ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

ISSUE BRIEF

September 12, 2023

An Overview of Medicaid Section 1915(c) Home and Community-Based Services Policy Flexibilities States Adopted During the COVID-19 Public Health Emergency

KEY POINTS

- During the COVID-19 public health emergency, states used Appendix K, a standalone appendix available during emergency situations, to amend their existing Medicaid Section 1915(c) home and community-based services waivers to make temporary changes to services, provider payments, eligibility, and other program and policy areas.
- As of January 2022, 47 states (including the District of Columbia) with Section 1915(c) waivers had one or more approved Appendix K documents, with most policy flexibilities taking effect in 2020.
- Of states with approved Appendix Ks for 1915(c) waivers:
  - 98% (46 of 47 states) adopted service-related policy flexibilities, which often allowed for remote options for care. Other service-related policy flexibilities included allowing level-of-care evaluations and re-evaluations to be conducted remotely. Overall, states adopted more service-related flexibilities than flexibilities in any other category.
  - 98% (46 of 47 states) adopted flexibilities related to provider qualifications.
  - 89% (42 of 47 states) adopted flexibilities that increased payment rates for providers. In addition, many states adopted flexibilities that temporarily included retainer payments for waiver providers, allowed for payment for services in an acute care hospital, or allowed payment for services provided by family members or other caregivers.
  - 38% (18 of 47 states) adopted access and eligibility-related policy flexibilities, including increasing the cost limits for entry into a 1915(c) waiver.
  - 94% of states (44 states) extended the duration for which their policy flexibilities were effective at least once during the study period (March 2020 through January 2022).

BACKGROUND

Home and community-based services (HCBS) are a range of medical and non-medical services provided in home and community settings that support individuals with functional limitations, including older adults and people with disabilities, to live in these settings rather than in institutions.[1] During the COVID-19 pandemic, high infection and death rates from COVID-19 among older adults and people with disabilities, concerns about COVID-19 exposure, and exacerbations of long-term care workforce shortages introduced new challenges to providing HCBS to people with long-term services and supports needs in home and community settings.[2,3] In response, many states introduced policy flexibilities into their Medicaid programs to support Medicaid enrollees' access to HCBS during the pandemic.[4]

Under Medicaid, states can use a variety of authorities to cover HCBS, including Section 1915(c) waivers and Section 1115 demonstration waivers.[i] In 2019, 47 states, including the District of Columbia, operated 1915(c) waiver programs, and more than half of Medicaid spending on HCBS went toward HCBS provided under these waivers.[5,6] In emergency situations, including natural disasters and pandemics, states have the option to amend existing Section 1915(c) waiver programs using Appendix K.[7,ii] During the federal COVID-19 public health emergency (PHE),[iii] states used Appendix K to request certain temporary (i.e., time-limited) modifications of their 1915(c) waiver programs. This brief describes 1915(c) waiver Appendix K policy flexibilities adopted by states during the federal COVID-19 PHE.

METHODS

From April through June 2022, we analyzed Appendix K documents posted on Medicaid.gov between March 2020 and January 2022 for 46 states and the District of Columbia.[7] Because Arizona, New Jersey, Rhode Island, and Vermont provided HCBS through 1115 waiver programs, we excluded these states from this analysis.[iv] We reviewed all versions of each state's approved Appendix Ks, extracting relevant information about adopted policy flexibilities, including start dates, end dates from the original applications, approval dates, and details of the policy changes.

All states included in our review submitted 1915(c) waiver amendment requests using a standardized Appendix K template from which they selected the policy flexibilities they wanted to adopt.[v] States included additional information in free text fields in the template to provide further detail on their desired flexibilities. We used this information to better understand the meaning and definition of various types of policy flexibilities. For this brief, we refer to a policy flexibility as a particular combination of Appendix K submission date, waiver title, policy flexibility category, and policy flexibility subcategory from states' original Appendix K application. To support states during the COVID-19 PHE, the Centers for Medicare & Medicaid Services (CMS) modified the Appendix K template to include a separate section called the COVID-19 Pandemic Response addendum. The COVID-19 addendum contains policy flexibilities that states identified as common needs in response to the COVID-19 pandemic. Data from this section were not extracted during data collection because these fields were pre-populated by CMS, and states were encouraged only to modify them if there was a critical need, resulting in little state-level variation.

As the COVID-19 PHE continued, some states submitted multiple Appendix Ks for the same waiver, all of which were included in our analysis. To determine final policy end dates for the policy flexibility expiration section only, we condensed information from separate Appendix Ks to obtain the latest end date.

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[i] States may use section 1915(c) waivers to provide a variety of medical and non-medical services to Medicaid enrollees who would otherwise require institutional care. 1915(c) waivers allow states to waive certain Medicaid requirements, allowing states, for example, to target waiver coverage to specific groups (e.g., individuals with intellectual disabilities), to limit the number of people who receive services through a waiver program, and to establish waiting lists for waiver services. Section 1115 waivers also allow states to waive Medicaid requirements when providing HCBS, allowing them to pilot demonstration projects that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP).

[ii] If covering HCBS through a Section 1115 demonstration waiver, states can also use Appendix K to amend HCBS-specific policies in their 1115 demonstrations during a PHE.

[iii] In response to the COVID-19 pandemic, the Secretary of the U.S. Department of Health and Human Services determined a public health emergency existed as of January 27, 2020.

[iv] The webpage for emergency preparedness and response for HCBS 1915(c) waivers on Medicaid.gov had Appendix K documents for Arizona and Rhode Island; however, these approved Appendix Ks modified the states' 1115 demonstrations.

[v] The Appendix K template and COVID-19-specific sample Appendix K template are available at 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.

Table 1 presents the policy flexibility categories and subcategories from the Appendix K template. Some categories did not have subcategories; in those cases, we leave the subcategory column blank.

Table 1. Policy Flexibility Categories and Subcategories in Appendix K	
Policy Flexibility Category	**Policy Flexibility Subcategory**
Access and eligibility	• Temporarily modify additional targeting criteria (e.g., waiving criteria regarding age limits for participation or frequency of service use) • Temporarily increase the cost limits for entry into the waiver
Imminent needs of individuals in the waiver program	
Increase Factor C[a]	
Other changes necessary	• Data collection • Modify service scope/coverage • Other changes necessary • Reporting
Services	• Temporarily add services to the waiver to address the emergency situation • Temporarily exceed service limitations or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency • Temporarily expand setting(s) where services may be provided (e.g., hotels, shelters, schools, churches) • Temporarily modify service scope or coverage • Temporarily provide services in out-of-state settings (if not already permitted in the state's approved waiver)
Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings[b]	
Temporarily include retainer payments to address emergency related issues	
Temporarily increase payment rates	
Temporarily institute or expand opportunities for self-direction	
Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances[b]	
Temporarily modify licensure or other requirements for settings where waiver services are furnished[b]	
Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications[b]	

Table 1 (*continued*)	
Policy Flexibility Category	**Policy Flexibility Subcategory**
Temporarily modify processes for level-of-care evaluations or re-evaluations (within regulatory requirements)[b]	
Temporarily modify provider qualifications	• Temporarily modify licensure or other requirements for settings where waiver services are furnished • Temporarily modify processes for level-of-care evaluations or re-evaluations (within regulatory requirements) • Temporarily modify provider qualifications • Temporarily modify provider types
Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver[b]	
Time period extension	

Source: Mathematica's analysis of Appendix K documents from 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.

Notes:

a. Factor C refers to the maximum unduplicated count of participants allowed to be served by a waiver program. [See "Application for a 1915 (c) home and community-based waiver: Instructions, technical guide, and review criteria." Baltimore, MD: CMS, 2019. Available at: https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf.]

b. The policy flexibility category was renamed for brevity.

FINDINGS

Overall Findings

All states with 1915(c) waivers had approved Appendix Ks, and there was substantial state-level variation in Appendix K submission strategies.[vi] Some states used separate Appendix K applications for each waiver and target population, and others used a single Appendix K for all waivers and target populations to which they extended flexibilities. For example, Alaska submitted one Appendix K to request multiple flexibilities for the following populations: people with intellectual and developmental disabilities, adults with physical and developmental disabilities, children with complex medical conditions, and the state's individualized supports waiver population. Over the course of the PHE, Alaska extended or expanded these flexibilities for all of these populations at once. In comparison, Alabama submitted one Appendix K for their populations with intellectual disabilities and a separate Appendix K for older adults and adults with disabilities, people in independent living, and people using technological assistance, both of which were extended multiple times. Alabama later submitted additional Appendix Ks that only extended or expanded flexibilities for the populations with intellectual disabilities. Often, Appendix K start dates were retroactively approved to January 2020 or other dates before the Appendix Ks were submitted, and end dates were often extended to either the "end of the PHE" or "6 months following the end of the PHE."

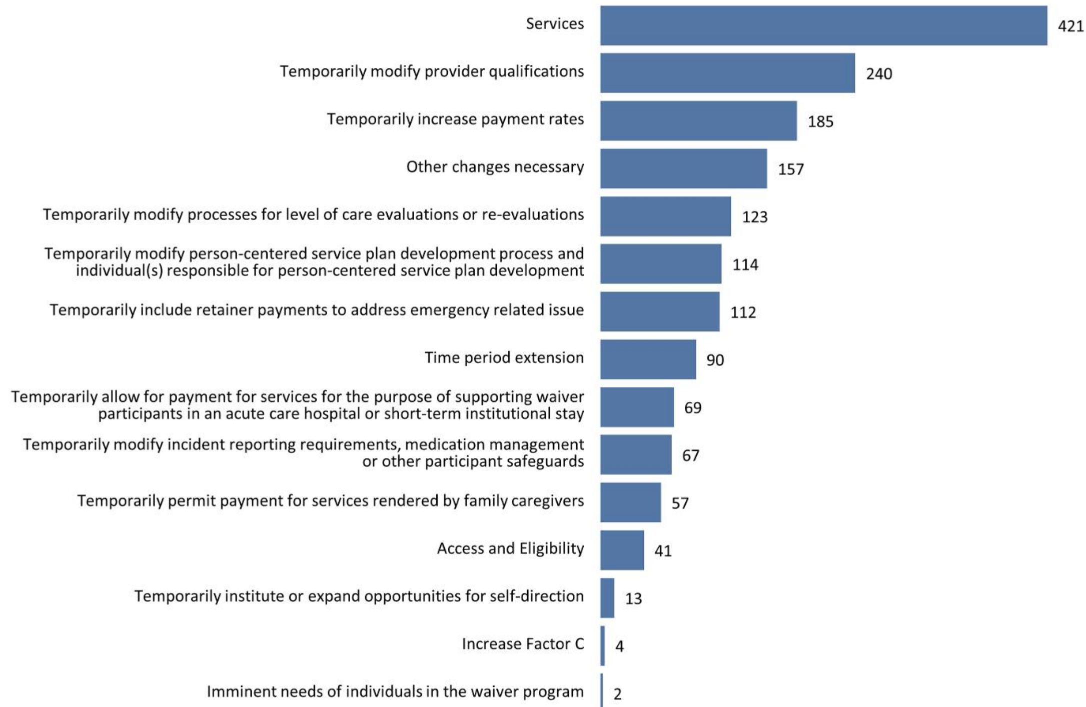
Most policy flexibilities (1,663, or 98%) had start dates in 2020, 2020, and most were approved or backdated to the first quarter of 2020 (1,594, or 94%). Flexibilities adopted in 2021 extended and built upon the initial flexibilities approved in 2020. States adopted 90 time period extensions for policy flexibilities over the course

[vi] We included only 47 states in this analysis. New Jersey and Vermont did not have Appendix Ks posted on Medicaid.gov at the time of analysis, and we excluded Arizona and Rhode Island because their Appendix Ks corresponded to Section 1115 demonstrations.

of the study period, 72 of which (80%) extended the end date of the policy flexibilities to either "6 months after the end of the PHE" or the "end of the PHE."

Of the 1,695 policy flexibilities adopted over the study period, half of these flexibilities were related to services (421 flexibilities, 25%), provider qualifications (240 flexibilities, 14%), and increases to payment rates (185 flexibilities, 11%) (***Figure 1***). Washington state adopted the highest number of policy flexibilities (187 flexibilities, 11%), and Virginia adopted the fewest (8 flexibilities, 0.5%). States adopted an average of 36 flexibilities. Counts of policy flexibilities adopted by each state are available in ***Appendix A***, ***Table A.1.***

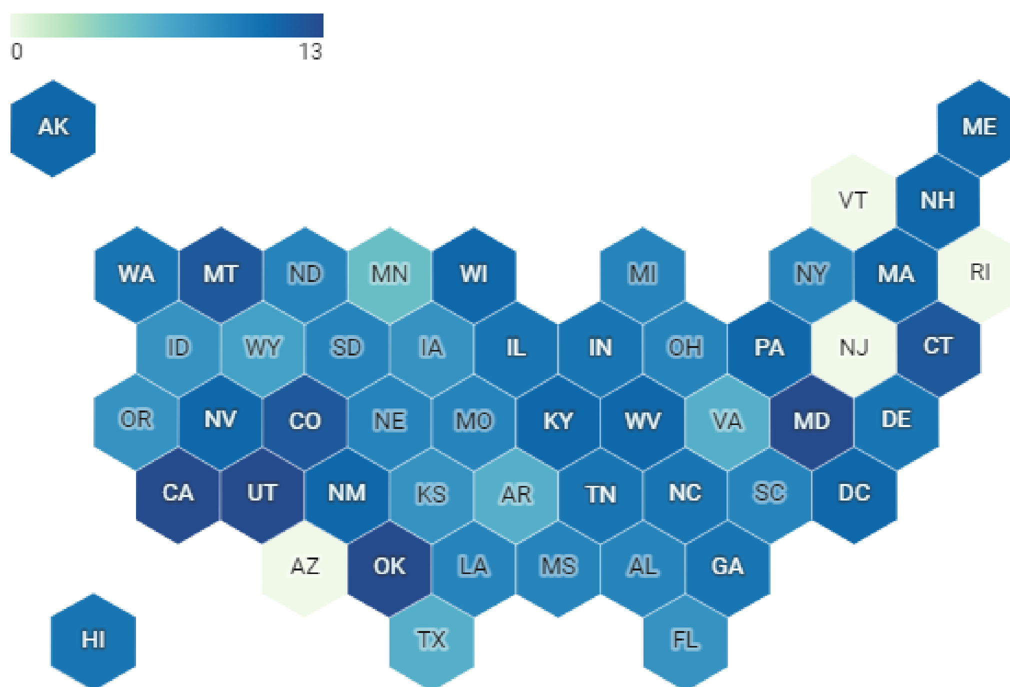
Figure 1. Number of Policy Flexibilities Adopted, by Category



Source: Mathematica's analysis of Appendix K documents from 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.

Almost all states adopted policy flexibilities related to services (46 states, 98%) and provider qualifications (46 states, 98%). Most states submitted policy flexibilities under a wide range of categories, with states using flexibilities in an average of 9.7 categories per state. California, Maryland, Oklahoma, and Utah submitted policy flexibilities under the most categories (13 categories) (***Figure 2***). In contrast, Minnesota (five categories) and Arkansas, Texas, and Virginia (six categories each) submitted flexibilities in the fewest policy categories. A detailed breakdown of the number of states that used each policy flexibility category is available in ***Appendix A***, ***Table A.2*** and ***Figure A.1.***

Figure 2. Count of Policy Flexibility Categories Used, by State



Created with Datawrapper

Source: Mathematica's analysis of Appendix K documents from 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.

Findings by Policy Flexibility Category

This section provides details on states' use of flexibilities in four key categories (services, access and eligibility, provider qualifications, and payment), as well as select flexibilities of other types.

