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COVID-19 State Resource Guide:

Leveraging Federal and State Authorities to Ensure Access to Long-Term Services and Supports for High-Risk Individuals

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Table of Contents

Introduction

This resource guide is a tool to help state officials and other stakeholders understand how temporary federal and state Medicaid flexibilities and emergency federal funding streams are being deployed during the COVID-19 pandemic to help ensure access to long-term services and supports (LTSS).[1] Populations that use LTSS are particularly vulnerable to contracting COVID-19 and experiencing severe cases due to their age or because often they live with one or more chronic conditions. In addition, roughly 2.5 million older adults and other individuals with complex care needs receive care in nursing homes and other congregate care settings, which are particularly susceptible to COVID-19 outbreaks.[2] Another 10 million individuals receive assistance at home or in their communities, which in many cases has been disrupted due to caregivers being subject to stay-at-home orders, having no access to childcare as schools shut down, not having adequate access to personal protective equipment (PPE) needed to provide care safely, and in some cases, caregivers entering isolation after becoming sick with or being exposed to COVID-19.

The first edition of this resource guide was published in June 2020, roughly four months after the first reported COVID-19 outbreak in the United States, in a long-term care facility in Kirkland, Washington. Since then, the federal COVID-19 public health emergency, which triggers the availability of many emergency flexibilities, has been extended four times,[3] and it is expected to continue throughout 2021.[4] As the emergency continues, significantly more states have pursued regulatory flexibilities, taken administrative action, and directed federal emergency funding to bolster their LTSS systems and ensure access to care for their most vulnerable residents. This updated guide reports on those developments.

[1] For additional federal flexibilities that address all Medicaid populations, as well as flexibilities available for Children's Health Insurance Program (CHIP) populations, the Centers for Medicare and Medicaid Services (CMS) has made available a comprehensive catalog that states can reference in the event of a disaster or public health emergency. This new resource guide provides updated resources to supplement the CMS catalog, including links to COVID-19-specific templates developed by CMS.

[2] As of February 2021, more than one-third of COVID-19 deaths in the U.S. are attributed to long-term care facilities, inclusive of staff and residents. In many states, long-term care facility staff and residents accounted for more than half of all deaths, reaching as high as 72% in one state (https://covidtracking.com/nursing-homes-long-term-care-facilities).

[3] https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.

[4] https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf.

Federal Emergency-Related Authorities

1915(c) Home- and Community-Based Services (HCBS) Waiver Program Appendix K

States may use an Appendix K to modify provisions in an existing 1915(c) waiver, including eligibility, scope of services, and provider qualifications. To streamline Appendix K submissions during the COVID-19 emergency, CMS issued a COVID-19-specific Appendix K template and instructions prepopulated with flexibilities commonly requested and relevant to the COVID-19 emergency.

Medicaid and CHIP Disaster Relief State Plan Amendment

States may use a Medicaid or CHIP Disaster Relief State Plan Amendment (SPA) during an emergency to revise eligibility, enrollment, and benefit requirements in their state plans. To streamline Medicaid SPA submissions during the COVID-19 emergency, CMS issued Disaster Relief SPA templates for Medicaid and CHIP that prepopulated available flexibilities. States may also document in a CHIP SPA (prior to an emergency) eligibility, enrollment, and cost-sharing modifications that go into effect only in the event of an emergency.

1135 Waiver

1135 waivers address Medicare, Medicaid, and CHIP services that can be furnished during an emergency to ensure sufficient access. The U.S. Health and Human Services Secretary may issue 1135 blanket waivers that apply to all states, though states may also request state-specific waivers. To streamline state-specific requests during the COVID-19 emergency, CMS issued an 1135 waiver request template/checklist that prepackaged flexibilities commonly requested and relevant to the COVID-19 emergency.

1115 Demonstration

States may use 1115 demonstration authority to waive a broad, but not unlimited, set of federal Medicaid rules and to authorize Medicaid expenditures not otherwise permitted.

Federal Funding Streams

CARES Act

Signed into law on March 27, 2020, the CARES Act provided two critical sources of funding to state, local, and tribal governments and health care providers: the Coronavirus Relief Fund and the Provider Relief Fund, respectively. The Coronavirus Relief Fund directed $150 billion to state governments for use at their discretion to cover "necessary expenditures incurred due to the public health emergency." The Provider Relief Fund distributed $178 billion directly to hospitals and health care providers impacted by the pandemic. While not all of these funds were targeted directly toward LTSS, many LTSS providers and recipients benefited from their use.

