pandemic operational protocols?
- Have state and provider staff who joined the system during the pandemic received training on those operational policies, procedures and requirements?
- Has the state enrolled new service providers to ensure it can meet HCBS conflict of interest requirements?

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Planning for Flexibilities That Cannot or Will Not Be Extended or Made Permanent (2 of 2)

- If previous service limits are restored, how will the state ensure a safe transition to previous levels or service? Forty-four states increased service limits during the PHE in a number of 1915(c) waivers.
- If allowance for payment of family caregivers is ended, are there alternative services or supports available if needed?
- If changes were made to access and 1915(c) waiver eligibility requirements and/or groups of people who could remain in a 1915(c) waiver that will end, plan for the transition to other HCBS or State Plan supports.

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CMS Guidance: Ending Temporary 1915(c) Appendix K Flexibilities (1 of 3)

Approved 1915(c) Appendix Ks and flexibilities within them automatically terminate when they reach the end date indicated in Section K-1-F of the template, or earlier if a state requested a different end date for individual flexibilities:

- All temporary changes must conclude and states must resume compliance with the language in their current, approved 1915(c) waiver upon termination of the Appendix K.

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CMS Guidance: Ending Temporary 1915(c) Appendix K Flexibilities (2 of 3)

- Any extensions of requirements in an approved waiver included in the Appendix K must be concluded by the end date of the Appendix K, with the exception of level of care (LOC) recertification extensions.
  - For example, if a state allows a 90-day extension for new providers to complete background checks, then only those providers enrolled at least 90 days prior to the end date of the Appendix K would be eligible for the full 90-day extension. A provider enrolled for 60 days prior to the end of the Appendix K would only be eligible for a 60-day extension.
  - CMS encourages states to get caught up on the LOC recertifications as soon as possible, even though the 12 months are available.

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CMS Guidance: Ending Temporary 1915(c) Appendix K Flexibilities (3 of 3)

- If the state finds there is no longer need for any of the provisions of the Appendix K, the state can end the entire Appendix K by amending the end date.
  - However, states need to ensure that ending an Appendix K flexibility prior to its approved expiration date does not impact adherence to requirements in SMDL 21-003 (implementation of the American Rescue Plan Act of 2021 (ARP) section 9817 which is the temporary 10 percentage point Federal Medical Assistance Percentage (FMAP) increase).

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Overview of HCBS-Related PHE Flexibilities That Can Be Made Permanent in 1915(c) Waivers and the CMS Approval Process

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CMS Guidance: 1915(c) Appendix K Flexibilities That May Be Approved in a Standard 1915(c) Application (1 of 4)

- Use of telehealth or other electronic methods of service delivery for:
  - Case management, personal care services that only require verbal cueing, in-home habilitation, individual supported employment, health coordination, peer support, counseling, training and support for family caregivers and other services that may be facilitated by telehealth while still facilitating community integration;
  - Evaluations, assessments and service plan meetings (note: in these cases there is a need for the state to establish a process for electronic signatures).

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CMS Guidance: 1915(c) Appendix K Flexibilities That May Be Approved in a Standard 1915(c) Application (2 of 4)

- States need to be mindful of the following in service definitions in which they are adding telehealth delivery:
  - How the remote service will be delivered in a way that respects privacy of the individual;
  - Assurance that telehealth will meet HIPAA requirements;
  - How individuals who need assistance with using the technology required for telehealth delivery of the service be supported;
  - How the remote service delivery will support community integration;
  - How remote service delivery will ensure the health and safety of an individual;
  - How the telehealth will ensure the successful delivery of services for individuals who need hands-on/physical assistance; and/or
  - How remote service delivery increases access to services that support improved health and welfare.

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CMS Guidance: 1915(c) Appendix K Flexibilities That May Be Approved in a Standard 1915(c) Application (3 of 4)

- Home-delivered meals, assistive technology, and other services the state feels will be beneficial to their waiver population going forward. (*Public notice and prospective effective dates are required for 1915(c) waiver amendments with substantive changes.)*
  - Reminder that meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).
- New or modified non-facility based community engagement services. Many facility-based day services suspended operations during the pandemic, accelerating opportunities for more individualized and integrated day supports that benefit community integration going forward.

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CMS Guidance: 1915(c) Appendix K Flexibilities That <u>May</u> Be Approved in a Standard 1915(c) Application (4 of 4)

- Rate increases for waiver services and recruitment and bonus payments for direct support professionals to enhance the provider pool. (**If the rate change requires a change in rate methodology, public notice and prospective effective dates are required for 1915(c) waiver amendments with substantive changes.*)
- States may wish to add retainer payment options post-pandemic at the permissible level of the lesser of 30 consecutive days or the total number of bed-hold days approved in the state plan.
- Continuing allowance of payment for family caregivers to render services.
- Adding or continuing new options for self-directed services and/or budget authority.

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Examples of Appendix K Flexibilities Made Permanent in Base Waivers

- Some states have already begun the work of amending 1915(c) waivers to continue changes made during the PHE. These include:
  - Adding services;
  - Rate increases; and
  - Adding the TEFRA/Katie Beckett optional eligibility group.