Services

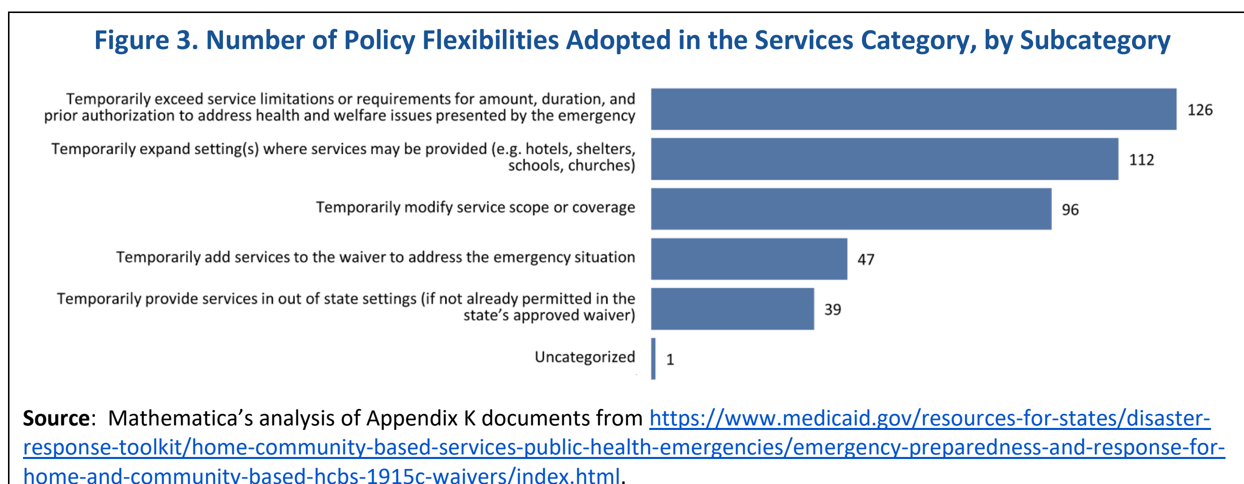
Of the 421 policy flexibilities classified in the services category, 30% (126 flexibilities) allowed states to exceed service limitations or requirements for the amount, duration, or prior authorization for services (***Figure 3***). This subcategory spanned a variety of modifications, including expanding eligibility for home-delivered meals, easing limitations on the number of hours of services that could be delivered via telehealth, and allowing for electronic delivery of a variety of services, including speech therapy, physical therapy, art therapy, day habilitation, and case management. A handful of policy flexibilities in this subcategory also increased cost limits for the waiver. Other services subcategories (temporarily expand settings where services may be provided and temporarily modify service scope or coverage) often included policy flexibilities that expanded remote provision of services or case management. Policy flexibilities classified in these subcategories overlapped with flexibilities in the temporarily exceed service limitations or requirements for amount, duration, and prior authorization subcategory.

In all, 27% (112 flexibilities) of the services flexibilities allowed the temporary expansion of settings in which services could be delivered (***Figure 3***). Types of settings in which services could be delivered included hotels, schools, churches, and shelters. Some flexibilities in this category allowed for the provision of case management or other services via telehealth or other electronic delivery method.

A total of 23% (96 flexibilities) of the services flexibilities allowed temporary modifications to service scope or coverage (***Figure 3***). Most of these were service expansions that modified settings in which services could be delivered. For example, Alaska allowed a range of HCBS to be provided in the home or other unlicensed locations, such as hotels or schools. A few flexibilities added additional services, such as transportation or home-delivered meals.

The remaining services subcategories (temporarily add services to the waiver and temporarily provide services in out-of-state settings) included policy flexibilities often related to acute service needs and provision.[vii] In all, 11% (47 flexibilities) were classified by states as temporarily adding services to address the emergency situation (***Figure 3***). These emergency situation flexibilities were more narrowly focused on immediate needs, mostly addressing services such as pest control, home-delivered meals, and assisted technology, or modified service modality, for example, by increasing self-directed service provision. Nine percent (39 flexibilities) allowed services to be provided in out-of-state settings (***Figure 3***). Although some states (for example, Connecticut and Georgia) limited the provision of specific services to neighboring states only, many (for example, Colorado and Louisiana) did not impose any additional geographic requirements***.***

Figure 3. Number of Policy Flexibilities Adopted in the Services Category, by Subcategory



Source: Mathematica's analysis of Appendix K documents from 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.

Payment

Most states adopted payment-related flexibilities, which often provided a payment mechanism for services expanded or modified through flexibilities in the other categories. The Appendix K template contains four types of policy flexibilities related to payment: 42 states (89%) adopted flexibilities that temporarily increased payment rates for providers, 37 states (79%) temporarily included retainer payments for waiver providers, 32 states (68%) temporarily allowed for payment for services in acute care hospital or short-term institutional stays, and 26 states (55%) adopted flexibilities that temporarily allowed payment for services provided by family members or other caregivers. A total of 423 flexibilities that states adopted were related to payment.

Among the flexibilities that increased payment rates for providers (185 flexibilities, 11% of total flexibilities), most focused on increasing payment rates across all types of providers. However, the amount states increased payment rates varied by type of service. For instance, Alabama increased payment rates for providers providing personal care, homemaker, and respite services by 10%, and increased payment rates for case management by 5.5%.

