



Federal and State Policy Actions: COVID-19

Last Updated: March 31, 2020

Disclaimer: This document provides a summary of selected waivers and actions being taken during the COVID-19 emergency period. For a comprehensive list of all information relating to COVID-19, please refer to CMS updates located at <https://www.cms.gov/newsroom>

Highlights as of March 31, 2020

What We're Hearing

- Personal Protective Equipment (PPE), and safety of health care workers, is a top concern across the care continuum
- Healthcare providers are paying significantly more for PPE than before the crisis
- PAC providers are willing and ready to be part of the solution for hospital overflow – segmentation and safety of their residents is a top priority
- Providers are appreciative of CMS flexibility and responsiveness and focus on taking care of beneficiaries

Medicaid Updates

- **Medicaid 1135 Waivers:** CMS approved flexibility for 38 states to implement core program flexibilities such as waiving PASRR, waiving FFS prior authorization, and relaxing provider enrollment requirements
- **1915(c) Appendix K:** CMS approved home and community based (HCBS) flexibility for 11 states including approaches such as expanded telehealth/ telephonic services, increased pay providers in certain situations, expanded benefits and program eligibility, and payment of family members

Medicare FFS Updates

- **New Interim Final Rule:** CMS is changing regs during the Public Health Emergency to give providers flexibility to provide services to Medicare beneficiaries
- **Reimbursement:** CMS has issued several blanket waivers that reduce requirements for PAC reimbursement in an effort to expand system capacity
- **Accelerated and Advance Payment:** CMS expanded program to cover most Medicare providers/ suppliers
- **Telehealth:** CMS expanded access to telehealth and encourages utilization (e.g., waives originating site, geography limitations, and provider requirements)

Medicare Advantage Updates

- CMS advice to Medicare Advantage plans:
 - **Cost sharing:** waive or reduce
 - **Telehealth benefits:** expand
 - **Prior Authorization:** waive for COVID-19 tests
 - **Medical and supplemental benefits:** cover services at non-contracted facilities at contracted/in-network cost-sharing
 - **Prescriptions:** waive refill requirements, increase access to home or mail delivery, relax out of network pharmacy rules

New Flexibilities To Increase PAC System Efficiency

	Pre-Acute	Acute/Inpatient	Post-Acute	Monitoring
Medicare FFS	Telehealth access and coverage expansion	SNF: 3-day inpatient waiver and coverage renewal IRF, LTCH: Reduced reimbursement requirements		Telehealth access and coverage expansion
	Lift of 2% payment reduction			
	HHA, IRF, LTCH, SNF: Expanded access to Accelerated and Advance Payment Program			
Medicare Advantage	CMS advice: Waive or reduce cost sharing for beneficiaries impacted by emergency			
	CMS advice: Relax prior authorization requirements related to COVID-19			
	CMS advice: Waive or reduce cost sharing of COVID-19 testing and services			
	CMS advice: Waive or reduce cost sharing of COVID-19 testing and services			
	CMS advice: Telehealth expansion			CMS advice: Telehealth expansion
Medicaid	CMS approved 1135 Waiver Flexibilities for 38 states			
	CMS approved 1915(c) Appendix K for 11 states			

Federal Actions

Federal Waivers in CARES Act Focused on PAC Providers

Section	Description
<p>3703 – <i>Increasing Medicare Telehealth Flexibilities during Emergency Period</i></p>	<ul style="list-style-type: none"> Removes the requirement that telehealth services must be delivered by a provider that has seen the patient within the past three years, thus enabling a broader range of providers to deliver these services
<p>3706 – <i>Use of Telehealth to Conduct Face-to-Face Encounter Prior to Recertification of Eligibility for Hospice Care during Emergency Period</i></p>	<ul style="list-style-type: none"> Permits hospice physicians and nurse practitioners to utilize telehealth to fulfill the face-to-face encounter requirement for hospice recertifications
<p>3707 – <i>Encouraging Use of Telecommunications Systems for Home Health Services Furnished during Emergency Period</i></p>	<ul style="list-style-type: none"> Encourages the use of telehealth technology, including remote patient monitoring, for home health services that are consistent with the patient’s plan of care
<p>3708 – <i>Improving Care Planning for Medicare Home Health Services</i></p>	<ul style="list-style-type: none"> Allows physician assistants, nurse practitioners, and other providers to certify and order home health services for individuals, as opposed to only the physician having the authority to do so, for the 6-month period following the enactment
<p>3711 – <i>Increasing Access to Post-Acute Care during Emergency Period</i></p>	<ul style="list-style-type: none"> Increases access to alternative PAC settings by temporarily waiving the requirements that patients at an IRF must receive at least 15 hours of therapy per week and the LTCH 50% rule, thus allowing LTCHs to maintain their LTCH designation even if more than 50% of cases are less intensive Temporarily pauses the LTCH site-neutral payment methodology

