

HCBS Webinar Series – April 23, 2020

Ensuring Continuity of HCBS during the COVID-19 Pandemic

Q&As and Resources

These questions were asked during the April 23 webinar on Ensuring Continuity of HCBS during the COVID-19 Pandemic on April 23, 2020. There was not enough time during the webinar to address all of the questions, so we have compiled the questions and answers with additional input for our panelists below. We have also consolidated the resources shared during the podcast by attendees.

Q&As

Telehealth

Can remotely-delivered personal assistance services accomplished with cueing be reimbursed if it is only offered telephonically, or must it be a combination of audio and video?

States have [broad flexibility](#) to cover telehealth through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use. Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

With regard to 1915(i) face-to-face assessments, the use of telemedicine or other information technology medium is authorized under federal regulations at 42 C.F.R. § 441.720 under certain conditions. With regard to 1915(c) waivers, the state can complete an Appendix K to allow case management to be done via telephone or other information technology medium and, where personal care services only require verbal cueing and/or instruction, the personal care service can be expanded to permit information technology medium as a resource.

CMS recently amended its [Section 1135 waiver](#) to address telehealth in Medicare:

This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>). Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

Is it permissible to provide 1915(c) Supported Employment such as job coaching services remotely? How about telehealth health coaching?

Yes. See the following Section 1915(c) Appendix K waivers as examples:

1. [Oregon](#)
2. [Maryland](#)

Are there resources to support individuals in purchasing technology? Is technology purchase covered under a waiver?

The state can add assistive technology to the 1915(c) HCBS waiver through an amendment if they do not already include it. They state has the ability, within reason, to define what is included. Technology should not subsume interaction with individuals and/or limit community access and integration.

What direct care can be done remotely?

Examples of flexibilities that States may consider in a [Section 1915\(c\) Appendix K waiver](#):

1. The state could add in-home supports as a service, modify provider requirements to allow for family members to be paid to render services, and a family member living in a setting that is quarantined can deliver services to the individual who has COVID-19.
2. The state could add retainer payments to habilitation day programs and continue funding when closure is necessary to prevent the spread of COVID-19 or the state could add an electronic method of service delivery for the day program allowing for services to continue to be provided remotely in the home setting.
3. The state could increase a service rate to solicit a larger pool of providers, compensate for additional risk, compensate for additional qualifications/trainings, and/or to pay for more intensive services.

Do you have examples of day habilitation programming offered remotely?

New York offers an example of how one state is approaching remote day habilitation in their [Interim COVID-19 Guidance Regarding Day Habilitation](#).

What is the impact of expanded telehealth opportunities on assessments and evaluations? Are the flexibilities extending current care supports absent required evaluations for change? Or are assessments being done telephonically or by a combination of audio and video?

States have the option [under 1915\(c\) Appendix K](#) to:

1. Allow an extension for reassessments and reevaluations for up to one year past the due date.
2. Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
3. Adjust prior approval/authorization elements approved in waiver.

4. Adjust assessment requirements
5. Add an electronic method of signing off on required documents such as the person-centered service plan.

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Payments

Can you speak to the "component that includes personal assistance and care" to qualify for retainer payments?

The 1915(c) Appendix K waiver does offer states the option to temporarily include retainer payments to address emergency related issues. See the [Section 1915\(c\) Appendix K](#) approved waivers list.

Can you go into a little more detail regarding the relationship between retainer payment and "bedholds"?

"Bedholds" 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, a similar concept applies to retainer payments. Retainer

payments can go to providers who are rendering community services to individuals (including personal care assistance) to ensure that that provider remains whole and available to that individual when the individual returns to that setting or that service. See [Olmstead Update No: 3 Subject: HCFA Update Date: July 25, 2000](#) for more information.

How do retention payments work in states that have MCOs as a middle man between DHS and the providers? Is there a way to ensure that providers get that money?

Generally this is done through state directed payments.

Are states submitting hazard pay as part of their waiver expansions? Which specific states have included hazard pay?

Hazard pay approvals can be found on the [Section 1915\(c\) Appendix K waivers](#).

How are states dealing with the increases of wages for direct care workers that might affect social benefits that these low wage workers depend on?

That is being addressed by the states on a state by state basis. CMS does not set the assets and/or income requirements to adjudicate eligibility for Social Security benefits and subsequent Medicaid eligibility.