[vii] One services flexibility was not assigned a subcategory and is not counted in any of the flexibility subcategories. This flexibility subcategory is shown in ***Figure 3*** as "uncategorized." The services subcategories are listed in ***Table 1***.

Similarly, flexibilities that temporarily included retainer payments for providers (112 flexibilities, 7%) broadly targeted waiver services providers, but they occasionally specified individual service categories (for example, in Louisiana, adult day providers who provide personal care services). Other flexibilities allowed for payment for acute hospital stays when other supports were unavailable (69 flexibilities, 4%) or services by family members or other caregivers (57 flexibilities, 3%). These flexibilities increased payment rates to essential health care workers or allowed for payment of services modified or allowable through other flexibilities (for example, services provided by family members).

Provider Qualifications

Most policy flexibilities related to provider qualifications modified training requirements or licensure information for providers, rather than allowing changes to the types of services providers could provide. In all, 46 states adopted 240 provider qualification policy flexibilities, representing 14% of all flexibilities (***Figure 1***). There was some variation in states' use of this category's subcategories. States classified more than half of provider qualification-related flexibilities (57%) under the temporarily modify provider qualifications subcategory. Most of these flexibilities allowed for online trainings or delayed trainings for staff, extended expired qualifications for individual providers, and allowed family members to provide services. A total of 64 flexibilities related to provider qualification (27%) modified licensure and other requirements for waiver service settings, reduced the frequency of certification reviews or waived the certification requirement entirely, and allowed flexible staffing ratios. A few policy flexibilities reduced the frequency of provider relicensing. In all, 40 flexibilities (17%) modified provider types. Almost exclusively, these allowed different types of providers to provide services beyond their usual qualifications. For example, in Mississippi, agencies, in addition to individual providers, were allowed to provide personal care.

Access and Eligibility

Fewer states used access and eligibility flexibilities. A total of 18 states requested modifications related to access and eligibility in their Appendix Ks, adopting a total of 41 flexibilities across the study period, representing about 2% of all flexibilities. Half of the policy flexibilities (22 flexibilities, 54%) within this category increased the cost limits for entry into a 1915(c) waiver; cost limits allow states to restrict whether someone qualifies for a waiver based on the expected costs of their care.[8] Most of these flexibilities allowed for higher total cost limits for both individual services and overall, effectively allowing more people to access services. The other access and eligibility flexibilities (18 flexibilities, 44%) temporarily modified targeting criteria by waiving criteria regarding age limits for waiver participation, re-enrollment, or frequency of service use.[viii]

Other Flexibilities

Policy flexibilities adopted by states in other categories modified person-centered care plan development (114 flexibilities, 7%) or modified the processes for level-of-care evaluations and re-evaluations (123 flexibilities, 7%). These flexibilities provided additional remote options for these assessments. Eight states adopted 13 flexibilities pertaining to self-direction. Flexibilities related to self-direction expanded the eligible population, changed geographic limitations, and allowed self-direction for additional services, such as personal supports or transportation.

[viii] One access and eligibility flexibility did not include a subcategory and is not counted in either of the category's two subcategories.

Policy Flexibility Expiration

Throughout the PHE, most states extended the policy flexibilities they adopted numerous times. States used either the "end of the PHE" or "6 months after the end of the PHE" as expiration dates. When flexibilities were allowed to expire, expirations often applied only to certain Appendix Ks rather than all flexibilities adopted by a state. Most states (44 states, 94%) requested to extend the duration for which their policy flexibilities were effective at least one time. By the end of our study period in January 2022, Arkansas, Louisiana, Nebraska, North Dakota, and West Virginia had not extended certain policy flexibilities, although these states might have adopted additional flexibilities after the end of the study period. A total of 41 unique flexibilities adopted by these states, evenly distributed across policy flexibility categories, expired during the study period.[ix]

- Flexibilities for **Arkansas**'s Community and Employment Support Waiver and flexibilities related to data collection for the state's Autism Waiver expired.
- One of **Louisiana**'s 14 flexibilities expired. This flexibility altered the type of provider delivering care in adult day health centers.
- In **Nebraska**, 14 flexibilities for populations enrolled in aged, disabled, traumatic brain injury waivers and adults with developmental disabilities waivers expired.
- In **North Dakota**, five out of 14 flexibilities expired, including the flexibility that allowed family members to provide services and the flexibility that modified person-centered care plan development for people with developmental disabilities.
- In **West Virginia**, 14 of 17 flexibilities expired. The expired flexibilities included provider type modifications, payments, and services for older adults and populations with disabilities, including intellectual disabilities.

DISCUSSION

Between March 2020 and January 2022, states made an unprecedented number of temporary, PHE-related modifications to their 1915(c) waiver programs, adding services, modifying service delivery, increasing provider payment rates, providing flexibility for assessments and care planning, and, in some cases, expanding eligibility. All states included in this analysis adopted 1915(c) waiver policy flexibilities using Appendix K during the study period, but the number and types of flexibilities they adopted varied substantially. Although some states, such as Washington, adopted many flexibilities, others, such as Virginia, adopted very few. Most states adopted policy flexibilities across a range of categories. Most flexibilities temporarily added services or modified the delivery of services for existing waiver recipients or changed provider payment or requirements, while a limited number of flexibilities expanded eligibility for waiver services. Some states adopted policy flexibilities for all of their 1915(c) waivers, and others adopted flexibilities for only select waivers and populations. Most states extended flexibilities and did not let them expire.

