

NASDDDS COVID-19 Response

Appendix K Emerging Patterns

Introduction

More than a decade ago, the Centers for Medicare & Medicaid Services (CMS) identified the need, on the heels of numerous natural disasters, to provide states with a streamlined mechanism to make adjustments to their 1915(c) Home and Community-Based Services (HCBS) waivers to respond to emergencies. Working with the National Association of State Directors of Developmental Disabilities Services (NASDDDS), ADvancing States (then called the National Association of States United for Aging and Disabilities), and other associations instrumental in the delivery of Medicaid HCBS, CMS developed Appendix K. This authority enables states, within the parameters of flexibilities permissible under 1915(c) of the Social Security Act, to make necessary adjustments to their approved waivers to ensure continuity of service and the health and welfare of individuals impacted by emergencies or natural disasters.

This issue brief will provide a synopsis of the types of flexibilities initially pursued by states to prepare for the spread of COVID-19 and the response to the public health and safety measures that are in effect throughout the country. CMS released a sample template with prepopulated items that has also been widely used by states.

Context

An Appendix K is used to advise CMS of expected changes to the state's current 1915(c) waiver and operations. While the Appendix K has been instrumental in allowing states essential flexibilities - including modifying payment strategies, adding services, expanding self-direction, etc. - to meet the urgent demands that emerge in disasters since its inception, never has it been more widely used than in response to the COVID-19 pandemic. Almost every state in the country has prepared or is preparing one or more Appendix K submissions to CMS to ensure the necessary flexibilities are in place to meet the needs of individuals with disabilities and individuals who are aging during these most extraordinary times.¹ To make submissions easier for states with multiple waivers during the COVID-19 pandemic, CMS provided guidance to states allowing them the option of submitting one Appendix K that would apply to all waivers. In addition, CMS developed an Appendix K addendum of common requests they have seen across the multiple submissions so that it could be used by states to quickly check off those changes they would like to apply. Those states not submitting an Appendix K specifically, but operate HCBS programs under different Medicaid authorities, have likely relied on the Appendix K contents to identify necessary areas of flexibility, such as in the Arizona section 1115 demonstration amendment submitted to CMS.²

¹ As of April 1, 2020, 13 states had received approval for their Appendix K submissions.

<https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html>

² <https://www.azahcccs.gov/Resources/Downloads/1115Waiver/COVIDFlexibilitiesRequest.pdf>

There are key factors that impact Appendix K content.

- Appendix K modifies an already approved 1915(c) waiver. To understand the necessary flexibilities that a state seeks, the Appendix K cannot be reviewed in isolation from the underlying program which it modifies.
- Appendix K does not stand as the sole mechanism in use in **any** state to enable flexibilities within the Medicaid program in response to emergencies. Most states (nearly 40 as of April 1, 2020) have approved section 1135 waivers, and many more states will have emergency section 1115 demonstration waivers and/or emergency state plan amendments (SPAs). The facets of each of these related authorities will, in fact, impact the contents of any state's request for an Appendix K.³

Description of Emerging Trends within Member State Appendix K Submissions

Transition Plans

An important component of the Appendix K template is the section related to transition plans. For the COVID-19 response, these elements have generally lacked specific detail due to the uncertain nature and duration of the emergency needs. NASDDDS will continue to offer assistance to states to prepare for the eventual resumption of typical practice when the temporary changes end and the waiver reverts to its original content as the emergency continues to unfold. Key activities states should include as early as possible include strategic surveillance activities to understand provider and system capacity post-emergency.

Access and Eligibility

In this section, states may note any adjustments they seek to make to cost limits applicable for entry into the waiver or may modify targeting criteria for the waiver. In the approved waivers thus far, we have seen states seek to lift cost limitations on waiver services. Notably, Colorado received approval to temporarily lift the cost limits for two support waivers. The state's other waivers are not bound by cost limitations for waiver enrollment.

Services

In this section, states may indicate whether they seek to add services or modify existing services available through the waiver; whether they seek to lift or amend existing service limitations on amount, duration and/or prior authorization procedures; or to expand the settings in which services can be provided, both in and out of state.

1. Service Changes and/or Additions

States have used Appendix K to add services or expand the scope of existing services. Many states have added or expanded access to home-delivered meals and specialized medical supplies. A number of states have modified the scope of certain services to ensure they meet the emerging needs of the people served. For example, Washington expanded the scope of

³ <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html>

transportation services to account for rides necessary for individuals to change the locale for purposes of avoiding the spread of COVID-19.

2. Service Limitations/Prior Authorization Procedures

Many states have used Appendix K to remove or increase limitations on a broad array of services (both in terms of overall dollar amounts and units per person). Examples of this include expanding the dollar limits imposed on assistive technology or specialized medical equipment and supplies. States also have increased the hours available for in-home supports, personal supports, respite, behavioral supports and habilitation to ensure that, regardless of where an individual may be during a period of social isolation, they have access to adequate supports and services. Kentucky increased limitations across a broad array of supports and services to ensure flexibility in meeting emerging and urgent needs.