Can you explain how a state can apply retainer payments when there are no institutional services? Is there capitation on the amount of services that can be reimbursed?

There must be a component of personal care included in the service and personal assistance retainer time limit may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bedhold" in nursing facilities. See [Olmstead Update No: 3 Subject: HCFA Update Date: July 25, 2000](#) for more information.

I would like more information about payments made to legally responsible adults. Does that include legal guardians of adults with intellectual and developmental disabilities who are provided waiver services to fill gaps created by lack of waiver staff?

[Under Section 1915\(c\) Appendix K](#), the state could add in-home supports as a service, modify provider requirements to allow for family members to be paid to render services, and a family member living in a setting that is quarantined can deliver services to the individual who has COVID-19.

How can families get PPE paid for thru the waiver for themselves and staff? How can intern get service be paid by the waiver?

To account for increased costs in PPE for home care workers, a [SPA or Appendix K for a 1915\(c\) waiver](#) could be submitted to amend payment methodologies for impacted services.

I don't see the state of Michigan listed on the Appendix K? Is there a response from Michigan?

Approved Section 1915(c) Appendix K waivers are posted [here](#).

Do Appendix K's need to be updated if time frame extends beyond original end date?

States and territories should contact their [CMS Regional Office](#) for guidance.

HIPAA

Can you provide more information about OCR's notice of HIPAA enforcement discretion?

[Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency](#)

State-Specific:

Pennsylvania

Could Pennsylvania please share its provider checklist for when staff or clients test positive?

Pennsylvania's Administrative Entities contact the provider and walk through the [checklist](#) when a suspected or confirmed case is reported.

Could Pennsylvania share their licensing pilot tool for doing licensure supervision remotely?

The remote inspection guidance and instructional video are in the final stages of approval.

Is the Pennsylvania "provider readiness assessment" available publicly?

Yes, Pennsylvania has provided their [Administrative Entity - Residential Provider Preparedness Assessment Tool for COVID-19](#) on their Web site.

Is anyone willing to share their templates for COVID-19 Wellness Check Ins?

Yes, Pennsylvania shares their [Supports Coordinator Check-In for Well-Being Tool](#).

What is the Warm Line?

[Pennsylvania's Statewide Support & Referral Helpline](#) is staffed by skilled and compassionate staff that are available 24/7 to respond to those struggling with anxiety and other challenging emotions due to the COVID-19 emergency. Staff at the Helpline refer callers to community-based resources that can further help to meet individual needs.

Who is manning Pennsylvania's Warm Line? Is it individuals with intellectual and developmental disabilities and families or providers?

Trained professionals from an agency with multiple business lines including suicide crisis line and supports coordination for people with intellectual and developmental disabilities.

Where are direct support professionals (DSPs) being regularly tested? Are there states that seem to have DSP testing under control? And how?

Pennsylvania, like most places, does not have necessary testing resources.

Trauma informed services are so important for re-entry to our "new normal" as we transition back. What tools do we have to support? Any research articles?

This an area of concern Pennsylvania is beginning to plan for. Pennsylvania is not currently aware of any research on trauma specific to COVID. Tools that Pennsylvania is building on are existing tools for trauma informed care and trauma treatment tools.

New York

Where can we find New York's visitor policy?

New York offers their visitation policy in their [Health Advisory: COVID-19 Guidance for Hospital Operators Regarding Visitation](#).

Miscellaneous

Do you have a state-by-state tracker of which states are implementing certain flexibilities as part of their Section 1915(c) Appendix K waivers? I have seen a lot of trackers on which states have submitted Appendix Ks and been approved, but not related to the content of the Appendix Ks and flexibilities.

Webinar participants shared these spreadsheets:

1. [Appendix K At-a-Glance](#)

2. [Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19](#)

What if people live in one state but receive medical services in another?

CMS is temporarily [waiving](#) requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met:

1. Must be enrolled as such in the Medicare program;
2. Must possess a valid license to practice in the state, which relates to his or her Medicare enrollment;
3. Is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and,
4. Is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area.

However, an 1135 waiver, when granted by CMS, does not have the effect of waiving state or local licensure requirements or any requirement specified by the state or a local government as a condition for waiving its licensure requirements.