FEMA

In 2020, the Federal Emergency Management Agency (FEMA) deployed $51.6 billion in funding, plus billions of units of PPE supplies and supplemental staffing, to states to respond to the COVID-19 pandemic.[5] In order to receive disaster relief funding, states and tribal governments must match a portion of the federal share with non-federal dollars, with FEMA typically providing no less than 75% of the share of costs. During the COVID-19 emergency, states were allowed to use Coronavirus Relief Fund dollars to pay for some of their share of costs. Use of FEMA funding to support the provision of LTSS was limited and included covering the cost of supplemental staffing and PPE.

[5] https://www.fema.gov/sites/default/files/documents/fema_covid-19-initial-assessment-report_2021.pdf.

How States Are Using Emergency Flexibilities

State responses addressing COVID-19 in their LTSS systems have consistently been focused on:

- **Expanding remote service delivery** options via video and audio-only modalities to ensure access to care while protecting the health and safety of both beneficiaries and providers.
- **Expanding and stabilizing providers and the LTSS workforce** through modified credentialing requirements and enhanced reimbursement rates/pay.
- **Maintaining continuity of care** by conducting virtual needs assessments, delaying reassessments, and extending prior authorizations.
- **Extending home care to new populations** by expanding eligibility criteria and scope of covered services.

State Spotlight: Washington Pauses Provider Training Requirements to Maintain Staff Capacity

Washington State waived certain LTSS provider training requirements that must be conducted in person. Without the waiver, the state's entire LTSS workforce—including certified nursing assistants (CNAs) and certified home care workers—would have been disqualified from working within 120 days due to their inability to access required training.

States also continued to leverage emergency federal funding to support all aspects of LTSS delivery during the pandemic, primarily from the CARES Act Coronavirus Relief Fund, FEMA, and revenue from Medicaid expenditures from increased provider rates authorized through the emergency authorities.[6] This emergency funding, which was often coordinated at the gubernatorial level or through cross-agency or cross-sector bodies, helped states provide retainer payments and hazard pay to direct care workers, pay for newly authorized services or services with higher utilization during the emergency, and pay for teams of temporary health care workers dispatched to long-term care facilities to provide enhanced infection control and testing. For example, Connecticut earmarked at least $115 million for staff incentive payments and overtime, and to cover new costs related to visitor screening at long-term care facilities and cleaning and housekeeping supplies for infection control.[7] Delaware used CARES Act funding to help establish a $100 million Health Care Relief Fund to support frontline health care providers during the emergency, including home health agencies, intellectual and developmental disability providers, nursing homes, and assisted living facilities.[8] New Mexico used state and federal emergency funding to distribute food in rural and frontier areas and provide temporary housing to individuals in quarantine in high-need regions. The state coordinated closely with tribal governments and businesses, including using hotel casinos to house quarantined tribal members.

Because the public health emergency is likely to remain in place through the end of 2021, states have an opportunity to assess the impacts of their COVID-19 responses and do careful post-pandemic planning. Many of the temporary changes states have put in place during the pandemic, through either federal authority or state action, are allowable outside of an emergency situation under non-emergency

[6] Additionally, the CARES Act Provider Relief Fund allocated $4.9 billion to nursing homes. Though some states provided nursing homes with technical assistance to access these funds, the money was distributed directly from the federal government without state involvement.

[7] https://portal.ct.gov/OPM/Coronavirus/Coronavirus-Relief-Fund/CRF-Overview.

[8] https://dhss.delaware.gov/dhss/dms/caresact/.

authorities, such as 1915(c) or 1115 waiver amendments or SPAs. The emergency authorities covered in this resource guide provide states with a simpler and expedited federal authorization process, including templates and preprints that identify commonly used emergency flexibilities. States are beginning to assess which temporary flexibilities they would like to and can make permanent using non-emergency authorities. States are also beginning to assess which temporary flexibilities they want to be able to "toggle on and off" during future public health emergencies, and how to implement the lessons learned from the pandemic into long-term LTSS system reform.

State Spotlight: Washington State Incorporates Pandemic Lessons in Its Plans for LTSS Reform

The COVID-19 emergency reinforced for **Washington** State policymakers the critical role that family caregivers play in the LTSS system. After the emergency ends, the state plans to seek new opportunities for working with and supporting family caregivers to keep LTSS recipients in their homes. The pandemic also highlighted for the state that LTSS is a continuum of care that includes both facility-based care and HCBS and that LTSS reform should include investments in both residential and community settings. This includes support for providers, enhanced infection control, and identifying more "creative" ways of delivering LTSS. To assess the impact of approved emergency flexibilities and conduct post-emergency planning, the state has convened multiple cross-agency workgroups that include the state's Medicaid, aging, and community service divisions. One group of flexibilities under review is eligibility attestation for individuals eligible for Medicaid on a basis other than modified adjusted gross income ("non-MAGI"). The workgroup will also explore how remote service delivery can address direct care provider shortages by establishing a remote-only supplementary workforce.

