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NEC‑ACL/CMS Promising Practices Training Series: Ensuring Continuity of HCBS During the COVID‑19 Pandemic

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All right. Then I will go ahead and start with a few logistics. Hello and thank you to everyone for joining us for the ensuring continuity of home and community‑based services during the COVID‑19 pandemic webinar. My name is Stacy Flemming and I will be providing technical assistance.

My information is also in the discussion notes pod in the top right‑hand corner. You can find a downloadable version of today's slides in the presentation files pod also on the right‑hand side of the screen. Once you click on the files, then the download file button should light up. Please use the chat pod to ask questions at any time. All of the questions will be collected and addressed at the end of the presentation during the Q&A period.

This call has been globally muted to avoid background noise. The audio is available through either the dial‑in phone number or the Adobe platform. So I recommend if you're listening on the phone while also viewing the presentation through your computer, to make sure that your computer speakers are muted or else you may hear an echo. Please do not place this call on hold. If you need to step away, then please disconnect and rejoin as needed.

This webinar is being recorded for quality and training purposes. And with that, I will hand it off to Lisa Bothwell, the program analyst in the center for policy and evaluation with the administration for community living.

>> Lisa: Hello, everyone. My name is Lisa Bothwell, and today I'm speaking through an American Sign Language interpreter. I work at the HHS Administration for Community Living.

ACL has partnered with the Centers for Medicare and Medicaid Services in these monthly webinars on home and community‑based services, and we thank you for joining us today. Coronavirus has affected all of us. Including those who rely on long‑term services and supports.

It's my pleasure to introduce this esteemed panel of speakers who have been taking on HCBS during this challenging time.

Ralph Lollar, our first speaker, works with CMS. Ralph has been the director of the division of long‑term services and supports within the disabled and elderly program group for the last eight years. Prior to that, Ralph worked in the state of New Jersey for over 30 years. He started his work as a direct care staff in an institutional setting, and has experience as a case manager, investigator, regulatory liaison, waiver administrator, as well as a number of other roles in the field.

Our next speaker is Sharon Lewis. She is a principal with Health Management Associates. Prior to joining HMA in 2016, Sharon was one of the co‑founders of the Administration for Community Living, serving for six years in leadership roles at HHS. And prior to her time at HHS, she worked as a senior disability policy advisor for the U.S. House of Representatives Committee on Education and Labor.

After Sharon, our next presenter will be Mary Sowers. Currently serving as the Executive Director for the National Association of State Directors, Mary has been with the National Association of State Directors in Disability Services since 2014. Prior to joining NASDDDS, she held senior positions and provided consultation to state governments during her tenure with Mercer government human services consulting. Mary also led Maryland's HCBS and self‑direction efforts for individuals with intellectual and developmental disabilities in the late 1990s and early 2000s.

After Mary, we will have Kristin Ahrens. Her work since has spanned from developing and managing supported living programs and self‑directed brokerage and working as the policy director for Pennsylvania's University Center for Excellence and Developmental Disabilities. She is now the deputy secretary for the Office of Developmental Programs at the Pennsylvania department of human services. Next is Nicole Jorwic, and she is the senior director of public policy at The Arc.

Nicole previously served as senior policy advisor for the state of Illinois. Prior to that appointment, Nicole was the CEO and president at the institute of public policy for people with disabilities.

The next speaker will be Gabrielle Szarek, who is the director of transition services at St. Louis Arc. In this role, she effectively deploys supports in the area of education, employment, independent living, and social development. Gabrielle started as an intern with The Arc in 2012.

And rounding out our excellent panel is Lydia Missaelides. I apologize for mispronouncing the last name. After serving as Executive Director for California Association for Adult Day Services, she is now the Executive Director of Alliance for Leadership and Education. She is the ‑‑ long‑term services and support subcommittee for a master plan for aging. She also serves as secretary of the board for California aging and disability alliance, a nonprofit seeking to create broad‑based public long‑term services and supports, insurance programs for the middle class.

Okay. So with all that, I would like to turn it over to Ralph to get started.

>> Ralph: Hi, folks. This is Ralph, and thank you for that introduction, Lisa. I'm really privileged to be able to speak with you today. And I know this is an unprecedented time worldwide, not just nationwide. So let me tell you what we are doing right now with regard to the COVID‑19 pandemic and our work with the state.

I'm going to give you an update on the work that has been done up to Tuesday of this week, which was April 21, and seems like weeks ago, based on the amount of work that everybody is doing in the time frame we're working in.

We had approved 11 ‑‑ 52 1135 applications by state. We approved 35 appendix K for 195 (c) in the state. There were multiple applications for some states. We have approved 16 Medicaid ‑‑ we have provided funding in states for specific work.

[ Speaker is soft and often indiscernible ]

And we are working to process [ INDISCERNIBLE ], and respond to all of the other requests [ INDISCERNIBLE ] at this time for assistance.

So I just went through what we have approved. Let me talk to you about what they are and what they mean. I'm going to give you essentially a Cliff Notes version on each of those. Section 1135 ‑‑

>> Ralph, could I interrupt real quick? There are some individuals that are asking that you speak a little louder, please.

>> Ralph: Is this better? I'm going to wait. Folks, write in on the chat line if this is better. If it is, we will continue this way. Does this work for folks?

>> They say it's better. Yes, yes, yes. Great. Thank you.

>> Ralph: So let's talk about what do these authorities mean? The 1135 is what states use to waive regulatory requirements that are set in regulation and/or statute. Such as timelines and for instance, in HCBS, the settings requirement. As states move people into alternate settings to render HCBS services, according to the regulatory requirements, any new settings added to a waiver must come in fully compliant. The 1135 allows the state to waive that requirement and serve individuals in those types of settings.

The 1115 is used to address home and community‑based services and other options through demonstration. It has some of the components of the 1135, but it doesn't specifically waive regulatory requirements. But it allows states to demonstrate how, by adjusting some of those requirements, the state can successfully navigate an issue at this time, obviously the COVID‑19 pandemic.

With regard to appendix K, they can be used for two things. They permit temporary modifications to the 1915C and/or the 1115 with home and community‑based programs. But last for the duration of the disaster, or in this case, the pandemic. These are services and/or modifications that are normally permissible in a waiver, however, the state has elected not to incorporate them into the normal day‑by‑day operation of the waiver, but recognizes the usefulness of implementing or adding such options as this time. Because it is temporary in nature, and does not change long‑term, the requirements of the states‑based waiver, they are deemed not to be substantive changes as described in regulation, and therefore do not require the public notice process that would otherwise hamper the ability for states to react immediately to the crisis.

In this case, appendix K can be dated back to the date that the pandemic was announced as being present by the secretary, and that would be January 27 of this year. And they can be held in place for an entire year's duration. So that would be January 26 of 2021, or any timeframe in there that the state wishes to operationalize the appendix K.

The disaster relief SPAs address issues in the 1915 (i) application the 1915 (k) application or any provision of service that needs to be addressed this prevents time‑limited options that are similar to the appendix K, but for authorities that the appendix K cannot reach.

