

Meeting the needs of Medicaid Home and Community-Based Services program participants during the COVID-19 pandemic and beyond

The challenge of providing Medicaid home and community-based services during the public health emergency ... and whenever “normal operations” resume

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Millions of Americans with chronic illnesses or disabling conditions rely on Medicaid to remain safely in their homes and communities through the help of home and community-based services (HCBS).

These same Americans are often at high risk for developing severe symptoms if they contract COVID-19 and may need to continue self-quarantine even once stay-at-home orders begin to relax, and businesses reopen. A variety of Medicaid policy options are available for states to continue to support these HCBS program participants and their providers, both during the pandemic and in its aftermath.

As the primary payer for institutional and community-based long-term services and supports (LTSS), Medicaid spent more than \$92 billion on HCBS in federal fiscal year (FFY) 2018.¹ Medicaid HCBS help individuals live independently outside of institutions like nursing homes by covering services that help with activities of daily living (ADLs). While home health is a mandatory benefit for Medicaid programs, all other HCBS are optional for states to provide. Regardless of a state’s normal HCBS benefits array, the COVID-19 pandemic presents unique challenges for HCBS program participants. During this pandemic and as stay-at-home orders begin to relax, individuals may have diminished access to HCBS.

For example:

- Many adult day care centers are closed or experiencing reduced attendance, causing an urgent need to find alternative service providers (some program participants transitioning to home-based settings, while others will require higher levels of care).
- Some individuals may be reluctant to allow professional or family caregivers to enter their homes due to the risk of exposure to COVID-19.
- Some professional HCBS providers or family caregivers may be quarantined themselves, preventing them from providing regular services to individuals.
- Reduced access to HCBS may also cause spikes in a variety of other medical conditions.

For instance, diminished access to HCBS will necessitate some program participants moving to a nursing home. Program participants who choose to remain in their homes, but now lack services, may experience an increased risk for hospital emergency room (ER) visits and inpatient hospital admissions. Not only are these options more costly than HCBS (and may be contrary to the wishes of some program participants) but the risk of exposure to COVID-19 is also higher in institutional settings. Additionally, moving HCBS program participants into nursing facilities may reduce the supply of beds available for individuals with COVID-19 who have more acute needs.

¹ O’Malley Watts, M., Musumeci, MB., & Chidambaram, P. (February 2020). Medicaid Home and Community-Based Services Enrollment and Spending. Kaiser Family Foundation Issue Brief. Retrieved May 8, 2020, from <http://files.kff.org/attachment/Issue-Brief-Medicaid-Home-and-Community-Based-Services-Enrollment-and-Spending>.

A critical aspect of the provision of HCBS is that the program participant is entitled to participate in a person-centered planning process.² Person-centered planning is a process directed by an older adult or person with a disability for choosing and organizing the services and supports that may be needed to live in the community. Due to the COVID-19 emergency, the challenges of rapidly reduced provider access and other changes to service needs will often necessitate an emergency update to the person-centered care plan for the impacted program participant. Even participants who do not require a service plan change may require additional check-ins from their care manager or connection to services that are not normally covered by Medicaid such as meal deliveries or social services. These challenges bring with them additional administrative costs for both states and HCBS providers, and a need for additional outreach efforts as they work to assure ongoing support for these participants.

There are also longer-term implications to consider:

- Once an individual moves to a nursing home, it becomes more difficult to transition that person back to a home or community-based setting, leading to ongoing increased costs from either remaining in the nursing home or reestablishing community residence, and potentially treatment in a setting less desirable to the individual.
- Many companies that provide HCBS, such as adult day care centers, are smaller companies that are dependent on regular cash flow to survive. In the absence of emergency financial support, these providers may be forced to close permanently, thereby creating a systemic HCBS access problem that could persist long beyond the pandemic.

In historically underserved areas where HCBS access was a concern prior to COVID-19, the pandemic may also serve to exacerbate healthcare access challenges states were already facing.

So how can a state address some of the challenges and risks related to diminished HCBS during the COVID-19 pandemic?