State Spotlight: Prior Experience With Natural Disasters Enabled a Rapid State Response

States that regularly experience natural disasters, such as hurricanes and floods, leveraged that experience in quickly seeking and implementing emergency flexibilities at the start of the pandemic. States with less historical experience responding to natural disasters are now considering how they can be better prepared to respond swiftly to future emergencies, such as by incorporating emergency-related clauses into their Medicaid managed care contracts.

North Carolina's experience navigating disaster authority processes, at both the federal and state levels, allowed the state to quickly draft flexibility requests for CMS and tap into preexisting communication channels to engage providers and other stakeholders in the process.

Florida policymakers turned to their natural disaster "playbook" when developing initial flexibilities requests. Florida updates its disaster playbook annually with "lessons learned" and expects to add a section on statewide public health emergencies for future reference.

Regulatory and Administrative Flexibilities

The tables below highlight state policy goals in implementing regulatory flexibilities and administrative actions available during the COVID-19 public health emergency, as well as specific examples of how states are ensuring continued access to LTSS by expanding the types of settings in which services can be delivered, bolstering pay and other supports for LTSS providers, and addressing barriers to care created by the COVID-19 pandemic.

Eligibility and Enrollment

These flexibilities seek to expedite or expand access to LTSS for beneficiaries by easing financial and clinical eligibility requirements for LTSS and removing barriers that could jeopardize beneficiaries' eligibility for services.

Policy Goal	Available Flexibility or Action[9]	State Implementation Example	Authority[10]
Increase the availability of HCBS in order to prevent a beneficiary from losing access to services or to minimize the number of individuals receiving care in acute or institutional settings	Increase the limit on an individual's expected cost of HCBS for eligibility to enroll in a 1915(c) waiver	**Alaska** increased the limit for an enrollee's expected cost of HCBS by $5,000 for entry into its I/DD HCBS waiver for individuals being treated for COVID-19 or whose primary informal caregiver is quarantined away from the individual.	1915(c) Appendix K: Template and Instructions
		Colorado allowed participants in its I/DD and children waivers to receive more services than would typically be allowed, if the participant is impacted by COVID-19.	1915(c) Appendix K: Template and Instructions
		Individuals enrolled in **New Hampshire**'s waiver for children with developmental disabilities who had already reached their $30,000 cost limit at the beginning of the emergency were able to access additional respite, enhanced personal care, and assistive technology services.	1915(c) Appendix K: Template and Instructions
		Tennessee did not disenroll or discontinue services for waiver participants who exceeded their individual cost limit due to emergency-related rate increases authorized via a 1915(c) Appendix K.	1915(c) Appendix K: Template and Instructions
	Modify service utilization requirements for 1915(c) waiver eligibility	**Kansas**, **Idaho**, and **Mississippi** suspended the requirement that HCBS waiver participants receive at least one service every 30 days, so that participants who can't receive services due to COVID-19-related disruptions beyond their control (e.g., stay-at-home orders) are not at risk of being disenrolled from the waiver. Participants continued to receive monthly monitoring to ensure health and welfare.	1915(c) Appendix K: Template and Instructions

[9] Some flexibilities or actions described in this column may overlap with federal maintenance of effort requirements included in the Families First Coronavirus Response Act.