New Mexico doubled its limit on assistive technology as a means to increase communication and health and welfare monitoring during this period and Washington and others removed the limitation on respite days. Washington also made the delivery of Community Guide and Staff/Family Consultation services permissible to occur on more than a one-to-one basis.

3. Service Setting Additions Adjustments

Multiple states have expanded the settings in which services can be provided. Some states have included an allowance for the provision of services in out-of-state settings as necessary to ensure the health and welfare of individuals served. In some instances, these provisions enable individuals to receive services in-home that were traditionally provided outside of home settings. These may include community support services, day support services, employment supports, and others. Many states, such as Alaska, have included broad flexibility for service settings when the individual requires quarantine.

Use of Technology

Almost universally, states are incorporating the use of technology into their service delivery systems. This includes the use of telehealth or remote supports for the delivery of waiver services, to the use of telephonic or digital contact for service planning and monitoring and other health and welfare activities, keeping Health Insurance Portability and Accountability Act (HIPAA) requirements in mind. Although the HIPAA Privacy Rule is not suspended during public health or other emergencies, the Secretary of Health and Human Services (HHS) may waive certain provisions of the Privacy Rule as indicated in the following communication found at: <https://www.hhs.gov/sites/default/files/hipaa-and-covid-19-limited-hipaa-waiver-bulletin-508.pdf>. States have included remote service provision for almost every service, except for tangible goods and services, transportation and, in some instances, respite.

States are working to understand individual access to necessary digital equipment for effective communication in this regard and are working to identify both targeted and broad-based solutions to both device availability and broadband connectivity.

Provider Flexibilities

Many states have increased the potential provider pool by permitting increases to the use of family caregivers for the delivery of services. States have been explicit in their Appendix K submissions regarding the circumstances and limitations that may apply for this option. States also are including specific oversight requirements, particularly when access to the broader community is hampered in the current circumstances. These strategies aim to support individuals and families while balancing both health and welfare and autonomy and choice.

States that have offered limited opportunities heretofore for self-direction are exploring strategies to increase their offerings during this pandemic to maximize choice and control and, hopefully, to leverage a non-traditional provider base.

States also have modified licensure and certification requirements for providers, as well as training expectations and background check requirements. These modifications range from elongating the performance period for regular reviews to permitting increased setting capacity if needed to address the needs of individuals. This may include necessary adjustments to otherwise requisite staffing ratios. It also may include strategies to ensure remote training opportunities for staff. Concerning background checks, states may permit individuals to work alongside or under the supervision of another staff pending certain clearance levels.

Person-Centered Planning, Assessments, and Level of Care Evaluations

As a general observation, states are lengthening the periods for planning and level of care (LOC) evaluations. In addition, they are including modifications to the minimum expectations regarding assessments and level of care determinations. In most instances, states are setting the expectations that all of these functions occur on a remote basis either through telephone contact or other media such as video conferencing platforms.

These same methodologies are included in most Appendix K submissions to conduct necessary health and welfare monitoring, in some instances with increased frequency than typically required given the circumstances of both the virus and the potential ramifications of social isolation.

Many states sought maximum flexibility concerning requirements related to gaining signatures for person-centered plans. For Appendix K, which is bound by that which is available in 1915(c) authority, the maximum flexibility is for states to use electronic means to collect signatures. CMS has advised that the 1135 authority may provide broader relief to allow verbal assent.

Payment Methodology Changes

1. Rate methodology adjustments

The vast majority of approved Appendix Ks include modifications and flexibility related to rates and rate methodologies. Some states, such as Pennsylvania, explicitly noted that their methodology remained intact but certain cost centers (such as those for supplies and staff wages) were poised to increase. Other states were broader in their description of the flexibility noting that adjustments will be made as necessary to ensure an adequate workforce.

Many states are drafting Appendix Ks with explicit language regarding the need for increased rates for staff who support individuals who have been exposed to or tested positive for the COVID-19 virus. Sometimes referred to as ‘hazard pay’, most states are characterizing these situations as extraordinary care payments or rates sufficient to meet individual, case-specific needs. Typically states are not changing rate methodologies, but are establishing additional payments and/or exceptions to current reimbursement levels.

2. Retainer Payments

Almost all states have elected the option of providing retainer payments as authorized in the Olmstead Letter #3. States are utilizing these payments for providers who are unable to continue business operations due to individual circumstances or broad state, local and municipal requirements to maintain a stable workforce. These payments are limited to the lesser of 30 consecutive days or the number of days for which the State authorizes payment for “bed hold” in nursing facilities. NASDDDS also has been keeping a compendium of all approved retainer payment language in Appendix Ks.

3. Support to Individuals in Hospitals

Almost all of the states submitting early Appendix K flexibilities included retainer payments for the purposes of permitting direct support professionals to accompany individuals into acute hospital settings. Thanks to legislative action during the course of the pandemic, with heavy NASDDDS input and influence, Congress passed a permanent fix to this issue, enabling – hospital safety considerations permitting – direct support professionals to accompany individuals during short term stays so long as they do not duplicate those services that would ordinarily be provided by hospital coverage.

