public partnerships PPL
Your #1 choice for self-directed care™

DECEMBER 2, 2020

Self-Direction - A Pandemic Response to Medicaid Home and Community-Based Services

ANALYSIS OF APPENDIX K

Suzanne Crisp
David Horvath
PUBLIC PARTNESHIPS LLC

Table of Contents

Introduction 2
Self-Direction as an Alternative and Supplement to Agency Services 2
Background and Research Approach 3
Expedited Access to Self-Directed Services 3
Hiring Legally Responsible Individuals 5
Goods and Services 6
New Services Added 7
Telehealth 7
Financial Management Services 8
Expansion of Settings 8
Increase Rates, Overtime, and Hazard Pay for Self-Directed Workers 9
Increased Budgets, Hours, or Units 9
Retainer Payments 9
Miscellaneous Approvals 10
Current Landscape 10
Conclusion 11
Attachment A: Chart Of State Activity Regarding Appendix K 12

INTRODUCTION

Self-direction is a proven approach to reducing program participants' and their families' anxiety to secure safe in-home care from someone they know and trust. This paper examines self-direction and its impact on reducing the threat of the COVID-19 Pandemic. It focuses on state Appendix K submissions to the Centers for Medicare & Medicaid Services (CMS) to ensure continuity of services by requesting immediate temporary changes to §1915(c) waivers. States asked for modifications to add, expand, suspend, delay, or relax specific program policies to ensure services are accessible and that adequate staffing is available. Briefly, self-direction provides positive outcomes during this emergency by:

- Supporting the individual's ability to maintain social distancing and isolation in their homes
- Allowing individuals to hire friends, family (even legally responsible relatives, guardians, or representatives), or someone they know and trust to work only for them
- Expediting participant and worker program enrollments to ensure quick access to services by delaying or suspending prescreening steps
- Extending the individual's ability to purchase items, goods, services, or equipment that prevent the virus's spread and protect both the individual and the worker
- Permitting individuals to purchase technology to support Telehealth using an individual budget
- Authorizing new self-directed services, such as self-directed home-delivered meals
- Supporting workers by increasing rates and paying retainer fees
- Expanding the settings in which self-directed workers may provide services, including support to individuals who are hospitalized
- Promoting individual community engagement, as appropriate, by ensuring individuals have sufficient Personal Protective Equipment (PPE) and proper escort services

Self-Direction as an Alternative and Supplement to Agency Services

COVID-19 presents additional challenges for people living in their homes who receive home and community-based services. These individuals are particularly vulnerable to contracting COVID-19 since they are at risk of institutionalization, experience one or more chronic conditions, and rely on individuals coming into their homes to assist them with the essential activities of daily living as well as other support services. People receiving home care have two options. One is to engage a Home Health or Personal Care Agency to send staff into the home to provide critical non-professional services. Usually, staff serve many clients and travel from home to home. Workers arrive at a time based on the Agency's availability and tasks performed are limited by what the Agency permits. The second option, self-direction, enables individuals to employ and manage staff selected by themselves, including friends, family, or neighbors. Participants hire their staff and may also have the option to purchase goods and services to enhance their independence. This option is referred to as budget authority and uses a participant's budget to buy permissible equipment, items, or supplies. Demonstrated self-direction benefits include increased access to available services, enhanced satisfaction with the

care arrangement, improved quality of life, and reduced caregiver stress. States and participants can realize these benefits at no increased cost through sound program design.

BACKGROUND AND RESEARCH APPROACH

The federal government offers states many opportunities to modify their policies to ensure Home and Community-Based Services (HCBS) are available to individuals during an emergency declaration. Examples of such options include: Disaster-Relief State Plan Amendments (SPAs), Traditional SPAs, §1135 Waivers, HCBS Waiver Appendix K, and §1115 Demonstrations. In many cases, states modified their programs by amending state regulations. Due to our focus on Appendix K submissions, one may see other state policy changes not reflected in this report. This discussion paper focuses exclusively on Appendix K modifications related to self-direction and § 1915(c) waivers.

Since March 2020, 38 out of 48 states (79%) have submitted Appendix Ks[1] to modify state Medicaid policy due to COVID-19. Many requests were made retroactively back to March 2020. While Appendix K submissions cannot make changes to administrative activity or modify rules outside the §1915(c), it does allow states to:

1) improve access to services;
2) modify provider qualifications;
3) streamline the application process, add services, increase rates, and issue retainer payments.

States may submit Appendix K applications to cover all §1915(c) waivers in their state or submit separate applications for each waiver program. As of June 2020[2], CMS has approved 71 Appendix K submissions covering all waivers in the state and has approved 87 submissions covering individual waiver programs.

The methodology used for this report includes a review of 158 approved Appendix K submissions[3]. Modifications were submitted from March 2020 to September 2020. The temporary modifications continue into March 2021 or the end of the emergency declaration. A chart summarizing the state activity is provided in Attachment A, at the end of this document.

Expedited Access to Self-Directed Services

With the introduction of COVID-19, Home Care Agencies, and Personal Care Agencies found it challenging to staff in-home services adequately. Workers worry about going into the homes of high-risk individuals, and many lost their access to childcare or needed to address schooling for their own children. Many workers decided their isolation was paramount for them and their families and chose not to return to work. Similarly, participants fear workers coming into their

---

[1] CMS HCBS Corvid Disaster Relief – slide deck by New Editions, August 2020
[2] Ibid
[3] https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html

homes, having just served other clients. Social distancing and the ability to quarantine were difficult, if not impossible. Some participants did not feel comfortable with one worker going from house to house, potentially spreading the virus to them, and declined services. Congregate settings such as Adult Day Care Centers were among the first settings to close their doors, leaving individuals without someplace to go during the day. Nursing facilities and other congregate settings became hotbeds for spread of the virus. Families sought ways to deinstitutionalize their loved ones into a safer home environment. All these factors apply considerable pressure on the home care system. At the same time, many family members find themselves unemployed or unable to report to their workplaces. Many of these family members became available to support their loved ones.

Could self-direction present viable interventions to address some of these challenges? Based on the review of the modifications requested by states and approved by CMS, the answer is a resounding "Yes". Participants could employ friends, family, or others known by the participant to deliver services such as bathing, dressing, grooming, running errands, and housekeeping. While enrollment into self-direction involves verifying worker qualifications, conducting criminal background screening, applying educational standards, and meeting training requirements, states used Appendix K to eliminate or reduce these barriers and hire staff as quickly as possible. Specific requests tied to prescreening potential workers include the following:

- ***Suspend or Delay Criminal Background Checks.*** Most states require criminal background screening on all personal care workers, including those employed under self-direction. In most cases, these screenings must be conducted before workers are authorized to begin delivering services and can delay participant access to services. To meet the challenges of COVID-19, several states sought and received permission to allow self-directed workers to begin furnishing services while criminal background checks were in process (District of Columbia, Maine, New Mexico, South Dakota, and Virginia). Some states suspend federal fingerprinting requirements (Delaware, the District of Columbia, Iowa, Kentucky, Maryland, New Mexico, South Carolina, Tennessee, Utah, and Wyoming) or allow workers to sign attestation forms to declare they had never been convicted of a crime. New Hampshire and Maryland currently administer abbreviated background checks. South Carolina suspends national criminal background checks for family members. Delaware allows family members to provide services before completing criminal background checks and training but requires potential workers to take CPR on-line. Wisconsin delays the revalidation of criminal background checks every four years. These modifications enable self-directed enrollment to occur in days rather than weeks.

- ***Modify Provider Qualifications.*** To expand the pool of self-directed workers, many states requested approval to modify provider qualifications. Kentucky suspends all provider qualifications except age (must be 18) so long as the participant agrees to the terms. Colorado, Maryland, and Illinois eliminate the need for a high school diploma or GED. Colorado lowers self-directed workers from 18 years to 16 years and Tennessee and Maine to 17 years of age. California received approval to temporarily modify self-directed provider qualifications so long as the worker is 18+

and possesses the skills and experience to provide the service, as verified by the participant and the Financial Management Services (FMS) provider. Wisconsin removes the qualification that providers must have two years' experience with the target population.