Other Medicare and Medicaid Provisions Affecting PAC Providers in CARES Act

Section	Description
3709 – <i>Adjustment of Sequestration</i>	<ul style="list-style-type: none"> • Lifts the Medicare sequester, a mandatory 2% payment reduction, from May 1 through December 31, 2020 to increase payments to health care providers in Medicare • Extends the Medicare sequester through 2030 instead of the currently stated 2029
3715 – <i>Providing Home and Community-based Services in Acute Care Hospitals</i>	<ul style="list-style-type: none"> • Permits state Medicaid programs to pay for direct support professionals to provide home and community-based care to hospitalized patients, thus aiming to transition the patient out of the hospital and into a home and community-based setting as soon as possible
3811 – <i>Extension of the Money Follows the Person Rebalancing Demonstration Program</i>	<ul style="list-style-type: none"> • Provides additional funding and extends the Money Follows the Person demonstration, a program that helps individuals transition from an institutional care setting to a home and community-based setting, through November 30, 2020
3812 – <i>Extension of Spousal Impoverishment Protections</i>	<ul style="list-style-type: none"> • Extends the Medicaid Spousal Impoverishment Protections program, a program that helps a spouse of an individual who qualifies for nursing home care to live at home in the community, through November 30, 2020 instead of the original end of May 22, 2020

CMS Has Issued Blanket Medicare Waivers and Regulatory Changes That Alter SNF Requirements

PAC Setting	Description
<p>Skilled Nursing Facilities (SNF)/Nursing Facilities (NF)</p>	<ul style="list-style-type: none"> • Permits Medicare to pay for SNF coverage without a 3-day inpatient hospital stay for beneficiaries who are dislocated or affected by the emergency • Grants renewed SNF coverage (up to an additional 100 days) for beneficiaries who had either begun or were in the process of ending their spell of illness by removing the requirement of 60+ days of custodial care at a noninstitutional setting in order for these beneficiaries to start a new benefit period • Relaxes timeframe requirements for Minimum Data Set assessments and transmission • Allows non-SNF buildings to be temporarily certified as and available for use by a SNF to isolate but continue to care for COVID-19 positive residents • Permits rooms in a SNF not normally used as a resident's room, such as dining rooms and conference rooms, to be used to accommodate beds and residents to provide surge capacity • Allows SNFs to move residents within a facility or transfer residents to another SNF in order to separate residents with and without COVID-19. <ul style="list-style-type: none"> ○ <i>If providing services under arrangement:</i> Transferring SNF should not issue a formal discharge for the patient since it is still considered the provider and should continue to bill Medicare for care. Transferring SNF is responsible for reimbursing the receiving SNF. ○ <i>If not providing services under arrangement:</i> Transferring SNF should discharge patient. Receiving SNF is responsible for billing Medicare. • Relaxes requirements for submission of staffing data through the Payroll-Based Journal system • Allows SNFs to suspend Pre-Admission Screening and Annual Resident Review assessments for new residents for 30 days. After 30 days, newly admitted patients with a mental illness or intellectual disability should receive assessment as soon as resources are available • Permits facility to restrict residents from organizing and participating in in-person resident group meetings

CMS Has Issued Blanket Medicare Waivers and Regulatory Changes That Alter HHA Requirements

PAC Setting	Description
<p>Home Health Agencies (HHA)</p>	<ul style="list-style-type: none"> • Waives 42 CFR 484.20(c)(1) to relax timeframe requirements related to OASIS Transmission • Allows MACs to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) (requests that grant 60% of the episode payment upfront to provider) to ensure the correct processing of home health emergency-related claims • Modifies the “homebound” requirement to permit patient to qualify for Medicare Home Health Benefit if requires skilled services and a physician determines they should not leave home due to a medical contraindication or COVID-19 symptoms • Waives requirement for nurse or other professional to conduct onsite visit every 2 weeks to evaluate if aides are providing care consistent with care plan • Uses enforcement discretion to allow NP, CNS, and PAs to order HH, create and review care plan, and certify HH eligibility