With regard to some of the flexibilities that are offered through and can be used in an appendix K and/or a disaster relief SPA, I think one of the principle or primary ones that we have seen a huge uptick on during this timeframe is tele help or remote monitoring and assistance as well as allowing for the addressing of electronic signatures. That's a critical need at this time due to quarantine orders and isolation requirements and our state‑at‑home orders.

So it allows services to be rendered remotely, specifically for individuals who require, for instance, personal assistance. But can be accomplished by verbal cueing. This is an excellent modality to render those services at this time. Because of the nature of the pandemic and the individual's life experience at this time, it does not hamper community integration to the same extent as others not receiving HCBS Medicaid services. So that's an important distinction that is significant for remote monitoring during this timeframe.

Electronic signatures are ‑‑ have always been an option for states. Some states are using appendixes and/or disaster relief SPAs to declare their intent to use electronic services and that certainly is acceptable.

And in some cases, telehealth services or remote services for assessments are not necessarily required to enter in during a SPA, because there is nothing prohibitive in the regulation that would not permit that type of service delivery system, unless the state has expressly said they would not do it that way in an application. For instance, the 1915 (i) does allow for face to face to be accomplished remotely. And unless the state expressly eliminated that option in the 1915 (i), they would not need to amend to include it.

One of the most popular flexibilities that we've seen is the use of retainer payments. There has been a huge uptick in all of the appendix K that we have approved to date, retainer payments are a significant part of the real estate in the application. So what the retainer payments mean, what they cover, and what are the limitations or allowances?

Retainer payments are covered under Olmstead III, which is the SMD letter published in 2000. And there are two specific conditions. One is that they can only be permitted for habilitation services that include a component of personal assistance and care. The retainer time limit may not exceed the lesser of 30 con sec tiff days or the number of days for which the state authorizes a payment for bed hold in nursing facilities. I say simultaneously where we have worked with states where they have defined multiple amounts of bed holds. For instance, we had a state that had 15 days for, I belief, hospital stays. And seven days for visits home. And that gave a cumulative of 22 days that were not mutually exclusive. So states should look at their language to determine just how broad they have made that option available in their state.

I want to note here that there is in the appendix K, the ability to allow for services, particularly and importantly, personal assistance services, that include, for instance, communication skills that a personal assistance has developed with the individual that would assist with the hospital in rendering services and/or behavioral intervention services. Those services that are not otherwise available in the hospital can be funded this way. It applies, the section 1375 of the CARES act applies to home and community‑based services in acute care hospitals. And those services can be rendered through a 1915C, D, I, J, K, or section 1115. So it pretty much cuts a swath of services that are home and community‑based in nature. And the services must be identified in the individual's person‑centered plan. They must be provided to meet the needs of the individual that are not met through the provision of hospital services. They cannot substitute for services that a hospital is obligated to provide. And they should be designed to smooth transitions between the acute care setting and home and community‑based settings. You can put those directly into your appendix K application.

The application with regard to the 1915 (i) and (k). The difference now is that the limitation of 30 days is lifted, so if the state is going to limit the amount of funding that is available for those services, the state would have to designate those limitations in the application. I need to emphasize here that time frames for any of these authorities such as the appendix or tools that you see appendix K or the 1115 or the SPA are not time limited, in that you can modify and get approval for an additional appendix K. State may have submitted an appendix K early on with services that they thought they needed and changes they thought they needed. But as they continued to work, they realize that there were areas that they didn't look to that they need to request aid in. The state can submit another appendix K, because they can be approved retro speculative in nature. They can go back to the date the first K was approved and/or any timeframe between the two.

And CMS will review and consider and approve as we absolutely can. So nothing is one and done. I can tell you that we often will look at something and if it is on the face of it not approvable, we speak with the state to ensure we understand their intent. Because often there are ways to get to the intent and meet the needs of the state and the individuals being served in another manner. We have had quite some success in working with states on that.

So I wanted to give you the flavor of what we're doing at CMS. And in doing so, I hope you also hear the amount of work that each state is going through to meet the needs of the individuals who require services across so many different service authorizations and applications. Everybody is working daily on this, and probably the most fortunate thing I can say to you today is that nothing is a one and done. So the ability to come in and amend and/or broaden your options is available and people should really consider that as they are moving forward, because you shouldn't delay in asking for something based on the fact that you don't know the totality of what you need. Get what you need now and add in the future.

So with that said, I'm not going to take up any more of your time, but what I'm going to do is introduce a colleague and friend, Sharon Lewis from health Management Associates. She's going to talk to you about states' responses to the COVID‑19 pandemic. Sharon? While Sharon is coming online, I would like to say that we will have questions and answers at the end, and we will all be present to address that. Sharon, are you on the line?

>> Sharon: I am here. Did that work this time? Can you guys hear me? Thank you, Ralph. And I appreciate everyone's time today. And I wanted to reiterate something that Ralph just said, which is CMS has been incredible in terms of turning around. States have been submitting them and CMS has been incredibly responsive especially in terms of the Appendix K. We have seen that occurring, so thank you Ralph, to you and your team and everyone at CMS for working with everyone.

I'm going to talk about the themes and some of the things that we're seeing in terms of the state responses that Ralph mentioned. You know, as this pandemic has unfolded, we have been able to see the strengths and weaknesses. It's been terrific to see so many people working together. To identify the flexibilities that they need, move quickly, and find those solutions. It's been really encouraging as well to see the number of states that have taken a cross‑disability approach. While many of the appendix Ks address specific element s of individual waivers. We are also seeing a lot of commonalities across different populations, different services, and consistency that is clearly meant that various operational agency and the state Medicaid agencies have been working hard together to come up with the best solutions.

I also wanted to reflect on one thing that Ralph talked about, which is the implementation of the CARES act opportunity to have home and community‑based services come into the hospital. While we're seeing many states pursuing that flexibility in their waivers, the challenge that we're hearing from people on the ground is that the current hospital policy situation that prohibits visitors from participating when someone is hospitalized is getting in the way. So it's not just the payment policy that folks need to be looking at the state level, but also how is the state implementing visitor policy and visitor restrictions? And whether the need to have communication or behavior support while or intensive personal care support that a hospital may not be able to provide when somebody is hospitalized on an in‑patient basis needs to be considered. For those of you who are interested, New York has actually put out a great policy related to that hospital visitor issue, and that's worth looking at.

So in terms of the common themes that we're seeing, these are related to the appendix K. And Ralph talked about the different authorities that states are using, and again, there are flexibilities that states are coming in and requesting through the 1115 and the disaster SPAs. Many states are waiving co‑payments and cost sharing elements. There have been several states that have included protecting people who are in ticket to work programs and buy‑in programs to insure that their cost‑sharing is not currently in effect. So there are many things that are interesting in the other waivers, but today I will be mostly focusing on the Appendix K.