[10] This column identifies the authority used in the corresponding state implementation example(s). For some flexibilities or actions, additional emergency authorities may be used to implement the same flexibility or action depending on the circumstances. For example, a different authority may be needed for a fee-for-service delivery system compared to a managed care system, and a Disaster Relief SPA may be needed depending on parameters outlined in a state plan.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
	Modify or expand the population a 1915(c) waiver targets	**California** prioritized individuals in inpatient facilities in state-designated "hot spots" for HCBS waiver intake processing—bypassing the waitlist—regardless of their length of stay.	1915(c) Appendix K: Template and Instructions
		Indiana created a new priority category in its HCBS waiver enrollment process for individuals who test positive for COVID-19 or are under quarantine orders. Individuals also qualify for the priority enrollment category if their primary caregiver tests positive for COVID-19 or is under a quarantine order.	1915(c) Appendix K: Template and Instructions
		Massachusetts suspended its 90-day continuous stay requirement for HCBS waiver enrollment for individuals transitioning out of a long-stay facility.	1915(c) Appendix K: Template and Instructions
		Massachusetts raised the age limit for enrollment in its Children's Autism Spectrum Disorder waiver from age 8 to age 10.	1915(c) Appendix K: Template and Instructions
		Ohio raised the age limit for current Home Care Waiver enrollees so that they may remain enrolled beyond their 60th birthday for the duration of the emergency.	1915(c) Appendix K: Template and Instructions
	Increase number of unduplicated 1915(c) waiver participants	**Utah** allowed an additional 250 participants to enroll in its HCBS waiver for individuals transitioning out of facility settings after a long-term stay.	1915(c) Appendix K: Template and Instructions
	Apply less restrictive income or resource counting requirements for Medicaid eligibility groups most likely to use LTSS	**Illinois** eliminated resource tests for certain aged, blind, or disabled Medicaid applicants.	Disaster Relief SPA
	Extend deadlines for conducting level-of-care and functional needs assessments and reassessments, and for annual person-centered care plan reviews	**Ohio**, **Oregon**, and **Hawaii** extended their deadlines for conducting initial functional needs assessments and level-of-care evaluations for LTSS recipients. Oregon also extended the deadline for annual reviews of person-centered service plans for individuals receiving 1915(k) state plan services.	1915(c) Appendix K: Template and Instructions 1135 Waiver 1115 Waiver
Modify Medicaid eligibility determination requirements, including verification processes, to reduce the number of uninsured individuals and expand access to HCBS	Expand presumptive eligibility to new LTSS populations	**Oklahoma** allowed hospitals to make presumptive eligibility determinations for individuals evaluated for Medicaid eligibility on a non-MAGI basis.	Disaster Relief SPA
	Postpone redeterminations for LTSS populations	**Pennsylvania** extended eligibility redeterminations for beneficiaries eligible for Medicaid on a non-MAGI basis to once every 12 months (the maximum allowed under federal rules).	Disaster Relief SPA
	Use less restrictive income or asset counting methodologies for state plan LTSS	Unemployment compensation will not be counted in an eligibility determination resource test for certain Medicaid applicants in **Washington**, including those who may be eligible based on their age or disability.	Disaster Relief SPA
	Reduce or eliminate the post-eligibility treatment-of-income (PETI) calculations for institutionalized individuals	**Rhode Island** residents in institutional settings will continue to receive a Home Maintenance of Need Allowance beyond the typical six-month limit if the residents (1) demonstrate a greater need due to COVID-19, (2) have been institutionalized for less than six months as of March 1, 2020, and (3) are unable to return home due to COVID-19-related restrictions (e.g., availability of HCBS, facility quarantines).	Disaster Relief SPA

Benefits and Care Management

These flexibilities seek to ensure beneficiaries can easily access services during the pandemic by expanding self-direction opportunities, covering new services, removing prior authorization requirements, or easing administrative requirements related to care management assessments and person-centered care plan development.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
Provide beneficiaries with flexibility in how they access services, to prevent gaps in services if the traditional workforce is diminished	Institute or expand opportunities for self-directed waiver services	**Florida** allowed HCBS waiver participants to self-direct personal support and transportation services. Prior to the implementation of this flexibility, self-direction was only available to individuals receiving 1915(j) HCBS.	1915(c) Appendix K: Template and Instructions
		Iowa added home-delivered meals and companion and homemaker services, and **Utah** added personal care attendant services, to the types of services that can be self-directed services.	1915(c) Appendix K: Template and Instructions
		Kentucky suspended financial conflict and pre-employment screenings for beneficiaries' immediate family members who provide self-directed services.	1915(c) Appendix K: Template and Instructions
Expand available services to ensure individuals can remain in their homes during the public health emergency and stay-at-home orders	Modify 1915(c) service, scope, or coverage, or add or expand services to a 1915(c) waiver	**Alabama** expanded home-delivered meals to waiver participants of all ages, providing two weeks' worth of meals when a participant has insufficient access to food due to COVID-19-related restrictions.	1915(c) Appendix K: Template and Instructions
		Hawaii provided coverage for PPE and other infection control supplies.	1915(c) Appendix K: Template and Instructions
		All HCBS waiver participants in **Tennessee** gained access to specialized medical equipment and supplies; semi-independent living; residential habilitation; support coordination; nutrition services; occupational therapy; physical therapy; speech, language, and hearing services; behavior services; family-model residential support; medical residential services; nonresidential homebound support services; orientation and mobility services for impaired vision; personal assistance; and supported living. **Tennessee** also added assistive technologies to support remote service delivery and monitoring, including motion sensors, smoke and carbon monoxide alarms, pressure sensors, and live web-based remote supports.	1915(c) Appendix K: Template and Instructions