While we did not evaluate the number of telehealth-related policy flexibilities that states adopted, we identified examples of flexibilities that expanded the delivery of HCBS through telehealth. Another study by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) identified telehealth as a method used by most states to expand access to long-term services and supports, including HCBS.[9] Separate research found that 93% of states adopted Appendix K policy flexibilities that temporarily allowed the delivery HCBS via telehealth for individuals with intellectual and developmental disabilities receiving waiver services during the COVID-19 pandemic.[10] We found that, in addition to allowing for the provision of HCBS via telehealth, many

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[ix] To accurately identify start and end dates for flexibilities that were extended multiple times, we identified unique flexibilities by state, waiver title, policy flexibility and subcategory, resulting in 631 unique flexibilities out of the original 1,695 flexibilities identified by Appendix K submission date, state, waiver title, policy flexibility and subcategory.

states' adopted policy flexibilities that permitted remote options for program administration, for example, by allowing level-of-care evaluations and re-evaluations to be conducted remotely.

Initial research suggests HCBS policy flexibilities adopted in response to COVID-19 may have helped people maintain access to HCBS.[11,12] A Medicaid and CHIP Payment and Access Commission analysis exploring future directions for HCBS after the pandemic found that flexibilities such as telehealth service expansion were key in helping serve Medicaid enrollees.[11] In addition, flexibilities such as expanding self-direction and temporarily increasing payment helped address staffing shortages and might be useful to consider for future policy planning.[11,13] A small qualitative study suggested that flexibilities that expanded self-direction and telehealth helped people maintain access to basic care during the early months of the pandemic.[13] Because of the variation across states in Appendix K policy flexibility adoption, further research into the impact of these flexibilities, including those pertaining to telehealth and remote administration of services, on service use and quality is necessary.

Limitations

This study has several limitations. First, states might have Appendix Ks that were not posted on Medicaid.gov and were therefore excluded from this analysis. In addition, any Appendix Ks states submitted in response to the COVID-19 PHE after the study period were not included. Many states, such as Alaska (August 2022), Maine (March, July, and September 2022), New York (February, May, July, and August 2022), North Carolina (July and August 2022), and Texas (July 2022), submitted additional Appendix Ks after the study period; we did not include these in this analysis.[7] Second, although flexibilities for states without any active 1915(c) waivers were removed from the analysis, there could be states with both 1115 demonstrations and 1915(c) waivers whose 1115 demonstration flexibilities were included in the analysis. Third, if a state submitted an Appendix K that only extended the end date of previously approved policy flexibilities, we assumed all flexibilities that were previously in place were extended. It is possible, however, that some subcategories of a policy flexibility category were extended and not every policy change was extended.

Fourth, states varied significantly in how they classified HCBS policy flexibilities adopted through their Appendix Ks. Many states classified similar policies in different categories and subcategories, perhaps because of their unique waiver requirements and populations, or their interpretation of the categories. For example, some states (e.g., Minnesota and Missouri) classified flexibilities allowing case management via telehealth under the services subcategory temporarily modify service scope or coverage, and others (e.g., New Mexico and Oregon) classified similar case management flexibilities in the services subcategory temporarily expand settings where services may be provided. Similarly, some states (e.g., Alabama and Connecticut) classified flexibilities regarding cost limits under access and eligibility, and others (e.g., Iowa and Oklahoma) classified them as services under the temporarily exceed service limitations subcategory. Some flexibilities categorized under other changes necessary, such as extending eligibility for individuals who would have otherwise aged out of a program (adopted by Texas), overlapped with other categories. This variation could be due to differences in state interpretation of the broad, generic categories used in the standardized Appendix K template. Our analysis relied on how states classified each policy flexibility in their Appendix Ks.

Fifth, when states updated their flexibility end dates, some states submitted their Appendix K documents using different groupings of waiver titles, waiver populations, and policy flexibility categories and subcategories. This could result in overcounting flexibilities by counting the same flexibility more than once. For example, Texas combined Deaf Blind and Multiple Disabilities, Community Living Assistance and Support Services, Home and Community-Based Services, Texas Home Living, Youth Empowerment Services, and Medically Dependent Children Program into one group in its May 14, 2021, submission. But in its April 13, 2021, submission, the state separated these populations into three different groups (Medically Dependent Children, Deaf Blind with Multiple Disabilities and Community Living Assistance and Support Services, and Texas Home Living and Home

and Community-Based Services). As a result, Texas has a larger total count of flexibilities because of these different combinations of their waiver populations.

Finally, the number of flexibilities might be overestimated if a state chose to submit a separate Appendix K for each of its waivers rather than grouping multiple waivers with the same policy flexibility together. The total number of recorded policy flexibilities a state adopted could be altered by how the state submitted its Appendix Ks, the number of HCBS waivers in the state, and the actual number of flexibilities it adopted.

CONCLUSION

Through Appendix K, states adopted a wide range of policy flexibilities for 1915(c) waivers during the COVID-19 PHE. Although many of these flexibilities arose from a need to address acute service and staffing needs, they could have long-term implications for the financing and delivery of HCBS. This accounting of states' use of HCBS policy flexibilities during the PHE could inform future emergency preparedness planning and decisions about making temporary modifications permanent. Further research into the use of these policy flexibilities, including those related to telehealth and remote program administration, and their effects on service use and quality could provide additional information for future policy and planning.

