



COVID-19 Changes to HCBS Using Appendix K: Approval Trends

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States have [many options](#) for adjusting their Medicaid services to best meet evolving needs under the COVID-19 pandemic.¹ One of the important mechanisms for ensuring people with disabilities have access to the home and community-based services (HCBS) they need to stay safely at home is an Appendix K to existing 1915(c) waivers.² This factsheet discusses CMS's guidance for using Appendix K for the COVID-19 pandemic and trends in the Appendix Ks approved thus far.

Appendix K for 1915(c) Waivers in Response to COVID-19

States may use Appendix K in an emergency to make a wide variety of changes to their 1915(c) waivers. Importantly, Appendix K can be used to add waiver capacity, lift budget and service limitations, add services, change provider qualifications, extend level of care (LOC) determinations and service plans, raise provider rates, and other changes that will improve access to services and help people with disabilities gain and maintain services they need in the community. However, there are limits to Appendix K; states cannot make changes to administrative activities, like establishing a hotline, or rules or requirements that are outside of 1915(c).

In response to COVID-19, CMS issued specific [Appendix K instructions](#) and an Appendix K template.³ The template included many useful flexibilities for the COVID-19 pandemic, including:

- allowing family members and legal responsible individuals to be providers,
- add retainer payments so people can continue to pay providers if they are under quarantine or in acute care so that those providers will not search for other work due to lack of payment,
- increase the pool of providers by raising rates and relaxing provider requirements,
- add home delivered meals and allow for additional providers for this service, including non-traditional ones,

- allow services to be provided remotely where feasible, and add medical supplies and equipment,⁴ and
- gives broad authority to states to change the assessment process and adjust assessment authority, without suggested guardrails.⁵

While the COVID-19 specific instructions and template suggest retainer payments for day programs and providing services via telehealth, it does not include increasing budgets so that congregate day programming that is closed can be replaced by other services or participants can access additional services they need should telehealth not meet their needs. Nor does the guidance suggest increases in self-direction that would allow people to seek services outside of provider agencies. The COVID-19 template also focused largely on HCBS participants who are quarantined or who have household members who are. It does not recognize the needs created when direct support staff and other providers cannot provide services due to the impact of COVID-19 generally, including closed schools. The template also fails to provide for increased waiver capacity to meet the needs of people on an HCBS waitlist who currently rely on caregivers who may become unable to meet those needs due to COVID-19. For example, Pennsylvania notes in its Appendix K that roughly 2,400 individuals on the combined waiver waitlists live with family and have primary caregivers over age 60 and potentially at risk, although Pennsylvania does not ask for increased waiver capacity to address this issue.⁶

CMS has been working with states to quickly approve different Medicaid amendments to meet changing needs under COVID-19. As of noon on March 30, 2020, CMS has approved Appendix K waiver changes for eleven states: AK, CO, CT, HI, KY, MN, NM, PA, RI, WA, and WV. CMS has also [approved 1135 waivers for 34 states](#), which generally allow states to modify a range of Medicaid requirements in a public health emergency.⁷ Appendix K and 1135 are not the only authorities states may use to modify their Medicaid programs, but Appendix K is the main source of changes for HCBS.⁸

Trends in Appendix K Approvals⁹

In the CMS COVID-19 Appendix K template, CMS encouraged states to only modify the prepopulated fields “if there is a critical need to do so.”¹⁰ This template did not actually use most of the typical Appendix K template and instead centered on an addendum that offered broad authority in many areas, such as allowing telephonic delivery of services, adding home-delivered meals, and decreasing provider qualifications. The approved Appendix Ks mostly do not reflect the CMS template. Most of the approvals are fairly complex, discussing changes to services and processes that states hope will maintain their HCBS programs during the pandemic. [Minnesota](#) has the most minimal Appendix K, with changes focused on allowing case management to be done remotely and at less frequent intervals, and to allow level of care (LOC) evaluations to be done remotely. Based on a review of the approvals, it appears that states may have to ask for additional Appendix K flexibilities as the pandemic situation

evolves. However, many states have taken similar initial steps into adjusting their HCBS programs under Appendix K.

The trend toward flexibilities for congregate care services throughout the Appendix K approvals is deeply concerning. Congregate settings, may have been the first affected due to social distancing recommendations. However, the more individually based HCBS services are already under significant strain and the COVID-19 pandemic is going to make this significantly worse. In addition, direct service workers for more individual services will likely either not be able to provide service due to the pandemic, or will need additional supports such as supplies, more time, or the need to take fewer clients to decrease risk. These concerns are largely not reflected in the Appendix K approvals.

The examples provided below are not a complete listing of approved state Appendix K features. For a chart of the approved Appendix Ks thus far at the section level, see the [KFF Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19](#).¹¹ The organization of the examples below reflect the organization of the Appendix K template and instructions.

General information:

Covered Populations:

Whether the entirety of the 1915(c) waiver population is impacted by the Appendix K changes varies between states. Most of the approvals say that the changes are based on need of the individual as they are impacted by the pandemic. A few states seem to narrow the changes to participants who either have COVID-19, are quarantined because of COVID-19, or have a household member that fits into those categories. The question of who is impacted by the changes can even vary within the same state, as the different Appendix Ks in Washington use a range of language about when waiver participants will transition to emergency service status.¹²

Transition Plans:

Many states follow CMS's suggestion in the COVID template and discuss transition to the additional services. However, under the typical Appendix K instructions, the transition plan is supposed to discuss how individuals will transition back to pre-appendix K services after the emergency is over.¹³ The COVID-19 Appendix Ks are almost all approved for a one-year period with varying start dates. This may include people who accessed the waiver under the Appendix K approval. CMS notes generally that "all applicable Fair Hearing rights apply."¹⁴ Despite this requirement, in states that specifically state the services must revert—automatically or through care planning—to pre-emergency plans of care, there is no mention of due process rights being provided.¹⁵

Waiver Amendments:

Increased Cost Limit:

States may increase the individual cost limit for the waiver which may help people state in the waiver or allow access additional services. The temporary cost limit should be specified.

- Increased cost limit if individual is being treated for COVID or the primary information caregiver is quarantined away (AK is for \$5,000 per year; CO lifts the cost limits for two of its 10 waivers; CT (in some waivers, as needed))
- Grant exceptions to individual budgets when needed due to COVID circumstances (HI (citing as examples: paid support replacement of natural supports, individual for group services, changes in service availability)

Not many states took this option. However, because many states lifted service limitations, it is not clear how, if at all, that impacts an individual's cost or budget limit in that state. Those waivers may or may not have cost limits generally.

Expanded Targeting Criteria:

In emergency situations, states may seek to broaden the population a given waiver serves. For example, a waiver that serves individuals with an Alzheimer's diagnosis might be change to a broader older adults population to prevent institutionalization during an emergency.

- [Colorado](#) allows enrollment of children onto Children with Life Limiting Illness (CLLI) waiver if they have a history of a life limiting illness or history of enrollment onto the CLLI waiver, with a physician's attestation of also being immunocompromised for the duration of the state disaster.¹⁶

Service Scope:

States can modify a service scope or coverage and is expected to submit the changed service definition from with waiver as part of the Appendix K. However, some states simply stated the changes in the Appendix K more completely and did not complete Section A of the Appendix K regarding services changes.

- Allow restrictions of visitors (AK, PA, RI, WA COPES waiver (if directed by Public Health Authorities))
 - [Rhode Island](#) waives all requirements of a community-based setting as required by 42 CFR § 441.301(c) and 42 CFR § 441.725.
- Waive choice of roommate requirement (AK, RI, PA)
- Increase in home-delivered meals (CO (2x/day and includes "Any entity providing home delivered meals" among others; KY allows any enrolled provider to consolidate the number of people in a setting on a given day)
- Allow coverage of life support, ancillary supplies, and equipment, as well as PPE equipment when needed (CO (SCI waiver); HI & WA Individual & Family Services (IFS) waiver (SMES to allow PPE and infection control))

- Add respite for waivers that did not have it previously (CO (in-home respite for CMHS))
 - WA IFS allows out of state respite for more than 30 days on a case by case basis
- Lift or allow increases to respite (most states)
- Allow for retrospective authorization (most states this change is listed under person-centered planning)
- Allow verbal or email documentation of plan changes and approval is sufficient (HI)
- Expand coverage of transportation necessary to prevent illness or meet immediate health and safety needs (certain WA waivers)
- Expand family consultation to include emergency preparedness consultation (certain WA waivers)
- Allow the use of assistive technology funds of more than \$250 but no more than \$500 to purchase the necessary technology to use video conferencing for ([NM](#))

Exceed Service Limits:

States usually limit the amount or duration of services in a waiver. An emergency may cause an increased need for services or changes in the mix of services a person needs. Under Appendix K, a state can allow for exceeding limitations on sets of services or individual service limitations.

- Increase or provide for unlimited respite (most states)
- Increase in personal care or similar hours (most states; AK (difference for those with respiratory illness already in waiver and continues in increase))
- Increase in case management (most states)
 - In contrast, Minnesota waived the requirement for a minimum number of case management contacts in a given period
- Allow specific services to exceed limits based on demonstrated need (most states; services vary and even vary within a state by waiver)
- Suspend limitations on nursing (most states)

Additional Services:

Section 1915(c) waivers allow for broad authority for states to offer “other services” not expressly authorized in the statute as long as those services are necessary to help a waiver participant avoid institutionalization. This is an area in which states can get creative regarding the services necessary in an emergency. If a state chooses to add services during an emergency to its waiver, it is expected to complete Section A of the Appendix K, which most states did when adding a service.

- Remote/telehealth Services
 - Use of remote support systems of monitoring to replace on-site staff (CO (all waivers))

- Most states allow remote provision of service through changing the service setting rather than adding a service
- Add nursing in settings not typically allowed (HI, PA)
- Add COVID-related information and training (some WA waivers)

Service Settings:

Waiver service definitions typically limit services to identified settings. Although some changes to services settings would be allowed by CMS, it recommends that the State advise CMS when such changes are likely to occur and the safeguards for ensuring participants get the services authorized in their plan of care and are provided in the best interest of the individual.

- Allow services to be provided through virtual means.
 - Most states, although not all, allow telehealth for waiver services where it is effective, and most do not require prior approval for use of virtual means. However, some place limits on the service and the method of telehealth.
 - CO only allows home and vehicle modifications and assistive technology to be done through video;
 - The [WA COPES](#) waiver Appendix K allows Adult Day Health to be delivered in the client's residence or through telephonic wellness checks.
 - [New Mexico](#) permits physical, occupational, and speech therapy, behavioral consultations, and private duty nursing to be done through telehealth or phone visits.
 - Most states when authorizing remote or telephonic methods for delivering services or carrying out person centered planning or level of care evaluation cite HIPAA protections. Minnesota specifically cited [OCR's HIPAA guidance during COVID](#) regarding good faith communications.
- Allows services to be provided in additional settings (most states)
 - Some limit this to settings licensed under the waiver, but most are much more broad and specifically allow services to be provided in hotel rooms, temporary placements, etc.
 - States do limit this to certain services and services by waiver, with a general trend toward allowing residential or congregate settings more stated flexibility

Many states limited the services that could be provided through remote or virtual means, but even for some of these services it was unclear how this mechanism would always meet the needs of that service. For example, [Kentucky](#) follows the CMS COVID-19 template and allows virtual delivery of services for cueing and monitoring. This may work for some, but many people who need cueing and prompting need supervision in tasks and it is not clear how this will happen virtually.

Kentucky is also one of the few states that puts any limit on where residential and respite services can be provided, requiring that the setting must be operable according to federal guidance on safe practices, the space must be sufficient to allow distancing, and have the needed facilities (kitchen, bathrooms, sleeping arrangement, treatment rooms, and safe medication storage). While providing for flexibility in service settings is likely necessary, guardrails such as necessary space for the number of people, required facilities, and minimal staffing ratios should be included to address health and safety concerns.

Family Caregivers:

Section 1915(c) waivers permit states to allow family caregivers and legally responsible individuals who would typically be prevented from providing services to be paid caregivers.¹⁷ Recognizing that an emergency may put stress on the provider pool and that in health emergencies isolation may be recommended, Appendix K allows states to temporarily allow family caregivers and legally responsible individuals to be paid providers. However, the OIG excluded provider list still applies.

- Allow payment for family caregivers/legally responsible individuals if regular staffing is not available or replacement staff cannot be found (AK, PA, WV (only for TBI waiver), NM)
 - Some states restrict this to certain services, usually unlicensed or non-professional services.
 - Only a few waivers restrict the amount of services provided by such caregivers. (PA Adult Autism waiver extends the 40 hour limit over seven days to 60 hours over seven days).
- Colorado has a general statement about allowing family/legally responsible caregivers

Provider Qualifications:

To increase the pool of providers in an emergency, the state may temporarily modify provider qualifications to ensure participants receive necessary services. The OIG excluded provider list applies here as well.