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
	Modify HCBS scope of coverage, or add new HCBS for individuals not enrolled in a 1915(c) waiver	**Arizona** expanded home-delivered meals to 1115 waiver participants with intellectual and/or developmental disabilities. Home-delivered meals were previously available only to certain elderly and physically disabled participants.	1915(c) Appendix K: Template and Instructions[11]
		Arkansas added a twice-weekly telephonic or in-home "well check" for beneficiaries with developmental disabilities.	Disaster Relief SPA
		Texas expanded eligibility for HCBS-like services to seniors and adults with disabilities who earn up to 300% of the federal supplemental security income (SSI) benefit limit and are not already enrolled in an HCBS waiver and who are not otherwise eligible for HCBS under the state plan. This authority is subject to an enrollment cap.	1115 Waiver
	Exceed service limitations or requirements for amount and duration of a waiver service	Personal care providers in **California** were allowed to exceed the maximum 12-hour workday limit if necessary to minimize a waiver participant's exposure to COVID-19 or when other providers are unavailable due to the public health emergency.	1915(c) Appendix K: Template and Instructions
		HCBS waiver participants in the **District of Columbia** can receive supported employment, periodic supported living, and in-home supports via telephone or other technology up to 100% of the time. Typically, those services must be provided in person at least 80% of the time.	1915(c) Appendix K: Template and Instructions
Suspend or modify administrative requirements to access care to prevent gaps in services when in-person visits are not possible due to stay-at-home orders or other social distancing requirements	Suspend prior authorization requirements or extend existing authorizations for fee-for-service and 1915(c) services	**Colorado** HCBS waiver participants won't need to obtain prior authorization for fee-for-service services deemed "necessary and appropriate" by the state. For services reduced in duration or scope, the state will notify beneficiaries.	1135 Waiver
		Montana HCBS waiver participants won't need to obtain prior authorizations for respite, companion, personal assistance, homemaker, and NEMT (non-emergency medical transportation) waiver services.	1915(c) Appendix K: Template and Instructions
		Existing prior authorizations will be automatically renewed for **New Jersey** beneficiaries during the public health emergency. New Jersey beneficiaries will also be able to fill drug prescriptions early and receive a higher quantity of the prescription in a single filling.	Disaster Relief SPA
	Suspend face-to-face requirements in HCBS settings and programs	**Arizona** delayed the deadline for a face-to-face encounter for up to one year from the date of home health service delivery.	1135 Waiver

[11] States may use a 1915(c) Appendix K to modify HCBS authorized under a Section 1115 demonstration if the HCBS could be provided under a 1915(c) waiver.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
	Modify level-of-care or medical necessity evaluation requirements, including allowing remote assessments	**Alaska** residents seeking to enroll in an HCBS waiver can receive an initial level-of-care evaluation via telephone or other technological platform.	1915(c) Appendix K: Template and Instructions
		Arkansas allowed electronic signatures on required documentation, including the person-centered service plan.	1915(c) Appendix K: Template and Instructions
		HCBS waiver participants in **Michigan**, **Rhode Island**, and **South Carolina** can be evaluated for services and attend person-centered service planning meetings remotely, including via telephone and/or video conference.	1115 Waiver 1915(c) Appendix K: Template and Instructions
	Modify care planning requirements	**Maryland** allowed delivery of state plan LTSS without updating the plan of care to include those services.	1115 Waiver
Address financial barriers to accessing services that arise during the public health emergency	Modify beneficiary cost-sharing requirements	**Georgia** suspended collection of Medicaid copayments for fee-for-service and managed care services and increased provider rates by the specific copayment amount.	Disaster Relief SPA
		Virginia waived copays for enrollees in its Family Access to Medical Insurance Security (FAMIS) program.	CHIP Disaster Relief SPA

Alternate Care Sites

These flexibilities seek to protect high-risk beneficiaries and workers from contracting COVID-19, or to mitigate the spread of COVID-19, by authorizing states to cohort COVID-19-positive beneficiaries in separate care sites from beneficiaries without COVID-19 and by authorizing the expansion of allowable settings where HCBS may be provided.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
Segregate individuals with confirmed COVID-19 to minimize spread in nursing homes	Establish COVID-19-only facilities for nursing home residents and hospital discharges requiring a nursing home level of care	**Michigan** helped congregate care facilities to separate or cohort COVID-19-positive residents from other residents by designating "regional hubs" to treat COVID-19-positive residents who do not require hospitalization.	State Administrative or Legislative Action
Ensure individuals receiving care in the community continue to do so when certain HCBS settings are inaccessible	Expand allowable HCBS settings where services may be provided	HCBS waiver participants in **Hawaii** who are admitted to a hospital or other short-term facility may receive residential supports (e.g., assistance with communication, behavior support) and personal assistance services while in those settings, if the services are not otherwise provided by the facility.	1915(c) Appendix K: Template and Instructions
		HCBS recipients in **Iowa** who are in an institutional setting (including an intermediate care facility) due to quarantine or because their community-based providers can't safely deliver services during the pandemic can receive HCBS in the facility in which they are residing. Direct care providers can also provide HCBS in their homes, or direct care providers may move into the care recipient's home, though both changes are subject to state approval.	1915(c) Appendix K: Template and Instructions
		HCBS waiver recipients in **New Hampshire** who moved into facility-based settings, including hotels, motels, shelters, or churches, may continue to receive waiver services that don't duplicate services regularly provided by the facility. HCBS waiver participants may also receive homemaker services in an adult family care setting or receive medical day services in a home setting.	1915(c) Appendix K: Template and Instructions
		Michigan allowed payment for personal care, community living, and other services to promote activities of daily living to support individuals in acute care hospital or short-term institutional settings.	1115 Waiver