APPENDIX A: COUNTS OF APPENDIX K POLICY FLEXIBILITIES

Table A.1. Total Counts of Policy Flexibilities, by State

State	Count of Policy Flexibilities	State	Count of Policy Flexibilities
ALABAMA	33	MISSOURI	53
ALASKA	19	MONTANA	25
ARKANSAS	18	NEBRASKA	57
CALIFORNIA	35	NEVADA	16
COLORADO	39	NEW HAMPSHIRE	15
CONNECTICUT	58	NEW MEXICO	23
DELAWARE	16	NEW YORK	41
DISTRICT OF COLUMBIA	30	NORTH CAROLINA	76
FLORIDA	17	NORTH DAKOTA	52
GEORGIA	20	OHIO	25
HAWAII	20	OKLAHOMA	77
IDAHO	23	OREGON	17
ILLINOIS	23	PENNSYLVANIA	110
INDIANA	39	SOUTH CAROLINA	24
IOWA	11	SOUTH DAKOTA	25
KANSAS	13	TENNESSEE	15
KENTUCKY	20	TEXAS	16
LOUISIANA	47	UTAH	21
MAINE	37	VIRGINIA	8
MARYLAND	33	WASHINGTON	187
MASSACHUSETTS	25	WEST VIRGINIA	50
MICHIGAN	31	WYOMING	25
MINNESOTA	29	WISCONSIN	36
MISSISSIPPI	65	TOTAL	1,695

Source: Mathematica analysis of Appendix K documents from 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.

Table A.2. Counts of Policy Flexibilities by Category and State												
	AK	AL	AR	CA	CO	CT	DC	DE	FL	GA	HI	IA
Access and eligibility	1	2	0	2	2	8	0	0	0	0	0	0
Imminent needs of individuals in the waiver program	0	0	0	2	0	0	0	0	0	0	0	0
Increase Factor C	0	0	2	0	0	0	0	0	0	0	0	0
Other changes necessary	1	0	3	1	2	8	1	1	3	1	1	1
Services	5	8	0	7	9	13	10	3	4	5	6	4
Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay	0	0	0	0	1	1	1	1	1	1	2	1
Temporarily include retainer payments to address emergency related issues	1	5	0	2	4	2	3	3	4	2	3	1
Temporarily increase payment rates	1	5	6	1	7	3	5	1	0	4	3	0
Temporarily institute or expand opportunities for self-direction	0	0	0	1	0	0	0	0	2	0	0	1
Temporarily modify incident reporting requirements, medication management or other participant safeguards	1	2	0	2	1	2	1	1	1	0	1	0
Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications	1	2	0	5	1	1	2	0	0	1	1	0
Temporarily modify processes for level-of-care evaluations or re-evaluations (within regulatory requirements)	1	1	2	6	4	8	1	1	0	1	1	1
Temporarily modify provider qualifications	4	6	3	3	6	6	3	3	1	2	1	1
Temporarily permit payment for services rendered by family caregivers or legally responsible individuals	2	0	0	1	1	5	2	1	0	1	0	0
Time period extension	1	2	2	2	1	1	1	1	1	2	1	1

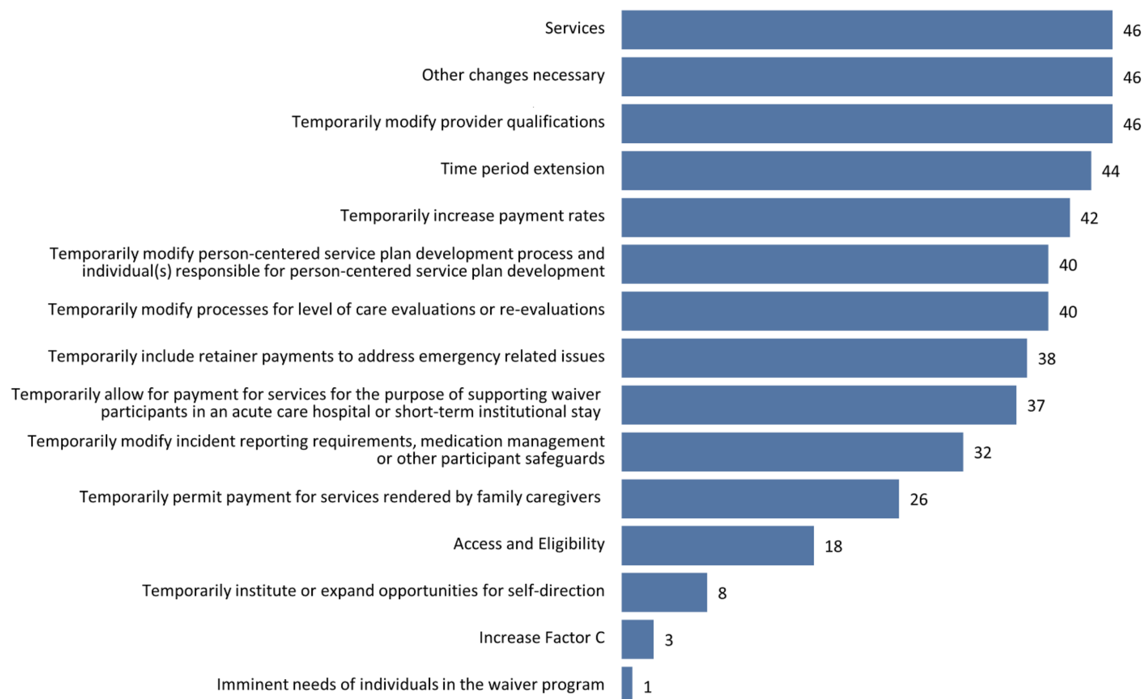
Table A.2. (*continued*)	ID	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO
Access and eligibility	0	1	0	1	0	0	2	2	0	0	0	0
Imminent needs of individuals in the waiver program	0	0	0	0	0	0	0	0	0	0	0	0
Increase Factor C	0	0	0	0	0	0	0	1	0	0	0	0
Other changes necessary	3	2	2	1	1	2	2	4	3	3	6	6
Services	4	5	12	3	6	18	6	9	12	6	14	12
Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay	2	1	0	1	1	0	1	2	2	1	0	5
Temporarily include retainer payments to address emergency related issues	0	2	0	2	2	5	2	4	2	0	0	0
Temporarily increase payment rates	4	5	5	0	1	4	5	2	6	3	4	4
Temporarily institute or expand opportunities for self-direction	0	0	1	0	1	0	0	0	3	0	0	0
Temporarily modify incident reporting requirements, medication management or other participant safeguards	0	2	1	1	1	0	2	2	1	1	0	0
Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications	3	1	1	0	1	5	1	1	1	3	0	5
Temporarily modify processes for level-of-care evaluations or re-evaluations (within regulatory requirements)	3	0	1	0	1	6	1	1	1	6	3	4
Temporarily modify provider qualifications	3	3	6	3	4	3	2	2	4	4	0	7
Temporarily permit payment for services rendered by family caregivers or legally responsible individuals	0	0	3	0	0	2	0	1	2	0	2	5
Time period extension	1	1	7	1	1	2	1	2	0	4	0	5

