

1915(c) Home and Community-Based Services Waivers Instructions and Technical Guidance

Brief Overview

The Centers for Medicare & Medicaid Services (CMS) developed Appendix K of the Section 1915(c) Home and Community-Based Services (HCBS) Waiver Instructions and Technical Guidance to help states accelerate requests for changes to their 1915(c) HCBS waiver operations in response to an emergency. This appendix was developed as a standalone appendix to be utilized by the state during emergency situations. It should be used by the state to seek approval of temporary/time-limited amendment(s) to its approved waiver. It includes actions that states can take under the existing 1915(c) HCBS waiver authority in order to respond to an emergency. These changes are time-limited and tied specifically to individuals impacted by the emergency.

Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS. CMS has provided this appendix in order to reduce the administrative burden during times of emergencies. In addition, CMS is committed to being responsive and sensitive to the pressures and timeframes that the state is operating under, and we will prioritize such amendments for review.

An Appendix K submission may include multiple waivers. The state will submit this document via the OneMAC system as their formal request to CMS to temporarily modify the 1915(c) waiver to address short term issues in response to an emergency or disaster. Please note that temporary additional services shall be reflected in the 372 form. Added services, costs, and utilization changes would be included for the waiver year affected. Added capacity should also be reflected in the 372 form.

Numerous changes that the state may want to make necessitate authority outside the scope of the 1915(c) authority. States interested in changes to administrative claiming or changes that require 1115 or 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, (b) suspension of general Medicaid rules that are not addressed in 1915(c), such as payment rules, eligibility rules or suspension of provisions of 1902(a) to which 1915(c) is typically bound. If operated with a concurrent section 1915 (b) waiver, the state may need to request commensurate modifications to their section 1915(b) waiver.

Please keep in mind that fair hearing rights under the provisions of 42 CFR § 431, Subpart E may apply. For example, when an individual does not meet the level of care and is denied entry into the waiver, they have a right to a fair hearing. Please review the CMS technical guidance provided in Appendix F of the HCBS Waiver Technical Guide for information regarding fair hearings.

The state may not make changes to a waiver that are not allowed under statute such as the inclusion of room and board costs. States are not required to apply the 1915(c) public input requirements in an Appendix K amendment; however, the Medicaid Tribal Notice/Consultation requirements do apply.

CMS encourages states to begin preparations to ensure that acute and primary medical resources

are available to meet the needs of individuals served through HCBS. CMS offers this appendix as a streamlined approach for amendments to 1915(c) waivers when emergencies arise. It should not, however, supplant the state’s comprehensive plan for emergency preparedness. There are numerous resources available to states to assist them in developing broad-based strategies for addressing emergencies. A few helpful links are noted below, but CMS encourages states to work in close cooperation with their state emergency preparedness resources, as well.

- [Link to the Federal Emergency Management Agency Resources Website](#)
- [Link to Ready.gov Website](#)
- [Link to Centers for Disease Control and Prevention Emergency Preparedness Website](#)
- [Link to National Institutes of Health Disaster Preparation and Recovery Website](#)
- [Link to US Food and Drug Administration Emergency Preparedness Website](#)
- [Link to US Department of Health & Human Services Emergency Preparedness Website](#)

As a part of the State’s overall preparations for emergency situations, CMS encourages states to engage individuals and families in these efforts. Assisting individuals to prepare for emergency situations can be a key to successful system-wide contingency planning. For individuals in the waiver, this effort should begin during the person-centered planning process (and described in the approved waiver document). However, these efforts should further include training and information for individuals and the people that support them to provide them with the information and resources necessary to begin individualized contingency plans, and to arm them with the tools to ensure that their back-up plans are current.

Requirements: Emergency Preparedness and Response

Detailed Instructions for Completing Appendix K

Item K-1: General Information

Check the appropriate box if this is an initial request or addition to a previously approved Appendix K.

Item 1-A: State

Instructions

Specify the state name.

Item 1-B: Waiver Title

Instructions

In the table list the waiver title and the waiver control number in the appropriate columns. The waiver number should be the next sequenced amendment number. Include all waivers in your state that you wish to include in the request.

Item 1-C: Type of Emergency

Instructions

Indicate the type of emergency. If the type of emergency is not listed, specify the type of emergency under the “other” category. The state may check more than one box. If the state

has multiple emergencies affecting different geographical areas and requiring different changes by type of emergency, the state should break out the information by type of emergency in the appropriate sections.