- ***Expand, Suspend, or Delay Training Requirements.*** While only the §1915(k) mandates training to be available to workers, states are otherwise free to set their training requirements. Most apply CPR, First Aid, and universal precautions training. Others require completing a specific number of training hours (Washington and Ohio). Several states requested the suspension or delay of training for workers during the emergency declaration, including the District of Columbia, Maine, Maryland, Minnesota, Michigan, Missouri, Montana, New Mexico, New York, Tennessee, South Carolina, South Dakota, Utah, and Wyoming. Illinois and Indiana permit flexible training for self-directed workers. North Carolina adds training/education/consultation as a waiver service to support self-direction through educational advancements for participants. This training focuses on supports for decision-making, strategies to promote independence, and person-centered planning. Washington temporarily waives training requirements for initial training and certification requirements related to continuing education and recertification. This applies to home care agencies and self-directed workers. Training on CPR, First Aid, reporting requirements may be electronically or telephonically rather than face-to-face contact in West Virginia.

Hiring Legally Responsible Individuals

CMS provides many opportunities to hire legally responsible individuals, including relatives and guardians, using various authorities. These authorities include §1915(c) §1915(i), §1915(j), §1915(k), and §1115 Demonstrations. While several states have adopted this policy, many states have been hesitant to implement such policies. State decision-makers have often expressed concerns that the program would evolve into an employment program for family members. Some worry that the free choice of participants might be compromised with pressure to hire a family member. While these are realistic concerns, many states have implemented controls to manage the labor pool's expansion. For example:

1) ensuring the family member meets at least minimal qualifications;
2) limiting the hours worked to 40 hours per week;
3) using an authentic person-centered planning system to ensure the participant desires such an arrangement; and
4) monitoring the situation with greater scrutiny.

These actions are all strategies that reduce concerns.

With the COVID-19 pandemic, widening the labor market to include such family members seems logical, even necessary. Twenty-three (23) states requested their waiver programs to allow such hires temporarily. These states include Alaska, Arizona, Connecticut, California, Colorado, Delaware, District of Columbia, Georgia, Iowa, Louisiana, Kansas, Kentucky, Maine,

Maryland, Montana, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, and West Virginia. Maryland and Arizona permit legally responsible relatives to work more than 40 hours per week.

Goods and Services

According to the 2020 AARP State Scorecard[4], 75% of self-directed programs include participant-directed goods and services to their programs under the auspices of budget authority. Budget authority grants participants access to an individual budget to make permissible purchases to increase their independence, and in some cases includes wage authority. CMS requires that goods and services meet the following guidelines.

- Address an identified need in the service plan
- Decrease the need for other Medicaid Services, including human assistance
- Promote community inclusion
- Increase safety in the home environment

One particularly appropriate request in Appendix K submissions involves expanding goods and services to include Personal Protective Equipment (PPE). Permissible purchases include masks, sanitizers, disinfectants, goggles, shields, and trash bags. Any item or supply that reduces the spread of the virus and promotes social distancing is considered. States requesting this expansion include Pennsylvania, Montana, and North Carolina. Michigan not only allows purchasing delivery services for groceries and other membership fees but expands goods and services to any item or equipment that would enhance social distancing. Michigan expands community transportation to include transportation on behalf of vulnerable participants to ensure social distancing and have errands run on their behalf. In North Carolina, the cap for goods and services increases to beyond $800.00. This service expands to cover PPE (facial tissues, trash liners, disinfectant spray and wipes, thermometers, and cloth face coverings) to protect both participants and workers.

The coverage of a tablet or smartphone to promote telephonic/electronic engagements with service providers is permits to enhance Telehealth in North Carolina. A smart device's approval does not include minutes or data above and beyond what is included in the initial device purchase. This expansion not only applies to those self-directing but those using traditional services as well. The participant uses a purchase order process developed by the case management entity to purchase the goods and services approved in the Service Plan or uses their self-directed individual budget to make purchases.

Many states request the expansion of goods and service items under traditionally delivered waiver services like specialized medical equipment, assistive devices and equipment, home modifications, and vehicle modifications. Colorado, Delaware, Hawaii, Mississippi, and Washington were approved to extend goods and services under these service categories. Often, providers are limited to Durable Medical Supplies stores or other specialized retail stores. While offering participants the ability to acquire the items is commendable, a more cost-effective

---

[4] https://www.longtermscorecard.org/publications/promising-practices/2019-self-directed-ltss-inventory

approach might be to use self-directed goods and services to implement such expansions. Participants are not confined to make purchases from specific providers and may seek more cost-effective means to acquire such items and shop for value. Also, permitting participants to have an individual budget allows them more choice and control, promotes person-centered planning, and affords more opportunities to create innovative approaches to meet their unique needs.

