

# Research

Emergency COVID-19 Pandemic Changes to Home- and Community-Based Services for People with Intellectual and Developmental Disabilities



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## EMERGENCY CHANGES TO IDD HCBS

### **Emergency COVID-19 Pandemic Changes to Home- and Community-Based Services for People with Intellectual and Developmental Disabilities**

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*Inclusion*

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### **Abstract**

The COVID-19 pandemic significantly disrupted Home- and Community-Based Services (HCBS) for people with intellectual and developmental disabilities (IDD). The aim of this study was to examine the emergency amendments states made to their HCBS waivers for people with IDD during the COVID-19 pandemic. To do so, we analyzed 294 *Appendix K: Emergency Preparedness and Response Waivers*, which states used to amend HCBS 1915(c) waivers for people with IDD. States' waiver amendments fell into the following categories: access and eligibility; assessments and person-centered planning; services; settings; providers; reimbursement rates; and safeguards and oversight. These temporary changes made to HCBS IDD waivers aimed to ensure people with IDD's access to services and maintain the quality of those services during the pandemic.

**Keywords:** People with intellectual and developmental disabilities; COVID-19; Home- and Community-Based Services (HCBS) 1915(c) waivers; Appendix K; Medicaid Long-Term Services and Supports (LTSS)

Home- and Community-Based Services (HCBS) 1915(c) waivers are a form of Long-Term Services and Supports (LTSS) which provide customized, wrap-around, community-based supports to people that would otherwise require institutional care to care for themselves because of disability, age, or functional limitations, such as people with intellectual and developmental disabilities (IDD). For example, HCBS for people with IDD often include residential supports, health and professional services, day and employment supports, respite and crisis services, transportation, and assistive technology. As a result of the preferences of people with IDD, the increased outcomes associated with community living, and the cost-effectiveness of community living over institutions, Medicaid HCBS waivers have become the largest funding stream for people with IDD. In fact, as of 2018, 79% of all LTSS for people with IDD was allocated to HCBS (Centers for Medicare and Medicaid Services, 2020).

The SARS-CoV-2 (COVID-19) pandemic, which began in March 2020, significantly disrupted HCBS (Gathright, 2020), the very safety net upon which many people with IDD depend upon to help support their health, safety, and quality of life (Burns, 2009). As research and knowledge about COVID-19 grew, it became increasingly apparent that people with IDD were at significantly greater risk for contracting and dying of COVID-19 than nondisabled people and other disability populations (Clift et al., 2021; Gleason et al., 2021; Hüls et al., 2021; Landes, Turk, Formica, et al., 2020; Landes, Turk, & Wong, 2020; Schott et al., 2021; Turk et al., 2020). This was due not only to their disabilities and medical conditions, but also because many people with IDD live in congregate settings and need personal care which requires close contact, both of which also increase their risks (Abrams et al., 2020; Brown et al., 2021; Chakraborty, 2021; Clift et al., 2021; Landes, Turk, Formica, et al., 2020; Landes, Turk, & Wong, 2020; Turk et al., 2020).

As a result of the increased risk to people with IDD, as well as government safety orders, most HCBS providers serving people with IDD had to close service lines, resulting in people with IDD not being able to receive certain services (e.g., day services) and in increased provider instability due to lost revenue (ANCOR Foundation & United Cerebral Palsy, 2021; Avalere Health, 2020; Bradley, 2020; Ervin & Hobson-Garcia, 2020). Direct support professional (DSP) turnover, which was already at ‘crisis’ levels prior to the pandemic, also increased significantly as a result of the added risks to DSPs, increased workloads, and/or DSPs needing to take care of their family members (ANCOR Foundation & United Cerebral Palsy, 2021; Gathright, 2020; Luterman, 2020). As a result of these issues, not only did the quality of people with IDD’s services decrease, many providers also struggled to function and stay in business because of a lack of resources and funds (ANCOR Foundation & United Cerebral Palsy, 2021; Bradley, 2020; Embregts et al., 2022; Lund et al., 2020; Nygren & Lulinski, 2020; Scheffers et al., 2021).