Several Medicaid program options may allow for emergency-related modifications to HCBS to reduce the risk for institutionalization, shore up the at-risk provider entities, and protect program participants and providers from the danger of infection.

MEDICAID HCBS FLEXIBILITIES AVAILABLE FOR COVID-19

States can choose some or all of these vehicles to support their unique emergency response needs for HCBS providers and program participants.

1915(c) Appendix K: To accelerate changes to home and community-based waivers during an emergency.

Emergency Medicaid and/or Children's Health Insurance Program (CHIP) state plan amendment (SPA):

To adjust policies like eligibility, enrollment, benefits, premiums and cost sharing, and/or payments for the following HCBS:

- Home health
- Personal care services
- Physical or occupational therapy
- Case management
- State Plan HCBS Option under 1915(i)
- Self-Directed Personal Assistant Services under 1915(j)
- Community First Choice under 1915(k)

Some policy changes are possible under **existing state plan authority**, only requiring state policy, regulatory, or statutory changes.

1115 waivers: To enable program changes and emergency funding options.

1135 waivers: To assure that sufficient healthcare items and services are available to meet the needs of Medicaid recipients.

1115 and 1135 waivers are discussed in further detail in Milliman's [Emergency Medicaid Waivers during the COVID-19 Pandemic](#) paper, published on April 8, 2020.

Utilizing Appendix K to adapt 1915(c) waivers to address the pandemic

Many states operate their HCBS programs through a special authority called 1915(c) waivers, which allow them to offer different benefit structures enabling individuals to live in the community rather than an institution (and at the same time the programs are, on average, lower-cost). States may want to evaluate how their 1915(c) waivers are operating during the

² CMS (January 10, 2014). Fact Sheet: Home and Community-Based Services. Retrieved May 8, 2020, from <https://www.cms.gov/newsroom/fact-sheets/home-and-community-based-services>.

COVID-19 pandemic to ensure that program participants continue to receive the services needed to safely remain in their homes and communities. Program evaluation should assess HCBS provider revenue concerns and possible longer-term access implications.

States may make temporary changes to their 1915(c) waivers during an emergency through the Appendix K template. Through this process, states may request time-limited amendments during emergencies; these templates can be completed retroactively, if needed. The Centers for Medicare and Medicaid Services (CMS) has published a COVID-19 Appendix K form template that is prepopulated to address a number of current concerns,³ including:

- Access and eligibility
- Benefit changes
- Family caregiver supports
- Provider qualifications
- Level of care evaluations
- Person-centered planning
- Retainer payments
- Self-direction opportunities

ADDRESSING THE NEEDS OF HCBS PROVIDERS

Similar to many small businesses during this pandemic, HCBS providers may be challenged financially with how to continue during or immediately after the COVID-19 pandemic. Those forced to limit services due to government-mandated business restrictions could see sizable revenue decreases. Some may even be faced with the reality of closing their doors. If the financial situation of these HCBS providers causes them to close due to lost business during the pandemic, there is a real risk of long-term provider access issues.

Some states have acted to temporarily increase the payment rates for those services that HCBS providers can continue to deliver during COVID-19. Per CMS guidance, states may increase particular service rates to incentivize larger pools of providers or to compensate for additional risk, qualifications and trainings, or more intensive services.⁴ Based on our review of CMS-approved COVID-19 Appendix K requests as of this writing, many states have requested flexibility to establish rate increases under existing reimbursement methodologies up to certain levels, with some states requesting increases up to 50%.

³ Medicaid. Emergency Preparedness and Response for Home and Community-Based (HCBS) 1915(c) Waivers. Retrieved May 8, 2020, from <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>.

⁴ Medicaid. 1915(c) Waiver Appendix K: COVID-19 Prepopulated Template Instructions, Item K-2-f. Retrieved May 8, 2020, from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-appendix-k-instructions.pdf>.

Another option is for states to add retainer payments to direct care providers for personal care and habilitation services when the waiver participant is hospitalized or absent from home, or when closure is necessary to prevent the spread of COVID-19.^{5,6} Per CMS guidelines, the retainer time limit cannot exceed the lesser of 30 consecutive days or the number of days for which the state authorizes a payment for a "bed hold" in nursing facilities.⁷ Some states have chosen to limit these retainer payments only for services to individuals under medical quarantine, whereas other states are offering broader retainer payments to providers with overall Medicaid utilization below a certain percentage of pre-COVID-19 levels.

Retainer payments are not permissible for all HCBS provider types. States should ensure compliance with federal guidance before pursuing this option.

LEVERAGING FAMILY CAREGIVER SUPPORTS

Many Medicaid program participants receiving HCBS through a 1915(c) waiver may have a family caregiver who is also self-quarantined at home with the individual. These caregivers may themselves be currently unemployed or otherwise now available to assist in providing care that an HCBS provider would typically provide (e.g., bathing). Federal guidance allows for states to temporarily permit payment for services provided by family caregivers or legally responsible individuals, if not already permitted under the state's waiver.

Adopting this temporary option allows for HCBS program participants to continue to receive some services and remain safely in their homes, while minimizing contact with outside providers who could transmit COVID-19. Additionally, as unemployment rates have increased during the pandemic, this opportunity may allow some family caregivers to earn some income while they are unemployed.

SUSPEND DISENROLLMENT REQUIREMENTS

Several states have received approval beyond the normal template options to temporarily waive requirements to discharge the HCBS program participant from the 1915(c) waiver if the individual is not utilizing services. There may be many reasons an HCBS program participant must discontinue receiving in-person services during the pandemic. Examples include changes to how services are being delivered during the pandemic, situations where the individual is relying on unpaid family caregivers with whom they are now quarantined, or because the individual must temporarily reside in another state to self-quarantine with someone in a support network.

⁵ Ibid., Item K-2-j.

⁶ CMS. 1915(c) Home and Community-Based Services Waiver Instructions and Technical Guidance: APPENDIX K: Emergency Preparedness and Response. Retrieved May 8, 2020, from <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf>.

⁷ CMS (July 25, 2000). Olmstead Update No. 3: HCFA Update. Retrieved May 8, 2020, from <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf>.

Suspending disenrollment requirements during this emergency period may help to ensure program participants are not penalized for a temporary reduction in utilization, especially when they believe the short-term changes are necessary to minimize the risk of being infected with COVID-19. This option may also permit a speedier return to the individual's normal waiver services package, because there is no requirement to recertify for the benefits.

Adapting state plan HCBS

In addition to or rather than utilizing 1915(c) waivers, many states provide HCBS through their Medicaid state plans. These benefits may include the mandatory home health benefit; optional personal care, occupational or physical therapy, and case management benefits; the State Plan HCBS Option (1915[i]); the Self-Directed Personal Assistant Services (1915[j]); and/or the Community First Choice (1915[k]) programs. Often, states include multiple program options from this list.

States have several choices for how to adapt their state plan HCBS benefits during the COVID-19 pandemic, including a state plan amendment (SPA), emergency SPA, 1135 waiver, 1115 waiver, and existing authority under state and federal law. Many of the issues discussed above for changes made under Appendix K can also be made using one of these options for HCBS administered through a Medicaid state plan. Because there are multiple authorities that can be used to make these emergency changes, states will want to consider the totality of their policy goals before selecting the most appropriate avenue.

As states evaluate the set of options to use that best address the HCBS changes, questions to consider include:

- Is it possible to make this change under existing federal and state authority?
- What start date is needed for this change?
- Is it likely that this change may need to continue past the date when non-HCBS services return to normal?
- Can this change be included in a larger waiver document request?
- Are there changes to managed care programs that need to be considered?

EXISTING STATE AUTHORITY

A state may be able to make changes to state plan HCBS benefits without submitting a SPA or waiver, depending on its state plan language, and state statutes and regulations. Minor changes to services that do not require provider or beneficiary notice, or CMS notification, may be permissible.

States should evaluate whether the changes they seek to make would be permissible under existing state authorities in order to minimize administrative burdens and avoid delays in implementation where possible.

STATE PLAN AMENDMENT

States may also submit a SPA to CMS at any time under the normal submission process (outside of the emergency SPA option) to make a variety of changes to their Medicaid programs, such as eligibility, covered benefits and reimbursement rates. Changes to the state plan can take effect retroactively to the first day of the quarter the SPA was submitted. CMS has 90 days to make a decision once a SPA is submitted, although this timeframe can extend if CMS requests additional information. If CMS does not decide within the 90-day timeframe, then the SPA automatically goes into effect.

The regular SPA process may be a good option for changes that are not as time-sensitive or for situations when a state may want the change to remain in effect for a duration longer than would be permitted under an emergency SPA or waiver. This process takes longer, in part because it would also include any mandatory beneficiary or provider notice and comment processes required by state or federal law (these processes can be waived with an emergency change request).

In cases where the policy change is desired for both emergency purposes and longer-term program changes, the state may wish to pair up an emergency SPA with a normal SPA, in order to get the benefit of a quicker approval during the pandemic as well as the longer-term impact of the change becoming effective for ongoing program operations.

EMERGENCY STATE PLAN AMENDMENT

In March 2020, CMS released an emergency state plan amendment template for states to use during the COVID-19 pandemic to expedite the amendment process. The emergency template allows states to waive requirements around submission date (i.e., receive approval earlier than the first day of the quarter it was submitted), public notice, and tribal consultation to implement changes more quickly. The emergency template can be used to change many aspects of the Medicaid program on a temporary basis, including:

- Suspending premiums and cost sharing
- Adding or adjusting benefits
- Extending utilization of telehealth
- Increasing or altering payment rates and methodologies

The template also welcomes other amendments so long as they “do not restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.”⁸

While the State Plan HCBS Option (1915[i]), Self-Directed Personal Assistant Services (1915[j]) and Community First Choice (1915[k]) programs are traditionally implemented via a separate preprinted form, a state could likely explore integrating these options into an emergency amendment.

A state may consider this option if an approval date prior to the beginning of the quarter is needed, if an expedient approval is needed, or if the state is confident these changes are only needed for a limited, pandemic-related time period.

1135 AND 1115 WAIVERS

Many states have submitted an 1135 waiver, which allows a state to suspend prior authorization requirements, change provider requirements, or ease administrative burdens. Additionally, states are also seeking emergency 1115 waivers to increase provider payments for additional new or enhanced services (e.g., telehealth or transportation). These options may be used instead of a state plan amendment for changes states may wish to make to address COVID-19. Options under both of these waivers are discussed in further detail in Milliman’s “[Emergency Medicaid Waivers During the COVID-19 Pandemic](#)” paper, published on April 8, 2020.⁹

⁸ Medicaid. Medicaid Disaster Relief for the COVID-19 National Emergency: State Plan Amendment Instructions. Retrieved May 8, 2020, from <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-instructions.pdf>.

HCBS beyond COVID-19

Even as stay-at-home orders and self-quarantines begin to conclude in some areas, it is likely that many HCBS program participants will continue to be considered high-risk for contracting COVID-19 and may require ongoing enhancements to their HCBS service packages. If pandemic-related HCBS provider business closures are widespread, states may struggle to meet these heightened ongoing needs.

Robust planning for sufficient ongoing HCBS access now will be important to assure the availability of ongoing care needs and avoid higher-cost levels of care, both in the near future and beyond. States should consider whether policy changes are necessary to address the needs of individuals and providers, not just during the pandemic but beyond the date when the public health emergency is declared over. Rather than ending their COVID-19 policy changes all at once, states may also wish to develop more gradual, phased approaches to return their HCBS programs and benefit structures back to pre-COVID-19 operation levels, understanding that nonemergency Medicaid authorities may be needed in order to continue their emergency measures past the public health emergency end dates.

⁹ Wentworth, K. et al. (April 8, 2020). Emergency Medicaid Waivers During the COVID-19 Pandemic. Milliman White Paper. Retrieved May 8, 2020, from <https://us.milliman.com/en/insight/emergency-medicaid-waivers-during-the-covid19-pandemic>.



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