Are there any special guidelines for Shared Living Programs? Can caregivers in such programs be considered "health care providers?"

Cybersecurity & Infrastructure Security Agency (CISA) in collaboration with other federal agencies [considers](#) home health providers, home-maker services, and personal assistance service providers that support activities of daily living as essential critical infrastructure workers in the area of healthcare/public health.

These services are extremely challenging for people who live in rural areas, any thoughts or ideas as to who to provide these services to them?

Yes, here are some [options](#):

1. Section 1902(a)(30)(A) of the Social Security Act requires that payments under the state plan must be consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. If a state determines that it is necessary to target payment increases to certain geographic regions within the state, certain safety net providers, or rural providers in order to assure access to Medicaid services, then the state may do so under the Medicaid state plan.
2. Federal financial participation is available for telephonic services. If a state's approved state plan excludes Federally Qualified Health Centers and Rural Health Centers services from being provided telephonically, CMS can work with the state to expedite processing of a state plan amendment to lift this restriction.

What is presumptive eligibility (PE)?

[Presumptive eligibility](#) can happen when:

A qualified entity is an entity that is determined by the state to be capable of making PE determinations for eligibility groups based on [modified adjusted gross income(MAGI)], as authorized under sections 1920, 1920A, 1920B, and 1920C of the Social Security Act and 42 C.F.R. Part 435 Subpart L. A state agency may designate itself as well as a county or another local agency as a qualified entity. To elect this option, the state must submit a SPA and indicate the eligibility groups for which the agency or agencies will determine PE. States can do so through the Medicaid disaster relief SPA template, which can be found here: <https://www.medicaid.gov/resources-for-states/disaster-responsetoolkit/state-plan-flexibilities/index.html>. Unlike for hospital presumptive eligibility (under section 1902(a)(47)(B) of the Act and 42 C.F.R. § 435.1110), states cannot designate a state agency as a qualified entity to make PE determinations for non-MAGI eligibility groups, which includes the new Medicaid COVID-19 testing group. For technology to support eligibility and Last Updated May 5, 2020 Page 16 of 70 enrollment for presumptive eligibility qualified entities, 42 C.F.R. Part 433, Subpart C would apply.

What are the overall implications to electronic visit verification?

For information on the current status of electronic visit verifications, visit the [CMS Electronic Visit Verification Web page](#).

Resources

- State of the States in Intellectual and Developmental Disabilities <https://stateofthestates.org/covid-19/>
- Appendix K At-a-Glance <https://docs.google.com/spreadsheets/d/12o-Gr0IrvT5sVYiq0jiRI8DjHUNxEwKtmwCw3BIGZdE/edit#gid=1486231367>
- Oregon Department of Human Services, COVID-19 Information and Resources (videos at bottom of page) <https://govstatus.egov.com/or-dhs-covid-19>
- Oregon Department of Human Services, Seniors & People with Disabilities, COVID-19 Information <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/Pages/ODDS-COVID-19-information.aspx>
- Pennsylvania Coronavirus-Related Provider Resources <https://www.dhs.pa.gov/providers/Providers/Pages/Coronavirus-Provider-Resources.aspx>
- Pennsylvania Autism Services, Education, Resources, and Training Collaborative (ASERT) <https://paautism.org/resource/coronavirus-resources/>
- Tell us what you know about children and adults with disabilities (including older adults) currently in nursing homes, congregate and other institutional facilities during the COVID-19 pandemic. Survey for Centers for Independent Living, Protection and Advocacy systems and

other disability advocacy organizations.

https://docs.google.com/forms/d/e/1FAIpQLSex06KzyyvFM4uPIyqZeStdChKG9-QCHf485uiMxaoQr_ORQw/viewform

- Carol Gray Social Stories <https://carolgraysocialstories.com/pandemic-social-stories-direct-access/>
- Able ARTS Work: Virtual Learning <https://www.ableartswork.org/>
- National Council on Disability; Preserving Our Freedom: Ending Institutionalization of People with Disabilities During and After Disasters
https://ncd.gov/sites/default/files/NCD_Preserving_Our_Freedom_508.pdf
- Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19
<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>
- National Empowerment Center (Warmlines: Crisis and Supplemental Supports Webinar)
<https://power2u.org/>