CMS Has Issued Blanket Medicare Waivers and Regulatory Changes That Alter PAC Requirements

PAC Setting	Description
<p>Long-Term Care Hospitals (LTCH)</p>	<ul style="list-style-type: none"> Excludes patient stays that do not meet the 25-day average length of stay requirement for LTCHs that admit or discharge patients in order to meet the demand of the emergency, and enables these LTCHS to still be paid as LTCHs
<p>Inpatient Rehabilitation Facilities (IRF)</p>	<ul style="list-style-type: none"> Allows IRFs to exclude patients from their population when calculating the 60% threshold requirement (each IRF must discharge at least 60% of its patients with 1 of 13 qualifying conditions) to receive payment as an IRF if patients are admitted as a response to the emergency (rule applies to both facilities that are classified as IRFs and those that are attempting to obtain classification) Removes requirement that physicians must conduct and document post admission evaluations for admitted Medicare patients Permits freestanding IRFs to work with acute care hospitals under arrangements to provide surge capacity Grants flexibility if IRFs are having difficulty conducting the required intensive rehabilitation therapy program due to disrupted staffing shifts
<p>Hospice</p>	<ul style="list-style-type: none"> Waives requirement for nurses or other professionals to conduct onsite visit every 2 weeks to evaluate if aides are providing care consistent with care plan Waives requirement that hospices must use volunteers, including to provide at least 5% of patient care hours Extends timeframe for updates to comprehensive assessments from 15 to 21 days Waives requirement to provide certain non-core services such as physical therapy, occupational therapy, and speech-language pathology

Survey and Certification in PAC

- CMS has developed a three-pronged survey approach during a three-week period of 3/20/20 – 4/11/20:
 1. Respond to Immediate Jeopardy investigations that pose imminent threat to patient health and safety
 2. Work with CDC to identify areas at risk of COVID-19 spread to ensure providers are compliant with infection control requirements
 3. Roll out a voluntary self-assessment infection control tool to providers
- CMS urges PAC facilities to use the self-assessment tool to ensure they are prepared to prevent the spread of COVID-19
- Facilities will be expected to take corrective actions to close any gaps identified in the survey inspection process
- Standard inspections of PAC facilities and revisit inspections not associated with Immediate Jeopardy will not be conducted during the emergency period
- CMS is suspending enforcement actions for penalties (outside of Immediate Jeopardy) due to lack of revisits to verify compliance

CMS Expanded Access to Telehealth Services with 1135 Waiver

- Medicare will pay for telehealth visits occurring all over the country, instead of limiting to beneficiaries living in rural locations
- Beneficiaries may receive telehealth visits in any healthcare facility and in their home, thus removing the “originating site” limitations
- Telehealth visits will be reimbursed at the same rate as in-person visits
- Waives requirement that beneficiary must have a prior established relationship with the practitioner who is providing the telehealth services
- Providers may reduce or waive cost-sharing for telehealth visits
- CMS will pay for >80 additional services delivered via telehealth including ED visits and home visits
- Permits telehealth visits via audio phones only (no video requirement)

Telehealth and PAC

- PAC providers may use telehealth to fulfill face-to-face visit requirements for patients in HH, hospice, SNF, and IRF

Home Health Agencies

- HHAs can provide services via telehealth if services are included in care plan and if services do not replace any required in-person visits in care plan

Hospice

- Providers can deliver routine home care via telehealth if feasible and appropriate

Skilled Nursing Facilities

- CMS will pay for initial nursing facility and discharge visits delivered via telehealth

Inpatient Rehabilitation Facilities

- Telehealth may be used to fulfill the requirement for physicians to conduct the required face to-face visits at least 3 days a week

Expansion of Accelerated and Advance Payment Program

- Expanded to a broader group of Medicare Part A providers and Part B suppliers during the emergency period
- Eligibility requirements for Medicare providers and suppliers include having billed Medicare for claims within past 180 days and to be in good standing
- Qualified providers/suppliers must submit a request to the MAC and payments should be issued within 7 calendar days of request
- Payment amounts differ by provider type – most will be able to request up to 100% for a 3-month period, while specific types of hospitals may request for a 6-month period
- Repayment period is extended to begin 120 days after payment is issued, and timeline varies by provider type