States have, really across the board, addressed the need for case management. Being able to be delivered to a telehealth mechanism. Ensuring level of care assessments and day to day case management activities can occur remotely. We have seen that across the board, and the opportunity to maintain access and continuity of care.

As Ralph mentioned, everyone is doing some kind of tell health, primarily most states have case management in there and many states have also addressed direct services.

Trying to ensure that we have a work force that is strong and standing after this pandemic is over. Including things like allowing family members and legally responsible individuals to be paid as providers. There has been a tremendous amount of flexibility requested in states around the settings that may come in in 1135. And another thing that is really important for everyone to note is that all of these requests that are coming into CMS are exactly that. They are asks for flexibilities that are allowed. It does not necessarily mean that everything that a state requested is being implemented. So as we have started to look at retention payments and changes to rates and some of the flexibilities, states have built the flexibilities in a way that they can use the tools if they need them. But it is not assured that these flexibilities and tools are currently being implemented in every state. The other thing that I think is really important to note is we're talking about the flexibilities; this is literally in the flexibilities and not what is in the underlying waivers. When we're talking about the things that the states are doing, it doesn't necessarily mean that a state ‑‑ another state is not implementing that flexibility. So for example, there have not been a tremendous number of states that have increased their use of self‑direction as part of the flexibilities in their appendix K. But we think that part of that is because that many states already have very strong authorities existing in their current HCBS waivers and/or in their state plans that support self‑direction, and they didn't need to request those flexibilities.

I will talk about the three buckets or approaches we have seen across states. And the speakers who follow me will get into more specifics. Next slide, please.

HIPAA guidance has really opened up how we can use technology, allow people to use common devices such as Skype or face time or zoom calls, allowing people to participate in services or engage with systems telephonically. The opportunity to use e‑mail as a way to respond and affirm things that are happening. All of the flexibilities these are taking advantage of. Many states are delivering their direct services remotely. That includes the case management pieces. But then also direct services. We have seen states delivering personal care and/or in‑home habilitation. That is now a simple check box on the appendix K for states to select that. Now again, that doesn't mean there are not more states that are doing it, but in terms of the states that have put that in their appendix K.

We are seeing states focus on making sure people have access to the assistive technology that they need and trying to find ways to streamline that.

In terms of expanding the home and community‑based services work force, states are doing everything they can to try and be flexible in supporting workers. A lot of states have reduced their screening requirements or delaying training requirements or allowing training to occur online. When a provider has challenges with a certification or licensing that is going to expire, they are expanding renewal periods and allowing automatic extensions. And then giving themselves some flexibilities around being able to redeploy or move staff around and continue to support people where they need. That includes many states adding the ability to ‑‑ for families to be ‑‑ to serve as paid providers, including legally responsible individuals, which may include spouses or parents of minor children. As well as Utah has looked at what are community based options.

Home‑delivered meals, transportation, or being able to purchase specialized medical equipment and assistive technology. And finally, the other approach we have seen is how do states enhance their payment policy in order to ensure that continuity in the home and community‑based services? As Ralph mentioned, we are seeing a tremendous number of states pursuing those retention payments.

We have seen a few states include retention payments, less so than some of the other flexibility. As long as that worker is continuing to work 20 hours a week. Anywhere from ‑‑ on top of their normal pay, tiered against their hours and whether or not they are working with people who have been confirmed to have COVID. They are actually implementing this policy. Not just the flexibility that they have requested. So with that, that is a quick run‑through of many of the things that we're seeing across the states and next slide, please. I am happy to take questions at the end. And then we're going to have a little bit of time to follow up. I'm pleased to turn it over to my colleague and friend, Mary.

>> Thank you so much. It's a pleasure to be with all of you today. I would like to start out the conversation with an echoing of thanks to CMS for their steadfast work and really quick turn around on policies and working collaboratively with states. I think, in my whole career, I have not been prouder to be associated with them. With heartfelt gratitude, I offer these comments. The goals for today, and I will be swift. But really to put a little color to the state design decisions that Sharon highlighted, and Ralph described, identified in deeper detail the strategies for case management and health and welfare that states have been employing during these most unusual circumstances. And importantly, some of the approaches to engaging the stakeholders that have been most beneficial to individuals and families to understand the thought processes and keeping the providers in the loop as well.

And operational considerations that really need to be tended to that tend to be in the weeds. And finally,.

>> States are operating where top priority is to keep individuals healthy and safe during the pandemic. They are also trying to ensure that individuals with disabilities have equal access to health care and just a quick shoutout to OCR's guidance on ensuring that individuals are not experiencing discrimination in health care settings. And finally with an eye towards not only ensuring that there are sufficient providers available today, that they are really ensuring that there's an opportunity for the work force to continue moving on.

And so, many states have included DSPs as part of the essential work force in the governor's declarations. But it's been spotty in terms of access to PPE and their availability for other aspects of the health care system. There are certainly states that have included in recognizing the importance of paying staff for hazard pay while Sharon mentioned Arkansas, there are a number of other states that have recognized the importance as they have been supporting individuals, both who have been exposed and those who may have been.

Expanding the pool of providers really, tapping into some less traditional provider pools during this time, but hopefully also to lay pavers. And of course the use of retainer payments. And thinking about the real important lattice of the CMS Medicaid authorities, how to leverage most effectively the authorities that Ralph described with the 1135.

The next slide, please? As we talked about already, the challenges that are inherent at this time that have really driven state decision making that you see manifested are the interest in making sure there are sufficient ‑‑ there seems to be an ongoing challenge with no sure remedy availability of PPE across the service delivery systems, the availability of testing to understand what the exposure being within the home and community base and institutional settings as well as the availability of technology for individuals supported in the providers that support them. We have recognized that there has been a tremendous and exponential growth in the use of technology for the delivery of supports and services and the way in which our states are engaging in supporting individuals with health and welfare. But it is laid bare that not everyone has equal access to technology. States are wrestling with how to ensure the access.

States are also recognizing their own opportunities or challenges with information technology and how they must really think about that differently. And finally looming large in all of our minds is the challenge of keeping folks safe and the difficulty of social distancing in congregating environments.

It is important to really think about all of the things around it. The need for the medical systems both to have access to medical care and also to have care available to individuals when they might leave the hospital and thinking about the post COVID considerations about insuring infrastructure for long‑term support. And thinking about both the opportunities and challenges of defining what normal means after this period.

Next slide.

So there are some ‑‑ one of the things I was hoping to do is just do some ‑‑ and this will not be an exhaustive list of states that have done wonderful and creative things during this time in terms of different strategies to assure health and welfare. So we know there has been use of technology for the delivery of services, but there's also been an increased use in the use of technology to make sure people are healthy and safe. That might take the form of remote check‑ins by case managers and amped up communication between individuals and families and case managers and providers. And we have seen Washington and Missouri really think about strategies to have really pointed questions and use of technology in ways that is extraordinarily effective. You will hear from my colleague in a moment, but Pennsylvania has also instituted wellness and safety check‑ins of folks who might live alone or with families as well as parts of the service delivery system, and parts of the tools has given folks an opportunity window into those pieces.