Remote Service Delivery

These flexibilities seek to protect beneficiaries from contracting COVID-19, by expanding and supporting the use of remote service delivery, in place of in-person visits, for care management and care delivery activities.

The Role of Remote Service Delivery for Populations That Use LTSS

Though states were able to significantly expand remote service delivery throughout their LTSS systems, many types of LTSS, such as those supporting activities of daily living (e.g., dressing, bathing), cannot be delivered remotely. For those services, states used emergency authorities to expand access to in-person supports in a way that kept both provider and recipient safe, such as authorizing "doorstep" wellness checks, self-direction opportunities with care provided by household members, and providing adult day services in a recipient's home or in outdoor settings. States also found that many LTSS recipients either lacked the technology to use remote services or did not know how to use the technology that was available to them. In response, states used emergency authorities to provide LTSS recipients with the necessary technologies (e.g., tablets, monitors) as well as assistance setting up and using those technologies. As states consider expanding access to remote LTSS beyond the emergency, they should also consider how remote service delivery can promote greater integration between LTSS, behavioral health, and physical health.

State Spotlight: Adult Day Goes Remote in California

Adult day health providers in **California** implemented new remote services, such as health and wellness checks. Remote delivery also removed traditional barriers to care, such as transportation, allowing adult day providers to engage their clients more frequently. Adult day providers also reported a reduction in client absences and more consistent attendance. Some adult day services, particularly those that address social isolation, cannot be replicated or replaced by remote service delivery. Instead, adult day providers in California provided "socially distanced" services, such as delivering a birthday gift or Thanksgiving dinner to a client's doorstep, or holding outdoor events. The state also used public-private partnerships to provide LTSS recipients with remote-enabling technology and are exploring opportunities for providing robotic pets for individuals with dementia and cognitive limitations. While remote adult day may continue in California as a supplemental or back-up service after the public health emergency, adult day is likely to return to in-person as soon as it is safe to do so. More broadly, the state is planning to add new services to the types of Medicaid services that can be delivered remotely on a permanent basis, including synchronous and asynchronous remote HCBS waiver services.

State Spotlight: Remote Services in Washington Help Keep Provider Doors Open (Virtually)

Washington State reported that the ability to provide remote LTSS financially stabilized the state's HCBS providers during the pandemic, many of which are small local businesses or single providers that may not have access to capital or loans to carry them through a downturn. Remote service delivery allowed providers in the state to maintain revenue and allowed LTSS recipients to maintain access to care at a time when many of them were unable or unwilling to have providers in their homes.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
Provide care virtually to minimize exposure to COVID-19 for beneficiaries and providers	Expand utilization of state plan remote service benefits	**Colorado** residents can receive services, including LTSS, via telephone or a live chat function. Typically, telemedicine requires a visual component, where the recipient can see the provider. Telemedicine visits also no longer require an initial face-to-face visit.	Disaster Relief SPA
	Add remote service delivery option for HCBS	**Idaho** waiver participants can receive certain waiver services remotely, including respite, supported employment, financial management, support broker, adult day health, behavior consultation and crisis management, community support, skilled nursing, case management, monthly monitoring, rehabilitation, personal care, and transition services.	1915(c) Appendix K: Template and Instructions
	Reimburse for remote services at in-person rates	**Arizona** and **Massachusetts** providers can deliver clinically appropriate, medically necessary Medicaid-covered services via telephone or live video and receive in-person reimbursement rates.	State Administrative or Legislative Action
		Colorado allowed reimbursement to federally qualified health centers, rural health centers, and the federal Indian Health Service for remote services provided to Medicaid beneficiaries at the same rate as in-person services.	State Administrative or Legislative Action
	Modify provider types and which providers can provide services remotely	**Massachusetts** allowed all Medicaid-enrolled providers to deliver remote services within their scope of practice via telephone or live video.	State Administrative or Legislative Action
		Providers in **Colorado** may deliver services remotely without having a pre-established patient-provider relationship prior to the remote encounter.	State Administrative or Legislative Action
	Add new HCBS waiver services to facilitate remote service delivery	**California** added assistive technology as an available waiver service. The service covers computer monitors, cameras, speakers, electronic devices that stream video, installation, repairs, and participant training on the technology.	1915(c) Appendix K: Template and Instructions
	Conduct Pre-Admission Screening and Resident Review (PASRR) evaluations remotely	Individuals in **Illinois** entering a Medicaid-certified long-term care setting can receive a PASRR screening via telephone rather than in person. State screening agents should coordinate with hospital discharge planners and long-term care settings to ensure a staff member is available to assist the individual being screened.	State Administrative or Legislative Action *(only if state has existing face-to-face requirement)*
	Expand remote service delivery to include audio-only modalities	**Alaska** expanded the definition of "telehealth" to include audio-only communications, such as telephone calls.	State Administrative or Legislative Action