Item 1-D: Brief Description of Emergency

Instructions

Briefly describe the nature of the emergency. The state should provide this information for each emergency checked in K-1-D above if different geographical areas are affected and if different modifications in waiver operations are needed. In addition, summarize the flexibilities being requested.

Item 1-E: Proposed Effective Date

Instructions

Specify the proposed effective start date of the Appendix K amendment and the end date. The proposed effective start date is the date that the amendment would take effect. Please note the end date cannot be more than one year from the effective date.

Indicate the anticipated end date of the amendment. The end date is the last day that the changes would be in effect.

A state may propose that an amendment take effect prospectively on some future date. An amendment also may be made retroactive to the first day of the waiver year (or another date after the first day of the waiver year) in which the amendment is submitted unless the amendment would result in a reduction. In these circumstances, amendments may only take effect on or after the date when the amendment is approved by CMS. For additional detail, please see the CMS HCBS Waiver Technical Guide, Policies Concerning Waiver Amendments and Item 1-E.1 (Proposed Effective Date) for information regarding effective dates and the section on “Policies Concerning Waiver Amendments”.

If the state seeks to modify its originally proposed effective dates/time span for the use of this appendix, this will require the state to transmit a revised 1915(c) Appendix K waiver amendment through the OneMAC system.

Item 1-F: Transition Plan

Instructions

Some of the temporary modifications that states make (e.g., modifying targeting criteria, adding or modifying services, increasing factor C, increasing individual cost limits, etc.) may result in individuals being temporarily enrolled in the waiver, or temporarily accessing additional services. A transition plan is necessary for waiver participants who might be adversely affected when the temporary changes cease, and the waiver reverts back to its original form. In these cases, all applicable fair hearing rights still apply. Please see the “Transition Plan” Section of the CMS HCBS Waiver Technical Guide for additional guidance or information regarding transition plans.

Item 1-G: Geographic Areas Affected

Instructions

Specify the geographic areas affected by the emergency. For example, the state may use geographic areas such as counties, cities, parishes, state planning regions or human catchment

areas, or political subdivisions such as counties or municipalities of the state. When the geographic area affected is limited to political subdivision, list the subdivisions. When the geographic area affected is limited to another type of geographic area such as state planning region, describe the area. The descriptions must be specific enough so that the geographic areas where the emergency is in effect are clearly specified. States may also indicate, “These actions will apply across the waiver(s) to all individuals impacted by the emergency.”

If multiple emergencies are checked in K-1-C, specify the geographic areas affected by each emergency.

Item 1-H: Description of State Emergency Plan

Instructions

Describe the state’s emergency plan, if available. Reference to or links to external documents is acceptable. This field is not required. CMS recognizes that this might be a subset of the state’s larger emergency disaster plan. States may have elements in their disaster plan relating to waivers that may be applicable. If so, provide a description or a citation.

Item K-2: Temporary Emergency-Specific Amendment to Approved Waiver:

Instructions

Below are examples of temporary/time-limited flexibilities that the state may wish to utilize during an emergency. Should the state wish to make permanent changes to the waiver to modify the appendices (Main Module through Appendix J) in the approved waiver, the state will need to submit an amendment request in the waiver management system (WMS).

- Add in-home supports as a service, or modify provider requirements to allow for family members to be paid to render services, including permitting a family member living in a setting that is quarantined to deliver services to the individual who has a highly contagious communicable disease.
- Add retainer payments to habilitation day programs or other programs providing personal care services, and continue funding (for example, when closure is necessary as a result of an emergency or to prevent the spread of a highly contagious communicable disease), 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.
- 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.
- Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- Adjust prior approval/authorization elements approved in waiver.
- Adjust assessment requirements
- Add an electronic method of signing off on required documents such as the person-centered service plan.

Item K-2-a: Access and Eligibility

K-2-a-i: Temporarily increase individual eligibility cost limits

Instructions

Indicate, if applicable, whether the state will impose a temporary increase in individual cost limits required for waiver eligibility during an emergency in order to assure the individual's health and welfare. Specify the temporary cost limit. For more information regarding individual cost limits, see Appendix B-2 of the CMS HCBS Waiver Technical Guide.

Technical Guidance

There may be instances where the state chooses to increase the individual cost limit for the waiver to enable more individuals to access HCBS. Such an increase may allow individuals to enter or stay in the waiver, who, because of the emergency situation, require services and supports that may exceed the previously imposed cost limits.

K-2-a-ii: Temporarily Modify additional targeting criteria

Instructions

Indicate, if applicable, whether the state seeks to expand the additional targeting criteria to serve additional individuals.

Technical Guidance

Some states may operate waivers for a fairly narrow target group. In emergency situations, the state may seek to broaden the population served through that waiver to ensure that individuals in the state have access to a broad array of HCBS. For example, a waiver that currently serves individuals who have Alzheimer's disease may be expanded to serve a broader aged population to enable the provision of HCBS and forestall institutionalization in emergency situations.

Item K-2-b: Services

K-2-b-i: Temporarily modify service scope or coverage

Instructions

If the state would like to temporarily modify service scope or coverage offered in the waiver, select K-2-b-i and use the table to list the name of the service in the first column and specify the type of change being proposed to the service. For each service affected, complete Section A (Services to be Added/Modified During an Emergency) by entering the entire service definition and highlighting the change(s). To temporarily allow for remote/telehealth delivery of services, complete K-2-b-ii below.

Technical Guidance

The State may need to temporarily modify a service scope or coverage. For each service affected, complete Section A by entering the entire service definition and highlighting the changes from the current approved waiver service definition. This will reflect the proposed change or expanded scope of the services existing service specifications and provider qualifications.

K-2-b-ii: Temporarily add Remote/Telehealth Delivery of Services

Instructions

If applicable, specify the services that the state will temporarily allow providers to deliver remotely/via telehealth, and check the assurance boxes.

Technical Guidance

“Telehealth” refers to a general service modality, and states may use other terms to reflect the use of telehealth in their HCBS waivers.

The state may temporarily allow for any waiver services to be delivered remotely/via telehealth, subject to the following assurances:

- The remote service will be delivered in a way that respects the privacy of the individual especially in instances of toileting, dressing, etc.
- The telehealth service delivery will facilitate community integration.
- The telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service may be rendered without someone who is physically present or is separated from the individual.
- The state will support individuals who need assistance with using the technology required for telehealth delivery of the service.
- The telehealth will ensure the health and safety of an individual.

Item K-2-b-iii: Temporarily exceed service limitations

Instructions

Indicate, if applicable, adjustments that may be taken to allow individuals to receive more services than those limitations identified in the state’s approved waiver. Such exceptions could include allowances for exceeding individual service limitations identified in Appendix C-1/C-3 or allowances for exceeding limitations on sets of services or other limitations identified in Appendix C-4. Describe how the proposed changes differ from what is in the currently approved waiver.

Technical Guidance

States frequently include limitations on the amounts or duration of services included in the waiver. In the event of an emergency, individuals may require additional supports or supports for a longer period than in ordinary times. In those instances, states may allow for exceptions to the service limitations in order to ensure the health and welfare of individuals served. Use this section to describe any changes to services limitations that the state would deem permissible in emergency situations.

K-2-b-iv: Temporarily add services to the waiver

Instructions

Indicate, if applicable, whether the state intends to temporarily add services to the waiver in order to address the emergency. Complete Section A- Services to be Added and/or Modified During an Emergency.

Technical Guidance

Regulations at 42 CFR §440.180(b)(9) permit a state to request the authority to offer “other”

services that are not expressly authorized in the statute as long as it can be demonstrated that the service is necessary to assist a waiver participant to avoid institutionalization and function in the community. During emergency situations, the state may wish to temporarily add services to an existing waiver in order to respond to the emergency. Examples of such services might include: emergency counseling, heightened case management to address emergency needs, emergency medical supplies and equipment, individually-directed goods and services, assistive technology, non-medical transportation.

The state may also wish to temporarily allow for emergency case management to assist waiver participants in gaining access to necessary medical, social, educational, and other services needed as the direct result of an emergency that causes significant death, injury, exposure to life-threatening circumstances, hardship, suffering, loss of property, or loss or community infrastructure. As with any service, CMS will expect the state to assure that there is no potential service duplication or payment, and that the services would not be available through any other resources. Note that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements apply.