- Extend certifications (AK, WA)
- Delay requirement for training, background checks, etc. (AK, HI, RI, KY, WV, NM)
- Waive training requirements (CO (CDASS authorized representative); HI)
- Modify screening/training requirements (WA, KY, NM)
- Allow residential program administrator to not meet regular qualification requirements (AK)
- Waiver caregiver age from 18 to 16 for specific services (CO (specific services for certain waivers))
- Waive conflict of interest requirements that typically prohibit case management from also being a provider. (KY (approved for 180 days or less and will be revisited to check on provider availability))

- Suspend or delay the requirement for supervision by a registered nurse or allow remote supervision by a registered nurse for home health aides (NM)

Provider Types:

To help expand the pool of providers, states may include additional provider types for different waiver services, including expanding to non-traditional waiver service providers. This could include things like allowing mold abatement specialists after a flood to provide chore-type services or using neighbors or acquaintances as service providers.

- Permit providers who are qualified providers for other services or under other waivers in the state to provide all services to all waiver recipients (within their professional scope) (KY, CO (specific services and waivers); HI (certain services for any Medicaid enrolled providers); NM)
- Specialized equipment and supplies and assistive technology providers may purchase necessary items from non-traditional vendors when supply or cost impacts occur due to COVID. (most WA waivers)
- Permit substitution of lower level staff in a service plan, such as substituting a companion for a homemaker when necessary and in order to maximize use of available staffing resources (CT)

Provider Licensure:

States may modify typical licensure or certification requirements. This typically would allow additional settings where services can be provided. 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 HCBS requirements. In COVID-19, states mostly used this flexibility to ease administrative burdens.

- Postponing licensure reviews or extending recertifications (RI, WV, CO (case-by-case basis));
- Waive provider ratios due to staffing shortages (HI (certain services))
- Tendency to focus on congregate providers, such as residential and day habilitation programs, as compared to other HCBS providers.

Level of Care/Assessment Process:

States are allowed to modify the level of care eligibility evaluations and re-evaluation processes, including the required timeframe in which the re-evaluation is to be completed. However, a state may not extend the timeframes for re-evaluations beyond 12 months past when the re-evaluation was due. In the COVID-19 template, CMS indicated broad authority to adjust assessment requirements, which in states that rely on assessment to determine amount of services, could have significant impacts.

- Most encourage telephonic evaluations and record reviews for new evaluations (AK, CO, HI, MN, PA, RI, WA IFS (requests in-person but mechanism to allow all electronic), WV)
 - Rhode Island states it will conduct in-person assessments to confirm LOC after the end of the emergency.
- Remote/telephonic reevaluations (CO, MN, PA, RI, WA, WV)
- Delay of annual evaluations for a variety of time (1 year (AK, HI, CT); case by case basis (WA for some, up to one year for other waivers); PA; RI (6 months); WV (until 7/1/2020 at choice of member; active members who decline remote assessment may continue services for three months after their anchor date)
- Waive requirement for physician attestation or level of care recommendation for ICF/IDD level of care and instead rely on other mechanisms such as confirmation of intellectual or developmental disability, records, etc. (NM, PA)
- Delay of assessment after enrollment (CO)
- Postpone assessment inter-rater reliability for up to 1 year when workforce is limited or client's household are impacted by COVID (most WA waivers)

The common LOC changes should help decrease face-to-face contact and administrative burden by extending certifications and using remote mechanisms. However, [Alaska](#) cites in this section that it can communicate electronically with care coordinators regarding approval of support plans, but that it may need additional time to send hard copies to participants.¹⁸ It is unclear if individuals will otherwise be told about the updated LOC criteria or the plans they may affect. This could have significant impacts on due process, especially if people are being reassessed because they need additional services and have had the services they need denied. This same concern is true for changes to the person centered planning process.

Increase Payment Rates:

Under Appendix K, states may temporarily increase provider payment rates and should list the provider types, rates by services, and whether the rate varies by provider. If the rate modifications last beyond the emergency, it would have to make additional waiver changes. The state must still demonstrate that the waiver is cost neutral.