To meet the challenges of this ever-growing crisis in HCBS, states began implementing emergency changes to their HCBS programs to promote the health, safety, and quality of life of waiver participants during the pandemic. During times of emergency, such as pandemics, states can utilize *Appendix K: Emergency Preparedness and Response Waivers* to temporarily amend their HCBS 1915(c) waiver programs (Centers for Medicare and Medicaid Services, n.d.-a). The aim of this study was to examine the emergency amendments states made to their HCBS waivers for people with IDD during the COVID-19 pandemic. Our research question was: how did states amend their HCBS waivers for people with IDD using emergency authorizations during the COVID-19 pandemic? To explore this research question, we analyzed Appendix K waivers which amended HCBS 1915(c) waivers for people with IDD.

## **Methods**

This study is an analysis of states' Appendix K: Emergency Preparedness and Response amendments to their HCBS waivers. We obtained CMS approved Appendix K waivers from the Medicaid.gov website's *Approved HCBS 1915(c) Appendix K Datatable* on April 7, 2022 (Centers for Medicare and Medicaid Services, n.d.-b). Our inclusion criteria required Appendix Ks be amending HCBS waivers specifically for people with IDD (i.e., intellectual disability, developmental disability, and/or autism spectrum). Moreover, only Appendix Ks for the COVID-19 pandemic were included – those for natural disasters, such as hurricanes, were excluded from data collection. This process resulted in a collection of 294 Appendix K applications.

In Appendix Ks, CMS requires states to document the ways it will temporarily change or amend each waiver for the emergency, in this case, the COVID-19 pandemic (Centers for Medicare and Medicaid Services, n.d.-a). States are required to check (yes/no) the applicable fields relevant to the changes they wish to make regarding access, eligibility, services, requirements, etc.. We analyzed the checkboxes by applying quantitative binary indicator coding – 1 was applied for yes, 0 for no — and then aggregating across Appendix Ks for each section; descriptive statistics – percent yes out of total – were then used to analyze trends across states (Hardy, 1993; Warner, 2013).

## Results

Between March 18, 2020, and April 7, 2022, 44 states and the District of Columbia temporarily amended their HCBS 1915(c) waivers for people with IDD to provide emergency supports and services (Table 1; three states did not offer HCBS IDD waivers, one state combined HCBS populations, and two states did not amend their HCBS IDD waivers using Appendix K). The waiver amendments made by states fell into the following categories: access and eligibility;

assessments and person-centered planning; services; settings; providers; reimbursement rates; and safeguards and oversight.

### **Access and Eligibility**

States utilized Appendix Ks to change IDD waiver access and eligibility to promote access to HCBS during the COVID-19 pandemic (Tables 2 and 3). Cost limits are the ratio between expected HCBS costs and institutional costs for the person being served; to control overspending states often cap costs (Centers for Medicare and Medicaid Services, 2019). During the COVID-19 pandemic, approximately one-quarter of states (26.7%,  $n = 12$ ) temporarily increased cost limits for entry into the waiver in order to help expand people with IDD's access to services. A number of states (13.3%,  $n = 6$ ) also modified additional targeting criteria, which defines the population served by the waiver.

### **Assessments and Person-Centered Planning**

States commonly amended their care assessments and person-centered planning processes during the COVID-19 pandemic. Most states (82.2%,  $n = 37$ ) temporarily modified the processes for level of care re/evaluations, which determine the need for services, within regulatory requirements. While doing so, most states (71.1%,  $n = 32$ ) allowed evaluations, assessments, and person-centered planning meetings to be conducted virtually/remotely in lieu of face-to-face meetings. Moreover, 68.9% of states ( $n = 31$ ) allowed required documents for evaluations and person-centered plans to be signed electronically. In addition, 62.2% of states ( $n = 28$ ) allowed an extension for reassessment and re-evaluations for up to one year past the due date. More than three-quarters of states (80.0%,  $n = 36$ ) temporarily modified their person-centered service plan development process.

### **Services**

States also utilized emergency authorizations to change the service in their HCBS waivers for people with IDD. Half of the states (51.1%,  $n = 23$ ) temporarily added services to the waiver to help address the emergency situation. Many states (64.4%,  $n = 29$ ) also temporarily modified the scope of their existing services. Most states (82.2%,  $n = 37$ ) elected to temporarily exceed service limitations, including amount, duration, and prior authorization, to help support people with IDD.