K-2-b-v: Temporarily expand settings

Instructions

Indicate, if applicable, adjustments to allowable settings where services can be provided that may differ from those identified in the state's approved waiver.

Technical Guidance

CMS recognizes that settings in which services may be provided may require temporary modification in times of emergency. One example, among many possible, may be to allow participants to receive services in the provider's home. Another example may be a situation where a day program has been closed due to an outbreak of a contagious illness. The day program staff may be available and willing to provide those same services in another location or in individuals' homes. Other examples include utilizing hotels, shelters, schools and churches. The state should describe safeguards that will be instituted to ensure that individuals receive the necessary services as authorized in their plan of care and that services are provided in the best interest of the individual. Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included.

K-2-b-vi: Temporarily provide services in out-of-state settings (if not already permitted in the state's approved waiver)

Instructions

Indicate, if applicable, whether services will temporarily be provided in out-of-state settings due to emergency situations. If the response is "yes", check the assurance boxes. In addition, in the narrative box, if the state is using a different rate methodology for the out of state providers, indicate this and provide information regarding the different rate methodology. Also, in the narrative box, add any additional provider qualifications for out-of-state providers, if applicable.

Technical Guidance

In accordance with 42 CFR § 431.52, the state may elect to provide services to individuals in out-of-state settings when emergencies arise. This can occur as a regular course of business in 1915(c) waivers, therefore, the state only needs to complete this section if the state has not permitted services to be provided in out-of-state settings in its current

approved waiver. The state may also wish to use this section to advise CMS if large numbers of individuals are requiring displacement. Applicable policies and considerations regarding the provision of waiver services out-of-state are delineated in CMS State Medicaid Director letter Olmstead Update #3. In brief, waiver services that are furnished out-of-state must meet the state of residence waiver standards and requirements. That is, the out-of-state provider that furnishes the services needs to meet the same qualifications as in-state providers and there must be a provider agreement in effect, and if there are any licensure or certification requirements for out-of-state providers, those out-of-state requirements must be met. In addition, when services are furnished out-of-state, they are subject to the same monitoring requirements as if they were furnished in-state. This includes assuring the health and welfare of the waiver participant and monitoring compliance with HCBS settings criteria. As discussed in Olmstead State Medicaid Directors Letter #3, a state may enter into agreements with other states to facilitate the provision of services out-of-state.

Item K-2-c: Provision of Services by Relatives, Legal Guardians, and/or Legally Responsible Individuals

K-2-c: Temporarily Permit or Revise Payment for Provision of Services by Relatives, Legal Guardians, and/or Legally Responsible Individuals if not already permitted under the waiver.

Instructions

Indicate if the state elects to allow the provision of services for payment by relatives, legal guardians, and/or legally responsible individuals or to modify allowable circumstances for such service provision already authorized in the state's approved waiver. Indicate the services to which this would apply, the safeguards in place to ensure that individuals receive necessary services as authorized in the person-centered service plan, and the procedures that are in place to ensure that payments are only made for services rendered.

If the state wishes to temporarily provide for extraordinary care payments to legally responsible individuals for the provision of personal care or similar services, additionally specify the following:

(a) the types of legally responsible individual(s) who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "extraordinary care", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the waiver participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; and (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services.

Technical Guidance

CMS recognizes that states may need to expand the pool of individuals who can provide services in case of emergency. In the event that the state chooses to allow relatives, legal guardians, and/or legally responsible individuals to participate in the delivery of services in a way that differs from the policies set forth in the approved waiver, the state should use this section to provide basic information on the situations where this would be acceptable. The

state should refer to the Instructions and Technical Guidance on this issue in Appendix C- 2 of Version 3.7.

Please note that individuals on the Office of Inspector General’s (OIG) excluded provider list may not receive Medicaid payment, regardless of the relationship to the individual. Also, whenever a legally responsible individual or relative/legal guardian is paid for the provision of a waiver service, the individual must meet the provider qualifications that apply to a service in accordance with 42 CFR §§ 441.302(a)(1) and (2) and there must be a properly executed provider agreement, in accordance with 42 CFR § 431.107(b). In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply. Lastly, other regulatory provisions such as 42 CFR §§ 441.301(c)(1) and (c)(4) regarding the person-centered planning process and HCBS settings criteria continue to apply, including the requirements at 42 CFR § 441.301(c)(1)(vii): “The person-centered planning process: offers informed choices to the individual regarding the services and supports they receive and from whom.”