There are issues on how to support individuals who might not be able to receive visitors and having folks understand what the containment and safety measures mean for their day‑to‑day activities. And we recognize that individuals, frankly, in all aspects of our society, that individuals supported in our service systems also have experienced some trauma with regard to the whole COVID experience, and recognizing that individuals might need mental health support during this time, both from the isolation that might entail or even just being relegate ed to one location.

So these are one of the other areas that our states have wrestled with is making sure they've got appropriate places for individuals who might be recovering from COVID to return to after a hospital stay. And that there are challenges with capacity and identifying those strategies for both isolating and quarantine when the virus is presumed or confirmed. And we've got states doing and evolving an interesting approach with reporting data on virus activity, confirmed individuals who have been hospitalized and unfortunately, folks who are deceased. And trying to gather information in realtime around staffing availability.

Next slide. So one of the things ‑‑ and our association works with states agencies. And we have had the wonderful bird's eye view to be able to identify those best practices that are emerging in terms of engaging with the stakeholders during this time. But frankly, they are good strategies to employ in non‑emergent times as well. We're seeing states have very strong conversations early in the processes. They are developing their decisions that they're frequently speaking with stakeholders. They're providing timely information that's both thorough but also easy to understand. And we are recognizing a number of states who have really embedded this process as a matter of routine in all of their work. Next slide.

So we have got really great, and again this isn't an exhaustive list. But just wanted to do a quick list of those states that have done really creative and wonderful things. We have seen extraordinary partnerships emerge during this time. Leveraging existing partnerships and great working relationships and in some instances building new ones. But some states have had great success with partnering with their councils and disability rights and other advocacy organizations. Washington comes to mind. We know that Georgia has had great success with their disability rights partner. We have seen really strong practices in identifying innovation during this time. So having the where with all to spot the innovations that are emerging and try to translate them to scalable or at least replicable activities. Connecticut has been publishing innovation. We see multimedia approaches to make sure that individuals receiving supports and their families have a strong understanding of different aspects of that. Many of you have probably already seen Oregon's online video that has really been tremendous in educating individuals about COVID.

As well as Missouri has a strategy where they're sharing stories from the field and really trying to identify those strong practices, those innovations, those heroes that are working among us daily to try to really amplify the good that is occurring during this time, even though there are many challenges afoot.

And finally, we have seen many of our states who participate in supporting families community of practice use that framework to really help shape communication s, for instance, for families in Ohio. There are many other examples along those lines.

>> Mary, just to let you know, we're at time.

>> Oh, got it.

>> Yeah.

>> So it just, suffice it to say, there are many wonderful things happening and I'm happy to answer questions for sure.

All right.

>> This is Kristin Ahrens. I will talk a little about some of the strategies that we have used for mitigation and in terms of response. So, I don't want to spend a lot of time on the mitigation piece, just because I feel like at this point in the pandemic, people are probably quite familiar with the mitigation efforts and the strategies that are being used. So I'll kind of breeze through this, but I think some of these are relevant when we start talking about recovery or reintegration of activities. One of the things to acknowledge, and in Pennsylvania we're certainly seeing this and we're seeing this across the country is that the greater the congregation, the greater the risk. So, everything from, you know, we've got lots of one to four person community homes in our HBS system to our intermediate care facilities that range from four up to over 100 people, that the people in the facilities are just at a tremendous risk because of the congregation and the dependence on care and the type of co‑morbidities that they tend to have. So, you know, as we look forward in terms of continuing to mitigation and respond to COVID‑19, it just means that we have to have that extremely high level of vigilance. And this won't change as we get further into the recovery.

So in terms of, you know, the sort of keys to the mitigation strategy, for us in our system, applying this to our residential program, we've ‑‑ we have largely applied the long‑term care facility guidance to our community homes. Of course our community homes fall somewhere, often somewhere between the kind of guidance that is very individuals in private homes and long‑term care facility. But the pieces that I think are particularly relevant are the piece around visitation and the pieces around staff screening, all of that guidance.

So implemented that across a community system. We have put into place the flexibilities using appendix K, making adjustments to our state regulations to allow for individual relocations that support that mitigation effort. So everything from, you know, a good example is a provider community home, three individuals, one younger who worked in a grocery store, so sort of a high‑risk occupation right now. Living with a couple of people that were over the age of 50, both had co‑morbidities that would make them more vulnerable to COVID infection. So that the provider relocated that person to an apartment and was supporting them there so they could continue their work, which is very important to them. A number of individuals who have decided they are ‑‑ have gone back with their family of Oregon and are living with family during this time period. And supporting that through our policies continued eligibility for the waiver, and maintaining their spot in the community home for when this is ‑‑ the risk is down, and they can come back.

Like other states, closing down the day program, discontinued one of the keystones of our program, which is all aimed at community integration. Discontinued those types of activities and then as other states did, wherever we could expand the remote and tele support, expanded that to the types of services that were possible to continue the availability of supporting people.

In terms of ‑‑ on that, that's a mitigation side. On the readiness side and the response side, we start seeing infections, making sure that providers are ready for that, making sure that individual families are ready for that. We have implemented a number of things. And put together, again, geared for our community providers, put together guidance that we went through with them that is a readiness assessment. This is everything from what are the ‑‑ what the PPE supplies do you have? What are the contingency plans for if you have an individual who becomes ill? How are you doing quarantine? How are you doing isolation? If you have a significant number of direct support professionals who are unable to come to work because they have a positive test result, what are the contingency plans around staffing?

So walking through those types of items, making sure that medical information, the quick support guide that people are going need if they are relocated, if they are in a hospital setting, if they are in an alternative care setting, what do they need? What is quick to grab and ready to go with them? Working with individual families to have those types of resources to make sure that they have the knowledge and ability to have that preparedness. And then at that provider level, we have ‑‑ our program is administered through we delegate a number of our waiver authorities to administrative entities which are counties. They do weekly calls with our providers to go through all of those preparedness activities. They also, when we have a provider that has a suspected positive case, staff or individual, we intervene again at that point with our county and our administrative entity partners. We have separate checklists to go through the things we need to make sure we have in place so the provider can respond to support that individual. And we make sure question ear ‑‑ we're containing infection as much as possible. When we have positive cases, making sure that we coordinate with local emergency management and system partners have been key

So the flexibility to respond, I have mentioned. We did submit an appendix K and we are working on another appendix K as this pandemic continues to evolve and evolve quickly. Trying to stay one step ahead, knowing the types of flexibilities are necessary at each stage. A lot of the flexibility that we look for in our K was aimed at flexibility around workforce. As we close down our day program, our day services, which in Pennsylvania we call community participation support, we made it very clear we did do retainers for those providers and made it very clear that we needed that workforce to be redeploy ed where they would be needed and that is in residential programs and individual and family homes. We have in Pennsylvania, like many states, has significant waiting list for our IDD population. And that waiting list, we have about 2400 care givers that are over the age of 60 knowing we may have family care givers who may become ill, we are going to be able to quickly deploy staff to support people in their homes. Or we are going to need emergency respite. So trying to keep the workforce that isn't working now because we have discontinued the community integration type activities, making sure we keep those experience and trained staff in the workforce where they are needed most to respond to this. The expanded service type that community participation support was not previously available in private homes.