New Services Added

Many new self-directed services are added as a result of Appendix K submissions. Iowa adds self-directed homemaker, and companion to their waivers. Florida's Developmental Disability waiver now includes self-directed personal supports and transportation, and their Long-Term Care waiver adds self-directed respite.

Area Agencies on Aging report food insecurity is a significant concern for those receiving in-home services. To that end, Connecticut, Iowa, North Carolina, Washington, North Dakota include self-directed home-delivered meals allowing participants to purchase meals via Uber Eats, Door Dash, and Grubhub.com. South Dakota adds self-directed home-delivered meals, personal care, nursing, adult companion, respite, and chore services. Maine adds Emergency Quarantine Services for individuals with COVID-19 at a rate of $27.72 per hour.

Telehealth

Telehealth services provide acute care, primary care, chronic care, and specialty care to participants in their homes. Telehealth supports social distancing and isolation and maintains continuity of care. While Telehealth technology is not new, states have been relatively slow to incorporate this service into Medicaid Waivers. However, COVID-19 and recent policy changes have propelled Telehealth to the forefront of innovations in the delivery of HCBS.

According to the Centers for Disease Control[5], "maintaining continuity of care to the extent possible can avoid other negative consequences from delayed preventive, chronic, or routine care. Remote access to healthcare services may increase participation for those who are medically or socially vulnerable or do not have ready access to providers. Remote access can also help preserve the patient-provider relationship at times when an in-person visit is not practical or feasible."[6]

Telehealth purchases consist of purchasing equipment in the participant's home, such as internet access, tablets, smartphones, laptops, larger computer screens, and other essential set-up items. Telehealth also involves training on how to use the equipment. States are free to add these components to existing service categories such as Assistive Devices, Specialized Medical Equipment, Home Modifications, or Self-Directed Goods and Services. States may also add Telehealth as a new service category available to traditional and self-directed options. Services impacted by Telehealth include case management, acute and primary care services,

[5] https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html
[6] Ibid.

and long-term services and supports. Massachusetts now allows 29 services to be managed via Telehealth and adds Assistive Technology as a waiver service to purchase or lease Telehealth technology. Washington adds Telehealth as a service under their Assistive Technology waiver service and now includes self-directed personal care to be conducted via phone or other technology. This expansion incorporates reminders, supervision, behavioral interventions, appointment reminders, and wellness checks. Pennsylvania allows Telehealth to be in its direct in-home services, including Community Supports, Companion ad Behavioral Support.

Financial Management Services

Financial Management Services (FMS) is a federal requirement for all §1915(c) waivers offering self-directed employer authority (the ability to hire and manage staff directly). The service assists participants and workers to

1) meet state and federal labor, tax, and insurance obligations;
2) process timesheets:
3) issue payroll checks; and
4) monitor individual budget balances.

States requested several modifications via Appendix K tied to FMS. Georgia and North Carolina, anticipating an increase in self-direction, are increasing their reimbursement rates for FMS. North Carolina raises the FMS reimbursement rate to $93.00 and allows FMS via phone. Georgia is increasing its elderly/disabled rate from $70 to $90 per member per month. The State's Intellectual/Developmental Programs augments their rate from $75 to $95 per member per month.

CMS also requires states to offer information and assistance to those selecting the self-direction option. This service aids participants to successfully self-direct their services. In Maryland, information and assistance (supports brokerage) increased its support function hours to up to 20 hours per month, again anticipating increased self-directed activity. West Virginia (AD and TBI Waivers), the District of Columbia, New York, Washington, suspends face-to-face information and assistance (resource consultant) and allows this function to be conducted by phone to expedite enrollment and safeguard consultants and participants.

Expansion of Settings

Typically, self-directed services are delivered in a participant's home or place of employment. To meet the challenges of COVID-19, Alaska, Arizona, Iowa, Illinois, Massachusetts, Missouri, Montana, New Mexico, and Nevada, North Carolina, and West Virginia request permission to provide self-directed services in a hospital or other acute care settings. Louisiana and Iowa sought approval to allow participants and workers to live together in either the participant's home or the worker's home.