CMS Relaxes Hospital Discharge Planning with Patients Over Paperwork Initiative

- CMS waived 42 CFR §482.43(c) which requires a hospital to inform patient of all PAC facilities available to the patient in the geographic area
- Applies to patients discharged home and referred for HHA services, patients transferred to a SNF for post-hospital extended care services, or patients transferred to an IRF or LTCH for specialized hospital services
- Hospitals will discharge patients to *available* PAC facilities instead of providing a comprehensive list of all available facilities and giving patient the option to choose

CMS Offers Flexibilities with Medicare Provider Enrollment

- Toll-free hotlines established for all providers and Part A certified providers/suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges
- Waives application fee, fingerprint-based criminal background check, and site visit components of screening requirements
- Postpones all revalidation actions
- Allows licensed providers to render services outside of their state of enrollment
- Expedites any pending or new applications from providers

CMS Granted Extensions for Medicare Appeals

- Review entities can grant extensions for filing an appeal in FFS, MA, and Part D
- Waived timeliness requirements for requests that require additional information to adjudicate the appeal
- Granted permission to review entities to:
 - Process appeals with incomplete Appointment of Representation forms – communication will only be sent to the beneficiary
 - Process requests for appeal that don't meet the required elements using information that is available
 - Utilize all flexibilities available in the appeal process as if good cause requirements are satisfied

CMS Granted Flexibility with Cost Reporting

- Delayed the filing deadline of cost report due dates for the following fiscal year end (FYE) dates:
 - Extended cost report due dates for October and November FYEs will be 6/30/2020
 - Extended cost report due date for FYE 12/31/2019 will be 7/31/2020

Federal Flexibilities for Medicare Advantage Plans

- CMS advised that Medicare Advantage Plans may implement the following changes during the emergency period:
 - Waive or reduce cost-sharing for beneficiaries impacted by emergency
 - Waive or reduce cost-sharing for COVID-19 lab tests, treatments, or services delivered via telehealth
 - Expand coverage of telehealth benefits
 - Waive prior authorizations requirements for services or tests related to COVID-19
 - Waive prescription refill limits to ensure pharmacy access
 - Relax restrictions on home or mail delivery of prescription drugs
- CMS is pausing many standard medical review activities, including prior authorization, and reprioritizing audits
- CMS is relaxing many star rating measure requirements, including removing the requirements to submit HEDIS and CAHPS measures

Federal Actions: Medicaid

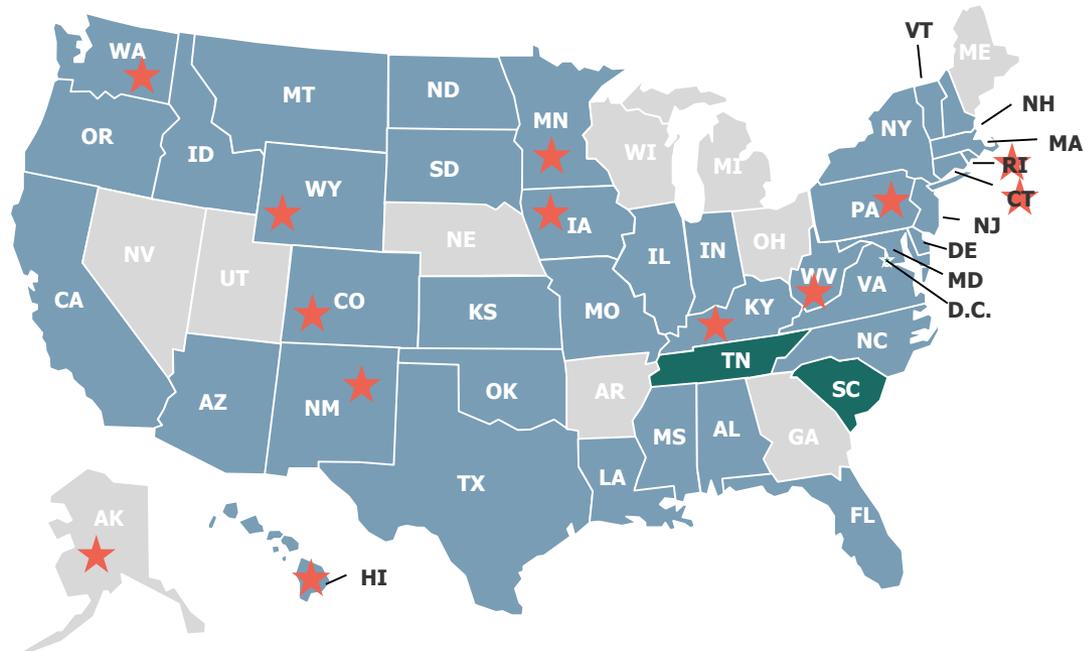
- CMS is allowing states to waive certain Medicaid authorities including:
 - Waive prior authorization requirements in FFS programs
 - Allow for out-of-state providers to provide care
 - Suspend certain provider enrollment and revalidation requirements
 - Suspend pre-admission and annual screenings for nursing homes
 - Expand provider qualifications/ increase provider pool
 - Permit payment to HCBS providers when an individual is in a short-term hospital or institutional stay
 - Increase HCBS waiver participants
 - Expand self-direction
 - Allow non-physician practitioners to order home health services and equipment

