Appendix K Retainer Payments: Considerations for Implementation

States may request waivers of existing Medicaid regulations allowing the provision of more agile services during emergencies, including the use of retainer payments. In particular, states may make changes to their 1915(c) Home and Community-Based Services (HCBS) waivers through Appendix K: Emergency Preparedness and Response. This template offers a variety of options, easing certain regulations and permitting states flexibilities in service planning and delivery. For other authorities such as State plan HCBS under the 1915(i) and 1915(k) Community First Choice (CFC) options, states may use an 1115 waiver to modify or expand services, including the option of retainer payments. States also may use retainer payments in managed care arrangements with state-directed payments.

What are retainer payments?

Retainer payments are intended to preserve staff capacity while an individual is absent from services, allowing payment to continue to providers while the individual is not receiving certain services. These are time-limited payments that may help “tide over” providers when the individual being supported is absent from services.

Retainer payments are not a new option. Some states have already included retainer payments in their “regular” 1915(c) HCBS waivers. The Centers for Medicare & Medicaid Services (CMS) announced the personal assistance retainer in Olmstead Update No. 3, July 25, 2000. This option was, in a sense, a “corrective” to the policy that only institutional settings such as nursing facilities could receive a payment to “hold” services while an individual was away from the facility for a short-term absence or hospitalization. The new policy permitted states to pay personal caregivers under the waiver while a person is hospitalized or absent from his or her home. Although the original language only referenced personal care, CMS broadened this option to include providers of habilitation services, such as residential and community-based habilitation providers including day and vocational supports. Because retainer payments are originally tied to personal care, CMS notes that when providing retainer payments to habilitation providers, habilitation services need to include at least incidental personal care as a component of the service. The CMS Core Services definition of personal care is quite flexible and can include cueing and prompting.

This coverage of both personal care and habilitation providers appears in the guidance for completion of the Appendix K template. Until this emergency, the retainer payment option was only permissible under the 1915(c) HCBS waiver authority. CMS now indicates states may request retainer payments...
under the 1915(i) State plan HCBS option and 1915(k), Community First Choice (CFC) state plan option using an 1115 waiver. Unfortunately, the retainer payment option is not currently permissible for “regular” state plan personal care services. NASDDDS collaborated with its sister associations (NAMD and ADvancing States) on a letter asking CMS to look into how these payments might be made available for State plan services.

**Are there time or reimbursement limits on retainer payments?**

CMS noted that retainer payments may “not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes payment for “bed-hold” in nursing facilities.” This means retainer payments are tied to states’ bed-hold policies. State bed-hold limits vary dramatically, with some states providing no bed hold days and others ranging from an annual maximum of twelve days per absence to as many as 48 days. Unless the state chooses to amend its nursing home bed-hold policy, the current bed-hold limit in the state plan amendment (SPA) amount serves as an upper limit on the annual number of allowable days retainer payments can be made. However, if the state bed hold policy is above 30 consecutive days, the limit of 30 days applies.

In guidance provided during a CMS All State Call in April 2020, CMS indicated that concerning the limit of 30 consecutive days, the count to the 30 days pauses if there is an interruption in the days for which a retainer payment is rendered. CMS offered the example of day programs that occur five days/week. The state can use the 30 days over six weeks, that is, five days/week for a six-week period.

**As of the publication of this paper, CMS’s final policy has not been confirmed regarding the authorization of “multiple” 30 day periods.** Although some states initially received authorization for more than one 30-day period, CMS did not approve this language in recent Appendix K submissions, asking the state to remove its requests for more than one 30-day period. As of the time of the publication of this document, CMS indicated that at present, they cannot approve multiple “sets” of 30-day periods within the Appendix K language. This policy is still under discussion and CMS noted that the final policy is forthcoming.

CMS does not specify any parameters for establishing what states may pay providers through the use of retainer payments. States may set payments rates (as they would with any service), but CMS reminds states that, “Such payments are not permissible when the state has included a cost-center in the rate paid to providers to address absences.” States do need to assure that the retainer payments do not duplicate payments already included in an established payment rate.

For managed care arrangements, CMS provided guidance in the May 14, 2020 Center for Medicaid and CHIP Services (CMCS) Informational Bulletin in Medicaid Managed Care Options in Responding to COVID 19. We provide a separate section below for retainer payments under managed care arrangements.
Implementation Considerations

1. What types of providers will be eligible for retainer payments in your state?

As indicated in the Instructions, Technical Guide and Review Criteria, Version 3.6 Waiver Application Guide (typically known as the Waiver Technical Guide), “Payment to retain providers may be particularly important for individuals and states in emergency situations. If the state elects to make such payments, describe the circumstances under which such payments are authorized and applicable limits on their duration.” As noted earlier, some states already provide for retainer payments in their approved waivers and the service must include at least “incidental” personal care services as a component of the provided service.