See related guidance at <https://wms-mmdl.cms.gov/WMS/faces/portal.jsp>.

Item K-2-d: Modify provider qualifications, types, etc.

K-2-d-i: Temporarily modify provider qualifications

Instructions

Provider qualifications may be temporarily modified in order to expand the provider pool. Indicate, if applicable, whether the minimum provider qualifications specified in the approved base waiver will be temporarily modified in response to an emergency situation. If the state chooses to modify provider qualifications, list each service affected, list the provider type, and the modification to the provider qualifications.

Technical Guidance

The waiver assurances at 42 CFR § 441.302(a) requires that: (a) there are adequate standards for all types of providers that provide services under the waiver and (b) that the standards must be met when services are furnished. Under normal circumstances, waiver services may only be furnished by providers who have been found to meet all applicable qualifications. During an emergency situation, the state may temporarily modify provider qualifications in order to ensure that waiver participants receive necessary services. For example, a state may wish to identify minimally acceptable provider qualifications during the emergency for a temporary period of time that may be a subset of the total qualifications included in the approved waiver application. Other examples include expanding the provider pool and temporarily modifying or suspending licensure and certification requirements. Please note that individuals on the OIG’s excluded provider list may not receive Medicaid payment. See related guidance at <https://wms-mmdl.cms.gov/WMS/faces/portal.jsp>.

K-2-d-ii: Temporarily modify provider types

Instructions

Indicate, if applicable, whether provider types will temporarily be modified in response to an emergency situation. Provide an explanation for the modification. List the services affected and the changes in provider types for each service.

Technical Guidance

CMS recognizes that states may need to expand the pool of available providers or to include non-traditional waiver service providers in the event of an emergency. Such consideration may be given to neighbors or acquaintances who may not typically be providers of services,

or may be agencies or entities that provide a specialization that is necessary to address the needs of a particular emergency situation (for example: mold abatement specialists after a flood to provide homemaker/chore-type services).

K-2-d-iii: Temporarily modify licensure or other requirements for settings where waiver services are furnished

Instructions

Indicate, if applicable, whether the state will temporarily modify licensure requirements for settings. Provide an explanation of the changes. Describe the settings that may be utilized to provide services to waiver participants during emergency situations. Also list the services that will be provided in those settings.

Technical Guidance

In an emergency situation, a state may need to provide waiver services in settings that are unforeseen in a typical service delivery situation or may need to modify the typical licensure or certification requirements. The state may need to identify additional settings where services can be provided in situations where individuals are unable to receive services in the settings where they would ordinarily receive them. This section of Appendix K can be used by states to request temporary accommodation related to service delivery location to ensure that individuals continue to receive necessary services. It should be noted that if a temporary placement is to exceed 30 days CMS expects the state to make every effort, within reason, to ensure the setting meets the regulatory requirements for home and community-based settings.

Item K-2-e: Process for Level of Care Evaluations and re-evaluations

K-2-e: Temporarily modify processes for waiver eligibility level of care evaluations and re-evaluations.

Instructions

Indicate, if applicable, whether the state intends to temporarily modify the process for level of care evaluations and/or re-evaluations within regulatory requirements, including the required timeframe in which the re-evaluation is completed. In the text box, describe changes in processes and/or the revised timeframes in which the re-evaluations will be completed (note that changes in the timeline for initial evaluations can only be authorized via Section 1135).

Technical Guidance

CMS recognizes that states may need to temporarily modify processes for level of care waiver eligibility evaluations or re-evaluations, including the required timeframe in which the level of care re-evaluation must be completed. Provide a description of the proposed modifications. Please note that states may not extend the timeframes for re-evaluations beyond 12 additional months past when the level of care is due.

Item K-2-f: Payment Rates

K-2-f: Temporarily increase payment rates or allow for supplemental payments

Instructions

Indicate, if applicable, whether the state intends to temporarily increase provider payment rates or allow for supplemental payments for waiver services. Provide an explanation for the increase. List the provider types, rates by service, the percentage of the rate increase, and specify whether this change is based on a rate development method that is different

from the current approved waiver (and if different, specify and explain the rate development method). If the rate or supplemental payment varies by provider, list the rate or supplemental by service and by provider. No room and board costs should be included in any changes, except as permitted for respite services in certain facilities.