State Actions

State Actions: Medicaid 1135 Waivers and 1915(c) Appendix K

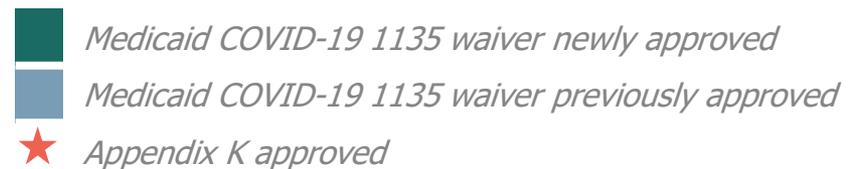
Previously Profiled

- **1135 waivers** previously approved by CMS: AL, AZ, CA, CO, CT, DE, FL, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, MN, MO, MS, MT, ND, NH, NJ, NM, NC, NY, OK, OR, PA, RI, SD, TX, VA, VT, WA, WV, WY
- **Appendix K** previously approved by CMS: AK, CO, CT, HI, KY, MN, NM, PA, RI, WA, WV



Status Update

- **1135 waivers** newly approved in SC & TN
- **Appendix K** newly approved in IA & WY



Implementing Full Scope of State Requests

- CMS notes it will work with states separately on requests that exceed the core 1135 provisions (e.g., food, housing)
- CMS is reminding states they can leverage blanket authority to deploy provider flexibilities. Examples include:
 - SNF 3-day waiver
 - SNF new benefit period without completion of 60-day break
 - IRF 60% waiver
 - LTACH exclusion of emergency patients from 25-day calculation
 - HHA relief on OASIS submissions

Summary of Key Attributes of 1135 Waiver Request Approvals

Suspend PASRR	<ul style="list-style-type: none">• Waives level 1 and level 2 assessments for 30 days• Treats new admissions like exempted hospital discharges
Suspend FFS PA	<ul style="list-style-type: none">• Allows waiver or modification of prior authorization for FFS State Plan benefits, up to 180 days
Extend Existing FFS PA	<ul style="list-style-type: none">• Allows previously-approved services to continue with new/renewed prior authorization
Modify State Fair Hearing Timeline	<ul style="list-style-type: none">• Allows delay for scheduling fair hearings and issuing fair hearing decisions• Allows managed care enrollees to proceed directly to state fair hearing• Allows enrollees an additional 120 days to request fair hearing
Relax Provider Enrollment	<ul style="list-style-type: none">• Allows for out-of-state providers <i>and</i> states can rely on other states' Medicaid and/or Medicare screening• Certain screening requirements for non-Medicaid/non-Medicare providers are waived
Allow Alternative Settings	<ul style="list-style-type: none">• Allows facilities to be fully reimbursed during emergency evacuation to an unlicensed facility (e.g., temp shelter)
Relax Public Notice Requirement	<ul style="list-style-type: none">• Waives State Plan Amendment (SPA) public notification requirements for COVID-19 actions• Allows states to shorten their tribal consultation timeframe

Summary of Medicaid 1135 Waiver Approvals

State	Suspend PASRR	Suspend FFS PA	Extend Existing FFS PA	Modify State Fair Hearing Timeline	Relax Provider Enrollment	Alternative Settings	Waive SPA Public Notice
AL	X						
AZ	X	X	X		X		
CA		X	X	X	X	X	
CO	X	X	X	X	X	X	X
CT		X	X	X	X	X	X
DE	X	X	X	X	X		
FL	X	X		X	X	X	
HI	X	X		X	X	X	X
IA	X						
ID	X	X	X		X	X	
IL	X	X	X	X	X	X	
IN	X	X	X	X	X	X	
KS	X	X	X	X	X		
KY	X	X		X	X	X	
LA	X			X	X	X	

Summary of Medicaid 1135 Waiver Approvals

State	Suspend PASRR	Suspend FFS PA	Extend Existing FFS PA	Modify State Fair Hearing Timeline	Relax Provider Enrollment	Alternative Settings	Waive SPA Public Notice
MA	X	X	X	X	X	X	X
MD	X	X	X	X	X	X	X
MN		X		X	X	X	X
MO	X	X	X	X	X	X	X
MS	X	X	X	X	X	X	
MT	X	X	X	X	X	X	
ND	X	X	X	X	X		X
NH	X	X	X	X	X	X	
NJ	X	X	X	X	X	X	
NM	X	X	X	X	X		
NC	X	X		X	X	X	
NY	X	X	X	X	X	X	
OK	X	X		X	X	X	
OR	X	X	X	X	X	X	X
PA	X	X	X	X	X	X	

Summary of Medicaid 1135 Waiver Approvals

State	Suspend PASRR	Suspend FFS PA	Extend Existing FFS PA	Modify State Fair Hearing Timeline	Relax Provider Enrollment	Alternative Settings	Waive SPA Public Notice
RI		X	X	X	X		
SC	X		X	X	X	X	X
SD	X			X	X	X	
TN	X				X	X	
TX	X		X	X	X		X
VA		X	X	X			
VT	X	X	X	X	X	X	
WA	X	X		X	X	X	X
WV	X	X	X	X	X	X	X
WY	X	X		X	X	X	

Appendix K: Alaska

The following examples are not exhaustive:

- *Applies to People with Intellectual and Developmental Disabilities, Alaskans Living Independently, Adults with Physical and Developmental Disabilities, Children with Complex Medical Conditions, and Individualized Supports Waivers*
- Increased cost limits for Individualized Supports Waiver
- Potential to restrict visitors in Residential Habilitation and Residential Supported Living Settings
- Increased respite hours as substitute for other services
- Additional monthly payment for care coordinators in instances of supporting individuals without regular services access
- Additional settings permitted including private homes and telehealth
- Family caregivers payable as direct service workers in some instances
- Telephonic/telehealth level of care evaluations
- Potential for payment rate increase for certain services/providers
- Renewed Person-Centered Service Plan
- Retainer payments up to 30 days when an enrollee is under medical quarantine

Appendix K: Colorado

The following examples are not exhaustive:

- *Applies to Elderly, Blind and Disabled, Community Mental Health Supports, Supported Living Services, Brain Injury, Spinal Cord Injury, Developmental Disabilities, Children's HCBS, Children with Life Limiting Illness, Children's Extensive Supports, and Children's Habilitation Residential Program Waivers*
- Expanded eligibility for home-delivered meals
- Expanded hours of personal care rendered by a relative of IHSS agencies
- Payment of family members for services including IHSS, personal care, respite
- Expanded caps on non-medical transportation, behavioral health services, therapy limits, respite care
- Virtual care and expanded settings permitted for numerous services, including adult day, day habilitation, various therapies, respite, meals and all F2F activity
- Potential for room and board coverage for respite (e.g., in a hotel)
- Allow State Plan Home Care Agencies and Hospice Agencies to provide skilled and unskilled services/ services outside enrolled specialties
- Expanded provider types for home delivered meals
- Increase FFS payment to all HCBS providers (8-13% enhancement, depending on provider type/program)
- Retainer payments for certain Medicaid providers in absence of ability to provide services

Appendix K: Connecticut

The following examples are not exhaustive:

- *Distinct requests for different HCBS waivers (e.g., Home Care for Elders, Personal Care Assistance, Acquired Brain Injury, Katie Beckett)*
- Most include:
 - Increase in cost limits to avoid institutionalization
 - Payment for family members to render companion services
 - Virtual (re)assessments/waived F2F; virtual case management
 - Substitute lower-level or alternative staff in a service plan
 - Limit in-home visitors
 - Adjust prior auth
- Individual waivers include:
 - Virtual case management, mental health counseling, and adult day health services
 - Add home-delivered meals
 - Allow additional providers to deliver home meals
 - Time and a half pay for companion services and personal care in the event of staffing shortages (>40 hrs)

Appendix K: Hawaii

The following examples are not exhaustive:

- *Applies to the Home and Community Based Services for People with Intellectual and Developmental Disabilities Waiver*
- Expanded benefit limits, e.g., private duty nursing, respite
- Expanded settings for adult day health and respite
- Telehealth permitted for services such as adult day health, F2F monitoring/check-in sessions
- Retainer payments to certain providers including adult day health

Appendix K: Iowa

The following examples are not exhaustive:

- *Applies to the Iowa Children's Mental Health Waiver; Iowa HCBS AIDS Waiver; Iowa HCBS Elderly Waiver; Iowa HCBS Intellectual Disabilities Waiver; Iowa HCBS Waiver for Persons w/Physical Disabilities; Iowa HCBS - Brain Injury (BI)Waiver; Iowa HCBS Health and Disability Waiver*
- Expands respite
- Adds home-delivered meals (excluding the CMH waiver) and telehealth/telephonic opportunities for services including case management, in-home habilitation, monitoring
- Allows for expanded settings, e.g., direct care providers' homes, allowing direct care providers to move into a member's home, allowing HCBS in certain facilities
- Providers retainer payments for select services excluding the CMH waiver (e.g., adult day care, consumer directed attendant care)
- Expands self-direction to include home-delivered meals, companion, and homemaker services
- Limits in-home visitors

Appendix K: Kentucky

The following examples are not exhaustive:

- *Applies to Acquired Brain Injury, Acquired Brain Injury Long Term Care, Supports for Community Living, Michelle P Waiver, Home and Community Based Waiver, and Model II Waivers*
- Exceed service caps and limitations for services including personal care, companion care, respite, home delivered meals, nursing supports, case management services
- Expand respite settings of care
- Allow telephonic/telehealth for adult day training, adult day health, personal assistance/community living supports
- Allow adult day training and adult day health services in the home
- Allow Medicaid-approved adult day health care providers to provide home-delivered meals and in-home nursing services *and* allow any enrolled waiver provider to provide home-delivered meals
- Remote level-of-care evaluations and person-centered service planning
- Increase pay in specific geographic regions
- Retainer payments for habilitation and PCS when an agency has been directed to close and the provider cannot enter an enrollee's home or provide telehealth

Appendix K: Minnesota

The following examples are not exhaustive:

- *Applies to Brain Injury, Community Alternative Care, Community Access for Disability Inclusion, Development Disabilities, and Elderly Waivers*
- (Re)assessments can occur via telephone or other remote methods rather than F2F
- Virtual case management

Appendix K: New Mexico

The following examples are not exhaustive:

- *Applies to Developmental Disabilities, Mi Via ICF/IDD, and Medically Fragile Waivers*
- Exceed service limits for assistive technology to allow remote care, supported living, and suspend certain prior auth reqs
- Expand available settings of care to include telehealth/telephonic for adult PT/OT/SLP, behavioral support consultation, case management, private duty nursing
- Allow community customized supports, community direct support to be provided in the home
- Allow home health agencies to hire relatives, friends, parents at the home health aide rate
- Remote supervision by registered nurse permitted
- Allow for HCBS services to be paid in acute care hospitals or short-term institutional stays when necessary supports are not available in those settings
- Retainer payments for certain personal care services (e.g., home health aides, homemaker, day habilitation)

Appendix K: Pennsylvania

The following examples are not exhaustive:

- *Distinct requests for different HCBS waivers (e.g., Community Living, Adult Autism, Community Health Choices)*
- Examples include:
 - Exceed service limits (e.g., adult daily living, residential habilitation, life sharing and supported living, respite, community participant support)
 - Expand services into new settings (e.g., respite provided in any setting with room and board included in the fee schedule rate; community participant support in the home)
 - Use of telehealth (e.g., companion, in-home and community support via remote/tele-support, remote F2F and reassessments, remote comprehensive needs assessment, remote support coordinator monitoring)
 - Payment of family members/ legally responsible individuals for certain services
 - Exceed staffing ratios (e.g., Residential Habilitation, Life Sharing and Supported Living; Community Participation Support)
 - Potential for increased payment rates and retainer payments for certain providers
 - Potential for suspended/delayed incident reporting
 - Payment of certain HCBS services while in the hospital

Appendix K: Rhode Island

The following examples are not exhaustive:

- *Applies to Rhode Island's Comprehensive Demonstration*
- Suspend in-person planning meetings and allow telehealth approaches
- Postpone level-of-care reassessments for LTSS and allow via telehealth for initial assessments
- Postpone service plan reviews (person-centered care plans)

Appendix K: Washington

The following examples are not exhaustive:

- *Distinct requests for different HCBS waivers (e.g., Residential Support, COPES, Individual and Family Services)*
- Examples include:
 - Exceed service limits (e.g., skilled nursing, adult day, transportation, home-delivered meals, community supports, respite)
 - Expand benefits (e.g., transportation)
 - Flexibility to modify who is responsible for (re)assessments and (re)assessment timing
 - Potential to increase payment rates (“add-on COVID-19 rate”)
 - Telehealth/remote opportunities (e.g., person-centered planning, assessments)
 - Expand service provision to emergency sites including hotels, churches, homes of direct care workers
 - Potential for delayed incident reporting

Appendix K: West Virginia

The following examples are not exhaustive:

- *Distinct requests for different HCBS waivers (e.g., Intellectual/Developmental Disability, Aged and Disabled Disability Waiver)*
- Examples include:
 - Exceed service limits (e.g., respite, person-centered supports, personal attendant, direct care services)
 - Expanded settings (e.g., out-of-home respite)
 - Payment of legally responsible individuals if primary caregiver is unable to provide services/supports (e.g., personal attendants, direct care staff)
 - Telehealth/remote opportunities (e.g., (re)assessments, person-centered monitoring, F2F case management, behavioral supports)
 - Retainer payments for agencies that provide day services
 - Payment of personal attendants during acute care hospital stays

Appendix K: Wyoming

The following examples are not exhaustive:

- *Applies to Supports Waiver and Comprehensive Waiver*
- Expands school services including respite, child habilitation, individual habilitation, and companion services
- Allows community support services to be provided in the home
- Modifies provider qualifications to suspend certain background and recertification reqs
- Allows for payment of HCBS in hospitals (adult day, community living, companion, personal care)
- Limits in-home visitors
- Allows for telephonic/telehealth provision of case management and monthly monitoring

Appendix

Toll-free MAC Hotlines

MAC	Hotline	Hours of Operation
CGS Administrators, LLC (CGS)	1-855-769-9920	7:00 AM – 4:00 PM CT
First Coast Service Options Inc. (FCSO)	1-855-247-8428	8:30 AM – 4:00 PM ET
National Government Services (NGS)	1-888-802-3898	8:00 AM – 4:00 PM CT
National Supplier Clearinghouse (NSC)	1-866-238-9652	9:00 AM – 5:00 PM ET
Novitas Solutions, Inc.	1-855-247-8428	8:30 AM – 4:00 PM ET
Noridian Healthcare Solutions	1-866-575-4067	8:00 AM – 6:00 PM CT
Palmetto GBA	1-833-820-6138	8:30 AM – 5:00 PM ET
Wisconsin Physician Services (WPS)	1-844-209-2567	7:00 AM – 4:00 PM CT

All non-practitioners are required to submit initial enrollments and information changes via the CMS-855/PECOS but this will be expedited by your MAC:

<https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf>

References

References

- CMS 1135 Waiver Approvals: <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/index.html>
- Appendix K details: <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/appendix-k/index.html>
- Federal and SSA Survey: <https://www.cms.gov/files/document/qso-20-20-all.pdf>
- Provider enrollment relief FAQs: <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf>
- CARES Act: <https://assets.documentcloud.org/documents/6819239/FINAL-FINAL-CARES-ACT.pdf>
- CMS Blanket Waivers: <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>
- Telehealth expansion details: <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
- Nursing Home Telehealth Toolkit: <https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf>
- CMS Memo – Prioritization of Survey Activities, <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0>
- CMS Survey Prioritization Fact Sheet, <https://www.cms.gov/newsroom/fact-sheets/kirkland-washington-update-and-survey-prioritization-fact-sheet>
- CMS Coronavirus Waivers: <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>
- CMS Fact Sheet – Sweeping Regulatory Changes to Address Patient Surge: <https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient>
- CMS Memo to MA Organizations and Part D Plans, <https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf>

CMS Fact Sheets by Provider Type

- Long Term Care Facilities: <https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf>
- Hospice: <https://www.cms.gov/files/document/covid-hospices.pdf>
- Inpatient Rehab Facilities: <https://www.cms.gov/files/document/covid-inpatient-rehab-facilities.pdf>
- Home Health Agencies: <https://www.cms.gov/files/document/covid-home-health-agencies.pdf>
- Long Term Care Hospitals: <https://www.cms.gov/files/document/covid-long-term-care-hospitals.pdf>