The majority of states submitting Appendix K: Emergency Preparedness elected the option of providing retainer payments. Attached is a compendium of approved Appendix K retainer payments. These payments can help to maintain a stable workforce; ensure continuous operations; support fixed facility and overhead costs; and, support the sustainability of waiver services for those providers who are unable to continue business operations.

Although the majority of states have elected this option, the identification of covered services and supports varies. The services identified as eligible for retainer payments most often include Personal Care, Residential Support and Day Support. States also include other services that have a habilitation or personal care component including Pre-vocational Services, Supported Employment, Group Supported Employment, Personal Assistance, Companion Support, and Career Exploration.

A few states expressly included self-directed services as eligible for retainer payments. As an example, New York’s approved Appendix K notes, “Retainer payments may also be made by a Fiscal Intermediary (FI) to retain ‘self-hired’ staff who are unable to work because of illness of the individual receiving services or his/her family member’s illness for Community Habilitation services and other services that include personal care as a service component.”

2. What conditions must be met for providers to be eligible for retainer payments?

In addition to identifying specific services as eligible for retainer payments, states also impose conditions for “earning” these payments. The following are samples of the stipulations in Appendix K submissions or implementation guidance from different states as to when they make retainer payments:

- **Nebraska** - When someone the provider supports is under medical quarantine, cannot safely reach the service location, is in a short-term facility stay, and/or in isolation.
• **Kentucky** - When there is a closure of a provider business and the provider cannot enter the participant’s home or provide services through other electronic platforms.
• **Arizona** - When there are reductions in the utilization of services related to COVID-19, such as missed appointments or decreased frequency of participants receiving services.
• **California** - When there are absences in excess of the average number of absences experienced by the provider during the 12 months before February 2020.
• **Delaware** - When attendance and utilization for the service drop by at least 50%.
• **Oregon** - Retainer payments are allowable in circumstances in which utilization for the service location drops below 75% of annual monthly average 10/1/19 to 12/31/2019.

3. **How are the amount and duration of retainer payments determined?**

There is a wide variety in determining the payment amount. Some examples of how states determine the amount of the payment include:

• **Delaware** - Retainer payments will be made at a percentage of the regular service rate using the CMS-approved methodology in the waiver, not to exceed 75% of the regular rate. Payment will not exceed the total amount the provider would have received had services been provided as expected. Units are limited to the average prior utilization for each person.
• **Kentucky** - The state will determine the rate and scope of the payment based on the severity of the situation.
• **Oklahoma** - Payments will not exceed 60% of the monthly average of total billing for any provider. Limit on the hours of retainer payments per day of 6 hours/five days per week for providers of prevocational, supported employment or day services.
• **Nebraska** - Providers will have 90 days from the date for which a retainer payment is being billed to submit a claim.

Nebraska established set rates for retainer payments in a previous Appendix K submission before submitting for COVID-19. For example:

• Agency-provided day and employment supports, $150/day
• Independent providers, $105/day
• Agency-provided residential services, $215/day
• Independent residential providers, $100/day

4. **What documentation must the provider submit to receive the payment?**

CMS does not provide any specific guidance but states will want to assure that providers meet the conditions of the retainer payment and there is no duplication of payment. States may not provide
for retainer payments if the state already includes an “absentee” factor in the payment rate. The Instructions Version 6.6 Waiver Application Guide Waiver Technical Guide notes, “[Retainer] payments are not permissible when the state has included a cost-center in the rate paid to providers to address absences.”

5. Duplication of Payments

Providers may be eligible for various types of financial relief including funds from the Paycheck Protection Program or other loans from the United States Small Business Administration (SBA). Now through the Public Health and Social Services Emergency Fund, known as the Provider Relief Fund, authorized through the CARES Act, tracking to establish that there is no duplication of payments will become even more important as providers directly receive funding. The first tranche of this fund was distributed to Medicare providers, but Medicaid-only providers, specifically including HCBS providers, are included in subsequent disbursements.

Some states also have decided to provide disbursements to providers through their specific CARES Act fund for States and localities. These funds (a portion of the overall $150 billion included in the CARES Act for this purpose) were disbursed to state and local entities based on a population formula. These funds also will need to be tracked, again to assure no duplication of payment.