Technical Guidance

CMS recognizes that extraordinary circumstances may necessitate adjustments to the payment and utilization estimates contained in the approved waiver. If such changes are necessary, the state should indicate, in the space provided, the proposed modifications. If these modifications are sustained beyond the timeframes identified in K-1, the state will need to make corresponding changes to Appendix J in the approved waiver. It should be noted that this is not an exception to the requirement that the state must demonstrate that the waiver is cost neutral during each year that the waiver is in effect.

Item K-2-g: Service Plan

K-2-g: Temporarily modify the person-centered service plan development process and/or individual(s) responsible for service plan development, including qualifications.

Instructions

Indicate, if applicable, temporary modifications to the person-centered service plan development process that are necessary as a result of an emergency. Also, indicate any changes pertaining to individuals responsible for person-centered service plan development, including qualifications and address participant safeguards. Note that the timeframe for person-centered service plans can only exceed the one-year regulatory requirement through the use of a section 1135 waiver. Also note that verbal consent is not permitted under this authority.

Technical Guidance

In emergency situations, the state may need to modify its person-centered service plan development process, including individuals who may be instrumental in the development of such plans. The state should describe, in the space provided, any modifications to the existing process of service plan development, and any safeguards that will be instituted to address individuals' needs. Such modifications should include emergency specific risk assessment and mitigation techniques. Furthermore, the state should include the strategies that will be employed to ensure that the service plan is implemented as designed for the individual during the period of the emergency, including how the state will ensure that individuals will receive services as authorized. See example below:

Person-Centered Service Plans that are due to expire within the next 60 days require case management contact to the participant using allowable remote contact methods to verify with the participant or representative that the current assessment and services, including providers, remain acceptable and approvable for the upcoming year. The state will verify, by obtaining electronic signatures/or electronic verification via secure email, consent from service providers and the individual or representative. The state will ensure the service plan is modified to allow for additional supports/and or services to respond to the current emergency. The specificity of such services including amount, duration and scope will be appended as soon as possible, but no later than 30 days from the day the first services begin, to ensure that the specific service is delineated accordingly to the date it began to be received.

Item K-2-h: Incident Reporting

K-2-h: Temporarily modify incident reporting requirements, medication management, or other participant safeguards to ensure participant health and welfare, and to account for emergency circumstances.

Instructions

Indicate, if applicable, whether the state intends to temporarily modify incident reporting requirements, medication management, or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances.

Technical Guidance

If the state modifies their incident reporting requirements, describe in the space provided the safeguards in place to ensure that the state has timely access to critical information regarding the health and welfare of the individuals served through the waiver. Such changes may include the expansion of individuals responsible for reporting incidents or adjustments to the method or timelines for data collection.

Item K-2-i: Payment

K-2-i: Temporarily allow for payment for waiver services provided in an acute care hospital in accordance with section 1902(h)(1) of the Act.

Instructions

Indicate, if applicable, whether the state intends to temporarily allow for payment for waiver services provided in an acute care hospital in accordance with section 1902(h)(1) of the Act. This may be a helpful tool when states are utilizing such settings for emergency shelter. Specify the waiver services that can be provided by the 1915(c) HCBS provider when they are not duplicative of services available in the acute care hospital setting; how the 1915(c) HCBS will assist the individual in returning to the community; and whether there is any difference from the typically billed rate for these HCBS provided during an acute care hospitalization. Also, check the boxes to affirm that the conditions are met for waiver services provided in an acute care hospital, as set forth under section 1902(h)(1) of the Act. If the services are not already included in the waiver, the state should also add them to K-2-b and attachment A.

Technical Guidance

States may need to ensure that individuals have access to necessary home and community-based services during a short-term acute care hospital stay. Under section 3715 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Congress added to the Social Security Act under section 1902(h)(1) a provision that allows states to provide HCBS in acute care hospitals under certain conditions. In accordance with section 1902(h)(1) of the Act, the services must be:

- identified in an individual's person-centered service plan (or comparable plan of care);
- provided to meet the needs of the individual that are not met through the provision of hospital services;
- not a substitute for services that the hospital is obligated to provide through its conditions of participation, under federal or state law, or under another applicable requirement; and
- designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

Item K-2-j: Retainer Payments

K-2-j: Temporarily include retainer payments to address emergency related issues

Instructions

A state may elect to make retainer payments to personal assistants when the waiver participant is hospitalized or absent from his/her home for a period of no more than 30 consecutive days or the number of nursing facility bed hold days identified in the state's Medicaid state plan. See Olmstead Update #3 (July 25, 2000) in Attachment D for additional information. If the state elects to make such payments, describe the circumstances under which such payments are authorized and applicable limits on their duration. This flexibility is available for personal care and habilitation services that includes a component of person care.