Increase Rates, Overtime, and Hazard Pay for Self-Directed Workers

Anticipating additional pressure on home care services, several states sought to increase the rates paid to self-directed workers to stabilize the workforce. The following lists the states making this request and include Louisiana (20%), the District of Columbia, Kentucky (up to 50% of the maximum rate), Ohio (12%), Maine (20%), Maryland (not to exceed 50% of the maximum rate), Massachusetts (50%), Michigan (not to exceed 50% of maximum rate), Pennsylvania (up to 40%), Washington (25% on a case-by-case basis), Tennessee (30%) and Wyoming (12.5%). Maryland pays hazard pay of up to $5.00 per hour, with a 30% increase in the rate for self-directed personal assistance. Pennsylvania is implementing hazard pay not through Appendix K but through state grants. Utah provides an enhanced hourly reimbursement to those directly impacted by COVID-19 to expand benefits, increase overtime, and issue hazard pay. Tennessee uses hazard pay of $5.00 per hour to apply to self-directed attendant services if COVID-19 is involved. Nebraska increases the provider rate to 15%, then over time reduced it to 10% and eventually 5%.

Increased Budgets, Hours, or Units

Several states requested permission to increase budgets. The Massachusetts Autism Waiver, an exclusively self-directed waiver, increases budgets from $25,000 to $28,000 per year. States increasing service caps or service limitations include Alaska, Colorado, Connecticut, Hawaii, Iowa, Kentucky, New Mexico, North Carolina, Oregon, Pennsylvania, and West Virginia. Benefit limit increases on Equipment, Modifications, and Technology are approved for North Carolina. Colorado extends self-directed hours from 40 to 48 per week. West Virginia (TBI) allows self-directed workers to exceed the limit on the time spent on essential errands for participants. South Dakota increases personal care for up to 120 hours per month. In Maryland, the FMS may authorize up to $2,000 above authorized individual budgets. Indiana waives the 40-hour limit on family caregivers. South Carolina removed limits on Adult Attendant Care and Personal Assistance as approved by case managers. New Hampshire increases the cap on In-Home support waiver to $33,000. Wisconsin eliminates the required three quotes from home modifications to expedite the delivery of needed services.

Retainer Payments

Retainer payments are made to providers while a participant is either in the hospital, absent from the home, or not available to receive services. The purpose of such payments is to add stability to the workforce and ensure enough workers are available. Several states requested modifications to their waiver programs to permit retainer payments if a participant is quarantined or hospitalized due to COVID-19. Payments are time-limited and do not extend beyond 30 consecutive days. CMS expects states to develop specific criteria to identify the parameters of when retainer payments are permissible. The following states apply retainer payments, specifically to self-directed workers. These include Connecticut, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Iowa, Maryland, New Hampshire, New York, North Carolina, Nevada, North Dakota, Oregon, South Carolina, South Dakota, and Utah (except for

legally responsible individuals). Virginia pays retainer payments to self-directed workers who experience a significant decline in service utilization due to COVID-19.

Miscellaneous Approvals

Miscellaneous requests include allowing self-directed staff to be shared if participants agree in Louisiana. Authorized representatives may be paid attendants in Colorado. California permits Personal Care self-directed workers to furnish services to participants enrolled in and receiving Personal Care services through the State Plan Personal Care when the provider is not registered as an In-Home Supportive Services (IHSS) provider. The expectation is that the individual would be required to enroll as an IHHS provider within 60 days to receive retroactive payments. New Mexico allows self-directed workers to provide services in other non-professional service types in the event of staff shortages.

CURRENT LANDSCAPE

With all the modifications approved by CMS, states and FMS entities have been challenged to implement the temporary changes. States submit change orders to their FMS vendors to implement approved Appendix K modifications. Change orders have been presented to increase rates, apply new benefits limits, pay retainer fees, and issue hazard payments, and modify prescreening steps to expedite enrollment. Anecdotally, we also know that states and FMS entities experienced a spike in self-directed enrollments between March and June of this year.

During an August 2020 Member Forum[7] sponsored by Applied Self-Direction, Liz Sandblom from the Massachusetts Department of Developmental Services (DDS) shared the State's self-direction program response to COVID-19. "Since the Pandemic began, The Massachusetts Department of Developmental Services (DDS) has seen a growing interest in self-direction throughout the state, including a spike in enrollment from March to June."[8] She went on to say "supports for individuals who self-directed prior to the Pandemic experiences less disruption than those who were receiving traditional supports."[9] She added, "individuals who self-directed could pivot to remote supports more easily due to their ability to adjust the expectations of employees."[10] Granite State Independent Living, a Center for Independent Living, during the same forum, found that 82% of COVID-19 deaths occurred in nursing homes while 0% of fatalities happened with those self-directing.[11]

[7] https://www.appliedselfdirection.com/covid-19-resources
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.