To help expand people with IDD's access to services and supports, 55.6% of states ( $n = 25$ ) also adjusted prior approval/authorization elements approved in their waivers. Typically, "When an item or service is subject to prior authorization, payment is not made unless approval for the item or service is obtained in advance either from state agency personnel or from a state fiscal agent or other contractor" (Centers for Medicare and Medicaid Services, 2019, p. 324). Amending the prior approval/authorization elements during the pandemic makes it easier for people with IDD to access services, such as hospital care, and items, such as medication and specialized medical equipment.

### **Settings**

During the pandemic, most states temporarily changed where HCBS could be provided to people with IDD. More than three-quarters of states (95.5%,  $n = 42$ ) added an electronic/remote method of service delivery so that people with IDD could remotely receive services in their homes. Moreover, 93.3% of states ( $n = 42$ ) expanded the in-person settings where services could be provided to people with IDD. In addition, 68.9% of states ( $n = 31$ ) allowed for people with IDD who are in an acute care hospital, nursing facility, or short-term institution stay because of COVID-19 or other reasons to receive the necessary supports which are not available or covered in that setting. Approximately one-third of states (31.1%,  $n = 14$ ) allowed HCBS to be



temporarily provided to people with IDD in out-of-state settings, if doing so was not already permitted in the waiver.

### **Providers**

Almost all states (95.6%,  $n = 43$ ) temporarily modified provider requirements. While doing so, the majority of states (93.3%,  $n = 42$ ) temporarily modified provider qualifications. In addition, 33.3% of states ( $n = 15$ ) modified provider types. Moreover, 64.4% of states ( $n = 29$ ) temporarily modified licensure or other requirements for settings where waiver services are furnished.

Almost two-thirds of states (62.2%,  $n = 28$ ) also amended their waivers so that, if not already permitted in the waiver, family members and other legally responsible individuals (i.e., legal guardians) could be paid to provide services to people with IDD. Approximately one-third of states (28.9%,  $n = 13$ ) authorized case management entities to provide direct services. Only six states (13.3%) amended their HCBS waivers to temporarily establish or expanded self-direction opportunities for people with IDD.

### **Reimbursement and Payment**

The overwhelming majority of states (88.9%,  $n = 40$ ) temporarily increased reimbursement rates for services. It was also common for states (77.8%,  $n = 35$ ) to temporarily include retainer payments to help providers continue operations, maintain their workforce, and survive to be able to provide services after the pandemic is over.

### **Safeguards and Oversight**

In terms of safeguards and oversight, to minimize infection and spread, 68.9% of states ( $n = 31$ ) temporarily waived the HCBS Settings Rule requirements (42 CFR 441.301(c)(4)(vi)(D)) that people with IDD be able to have visitors of their choosing at any time. Approximately two-

thirds of states (68.9%,  $n = 31$ ) also temporarily modified incident reporting requirements, medication management procedures, and other participant safeguards. Finally, 95.6% of states ( $n = 43$ ) made ‘other’ necessary changes to address the needs of waiver participants with IDD.

### **Discussion**

People with IDD faced a lack of continuity and security during the COVID-19 pandemic, with HCBS service provision being significantly disrupted (Friedman, 2021a). For these reasons, the aim of this study was to examine the emergency amendments states made to their HCBS waivers for people with IDD during the pandemic. Our findings revealed most states made changes to their HCBS waiver programs, expanding service delivery to ensure people with IDD could access the services and supports they needed during the pandemic. This ranged from expanding existing services to exceeding service limitations to adjusting prior approval/authorization elements. States also increased the variety of service settings, expanding the in-person settings where services could be provided and implementing telehealth, which had not commonly been used with people with IDD before in HCBS (Friedman, 2022; Friedman & Rizzolo, 2017). While telehealth use rapidly grew during the pandemic to compensate for in-person restrictions and has the potential to expand people’s access to care and reduce health care disparities (Centers for Disease Control and Prevention, 2020; Dinesen et al., 2016; Scheffers et al., 2021), it is important to note that telehealth can be inaccessible for many people with IDD and people with IDD are less likely to have access to technology than nondisabled people (Anderson & Perrin, 2017; Annaswamy et al., 2020; Dobransky & Hargittai, 2016; Krysta et al., 2021; Lazar & Jaeger, 2011; Young & