The End of Pandemic-Era Flexibilities in Medicaid Home- and Community-based Services

What Agency Leaders Need to Know

This resource is designed to help Medicaid agency leaders, as well as their colleagues in aging & disability agencies, prepare for the end of federal flexibilities that Medicaid adopted to support older adults and individuals with disabilities during the pandemic. This is particularly important as the federal declaration of the COVID-19 Public Health Emergency (PHE) is scheduled to sunset on May 11, 2023. This guide provides background information about those flexibilities, outlines steps Medicaid agency leaders need to take before they expire, lays out the array of authorities Medicaid programs used to institute those flexibilities, and inventories how states used 1915(c) Appendix K (the most frequently used pathway) to support affected Medicaid members.

BACKGROUND

Older adults and people with disabilities were at heightened risk of serious illness and death from exposure to COVID-19. In addition, these individuals would have been disproportionately likely to be hospitalized or faced placement in a skilled nursing facility, should the home- and community-based services (HCBS) on which they relied have been interrupted or entirely suspended. In recognition of this, the federal government gave Medicaid programs broad flexibility to respond to the impacts of the COVID-19 pandemic on these Medicaid members, effective in 2020.
In response, all states adopted some combination of federal flexibilities to modify how and from whom individuals received services, which allowed older adults and individuals with disabilities to remain safely at home without reducing their needed services. These flexibilities also helped states shore up the HCBS delivery system and ensure access to care. In particular, an overwhelming majority of states used Appendix K (a standalone appendix to 1915(c) HCBS waivers used by states in emergencies) to:

- Expand covered services, such as home-delivered meals;
- Expand provider types, notably including authority to pay family caregivers for providing services; and
- Implement provider retention payments and temporary rate increases, particularly for direct care workers.

In addition, states used several other authorities (see table below) to suspend prior authorization requirements and/or cost sharing; use telehealth for assessments, evaluations, and person-centered planning; and suspend provider enrollment and credentialing requirements.

STATE ACTION NEEDED

The federal government intends to end the PHE declaration on May 11, 2023. Many emergency flexibilities will expire on that date, but others are effective to a sunset date specified by the state or a maximum period set by the federal government. As this date approaches, Medicaid and aging and disability agency leaders should determine:

1. how best to meet member needs ongoing;
2. which flexibilities to make a permanent feature of their program (if allowed under federal law) and which to sunset;
3. the timeframe and process for seeking necessary approvals from CMS; and
4. how to ensure effective transitions for all those involved, including engaging and informing members, caregivers, and providers about any changes that are being made, and how this will affect access, delivery and receipt of HCBS services ongoing. For example, states like Louisiana, Ohio and North Carolina are engaging with stakeholders, including members and their families, about the implications of continuing or discontinuing these flexibilities.

Medicaid Disaster Relief Authorities			
Authority	**Description of Authority and Permissible Flexibilities**	**Effective Date**	**Termination Date**
State-Specific 1135 Waivers	Section 1135 of the Social Security Act gives the Secretary of Health and Human Services (HHS) the authority to waive certain Medicare, Medicaid or CHIP requirements in areas impacted by a federally declared public health emergency. These waivers are targeted to policies that ensure sufficient health care items and services are available to eligible individuals during a crisis. These authorities apply across the entire Medicaid and CHIP program. A CMS-developed Medicaid template included options among which states selected including: • Waivers of person-centered planning requirements; • Flexibility in timelines for preadmission screening and resident review assessments to take place and Nursing Home Minimum Data Set authorizations for nursing facility residents; • Extension of fair hearing timelines; • A range of options for expanding the pool of available providers, such as allowing out-of-state providers to deliver services without being licensed in the state, and expediting waiver enrollment; and • Flexibility in deadlines and process for certain reporting requirements.	March 1, 2020	Expires May 11, 2023 (end of the PHE). There is no phasedown period.
1135 Blanket Waivers	Section 1135 of the Social Security Act gives the Secretary of HHS the authority to waive certain Medicare, Medicaid or CHIP requirements in areas impacted by a federally declared public health emergency. In addition to the state-specific waivers (above), CMS provided blanket waivers of federal requirements for Medicare providers. They do not apply to conditions of payment. Blanket waivers do not require state action. Please see this link for information on the status of these waivers, an important example of which was waiver of the three-day hospitalization that is required for Medicare coverage of a skilled nursing facility stay.		