Provider Capacity and Workforce

These flexibilities seek to expand the pool of LTSS providers and financially support providers and workers to ensure beneficiaries can receive services to which they are entitled during the COVID-19 pandemic.

State Spotlight: Family Providers Help Tackle Workforce Shortages in New Mexico and Florida

The pandemic stretched thin an already overburdened and under-resourced HCBS workforce. Many states responded by authorizing family members and other close relations to provide personal care services. Currently, 39 states have adopted this approach for waiver services, most commonly personal care services.[12]

New Mexico allowed parents of minor children along with guardians and spouses to provide personal care services to their child or spouse (respectively) as long as they were employed through a provider agency and met the standard provider training requirement. The state is exploring maintaining this option after the end of the public health emergency.

Florida supplemented its direct care workforce by promoting existing self-direction opportunities that allow LTSS beneficiaries to select their caregiver.

Both New Mexico and Florida report upticks in the number of recipients self-directing their care and the number of parents, guardians, and spouses who are providing services.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
Expand the number and types of people eligible to provide HCBS to prevent gaps in services	Allow family members or legally responsible individuals of LTSS recipients to provide LTSS	Provider agencies in **Maine** can hire a relative or spouse of a waiver participant to provide waiver services, including personal support and attendant services.	1915(c) Appendix K: Template and Instructions
		Beneficiary representatives in **Alaska** and family caregivers in **Georgia** can provide state plan personal care services if a traditional provider is not available and the state can make a "reasonable assessment" that the caregiver is capable of providing needed services.	1135 Waiver
	Allow entities that provide case management and/or that are responsible for the development of a person-centered service plan to also provide HCBS; conflict-of-interest requirements remain in place	**Oregon** and **Virginia** allowed case management entities to provide waiver services or state plan HCBS—such as attendant services and supports to accomplish activities of daily living, functional skills trainings, and safety modifications to an individual's physical environment—that are covered through 1915(i) and 1915(k) SPAs (Oregon), as well as 1915(c) waivers (Oregon and Virginia), in order to enable sufficient provider capacity to serve impacted beneficiaries.	1135 Waiver 1915(c) Appendix K: Template and Instructions

[12] https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table5.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
	Modify LTSS provider types, qualifications, and licensure or other requirements	Certified nursing assistants (CNAs) in **California** can provide private duty nursing services. Typically, private duty nursing must be provided by a registered nurse, licensed vocational nurse, or certified home health aide.	1915(c) Appendix K: Template and Instructions
		Wisconsin allowed providers licensed in other states or enrolled in the Medicare program to provide the same or comparable services in the state; modified qualification requirements for provider trainers; delayed revalidation of background checks, licensing, and certification review; removed a requirement that providers must have two years' experience working with the target population; allowed nursing students to provide nursing services; and expanded the types of providers that can train unpaid caregivers.	1915(c) Appendix K: Template and Instructions
		Graduate Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) in **Missouri** who have not yet been licensed can provide private duty nursing services.	1135 Waiver
		Waiver participants in **Illinois** can receive personal support services from providers in another state on a short-term basis, if the participant's regular caregiver is absent or requires respite.	1915(c) Appendix K: Template and Instructions
		North Carolina allowed out-of-state providers to provide waiver respite care, without prior approval from the managed care entities that administer the waiver, while the participant's family or regular caregiver is out of state due to evacuation or displacement.	1915(c) Appendix K: Template and Instructions
	Expand the types of providers who can "order" a service or supplies	Advanced practice registered nurses and physician assistants in **Missouri** may order home health services, establish and review a care plan for home health services, and certify a beneficiary is eligible for home health services.	Disaster Relief SPA
		Idaho allowed advanced practice nurses and physician assistants to order equipment and supplies.	Disaster Relief SPA
Ensure provider sustainability in light of lost revenue due to increased cost related to COVID-19	Provide retainer payments to LTSS providers	**Arizona** providers who experience a reduction in service utilization due to COVID-19 can receive retainer payments. Eligible providers include habilitation and personal care service providers.	1915(c) Appendix K: Template and Instructions
		Delaware provided retainer payments to state plan personal care and adult day providers, and HCBS waiver habilitation, prevocational, and supported employment providers. Retainer payments are made when a client is hospitalized or otherwise not utilizing services, when the provider's overall attendance and utilization drop by at least 50%, or when the state deems it necessary to preserve its provider networks. Providers must attest to maintaining wages and not laying off staff in order to receive payments.	1115 Waiver

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
		The **District of Columbia** provided retainer payments equal to 25% of the standard per diem rate to adult day providers when a participant was unable to attend and the service was not delivered remotely. Payments may be made for up to 30 consecutive days and for multiple consecutive-day periods. Providers must attest to maintaining wages and not laying off staff in order to receive payments.	Disaster Relief SPA
	Temporarily increase payment rates for nursing homes and HCBS to maintain provider capacity	**Alabama** increased rates for residential habilitation waiver services by 19% to account for an increase in staffing and direct service delivery due to the suspension of day services. Rates for other waiver provider types were increased in varying amounts to account for overtime pay due to high numbers of workers calling out sick and to account for additional infection control supplies.	1915(c) Appendix K: Template and Instructions
		Iowa provided $300 per day to nursing facilities for each Medicaid beneficiary residing in a designated COVID-19 isolation unit or in a COVID-19 designated facility who was discharged from a hospital to the nursing facility, has pending COVID-19 test results, or is COVID-19-positive.	Disaster Relief SPA
		Maine increased rates by 10% for certain 1915(c) waiver services to account for additional staffing needs, infection control supplies, and other unanticipated costs.	1915(c) Appendix K: Template and Instructions
		Michigan increased rates for 1915(k) and 1915(i) state plan services to maintain provider capacity during the public health emergency. Rate increases are not to exceed 50% of federally approved rates outside of the public health emergency.	1115 Waiver
		Nebraska increased rates for nursing facilities by $20 per day per Medicaid beneficiary.	Disaster Relief SPA
		New Mexico increased rates by 30% to nursing facilities for residents who test positive for COVID-19 and need inpatient level of care in a nursing facility setting.	Disaster Relief SPA

Reporting and Appeal Requirements

These flexibilities seek to monitor the prevalence of COVID-19 among LTSS recipients or minimize administrative and reporting burdens on state agencies, providers, and LTSS recipients to focus efforts and resources on the COVID-19 response.

Policy Goal	Available Flexibility or Action	State Implementation Example	Authority
Monitor the impact on and risk of COVID-19 exposure for HCBS waiver participants	Modify incident reporting requirements	**Alabama** waiver providers must submit an incident report for waiver participants who test positive for COVID-19, disclose possible exposures to other waiver participants or staff, and submit an incident report for other participants potentially exposed.	1915(c) Appendix K: Template and Instructions
		New Hampshire is tracking all positive COVID-19 results for HCBS waiver participants.	1915(c) Appendix K: Template and Instructions
		Tennessee is tracking all COVID-19 testing for HCBS waiver participants, regardless of the test results.	1915(c) Appendix K: Template and Instructions
Reduce administrative burdens for providers and recipients	Extend deadlines or modify reporting or appeal requirements	Medicaid beneficiaries in **Florida** who are impacted by COVID-19 have additional time to submit an appeal or request a fair hearing. Fair hearings and fair hearing decisions may also be delayed if there are workforce shortages.	1135 Waiver
		Virginia suspended data collection for performance measures, other than those needed for health and welfare assurance.	1915(c) Appendix K: Template and Instructions

Looking Ahead

Many states around the country have used the regulatory and administrative flexibilities and federal funding described in this resource guide to ensure that vulnerable residents continue to receive critical health care services—including LTSS—during the COVID-19 pandemic. As states begin to consider which flexibilities to start unwinding, which to make permanent, and which to adopt for future COVID-19 "waves" and other public health emergencies, state policymakers should engage care recipients, caregivers and providers, and where applicable, the organizations that represent them to evaluate how approved flexibilities have impacted them over the past year. States can also use evaluations to determine the direction of broader LTSS system reform, such as expanded remote service delivery and increased supports for the LTSS direct care workforce. To support this process, federal policymakers should provide states with technical support and ongoing guidance on temporary flexibilities that can be made permanent and authorities for doing so.[13] States would also benefit from a centralized and defined process for federal support and approval of post-pandemic policymaking, and state-to-state learning opportunities when possible.

[13] CMS issued guidance on extending temporary flexibilities beyond the emergency in a December 2020 State Health Official letter: "Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency."

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