- Set increase in rates for residential, respite, and chore providers when the participant or someone in their household is quarantined because of COVID (AK)
- Allow for increase in rates based on availability of services that impacts ability of participants to receive the service (AK & KY up to 50%, PA up to 40% for some but not all waivers, most WA waivers have no limit, but the Residential Supports, New Freedom, and COPES waivers state a 25% cap); CT TBI & ABI waivers allow for time-and-a-half payment when working over 40 hours/week subject to departmental approval for some services due to staff shortage with a note that a new rate is in development to meet this need)

- Colorado creates a set increased rate that is largely biased toward more congregate settings. It has two separate enhanced rates, an 8% enhanced rate for most of the services, and then has a 13% enhanced rate for what are mostly residential services (varies by waiver).
- Increased to account for excess overtime to cover staffing needs and to account for infection control supplies and services costs (PA)

Person-Centered Planning Process:

The state may modify the person-centered planning process, including who is involved, during an emergency. But it must also still have safeguards to ensure that individuals' needs are met and how the service plan will be implemented during the emergency.

- Extend current plan of care if it is meeting the individual's needs and the renewal date occurs within the emergency period
 - States vary in the time the plan will be extended. For example, Alaska extends for 12 months, Rhode Island postpones for five months, and West Virginia for three months with additional time granted on a case-by-case basis.
- Case management through remote/telephonic means (most states)
- Allow for retroactive approval for services needs to meet COVID-based needs (HI, WA, WV; some states require the plan to be updated within 30 days (AK, NM, KY))
- Use of electronic signatures, email approval, or verbal approval (HI, KY, PA, most WA waivers)
- Modify timeframes or processes for planning (HI)
- Suspend prior authorization requirements (NM)

Incident Reporting:

States may temporarily modify incident reporting requirements, medication management, or other participant safeguards to ensure individual health and welfare. If a state does so, it must describe the safeguards in place to ensure the state has timely access to information regarding participants' health and welfare. Examples of changes could include expanding the individuals responsible for reporting incidents or adjustments to the method or timelines for data collection.

- Modify timelines for reporting (HI) (WA for staff shortages)
- Suspend requirement to submit report for and conduct investigation for deviation of staffing, but must report when shortage results in failure to provide care (but no investigation required) (PA)
 - Most of the PA waivers note that the providers must ensure that participants at the highest risk continue to receive services.
- Permit case assessment/required visit in response to incident to occur remotely (HI)

- Providers must submit critical incident reports to report any waiver-funded disruption extending beyond three calendar days to services document in the PCP. This includes disruptions due to staff unavailability related to COVID staff infection, quarantine, or other pandemic-related circumstances. (KY)
- Delay in method and timing of reporting if person needs to evacuate current setting (CO)
- Providers must submit critical incident reports for participants who tested positive for COVID-19 and disclose in the incident report the exposure of COVID-19 positive participants with any other waiver participants and/or staff. Providers need not conduct an investigation or submit a corrective action plan unless directed by the state to do so (KY)
- Extension to respond to CMS evidence reports (AK)

Supports in Acute Settings:

A state may temporarily allow waiver services to be provided to support a participant in an acute care hospital or short-term institutional stay when those supports are not available in the setting, such services are not covered by the institutional staff, and the individual requires those services. This is commonly used for communication needs, intensive personal care, or behavioral needs.

- Usually restricted to certain services, such as personal care and behavioral
- Limited to 30 days (AK, CO, HI)
- Explicit exclusion of ICF/IID (HI)
- Most do not require prior approval (WA IFS exception)

Some of the approvals seem more focused on congregate or residential services as opposed to being inclusive of all HCBS that may be helpful in supporting an individual in an acute setting. Given that the COVID-19 pandemic may mean temporary hospitals or acute care setting, decreased staffing ratios, and other issues, it seems shortsighted to not be as inclusive as possible of the types of services that can be provided in acute care settings.

Retainer Payments:

Payments may be made to personal assistants when a participant is hospitalized to help the participant maintain that provider.¹⁹ This option may only be implemented for a time limited basis.

- Some states limit to when an individual is under medical quarantine and is often only for specific services
- May not exceed 30 days (AK, CO, HI) (KY is 24 consecutive days)
- Limits to 40 hours per week when the participant is unable to receive services for direct care workers (HI (not for other services))

- State will determine rate and scope of retainer payments based on severity of situation (KY)
- Retainer payments not to exceed 75% of monthly average for total billing (PA)

Alaska is among other states that focus retainer payments more on residential and congregate care settings.