NASDDDS continues to track federal activity on the Provider Relief Funds and how funds will be distributed to HCBS/Medicaid providers. NASDDDS advocated for an approach to fund distribution that is inclusive of the diverse network of HCBS providers in intellectual and developmental disability (I/DD) systems, including smaller providers who may receive fewer Medicaid funds but are possibly most vulnerable to the impacts of the pandemic. According to a Medicaid.gov news release on June 9, 2020, “HHS expects to distribute approximately $15 billion to eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Distribution. HHS is launching an enhanced Provider Relief Fund Payment Portal that will allow eligible Medicaid and CHIP providers to report their annual patient revenue, which will be used as a factor in determining their Provider Relief Fund payment. The payment to each provider will be at least 2 percent of reported gross revenue from patient care; the final amount each provider receives will be determined after the data is submitted, including information about the number of Medicaid patients providers serve.” States will want to work with providers on keeping track of these funds for reconciliation purposes if they also are receiving retainer payments.

In Pennsylvania, the Office of Developmental Programs authorizes the payment, thus providers do not have any additional documentation requirements. The payments are based on historical information and ODP established a Medicaid Management Information System (MMIS) “reason code” to track these payments.
For Arizona’s initial payments, an attestation template was developed to ensure providers understood their responsibilities and what information is requested to approve a retainer payment. This attestation includes information such as basic provider data, a summary description of the decline in utilization, a summary estimate of the units it will bill for a retainer payment, and confirmation the provider understands billing procedures that are subject to future audit, including that retainer payments can only be billed for services identified in the plan and that do not duplicate payments for services incurred. With subsequent payments, there are additional procedures and expectations related to direct support professional wage increases.

6. Managed Care and Retainer Payments

In the May 14, 2020 guidance, CMS affirmed that retainer payments are permissible under managed care arrangements. CMS reminds states that the same requirements that pertain to fee for service payments apply to managed care arrangements, noting that, “... section 1915(c)(4)(B) of the Social Security Act allows certain providers to continue to bill for individuals enrolled in a Medicaid program, and individuals receiving personal care or habilitation services that include personal care specified in their person-centered service plan when circumstances prevent such individuals from receiving these services.” CMS indicates that, “States should review the guidance relevant to when and how retainer payments may be authorized, as having authorization for those payments is necessary before states can direct their managed care plans to make such payments.”

In order to include retainer payments in a managed care arrangement, these payments must first be, “authorized as part of the 1915(c) HCBS waiver, section 1115(a) demonstration waiver for 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state-directed payment preprint must be submitted to effectuate the state-directed retainer payments under a state’s contract with its managed care plans.”

CMS advises states that they may implement, “state-directed payments under 42 CFR 438.6(c) that contractually require managed care plans to make these retainer payments to providers where the authorized service is covered under the contract.” CMS cautions states that the payments must meet all the requirements of 42 CFR 438.6(c), as well as the guidance established for the 1915(c) HCBS waiver use of retainer payments (described above). The guidance provides in-depth information on how to establish state-directed payments and developed a pre-populated template for states to use. CMS did indicate they will not require rate certification amendments, “...for new state-directed payments if the amounts are within the +/- 1.5 percent per rate cell de minimis amount in accordance with 42 CFR 438.7(c)(3).”
Again, the guidance is quite detailed and includes a sample of how to request these state-directed payments. CMS has a page of resources on state-directed payment established during the COVID-19 emergency, which can be found at:

Conclusion

Many states elected the retainer payment option as it is a useful tool to help stabilize the HCBS provider networks. But, given the extended timeline of the COVID-19 emergency, states will want to review other options for stabilizing the provider network such as enhanced payments, staff bonuses, and other ways to compensate the workforce as a means to retain workers through this emergency. Appendix K, Section f provides states the authority to temporarily increase payment rates. CMS requires that the state, “Provide an explanation for the increase, list the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.” This gives states considerable latitude to establish “special” payments during this emergency. And of course, states will also want to encourage providers to pursue the various resources that are available for businesses impacted by COVID-19 through the SBA (https://covid19relief.sba.gov/#/).
Notes


Washington is the first state to receive approval for retainer payments under their 1915(k) CFC program using the 1115 authority.


iv Personal care definition: “Core Service Definition (Services differ in scope and nature from personal care under the state plan or personal care is not provided under the state plan): A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law.” Instructions Version 6.6 Waiver Application Guide, p.144


vii Instructions Version 6.6 Waiver Application Guide, p.147


ix Attached please find a compendium of approved Appendix K retainer payment approvals.

x Instructions Version 6.6 Waiver Application Guide, 6. P.160

xi CMS published two examples of 438.6(c) preprints to facilitate review of state-directed payments discussed in the managed care guidance:

Example of states requiring managed care plans to make retainer payments allowable under existing authorities to certain habilitation and personal care providers (DOCX, 72.5 KB) ; and,

Example of state requiring managed care plans to temporarily enhance provider payments in response to COVID-19