This is another one where these providers have relationships with individuals and families, sometimes multi‑year and sometimes decade relationships. We work with the families to try to support some activities in the home. Be available if they do need that service in the home.

Like many states we expanded the types of services allowed by relatives both in the type and scope, how much of those services they could be providing. And then allow that movement within the system to where they are needed most. Did a number of modifications to our training requirement s and staffing requirements.

Other things that we knew we would need, and this is all panning out as the pandemic is unfolding in Pennsylvania. There are very few of these flexibilities we haven't used. Expanding where the HCBS can be provided. So modifying the size of homes that was previously allowable under our waiver agreements and our own regulations. Allowing the residential services to be provided in hotels when we need quarantine or isolation sites. Allowing it to be provided in private homes. This is still pending. Using adult training facilities or vacant ICF space for alternative care if we need that in terms of quarantine or isolation space. We have two of our waivers with annual caps for COVID. We have lifted those caps if that is needed in terms of emergency services to respond. Lastly about oversight of the program. We have been playing around with doing remote onsite inspection for our licensing. We had been using that just to validate our plan of corrections. We have had some complaints come in, and we have used remote technology to do those inspections. Continuing to do that, but looking to expand that for our annual inspection s as this pandemic seems like it will continue for some time.

As Mary Sowers mentioned, one of the other things that we have been focused on here in Pennsylvania is wellness. Just recognizing how tremendously disruptive this has been for people's lives. How isolated individuals and families are, how complete change of routine and ritual is very difficult. We developed a wellness monitoring tool that we worked with to support coordinators to develop. We have asked them to be connecting that weekly. We have a number of adults particularly with autism that live on their own. Trying to pay some special attention there. Have pushed our community participation support providers to offer remote services to be working with individuals and families to be doing some kind of structured activities during the day and deliver that remotely. So making sure that families or individuals that are struggling to cope with this level of change have the additional support they need and that being done remotely.

We have developed, like other states, many resources for individuals and families to help everything. We've got social stories that explain social distancing, social stories and graphic support to help people understand proper hand washing, all of that. That's going to be very necessary going forward, too. We worked with our partner office to launch a warm line. And folks there have good experience with IDD as well.

Very quickly, because I think my time is coming to a close here, too. Just a couple of points about the post surge, or when we start lifting the state at home orders. I know as much as everyone is eager for this, the risk to our population does not change. Frankly, in some ways, may make our population even at greater risk. So some of the things I just ‑‑ I can't emphasize the importance of enough is testing. The community system, every person we have that is suspect ed COVID or tests positive, we use quarantine. It means isolation for 14 days, which means different staffing, which potentially means relocation of people. Phenomenally disruptive to the system. Rapid testing can resolve many of the issues more quickly and will be key to stabilization. The other thing in Pennsylvania that we will be implementing as we lift the stay‑at‑home orders, because the risk doesn't change for our population is looking at we're building out some tool kit guidance for individual plan ‑‑ planning at the individual level. Is it someone who will struggle to wear a mask because of sensory issues? Is it someone who doesn't understand social distancing and will have trouble complying with that out in public? What are the risks because of their own co‑morbidities? Are there risks associated with their preferred activities? And developing a plan? What is the plan for that person? What skills can they learn and what support do they need to help get through this time period until we are at the other end of the pandemic.

And the last thing, and this was mentioned by previous speakers, too. No answers to this. We are just starting to wrap our heads around what this might look like. But arranging the system around trauma‑informed care. The level of trauma that will and is being experienced through this time period is something that we're going to have to think through at a very systems level to try to address. So those are some of the things that we are looking at working on next. And appreciate the time to present. Thank you.

>> Nicole Jorwic: I'm the senior director of public policy for The Arc and I work a lot with our state chapters. I will talk about what our chapter network is, what I'm hearing from our chapter network. And I'm very excited to have folks hear directly from one of our chapters about their initiatives. We know obviously from all the conversations and all the previous speakers that people with disabilities are ‑‑ face high risk because of the COVID‑19 pandemic. We also know that the need to social distance is creating new challenges for people with disabilities for the direct support work force when it comes to access to those services. And also a family member I understand the challenges that families are going through as well as the struggle of providers to transition. We see job losses and furloughs and downsizing. There are people with disabilities facing service disruptions.

Providers are doing great work to support individuals virtually and in a variety of ways. First we have to talk about the reality on the ground. This is leading to higher turnover. I can't tell you how many stories I hear about the heroic things that direct support professionals are doing, things from quarantining with individuals who are impacted.

But if they don't have access to PPE, personal protective equipment, they are putting themselves at risk and also they are continuing to come into the home. We have heard of several instances of also the work force being a carrier. So we have to be conscientious of making sure that for the health and safety of staff and individuals that access to PPE is there. I also know that I'm hearing from chapters all over about the ‑‑ about direct support professionals. Generally about health and safety. We know also that family members have always been an unpaid work force, and it's never more true than right now. It has been discussed about moving staff between settings, and that is something that we are hearing a lot about, whether it's moving someone from a day program. But obviously that won't work in every scenario. And it won't work in some cases without additional training and that has to be a consideration. Not every support can be done virtually or from six feet away.

We are seeing chapters be really innovative with what can be done. We are not obviously just talking about accessibility by having accessibility.

The right type of applications to support an individual, which are going to vary and differ and also staff training on the programs. We have heard ‑‑ obviously zoom has become widely used. That's an expensive tool. So there have been a lot of grant programs and other funding that our chapters are able to connect with in order to access the software. But everyone has to be able to use it including individuals with disabilities.

[ INDISCERNIBLE ]. Access to Wi‑Fi or internet is also very important. I have heard of trouble getting access to that.

I have also heard stories of individuals who have Wi‑Fi and have been paying for it for years but never knew they had access. I guess there is a small silver lining is finding out you have a service you didn't know you had.

Chapters and [ INDISCERNIBLE ] have been ‑‑

[ Background noise ]

To keep individuals safe ‑‑ not safe, but busy and occupied with their time. Chapters have partnered with, as I said, some grant funding, but also partnering with local university center to collect iPads. I know that's happening in Pennsylvania. We are seeing opportunities among the chaos. There are opportunities for things like engaging with younger families. Not every provider might have interaction with younger individuals until they enter the adult service system. With these wild times, it leaves room for those connections to be made to support families that are not necessarily in the system, but to see what types of services can be provided. Retainer payments have helped keep programs from permanently closing. But we have to think strategically of what the new normal will look like.

We have chapters that are looking at the opportunities to support families and be flexible with creative one‑on‑one support. We have seen growth in respite services, but again, that's dependent on individuals come into ‑‑ in and out of the home. So that ‑‑ hopefully we will see it grow.