Self-Direction:

Expansion of self-direction, including expanding services and decision making authority, is a useful option for states during an emergency. Adding participant-directed goods and services under self-direction would allow greater flexibility for individuals to access what they need during the emergency, including from non-traditional sources.

- Suspend all required additional screening specifically required for immediate family members to approve them as an employee. Once the emergency period has ended, employees including family members must go through screening (KY)

Other Changes Necessary:

States may indicate additional temporary changes needed to address imminent needs of participants during an emergency. This is not an unlimited authority and states would need to work with CMS as to what this encompasses.

- Allow participants to receive only one service per month for the length of the disaster without being subject to discharge. Those services may be telephonic/remote (CO)
- Allow participants to receive fewer than one service per month without being subject to discharge (HI (120 days, requires monitoring by case manager); WA (most waivers for 90 days); WV)
- Delay or cancel on-site provider validations and reviews for quality management, performance measure reporting, and financial audits (HI)

Advocacy Recommendations:

The Appendix Ks approved thus far cover many key flexibilities to help maintain or improve access to HCBS during the pandemic. Flexibility in rates, providing services through remote mechanisms, allowing family members and legally responsible individuals to be caregivers, lifting limits on respite and other services to adapt to changing needs, and extending certifications and plans of care should help states, providers, and participants adapt to the changing dynamic. Some of the other common themes, like allowing services to be provided in any setting, especially residential ones, and waiving or delay provider qualifications could be putting participants at risk of abuse and neglect if there are not appropriate, functioning systems in place that give them an opportunity to report issues and have them acted upon.

The typical systems that protect against such issues may not be in place, such as no posted signs and numbers to report issues in new or different settings, and entities that accept reports may be difficult to reach or get a response from. Advocates should consider what protections could be in place and functional that would permit the requested flexibilities, yet still provide protections. This could include guardrails on what safeguards facilities must minimally have and having case management clearly inform the participant how they can raise issues. Advocates should also be watching for flexibilities that support congregate care settings to greater advantage than more individualized services.

States must also be clearer about what due process protections will be in place under some of these flexibilities. For example, if the state denies a request for additional services or to exceed limits, will it provide appeal rights. Or will the combination of flexibilities be used such that care planning will occur in a way that discourages, and effectively denies, requests for services in a way that violates due process. Also, states need to be clearer about what happens when the emergency ends and services return to their previous position. What will happen if the provider network is so adversely affected that people cannot find providers at the previous rate? In general, how will the state approach person-centered planning and providing due process for changing services back to their previous state?

The Appendix Ks approved to date have also not taking up the flexibilities that could be critical, such as temporarily expanding waiver capacity for people whose caregivers are impacted by COVID-19 in such a way that they cannot provide the supports they currently do. Appendix K would also allow states to offer the service of “goods and services” that would allow greater flexibility in allowing people to access what they need through non-traditional mechanisms, but states have yet to take this option. And very few states have taken the opportunity to increase the home-delivered meals service to help people who may now be at home more often or need to limit individuals coming to their home to prepare a meal. Even fewer have opted to broaden approved providers of those home-delivered meals.

Each state will differ in what will be most effective during this pandemic. Advocates should look at the Appendix K instructions, the COVID-19 specific materials, and what other states have done to get ideas of what their state could do. But advocates should also think creatively about what the population of people with disabilities need from their Medicaid HCBS system. Appendix K permits significant flexibilities and more is possible than what has been approved thus far.

ENDNOTES

¹ Leo Cuello, NHeLP, Overview on Using Medicaid to Respond to COVID-19, <https://healthlaw.org/resource/overview-on-using-medicaid-to-respond-to-covid-19/> (Mar. 19, 2020),

² See generally CMS, Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers, <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/appendix-k/index.html>.

³ *Id.* (for Appendix K template); CMS, Appendix K Instructions, <https://www.medicaid.gov/state-resource-center/downloads/1915c-appendix-k-instructions.pdf>.

⁴ *Id.*

⁵ Appendix K Template & Instructions, *supra* note 3.

⁶ See, e.g., Pennsylvania Consolidate Waiver Appendix K 2, <https://www.medicaid.gov/state-resource-center/downloads/pa-0147-appendix-k-appvl.pdf>.