CONCLUSION

The positive impact of self-direction on living with the COVID-19 Pandemic is considerable. The increased choice and control experienced by participants:

- reduces anxiety,
- expands the workforce,
- supports safe access to services,
- encourages social distancing,
- reduces food insecurity, and
- limits the risk of exposure to the virus.

Temporary modifications states have requested and implemented could become permanent program policy changes. For example: expansion of goods and services to non-self-directed populations; allowing legally responsible individuals to be paid providers; permitting direct care workers to begin providing services while screening is in process; expanding goods and services to cover PPE; paying retainer fees while participants are hospitalized; and, increasing options for home-delivered meals. States could make these options and others permanent by submitting wavier amendments to CMS. Our future with COVID-19 is uncertain but hopeful. However, once this pandemic is resolved, other emergencies may follow. Making many of these CMS-approved modifications permanent changes to waiver programs and further expanding access to self-directed services could better position states for the future.

ATTACHMENT A: CHART OF STATE ACTIVITY REGARDING APPENDIX K

This chart represents a summary of Appendix K approvals for HCBS as of 10/01/2020. Thirty-eight states have been approved to make changes to their Waivers or Section 1115 Demonstrations (AZ and RI using the Appendix K template). Those listed in this chart pertain only to self-direction.

Section 1915 c Appendix K Approved Waivers[12]		
Waiver Provision	**Approved State**	**Comments**
Expedited Access to Services		
Suspend or Delay Criminal Background Checks to Hire New Workers Sooner		
Begin work before completion of criminal background checks.	DC, NM, SD, VA	
Suspend criminal background checks.	DE, DC, IA, KY, MD, NM, SC, TN, UT, WY	
Conduct abbreviated criminal background checks.	NH, MD	
Suspend national background checks for family members.	SC	The participant must agree to this.
Delay revalidation (every 4 years) of criminal background checks.	WI	
Allow flexible criminal background checks.	IN	
Suspend additional screening required explicitly for immediate family members to approve them as an employee if self-directing.	KY	

[12] This document was prepared on 11/10/2020.
Source: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-heath-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html

Suspend or Delay Provider Qualifications to Hire New Workers Sooner		
Suspend the high school education requirement.	IL	
Expand the provider pool by allowing any enrolled provider to work in all waivers.	MT	
Suspend/extend provider certification.	SC, SD, WY	
Waive direct service worker requirement to be licensed with the Nevada Bureau of Health Care Quality and Compliance.	NV	
Waive health screening for direct care workers.	MD	
Extend all licenses, permits, and registrations to 30 days after the emergency declaration ends.	MD, TN	
Lower the age of direct care workers from 18 to 16.	CO	
Allow direct care workers to provide Personal Care, Companion, and Residential Habilitation.	FL (DD)	
Lower the age of direct care workers to 17.	ME, TN	
Remove 2-year experience for individual providers.	WI	
Relax provider qualifications.	MI	
Suspend criminal background checks.	ME	
Modify Training Requirements of Direct Care Workers		
Delay CPR and First Aid for 90 days.	IN	
Direct care workers may provide services before the completion of training.	NY	

Apply abridged training for personal support workers.	IL	
Extend training requirements for 60 days from the original date of services for DD and Pas.	MT	
Suspend self-direction training.	SC	
Offer CPR and First Aid training on-line.	DE, MD, WV	
Suspend CPR and First Aid Training.	DC, ME	
Allow direct care workers to administer medications if trained in MMTP.	MD	Maryland Methadone Treatment Program (MMTP).
Suspend the required training.	DC, MD, ME, NM, TN, WY, UT	
Hire Legally Responsibility Relatives to Expand the Labor Force		
Hire legally responsible relatives.	AK, AZ, CT, CA, CO, DE, DC, GA, IA, LA, KS, KY, ME, MD, MT, NH, NC, ND, OH, OK, PA, VA, WV.	AZ removes the 40-hour limit per week.
Allow legally responsible relatives to work more than 40 hours per week.	MD	
Hire family members to provide Personal Care but not legally responsible ones.	MS	
Hire legally responsible relatives for Personal Care, Chore, Respite, and Supported Living.	AK, VA	
May hire friends and family at the home health aide rate if home health aides are unavailable.	NM	