All in all, disability service providers are being challenged to build [ INDISCERNIBLE ] on the tracks while the train is moving. Home and community based services to support innovative programming. And also we will have to start thinking about what the post COVID world is going to look like.

After all of this is over, we hope to see the service innovations at work, given the opportunity to scale and to see how the services from [ INDISCERNIBLE ] can benefit from [ INDISCERNIBLE ] during this crisis. And I think that that's what our chapter network is really trying to focus on. We know that as states are going to be re‑opening that there are specific and critical components of that that are going to directly impact the disability community, not only from a health and safety perspective, but also ‑‑ just as with relief packages, people with disabilities need to be thought of just as is true with recovery.

At this point, I will turn it over to Gabrielle to talk about one program that shows great potential and is already showing great success in Missouri. Thank you for your time.

>> Gabrielle: Good afternoon. A little about our chapter. We are a very large agency. We support about 4,000 individuals any given year in a variety of different service areas. So everything from children services through respite and family support. We have a lot of leisure and recreation programs supported employment, day programs, residential houses. So a lot of service areas across our entire agency. So today I want to speak about the programs that we have been offering for teens and young adults. I oversee our transition services department. And we successfully have moved 100% of our programming to a virtual platform. With some of these ideas, I hope that it can be things that you can alter to use in some of your programs. I also want to recognize that I know with everything going on that there are so many different resources and activities out there. So these are just a few ideas to spark creativity. As an agency, I wanted to highlight some things. A huge part of this is recognizing that we're all in this together.

Like I mentioned, we are a very large agency. But there's a lot of things that we have done as an agency from the very beginning. We're in St. Louis, Missouri. We are in our sixth week of offering virtual support.

One thing our executive director implemented from the very beginning was a meeting. We meet currently three times a week. It's a 30 minute meeting. It's a great opportunity to see what is going well, if there are any challenges arising and keeping everybody informed. It's amazing that sitting in the check‑in meetings, how much that has impacted just the support from the departments. The collaboration has increased. We are sewing so many positive outcomes from starting that from the beginning. I will be talking about our launch program. And we have increased our staff meeting to, we're meeting about every other week. Just having that time to make sure that everybody is doing well, having what they need to provide these virtual support and then we have implemented a lot of things to make sure that we're constantly sharing ideas and resources. We have a SharePoint site, and on that we have a calendar that notes all of the virtual offerings that are being offered week on week. Those are outside of what we're doing in residential and day programs. We have broken it up into each of the life areas. We save ideas and resources in those folders. So anybody in our agency can access those.

There is also a group of seven or eight of us directors who meet weekly to collaborate. So while we may be doing different program areas or supporting individuals with different means ‑‑ sorry. The chat thing is going in and out. That is a great time to ‑‑ that isn't a great time to collaborate with other departments. It is interesting how when, you know, another department that they might be supporting individuals with higher support needs or different support needs and just hearing ideas from each other, sometimes having an outside perspective, it has really sparked a lot for people to be able to collaborate. And then also among the departments, we have been shadowing each other for different virtual support. Because while, you know, recognizing that each person when they're providing virtual support, everybody department has their own tools. And every facilitator and teacher that's presenting, everybody does things differently.

So we have been maximizing what we can learn from each other.

So a few different initiatives that we have been working on. The launch program. We have different events called bounce forward. So I will be talking about those, too, and giving examples of what we have been doing virtually. In addition, we offer a lot of different family workshops. We have a whole family support group. It's a twist on a support group. And we partner with the University of Missouri St. Louis. It's a post-secondary program for young adults with disabilities. We work on different social skills and building those up. So all of those initiatives have now moved to virtual platforms. Our program is designed for 16 to 25‑year‑olds as they are graduating from high school and into the real world. Pursuing some type of post-secondary program. This is a newer program. We just started it in June of 2019. It is private pay, so I wanted to note that. It made it easier, so this is one of the first programs at our agency that we moved 100% virtual.

That allowed us to be able to see what were the pros and cons of that and relate it to other areas as we got everything up and running virtually. So this program is a combination of individual coaching sessions and group classes. We also offer a dozen group classes each month where individuals can work on everything from money management skills to how to have a conversation and different social skills, really just a variety of different offerings. We work on a lot of independent living skills and employment.

And since we have gone virtual, in addition to offering the individual group, we have implemented something called daily boost. So recognizing how COVID‑19 has made an impact on our entire world, we wanted to recognize that there are a lot of individuals who struggle with mental health. So recognizing how scary this time can be. And it's such an unknown to everybody. We started the daily boost. It's just two to three times a week of added bonus opportunity for individuals to log on for 20 to 30 minutes and engage in something positive and fun. So we have done everything from having in‑home scavenger hunts. Last week one was about practicing gratitude and how that can bring a lot of positivity.

We had to do a quick turnaround. Our whole agency has been using the Zoom platform. It has worked really well for us. Before we went virtual, there were a lot of priorities that we had to make sure we were keeping in line before we implemented anything. But really keeping goals a priority. Making sure that individuals and families are happy. We didn't want to lose sight of what our overall vision or goal was. Gaining feedback throughout the whole experience and finding ways to keep everybody engaged, motivated, and positive. We had a family feud. We did a virtual escape room. And then gratitude and positive thinking. We have done extra training with transition advisors, too, to make sure they all understood how to use the Zoom platform and had a good handle on using that technology. And then our group classes, when we offer those in person, they are typically a lot of hands‑on activities and discussions. So that was quite a process. So here is an example of the scavenger hunt that we have done. It's a lot of fun. Things you can find around your house. It has gotten pretty competitive. We turned into a tournament.

So that's been a fun idea. We have also done that for some of our bounce forward events. This is an example of an escape room that we offered. There are all of these different codes. They only got so many hints. We got to work together as a group to figure out different codes to get through. Here is a picture for one of our team meetings. For an ice breaker, we did a unique ice breaker where each advisor had to take a turn in describing a picture to the rest of the group. And so, when they had to describe that, the rest of the group had to draw it. And then we, after that, we then related that to how virtual support ‑‑ how you have to describe so much more when you're doing the support. It is a reminder that when I'm asking somebody in person, they might not understand exactly what I mean. So using everything that we can through video technology and also by describing and making sure that people understand what we're talking about. So that was a fun ice breaker.

Next up is a couple of examples we used for bounce forward. These are opportunities for teens, young adults, and their families to get together to encourage individuals to start making plans for their future. In person, we usually offer events such as a BBQ in the park. Moving this to a virtual platform has been different, but positive. We have offered what to do at home. It was about a week and a half after we started. It gave all different types of ideas and ways to stay positive, active, and engaged. So it was more of a workshop setting. We did a scavenger hunt with this group. We have a trivia night coming up. We are having guest speakers from five different areas talk about what their jobs are, what experience they needed, to giving individuals that are working towards getting a job that opportunity to hear from a variety of different careers. We have a Facebook group to share resources and events going on in the area.