⁷ CMS, Trump Administration Approves 34th State Request for Medicaid Emergency Waivers (Mar. 27, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-approves-34th-state-request-medicaid-emergency-waivers>; see also CMS, 1135 Waivers, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers> (describing the 1135 authority generally); CMS, Federal Disaster Resources, <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/index.html> (posting the 1135 approval letters).

⁸ See Cuello, *supra* note 1, at n. 1 *citing* Medicaid and CHIP Coverage Learning Collaborative, *Inventory of Medicaid and CHIP Flexibilities and Authorities* at 3 (Aug. 20, 2018), <https://www.medicaid.gov/state-resource-center/downloads/mac-learningcollaboratives/medicaid-chip-inventory.pdf> (describing the various flexibilities states have to adjust their Medicaid programs); see also NASDDDS, COVID-19 State and Federal Resources, <https://www.nasddds.org/news/covid-19-state-resources-and-materials> (collecting federal and state Medicaid updates and announcements).

⁹ The states did not consistently categorize changes in the same way. This factsheet groups the changes under the topics the way that most states did.

¹⁰ Appendix K Instructions.

¹¹ Kaiser Family Foundation, Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19 (Mar. 27, 2020), <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>.

¹² See, e.g., WA Individual and Family Services, Appendix K 2, <https://www.medicaid.gov/state-resource-center/downloads/wa-1186-appendix-k-appvl.pdf>. (“IFS waiver participants will transition to emergency service status as soon as it becomes evident that they are impacted by the COVID-19 outbreak. This will be evidenced by contraction of COVID-19 by the waiver participant, their provider or their housemate, local quarantines, or other guidance of isolation or precautionary measures issued by local or federal health departments.”) Compare WA New Freedom 2, <https://www.medicaid.gov/state-resource-center/downloads/wa-0443-appendix-k-appvl.pdf> (“Individuals will transition to pre-emergency service status as soon as circumstances allow. Individual needs will be reassessed, as necessary, on a case by case basis following the return to pre-emergency services.”); WA Community Protection 2, <https://www.medicaid.gov/state-resource-center/downloads/wa-0411-appendix-k-appvl.pdf> (“Community Protection waiver participants will transition to emergency service status as soon as it becomes evident that they are impacted by the COVID-19 outbreak. This will be evidenced by contraction of COVID-19 by the waiver participant, their provider or their housemate, local quarantines, or other guidance of isolation or precautionary measures issued by local or federal health departments.”).

¹³ CMS, 1915(c) Home and Community-Based Services Waiver: Instructions and Technical Guide -- Appendix K: Emergency Preparedness & Response, <https://www.medicaid.gov/state-resource-center/downloads/1915c-appendix-k-instructions.pdf>. (“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. Please see the “Transition Plan” Section of the CMS HCBS Waiver Technical Guide for additional guidance or information regarding transition plans. Please note that all

applicable Fair Hearing rights apply.”) Compare CMS, Appendix K COVID Template Sec. G, available at <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/appendix-k/index.html> (Regarding transition plan: “All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.”) Typically, a transition plan is supposed to address how individuals and their services will be impacted by changes to a waiver, how those who will be ineligible will be transitioned to other services, the timeline for transitioning, and how participants will be notified and the opportunity for a fair hearing. CMS, 1915(c) Technical Guide 57-59 (Jan. 2019). See also note 11, *supra*.

¹⁴ CMS, 1915(k) Instructions, *supra* note 13.

¹⁵ See, e.g., Pennsylvania, Community HealthChoices 3, <https://www.medicaid.gov/state-resource-center/downloads/pa-0386-appendix-k-appvl.pdf> (“Upon the date the Department has declared that the statewide emergency has ended, services will resume automatically, without further action by the Participant or the by Person-Centered Planning Team, to the amount, frequency and duration approved in the participant’s Person-Centered Service Plan (PCSP) prior to implementation of Appendix K changes.”)

¹⁶ Colorado, Combined Waivers Appendix K 3, <https://www.medicaid.gov/state-resource-center/downloads/co-combined-appendix-k-appvl.pdf>.

¹⁷ Elizabeth Edwards, NHeLP, Q&A Relatives as Paid Providers (Dec. 5, 2014), <https://healthlaw.org/resource/qa-relatives-as-paid-providers/>.

¹⁸ Alaska, Combined Appendix K 6, <https://www.medicaid.gov/state-resource-center/downloads/ak-combined-appendix-k-appvl.pdf>.

¹⁹ See Olmstead Letter #3, <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf>.