In the dialogue box include the percentage of the current rate to be paid if the retainer payment is less than 100% of the service rate. Also, specify the process the state will utilize to monitor payments to avoid duplication of billing. Please note for states that use managed care delivery systems for these services, in addition to the Appendix K approval, approval of a state directed payment may be necessary to effectuate retainer payments in Medicaid managed care plans. State directed payments must comply with the requirements of 42 CFR section 438.6(c) and other federal requirements, including 71116 of the Working Families Tax Cut legislation. Questions about state directed payments or preprint submissions should be directed to statedirectedpayment@cms.hhs.gov.

Technical Guidance

Payment to retain providers may be particularly important for individuals and states in emergency situations. This option can be implemented for a time-limited basis (not to exceed the limits identified in Olmstead Letter #3).

Item K-2-k: Opportunities for Self-Direction

K-2-k: Temporarily institute or expand opportunities for self-direction

Instructions

States may elect to expand the utilization of self-directed models of service provision. If applicable, provide an overview of self-direction opportunities and any temporary expansion to self-direction opportunities that will be used during an emergency. List the services that may be self-directed during an emergency. Also, provide an overview of participant safeguards.

Technical Guidance

There are many instances where the expansion of self-direction may be a useful option in an emergency situation. States may wish to expand the services available for self-direction, or to expand the decisionmaking authority (for employer or budget authority) that has been imparted to individuals in the waiver. Additionally, the state may seek to temporarily add participant-directed goods and services as a service available under the waiver to enable the individuals to obtain goods and services in accordance with the guidance for this service in the HCBS Waiver Technical Guide that would meet specific needs arising from the emergency situation. If the state wishes to temporarily add a new service, complete K-2-b-iii ***“Temporarily add services” and Section A.***

Item K-2-l: Increase Factor C

K-2-l: Increase Factor C

Instructions

If the state elects to temporarily increase Factor C (the unduplicated number of waiver participants), in the table list the waiver title and control number and the proposed revised Factor C. In the text box, explain the reason for the increase in Factor C.

Technical Guidance

During an emergency situation it may be necessary for a state to temporarily increase Factor C due to changes that a state is making in the waiver such as expanding additional targeting criteria in order to serve more individuals. It may also be necessary for a state to temporarily increase Factor C due to an increase in the number of people entering, exiting, and re-entering the waiver. Please note that this will only apply for the duration of the emergency (dates specified by the state with this Appendix K) and should the state wish to make this increase to Factor C permanent, the state will need to add an amendment request in the waiver management system (WMS) to the approved waiver.

Item K-2-m: Other

K-2-m: Other changes necessary

Instructions

Indicate, if applicable, additional temporary changes to the 1915(c) waiver that are needed by the state to address imminent needs of individuals in the waiver program. Examples include changing billing processes, uses of contracted entities, changes to electronic visit verification (EVV) processes, and/or suspending reporting requirements such as 372 reporting or evidentiary reports. In addition, the state may suspend the collection of data for performance measures other than those identified for the health and welfare assurance and note that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the emergency. While the Appendix K cannot waive statutory EVV requirements, states can account for the inability to use EVV due to the disaster in their error rates. Explain the changes in the text box.

Technical Guidance

States can temporarily modify their waivers with changes that are permissible under the 1915(c) waiver authority during an emergency situation in order to address needs of individuals in the waiver program. CMS is available to provide technical guidance on a case-by-case basis.

Contact Persons

Complete as appropriate for the operating agency and the Medicaid agency. These contacts should be accessible to CMS.

Authorizing Signature

Complete as appropriate. NOTE: CMCS will accept legal electronic signatures.

Section A---Services to be Added/Modified during an Emergency Response

If the state selected K-2-b-i; K-2-b-iv