Real quick. I know I'm getting at time. I want to give you examples. This is from our “What to do at home” workshop that we offered. Each area had its own topic and things to do at home. Ways to stay positive. Things to engage in. Really gave a lot of good ideas. We will be offering this in a free family workshop coming up next week as well.

So that is the end. I would be happy to answer any questions. So, feel free to ask. Here is my contact information if anybody would like to ask any questions. Next up, I will pass it on to Lydia.

>> Lydia: Hi, everyone. Thank you for the opportunity to share our realtime experience in California responding to the coronavirus public health emergency. And I want to express my thanks to all of you in the field who are on the call today working hard each day to support older adults and people with disabilities during this incredibly unique time that we're experiencing.

So I'm going to describe to you our rapid response redeployment of adult day health care in California. I want to start by saying we have two models of adult day programs. I'm going to focus on adult day programs. They are regulated differently. And talk about ADHC today, which is a Medicaid reimbursable service under our 1115 waiver. We are going to talk about the redesign of that program. It's been an incredible experience. I think most of you know that adult day services are not defined under federal law. While there are many common design elements across our state, there's a great deal of variation of how it is designed, regulated, paid for, including private pay. Veteran's administration, area agencies on aging, and of course Medicaid under either a 1915 (c) state plan or a 1915 waiver. You heard Ralph talk about those earlier.

This describes the services we have designed as part of the adult day health care what we call under Medicaid here, the CBAS program. It is important to point out that adult day health care compared to adult day programs in our state is a licensed health facility. At its heart there's an interdisciplinary team comprised of the services you see on the slide. The Medi‑Cal is now called CBAS.

So the core services are nursing, social work, personal care, therapeutic and person‑centered activities and congregate meals. Since 2012, individuals have to be enrolled in Medi‑Cal managed care to receive services. This authorizes a person‑centered plan of care and authorizes the number of days of attendance. And these are the core services that someone can be expected to receive each day of attendance.

We have other clinical services available based on their IPC, individual plan of care. You can see here, physical therapy, occupational therapy, speech therapy, behavioral health, special diet orders from physician, and transportation to and from the center.

Participants have to be enrolled in one of the managed care programs. We are currently serving approximately 23,000 participants in 22 centers. Average age is around 75. About 40% live alone. Roughly the same have a dementia diagnosis. And there's a great deal of diversity in language culture and race reflecting our California neighborhoods.

March 15, our governor ordered that no more than 10 people could gather together in any public place. That was our first clue something was coming. By March 19, only four days later, the governor ordered a shelter in place for the entire state of California. That meant centers could no longer bring people in for regular center services. So centers immediately went into emergency operation mode, cancelling transportation and calling families that could not come to the center, but to sit tight for further communication. We were going to figure out how to continue to serve these individuals during this crisis.

By March 21, at lightning speed I have never seen government move at before, the governor asked CMS for flexibility to operate adult day health care as a temporary alternative service platform, and we began planning with our state partners what this model looks like in this time of COVID‑19.

And in the meantime, since March 21, multiple guidance letters have emerged and been implemented across the state, both to our managed care partners and to the centers.

The driving force behind all of our efforts have been safety. Family and staff. The rapid response to COVID‑19 has required an incredible partnership between adult day services leadership and our entire network for our state department, 22 managed care partners to make this quick pivot to a different way of delivering adult day health care services. All of this is done while keeping intact the poor of our adult day health care program philosophy, teamwork, and our ability to deeply connect to the participants and their care givers' living situation, physical and mental health status.

All the while with staff and participants sheltering in place. I am extremely proud of how our state and provider community participants have risen to this challenge. It's been the most amazing experience of my 35 year career. The charge from the governor has been clear to maintain the infrastructure, continue to surveil participants to avoid the need for them to go to the emergency department and hospital as much as possible given their chronic condition. And keep reimbursement flowing. So the state in partnership with all of us have created a structure call ed ‑‑ a center without walls, using the strength of the team‑based model and the deep trust that exists among the participants and staff for each other, the centers are organizing themselves into a different way of providing services during this extraordinary emergency.

We are building and implementing a strength‑based model using these different modalities: Telehealth, doorstep delivery, we're calling it; telephonic care management. And limited in center one‑on‑one care.

Next slide, please.

I think we went one slide ahead. Oh. Okay. We're missing a slide. Okay. Let's go to the next one again. All right. The principle that we're all following is safety ‑‑ while this isn't regular, we are finding that providers are able to quickly shift gears, making short‑term action plans and providing targeted interventions as needed.

So the way this is set up is the minimum requirement is the weekly COVID wellness check in. And any other services that are needed at a frequency that matches the currently authorized. Arrange for delivery or conduct doorstep delivery of needed household or medical supplies, meals, food, medical equipment, activity packets, and then of course telehealth services. That could be health education, a nursing assessment, counseling, and so on. So in realtime today, our department of aging is reviewing 236 plans of operation. We will notify next week of approval or denial. Reimbursement should be no less than the per diem rate. They are free to ask for more or viewer days, but it's up to the managed care plan to evaluate medical necessity. As I said earlier, I cannot express enough the incredible partnerships created. My organization. They are all working together to respond as quickly and smoothly as we have to this public health emergency. We are conducting weekly webinars and weekly leadership meetings and weekly meetings with our managed care partners and the state department on aging. We have designed training. Care coordination. We have developed forms that can be used in this environment. Our COVID 19 risk assessment form. And we have built up a library of resources. What has been most amazing to me to see is we have truly become a learning community together. We are all looking forward to a time when participants can return to their center lives. In the meantime, everyone is doing their best to keep everyone safe and healthy at home.

This experience has be difficult but also created opportunity, as you have seen from our other speakers. We are building a strong foundation for future emergency operations, and we have certainly begun to envision and beginning to create a more flexible person‑centered model going forward. We are envisioning a time when there is more widespread access to a vaccine, and we don't have the same physical distancing requirements that we believe that is going to be quite a ways off. So we're in this for the long term, for at least the 12 to 24 months.

So we're all striving to do the best we can for our own families and participants and that's all we can hope for and expect as we support each other every step of the way through this pandemic. So I will stop there. Next slide you can certainly reach out to me if you have any questions about our model.

I will hand it off to Stacy now.

>> Thank you very much. I just wanted to check in with Lisa and Ralph to see if there is anything else you wanted to say before we get into the questions?

>> Ralph: I did want to clarify that [ INDISCERNIBLE ]... or for all waivers in the state. If there is a special section of appendix K that is prepopulated based on what we have seen as the heavy hitters in COVID and those include electronic service delivery, home delivered meals, conflict of interest, provider qualifications to add family members to render services, and processes that states need, such as lifting prior approvals, prior authorizations, and/or limits on services. I would just add that to what I said earlier and be quiet now and let people ask their questions. Thank you.

>> Ralph, I saw some comments in the chat pod that you were muffled at the beginning. If you could restate the beginning of your statement there.

>> My apologies, sure. I wanted to make sure that folks knew that the Appendix K can be used for one waiver in a state, multiple waivers, or for all waivers in a state.