4. Quality Improvement/Health and Welfare/Incident Management

States are devising strategies to ensure that case managers have sufficient contact with individuals to enable careful health and welfare monitoring. They are devising strategies to enable a redesign of case management functions. These strategies include the use of remote supports, with increased periodicity in some instances. States continue to undertake gap analyses to ensure uniform ability to contact and communicate with individuals in the waiver.

Most states are contemplating adjustments to their incident management and reporting to both focus the attention on the highest priority incidents (abuse, neglect, and exploitation) and are designing policies for the collection of necessary information regarding the prevalence and location of COVID-19 exposure among people supported through the waiver programs.

States also are advising CMS through the Appendix K of standard assurance /subassurance reporting that will be disrupted due to atypical practices in place during the emergency response.

Conclusion

States are utilizing the Appendix K for the paramount purpose of ensuring the health and welfare of individuals served but also are striving to ensure the long-term sustainability of the service delivery system and provider pools during long periods of social distancing requirements.

States are preparing for the spread of COVID-19 and including many provisions that “might” be necessary. The provisions approved in the Appendix K can be exercised on an as-needed basis.

Because any single Appendix K does not exist in isolation, it is insufficient to review Appendix K applications and draw firm conclusions about the state’s approach to HCBS in an emergency. For example, a state that already offers maximum flexibility for self-directed services in its underlying 1915(c) waiver will not need to request additional flexibilities in its Appendix K. The absence of this election in the Appendix K is not an indication whatsoever of the state’s commitment to self-directed services. Similarly, a state that has gained broad approval within the approved section 1135 waiver to maximize enrollment of non-traditional providers, need not include such provisions within the Appendix K.

In summary, while we will broadly describe the emerging trends we are identifying within our members’ submissions, great caution should be taken regarding state priorities or intentions without a thorough studying of associated authorities and, in the final analysis, those provisions that were ultimately utilized. Also, in many instances, the approved Appendix K applications as of today may represent only the earliest iteration. NASDDDS expects states to refine their needs as the pandemic ensues and expects amendments as needed to reflect those ever-emerging needs.

Links to Approved Appendix Ks during the time this analysis was written:

Alaska:

<https://www.medicaid.gov/state-resource-center/downloads/ak-combined-appendix-k-appvl.pdf>

Colorado:

<https://www.medicaid.gov/state-resource-center/downloads/co-combined-appendix-k-appvl.pdf>

Connecticut:

<https://www.medicaid.gov/state-resource-center/downloads/ct-0140-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/ct-0301-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/ct-0302-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/ct-0653-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/ct-0993-appendix-k-appvl.pdf>

<https://www.medicaid.gov/sites/default/files/2020-03/ct-1085-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/ct-combined-appendix-k-appvl.pdf>

Hawaii:

NASDDDS

National Association of State Directors of Developmental Disabilities Services

<https://www.medicaid.gov/state-resource-center/downloads/hi-0013-appendix-k-appvl.pdf>

Iowa:

<https://www.medicaid.gov/state-resource-center/downloads/ia-combined-appendix-k-appvl.pdf>

Kansas:

<https://www.medicaid.gov/state-resource-center/downloads/ks-combined-appendix-k-appvl.pdf>

Kentucky:

<https://www.medicaid.gov/state-resource-center/downloads/ky-combined-appendix-k-appvl.pdf>

Minnesota:

<https://www.medicaid.gov/state-resource-center/downloads/mn-combined-appendix-k-appvl.pdf>

New Mexico:

<https://www.medicaid.gov/state-resource-center/downloads/nm-combined-appendix-k-appvl.pdf>

Pennsylvania:

<https://www.medicaid.gov/state-resource-center/downloads/pa-0147-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/pa-0235-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/pa-0324-appendix-k-appvl.pdf> (amended)

<https://www.medicaid.gov/state-resource-center/downloads/pa-00354-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/pa-0386-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/pa-0593-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/pa-1486-appendix-k-appvl.pdf>

Rhode Island:

<https://www.medicaid.gov/state-resource-center/downloads/ri-11w00242-appendix-k-appvl.pdf>

Washington:

<https://www.medicaid.gov/state-resource-center/downloads/wa-0049-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wa-0409-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wa-0410-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wa-0411-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wa-0443-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wa-1086-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wa-1186-appendix-k-appvl.pdf>

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National Association of State Directors of Developmental Disabilities Services

<https://www.medicaid.gov/state-resource-center/downloads/wa-40669-appendix-k-appvl.pdf>

West Virginia:

<https://www.medicaid.gov/state-resource-center/downloads/wv-0133-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wv-0134-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wv-0876-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wv-1646-appendix-k-appvl.pdf>

<https://www.medicaid.gov/state-resource-center/downloads/wy-combined-appendix-k-appvl.pdf>