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Examples of Changes States Have Included in Appendix Ks with the Intent to Add to Base Waivers

Some states included language in their Appendix K submissions indicating an intent to add to base 1915(c) waivers. These changes include:

- Adding waiver services;
- Rate increases using ARP funds;
- Adding adult dental services; and/or
- Rate increases to account for minimum wage increase.

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CMS Guidance: 1915(c) Appendix K Changes States Would Like to Continue

- Changes made through a 1915(c) Appendix K that states would like to continue beyond its expiration date must be submitted as a regular amendment to the state's 1915(c) waiver application via the Waiver Management System (WMS).
- These waiver amendments must adhere to all regulatory provisions, and policies and procedures detailed in the Version 3.6 1915(c) waiver application and accompanying instructions, technical guide, and review criteria.
- CMS encourages states to submit 1915(c) waiver amendments as soon as possible. States do not have to wait until the flexibilities will expire, especially if conditions allow resumption of normal operations sooner. Reach out to CMS with questions prior to submissions.

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1915(c) Amendments with Substantive Changes

- Changes to 1915(c) waivers may only be approved with a prospective effective date and waiver applications and/or amendments must be submitted at least 90 calendar days in advance of the proposed effective date.
- States will need to follow the existing requirements for public notice, including notice to tribal governments.
- States should consider the time needed to conduct adequate public notice and submit the amendment in order to allow for the prospective approval prior to the end of the PHE.

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Other Considerations for HCBS Programs when Unwinding from the PHE

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Additional Unwinding Considerations

- While the COVID-19 PHE presented multiple challenges, it also presented opportunities to strengthen and expand HCBS and rebalance state systems for long-term services and supports. As states implement ARP 9817 spending plans, states can consider how complimentary changes may be made in 1915(c), 1915(i) and 1115 programs.
- States can prepare for how ARP 9817 initiatives can be sustained upon the exhaustion of funding no later than March 31, 2025.
- As the pandemic illustrated the importance of transitioning quickly from hospitals and nursing facilities when medically ready, systemic barriers and new solutions to overcome those barriers can be considered for inclusion in the long-term services and supports system.
- As states prepare to unwind and/or make temporary or permanent changes to HCBS programs, it is critical that states ensure the changes are in compliance with the settings regulations.

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Maintenance of Effort (MOE)

- As of February 2023, there are two major statutory provisions that impose maintenance of effort requirements on State Medicaid programs.
  - Families First Coronavirus Relief Act (FFCRA), as amended by the Consolidated Appropriations Act, 2023, and
  - American Rescue Plan Act of 2021 (ARP).
- These two statutes have different requirements and states should be aware of both sets of expectations as states are unwinding and making adjustments to 1915(c) waivers.
- CMS reminds states that the expiration of a COVID-19 PHE authority does not result in a MOE violation.

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MOE Considerations and Section 9817 of the ARP Requirements

- CMS expects states to demonstrate compliance with section 9817 of the ARP, beginning April 1, 2021, and until the state funds equivalent to the amount of federal funds attributable to the increased FMAP are fully expended, no later than March 31, 2025. To demonstrate compliance with the requirement not to supplant existing state funds expended for Medicaid HCBS, states must:
  - Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
  - Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
  - Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

Note: The expiration of Appendix K flexibilities upon the expiration of the Appendix K itself is not an MOE violation.

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Summary

- States should prepare now for unwinding HCBS-related PHE flexibilities.
- CMS is available to answer questions and provide technical assistance to assist states in the unwinding process.
- States do not have to wait until the flexibilities will expire, especially if conditions allow resumption of normal operations sooner. CMS encourages states to submit 1915(c) waiver amendments as soon as possible.
- If states choose to end HCBS-related PHE flexibilities prior to expiration of the flexibility, states will need to ensure there are no MOE violations.
- States need to be mindful of the settings transition period (March 17, 2023) as they request permanent changes to HCBS programs.

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Resources (1 of 3)

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

- HCBS@cms.hhs.gov

To Request Technical Assistance:

- HCBSettingsTA@neweditions.net

Guidance and Resources for Unwinding and Returning to Regular Operations after COVID-19:

- https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html

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Resources (2 of 3)

Post-Pandemic Re-Integration and Assessment of Community Interactions (June 2021 HCBS Training)

- https://www.medicaid.gov/medicaid/home-community-based-services/downloads/post-pandemic-reintegration-assessment-of-community-interaction.pdf

Preparing to Unwind from the Pandemic: Expanding Self-Direction (February 2022 HCBS Training)

- https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-ta-expanding-self-direction.pdf

After the Public Health Emergency: Changes to Home and Community-Based Services and Delivery Methods (May 2022 HCBS Training)

- https://www.medicaid.gov/medicaid/home-community-based-services/downloads/after-phe-may-2022.pdf

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Resources (3 of 3)

American Rescue Plan Act of 2021 State Medicaid Director Letter

- https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf

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Questions

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