And that option is the state's to determine based on their particular needs.

>> Thank you. And Lisa, was there anything else you wanted to say before we jumped into the questions?

>> Yes. This is Lisa Bothwell with the Administration for Community Living. We are going to provide copies of this webinar, which will be posted on our website. I know that that was a question many people were asking. I also believe that new edition has the ability to send that to everyone who is registered via e‑mail.

>> Great. Thank you. We will get right into the questions and answers, taking us back to the beginning. Ralph, that means you will be on deck for a number of these. What is the option to show the best outcome for persons who are developmentally disabled as far as compliance with the Olmstead act and the HCBS rule?

>> Ralph: I'm trying to relate that specifically to the pandemic. And we wouldn't be advocating for the movement of anyone now into a different setting based on the requirements to avoid the spreading of the virus. So I'm struggling to understand how the question would relate to the pandemic.

>> I can clarify if that would help.

>> Please.

>> My question is, you know, [ INDISCERNIBLE ]. And I'm just wondering if there's anything historically that we can refer to that has shown outcomes that allow for individuals that are vulnerable to not be further institutionalized and/or remain in their communities? Any of these have shown more flexibility or improvement in complying with Olmstead? If you don't know, that's okay. It's a hard question.

>> Ralph: Yeah, I really cannot say that an appendix K or 1135 or 1115 in a disaster situation has been looked at to measure against Olmstead. I think the important thing to remember in the situations that we are talking about is that they are temporary in nature, and individuals are intended to be at the end of this whole with regard to all of their rights and opportunities as expected in their normal walk of life.

>> Thank you.

>> And I will add this. To be placed against services ‑‑ than individuals not receiving services. It is still expected that there will be a match for match of what the life experience will be for the individual. Okay.

>> Okay. And the next question is remotely delivered personal assistance service accomplished with cueing. Is this telephonic only or telephonic and video?

>> It can be either. The only stipulation is they have to meet the HIPAA requirements, but as most people know, OCR, the office of civil rights, has issued some clear guidance regarding how they are expected to be provided during this time frame. And there is a lot more flexibility. That should address the issue. It can be telephonically or with video link.

>> Is it permissible to provide job coaching services remotely?

>> In this situation, it certainly would be.

>> Okay. The next question asked regarding providers needing signatures. Is verbal consent permissible versus trying to get signatures back via mail?

>> Verbal consent is only permissible if it is waived through an 1135. However, we do allow for language that allows the services to begin to be delivered while awaiting a signed, dated copy by mail. I would be clear about the fact that ‑‑ because I have heard confusion about this. You can have an individual sign‑off sheet for each provider and each individual. It does not have to be the same sheet. So that alleviates some of those issues as well. You would need the 1135 authority to accept in lieu of what is currently required.

>> Okay. Can you speak to the component that includes personal assistance and care to qualify for retainer payments? Such as a day program that provides assistance to some and not others.

>> There is not an expectation that you go through is the service a service that generally provides personal care as a component of that service.

So for instance, it is difficult to see or conceive of a residential habilitation service that doesn't, at some level, have personal care or personal assistance components. It is most common that day programs also include personal care services as part of the totality of services being rendered there.

>> The next question is what are the overall implications of electronic visit verification?

>> I cannot answer that at this point with any kind of clear answer. The bottom line is the language is statutory with regard to everybody who currently has a good faith effort approved, and that is 49 states.

Is expected or required to be fully compliant by January 1, 2021. I can tell you that I am very aware that congress and government is looking closely at this issue and considering ways to provide relief. I just don't have any definitive answers as this time.

>> Next question, can you go into a little more detail regarding the relationship between retainer payment and bed holds?

>> Sure. Bed holds ensure that an individual has a place to return to when they are hospitalized or when they go home or when something happens in their life that takes them out of the institutional setting in which they reside. From that concept, the SMD was created that allowed for similar retainer payments as opposed to bed holds to providers who are rendering community services to individuals that include personal care assistance to ensure that that provider remains whole and available to that individual when they return to that setting or that service. That's the straight relationship. I think by interpretation, one would recognize that the need to keep the community provider system whole to ensure that individuals have the ability to return to full home and community‑based services as opposed to only having the institutional option available at the end of something as severe as this pandemic is very important to CMS and the states.

>> There is a question, I am interested in the review process of appendix K applications. How much back and forth is there? What is the approval rate?

>> Oh good lord. It depends on what comes in the. We have had states send in drafts. We have had states send in everything they can think of and then ask us to go through and tell them what is approvable. We have had states send in a single request. For instance, we received one for a specific rate increase for a specific service. So it's difficult to give you finals on that. I would say that generally we're moving things within five days. And with regard to the conversations back and forth between the states, I would say probably at least two contacts, generally, are made. But if more are required, staff are available and working with states on an ongoing basis.

>> Okay. And I see that we are at time, and I am going to ask you this last one, because I think people might be interested. I'm just wondering, is there a state‑by‑state tracker or grid of what states are implementing certain flexibilities as part of their case? I have seen lots of trackers on which states have submitted and been approved, but not information related to the content and the flexibilities in there.

>> Right. You can access approval letters and appendix Ks online, but there isn't a specific document or table that would say retainer payments and tell you every state that did retainer payments. Or rate increases in every state that does that. It is ‑‑ it is an interesting suggestion, and one I will take under consideration.

>> Hi, this is Sharon Lewis. I would add to that, that while CMS and ACL don't have government‑sponsored tracker, the Kaiser family foundation does have one. And I see that Amy just posted it in the chat for folks. But there are several different trackers out there that various organizations are doing.

>> Sharon, that's wonderful. Thanks.

>> Thank you. And we are at time. So I wanted to check in with Lisa and Ralph for any additional parting words before we end the call.

>> This is an extremely challenging and interesting time in our history. I don't think I need to remind anyone of that. I am amazed and overwhelmed on a day to day basis by the way people are responding and by the thoughtfulness and consideration with which they are providing their asks to CMS. And working through issues with us. I would underscore repeatedly where we cannot say yes to a request, understanding the intent of the request often allows us to work with the state to find a way to meet that need in another way. And so don't stop with "I can't do it this way." But rather, this is what I want to accomplish. Please help me get there.

And we will do everything we can to do that. And I'm just going to say that I have an incredible number of staff who are working their hardest at this day by day and appreciate and recognize that all of you are, too.

So thank you for having me and allowing me the opportunity to speak.

>> Hi. This is Lisa Bothwell. And I also want to echo what has been said and thank everyone for being part of today's phone call. I want to thank the panel for their time and expertise. As I mentioned before, we are planning on posting this recording of this webinar on our website, and we will be e‑mailing everyone to let them know the link through New Editions when the webinar is posted.

So thank everyone for joining. We appreciate your participation and your time and all of the hard work that is going on during these very challenging times.

>> Thank you. That ends today's webinar. Have a nice day, everyone.

>> Take care, folks.

[ End of realtime captioning ]