Allow Goods and Services to Purchase Necessary Items to Combat the Virus		
Increase service limitations for goods and services.	IL	
Expand goods and services to cover Personal Protective Equipment (PPE) and items.	PA, MT, NC	
Allow purchase of delivery services for groceries and other membership fees.	MI	
Modify community transportation to include transportation on behalf of vulnerable participants, to ensure social distancing and have errands tun their behalf.	MI	
Increase goods and services beyond $800 per year.	NC	
Expand goods and services to include telehealth. See more in the telehealth section.	NC	Includes smartphones, tablets, and internet costs.
Add New Services		
Add home-delivered meals to service offering (Goods and Services).	CT, IA, NC, ND, WA	Includes purchasing from Uber Eats, Door Dash, and Grubhub.com.
Add personal supports and transportation as self-directed services.	FL (DD)	
Include self-directed respite services.	FL (LTC)	
Permit self-directed home-delivered meals, personal care, nursing, adult companion, respite, and chore services.	ND	
Expand home-delivered meals to an additional daily meal, and dietary guidelines are waived. Shelf-stable meals may be delivered.	ND, WA, NC	North Carolina added one lunch meal for the disabled and elderly population. Expanded home-delivered meals to include Uber Eats, Door Dash, and Grub Hub may be used.

Include emergency quarantine services for individuals with COVID-19	ME	
Add home-delivered meals.	KS, MA, MS, SC	MA – to all waivers.
Expand home-delivered meals to non-traditional providers.	CT, IA	
The participant-directed delivery method may be used for the delivery of Habilitation Training Specialist services.	OK	
Add the ability to purchase goods and services to the waiver (those self-directing and those who are not self-directing). Case managers will issue purchase orders to acquire approved items if approved in the Plan of Care.	NC (Community Alternatives Waiver)	Participant and Individual goods and services – coverage of sanitation (disinfectant) wipes, hand sanitizer, and disinfectant spray, when these items are not covered by the state plan, for CNAs or personal assistants who can continue to render in-home and respite services to waiver participant in their homes. The coverage of facial tissue, thermometer, and specific colored trash liners to distinguish dirty linen of infected household member to prevent spread, when these items are not provided in the state plan. The coverage of three cloth face coverings for the waiver participant in promoting compliance with the state's face covering requirement.
Add Telehealth to Support Access to Services		
Allow telehealth to be part of direct in-home services.	PA	
Permit 29 services to be offered using telehealth.	MA	

Expand specialized medical equipment, assistive devices, and equipment as telehealth opportunities.	CO, DE, HI, MI, WA	
Allow self-directed Personal Care to be conducted by phone or other technology.	WA	Includes medication reminders, supervision, behavioral interventions, appointment reminders, and wellness checks.
Add purchase of smart phone to goods and services.	NC	The coverage of a tablet or smartphone for identified waiver participants to promote telephonic/electronic engagements with service providers for telehealth, monitoring, and linkage and is restricted to individuals who do not have access to tablets or smartphones through the state plan. The approval of a smart device does not include minutes or data above and beyond what is included in the initial device purchase.
Modifications to Financial Management Services (FMS)		
Conduct FMS over the phone.	NC	
Increase the rate for FMS to $93.00. When FMS is shared between vendors, the rate is $46.50.	NC	

FMS rate increased from $70 to $90 per member per month (Disabled/Elderly) and $75 to $95 for (IDD) per member per month.	GA	The state anticipates increasing self-directed activity from traditional services.
Suspend face-to-face enrollment by PPL Resource Consultant.	WV (A/D) (TBI), DC, NY	
Allow support brokerage to increase up to 20 hours per month.	MD	
Allow support brokerage to be furnished via phone or other electronic means.	DC, NY	
Expansion of Settings		
Permit self-directed personal care to be conducted in a hospital setting.	AK, AZ, IA, MA, MO, MT, NM, NV, NC, WI, WV (TBI)	
Workers and direct care workers may live in the same home.	LA, IA	
Furnish personal care and companion services while the participant is in an acute care hospital.	AK, AZ, IA, PA, TN, WV, WY	IA is specific to self-direction. AZ may not expand past 30 days.
Conduct personal care outside the home.	WA	
Allow payment for direct care workers to support a member who resides in the natural family home during acute care hospitalizations.	WV (TBI)	
Allow day services to be conducted in the home.	WI	Applies to individual providers.
Conduct Personal Care outside the home.	WA	Meal preparation, essential shopping, and laundry.

Allow retainer payments to be made for Day Habilitation Supplemental Services	MA	It may not exceed 30 days.
Increase Rates, Overtime, and Hazard Pay for Direct Care Workers		
Increase rate for individual providers up to 30% and not less than $20.00 per hour if the participant is COVID-19 positive.	WI	
Enhance the rate of up to 50% if participant or family member is impacted by COVID-19.	MA	
Increase direct care worker rates.	LA, KY, OH, ME, MD, MI, PA, TN, WA, WY	Breakdown of rates: LA 20%, KY up to 50%, OH 12%, ME 20%, MD not to exceed 50%, MI not to exceed 50%, PA up to 40%, TN 30% WA 25% on a case by case basis and WY 12.5%.
Increase provider rates up to 10% of historical averages.	MA	
Increase payment rates to include excessive overtime of direct support workers.	DC, ME, PA	In PA, rates are not expected to exceed 40%. DC includes home health agencies. ME rates increase to 20%. Personal services and nursing to 30%, residential care by 10%. Also, hazard pay of $5.00 if the attendant serves a person with COVID-19.
Increase direct care worker rates for self-directed workers.	DC	

Increase personal care and nursing service payments by 30%. Issue hazard pay of $5.00 per hour.	TN	
Increase rates to account for risks – may not exceed 5%.	MI	
Enhance hourly reimbursement to those directly impacted by COVID-19 to expand benefits, increase overtime, and issue hazard pay.	UT	
Increase rates for respite.	IL	
Enhanced independent provider pay to 15% with incremental deductions over time.	NE	
Increase Budgets, Hours, or Units		
Increase Autism self-directed budgets from $25,000 to $28,000.	MA	This program is exclusively self-directed.
Increase service limitations for selected services.	MD, NC, NE, WA	MD – personal supports ay exceed services limitations. FMS may authorize up to $2,000 above authorized budgets.
Increase person-centered support services.	WV	
Expand out-of-home respite.	WV	
Expand respite services from 30 to 90 days.	CT, HI, NC	CT 30 to 90 days, HI – may not exceed beyond 760 hours annually. NC may not exceed 720 hours.
Increase benefit limitation of support employment, supported living, and in-home services by 20% to provide telephonic and other technology.	DC	
Remove cost limits for respite and chore.	IA	

Remove cost limits for Respite.	IA	
Increase service limitations in Respite and Chore.	AK	Increase more for chronic respiratory illnesses.
Increase service caps and service limitations.	CO, HI, KY, NM, PA, CO	Some States are Lifting Service Caps and Service Limitations on All Waiver Services. (KY) Expand Respite (HI)
Increase the benefit limit on Equipment, Modifications, and Technology	NC	
Increase budget allocations and service limits.	ME	Personal care – 20%, respite – 20%, care coordination – 20% and assistive technology to $6,000.00
Suspend limits on home-delivered meals.	MI	
Apply Retainer Payments for Direct Care Workers		
Issue retainer payments to direct care workers.	IA, MD, UT	UT – This does not apply to legally responsible relatives.
Apply retainer payment to personal care workers and facility closures.	OR	
Retainer payments may be made by a Fiscal Intermediary to retain “self-hired” staff who are unable to work because of the participant or his or her family due to COVID-19.	NY	
Make retainer payments to direct care workers for authorized hours if a participant is unable to receive services due to COVID-19.	HI, IA, NV	HI – May not exceed 40 hours, and the limit is 30 days.

Add or increase retainer payments for Personal Care.	MT	May not exceed 30 days.
If participants experience a reduction in work hours, workers will be paid equal to the difference between provider payments based on actual hours worked.	OR	
Make retainer payments to Personal Care Workers.	CO, CT, FL(DD), UT	
Miscellaneous Actions		
Allow waiver personal care workers to provide services to participants enrolled in and receiving Personal Care service through State Plan Personal Care (IHHS) when the provider is not enrolled as an IHHS provider.	CA	The expectation is that the individual would be required to enroll as an IHHS provider within 60 days to receive retro payments.
Allow staff sharing for self-direction.	LA	
Allow authorized representatives to be paid attendants.	CO	
Allow direct care workers to provide services in other service types in the event of staffing shortages.	NM	For non-professional services.