Table A.2. (*continued*)												
	MS	MT	NC	ND	NE	NH	NM	NV	NY	OH	OK	OR
Access and eligibility	0	0	10	0	0	1	0	0	0	1	2	0
Imminent needs of individuals in the waiver program	0	0	0	0	0	0	0	0	0	0	0	0
Increase Factor C	0	0	0	0	0	0	0	0	0	0	0	0
Other changes necessary	8	3	7	2	2	2	2	1	5	2	5	2
Services	14	6	25	22	12	3	5	4	8	4	21	1
Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay	0	1	4	0	3	1	2	1	0	0	4	0
Temporarily include retainer payments to address emergency related issues	0	1	6	3	2	1	2	1	6	0	3	3
Temporarily increase payment rates	5	2	0	4	14	0	3	2	7	5	15	1
Temporarily institute or expand opportunities for self-direction	0	1	0	0	0	0	0	0	0	0	3	0
Temporarily modify incident reporting requirements, medication management or other participant safeguards	7	1	0	3	0	1	1	1	3	0	3	0
Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications	7	1	2	5	4	1	2	1	4	2	4	2
Temporarily modify processes for level-of-care evaluations or re-evaluations (within regulatory requirements)	7	1	6	2	4	1	2	1	3	2	4	2
Temporarily modify provider qualifications	11	5	7	9	8	2	2	2	2	5	10	4
Temporarily permit payment for services rendered by family caregivers or legally responsible individuals	5	1	5	2	0	1	1	1	0	2	1	0
Time period extension	1	2	4	0	8	1	1	1	3	2	2	2

Table A.2. (*continued*)												
	PA	SC	SD	TN	TX	UT	VA	WA	WI	WV	WY	
Access and eligibility	0	1	0	2	0	1	0	0	1	1	0	
Imminent needs of individuals in the waiver program	0	0	0	0	0	0	0	0	0	0	0	
Increase Factor C	0	0	0	0	0	1	0	0	0	0	0	
Other changes necessary	9	4	4	1	6	2	2	20	3	5	2	
Services	25	9	3	3	4	3	1	44	10	7	6	
Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay	7	0	1	1	0	1	2	10	2	4	2	
Temporarily include retainer payments to address emergency related issues	8	1	2	0	1	2	1	13	3	4	0	
Temporarily increase payment rates	10	1	4	2	2	2	1	17	1	3	5	
Temporarily institute or expand opportunities for self-direction	0	0	0	0	0	0	0	0	0	0	0	
Temporarily modify incident reporting requirements, medication management or other participant safeguards	9	2	1	1	0	1	0	10	0	0	0	
Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications	10	3	2	1	0	1	0	17	3	6	0	
Temporarily modify processes for level-of-care evaluations or re-evaluations (within regulatory requirements)	6	0	0	1	0	1	0	17	1	6	2	
Temporarily modify provider qualifications	17	2	4	2	2	3	2	37	8	10	6	
Temporarily permit payment for services rendered by family caregivers or legally responsible individuals	4	0	0	0	0	2	0	0	1	3	0	
Time period extension	5	1	4	1	1	1	1	2	3	1	2	

Source: Mathematica's analysis of Appendix K documents from 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.

Figure A.1. Count of States with at Least One Flexibility per Category



Source: Mathematica's analysis of Appendix K documents from 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.

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