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Appendix K for 1915(c) Waivers	Appendix K is a standalone appendix that may be used by states during emergency situations to request amendments to approved 1915(c) HCBS waivers. It only applies to services delivered under 1915(c) waivers. CMS provided a COVID-focused template that states used for each 1915(c) for which they were seeking flexibilities. Key areas of flexibility included: • Delivering services remotely or via technology; • Allowing family members to be paid to provide care in the home; • Retention bonuses and temporary rate increases for HCBS providers; and • Changes in the assessment and person-centered planning process. States most frequently used the Appendix K pathway to implement emergency flexibilities to respond to the needs of older adults and individuals with disabilities. More information on how states used this pathway is in the table that follows.	January 27, 2020 or any later date elected by state	The date identified by the state, or if none, no later than six months after the expiration of the PHE (November 11, 2023)
Attachment K for Section 1115 Waivers	Attachment K is an extension of a state's section 1115 demonstration Special Terms and Conditions (STCs) for those states that deliver LTSS through that waiver authority. They are used for emergency situations to request modifications to an approved 1115 waiver demonstration's STCs and only applies to the LTSS services contained in that demonstration. States were instructed to use the Appendix K template to submit requests for these flexibilities.	January 27, 2020 or any later date elected by state	The date identified by the state, or if none, no later than six months after the expiration of the PHE (November 11, 2023)

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Medicaid Disaster Relief State Plan Amendments (SPAs) for the COVID-19 PHE	The disaster relief SPAs allow states to make temporary changes in their State Plan. It provided broad options allowable within the existing State Plan, and it is not applicable to pre-existing 1915(c) waivers or section 1115 demonstrations. CMS provided states with a template to complete and submit. Options in the CMS template include the following options related to: • Eligibility: adopt new groups, increase income limits, and loosen nonfinancial requirements, such as extending the reasonable opportunity period for noncitizens. • Enrollment: expand presumptive eligibility and extend redetermination periods for non-Modified Adjusted Gross Income (MAGI) populations. • Cost Sharing: suspend out-of-pocket costs and allow hardship waivers. • Benefits: add new benefits, modify current benefits, and expand telehealth. • Payment: increase rates for certain services. • Prescription Drugs: increase supply limits, expand prior authorization, and/or add to state preferred drug lists.	March 1, 2020 or any later date elected by state	Expires May 11, 2023 (end of the PHE) unless state seeks a temporary extension through a streamlined SPA review process.
1115 Waivers	Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to approve demonstration projects that are likely to promote the objectives of the Medicaid program. These are broad waivers that are used for more than just disaster response. However, CMS developed a 1115 waiver opportunity for COVID-specific flexibilities. This option was available to all states, regardless of whether the state had an existing 1115 waiver (as opposed to Attachment K, see above, which was only for	March 1, 2020 or any later date elected by state	The termination date for authorities approved under section 1115 authority end on the date identified in the state's approval documents.

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	states with an existing 1115 waiver to deliver LTSS). This CMS-developed 1115 pathway allowed states to implement changes to state-plan services as well as to HCBS not delivered via a 1915(c) waiver or existing section 1115 demonstration, such as through 1915(i); 1915(k); or 1905(a) state plan benefits. States had the option to complete and submit a CMS-developed template that included, but was not limited to, the following options: • Changes to benefits • Waiver of statewideness • Provision of services in a different amount, duration, or scope for certain individuals • Adjustment of payment rates • Waiver of premiums, cost-sharing, or other participant costs		

Appendix K HCBS Flexibility Unwinding					
Flexibility	**State Count**	**Cannot be added to 1915(c) waivers on ongoing basis**	**May be approved in 1915(c) waivers on ongoing basis** (will require waiver amendment)	**States' Use of the Authority**	**Considerations Post-PHE**
Modify services	51		X	States used this to expand their service array (e.g. to include home-delivered meals, assistive technology, dental services, and others) as well as to cover other services that states identified as being beneficial to its waiver population, including new or modified non-facility-based community engagement services.	
Modify provider qualifications	49		X		
Modify payment rates	49		X		
Allow retainer payments	42		X		States have the option to extend these payments for the lesser of 30 consecutive days or the total number of bed-hold days approved in the State Plan.
Modify person-centered planning (PCP) and person-	42	X		States extended timeframes for recertification of person-centered planning processes.	

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centered service plan (PCSP) requirements					
Waive visitor settings criterion	42	X		This allowed states to eliminate or modify access of visitors for infection control purposes.	
Allow virtual/remote evaluations, LOC determinations, assessments, and person-centered planning	41		X		CMS indicated they will approve if appropriate. CMS has not released additional clarification on the circumstances under which it would be considered appropriate.
Add electronic method of signing off on required documents	41		X		
Add electronic service delivery	40		X	States used this to authorize telehealth/electronic service delivery for case management, personal care (verbal cuing), in-home habilitation, individual supported employment, health coordination, peer support, counseling, training and support of family caregivers, and other services offered via telehealth while still enabling community integration.	

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Adjust prior approval/prior authorization elements approved in the waiver	37		X		States should ensure that any permanent changes that they are proposing to make do not violate Maintenance of Effort requirements for continuing to access enhanced federal HCBS match American Rescue Plan Act (ARPA).
Adjust assessment requirements	35		X		States should ensure that permanent changes do not violate Maintenance of Effort requirements for continuing to access enhanced federal HCBS match under ARPA.
Allow payment for HCBS respite in institutional settings	35		X		For a time limited period not to exceed 30 days (or less at state option).
Changes to participant safeguards	33				CMS has not yet provided guidance. States should refer to the 1915(c) Technical Guide or consult with a CMS analyst.

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Extend dates for Level of Care determinations	32	X		Extend dates for Level of Care re-evaluations	States must conduct Level of Care re-evaluations in accordance with their 1915(c) waiver following expiration of the Appendix K.
Allow spouses and parents of minor children to be paid providers	29		X		CMS has indicated that payment to legally liable individuals may be approved. For purposes of personal care services, the state must distinguish between customary and extraordinary care. See pgs. 119-123 of the CMS 1915(c) Technical Guide.
Modify access and/or eligibility	23		X		States should ensure that permanent changes do not violate the Maintenance of Effort requirements for continuing to access

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					enhanced federal HCBS match under ARPA.
Modify providers of home-delivered meals	22		X		
Allow other practitioners to deliver services	21		X		
Case management conflict of interest provision	18	X			

CONCLUSION

Medicaid and aging and disability agency leaders must work together to determine how they will meet the needs of older adults and individuals with disabilities as federal emergency authorities expire. Agency leaders must decide which flexibilities to make a permanent feature of their program and which ones to allow to sunset. This work is of critical importance, given the profound impact state decisions could have on members with the most significant health care and social support needs. It could impact how individuals access services (e.g., from paid family care givers) and the array of services and supports available to them. Members have been accessing services under these emergency authorities for nearly three years and are likely unaware of the temporary nature of these policies.

These decisions are best accomplished with input from those who will be impacted. This includes Medicaid members, HCBS and home health providers, and other community partners, like Area Agencies on Aging. Agency leaders should identify a range of opportunities and pathways to gather this input, such as through listening sessions, notice and comment periods, and other means.

Once the agency leaders make these decisions, they will need to provide impacted individuals with appropriate notice and time to transition. This is particularly important for members who may experience a contraction in services or a change in the means by which they access services. HCBS providers also need appropriate notice and information about transitioning back to pre-pandemic policies

and processes, especially about any changes in payment and rates. If agency leaders decide to make flexibilities a permanent feature of their program, they will also need to seek necessary state and federal approvals to do so.

At the beginning of the pandemic, Medicaid and aging and disability agencies took swift and decisive action to ensure older adults and individuals with disabilities could remain safely at home. As we prepare for the end of the PHE, agency leaders need to bring the same level of attention and care to how the program emerges from the emergency period and continues to meet the needs of individuals who rely on HCBS.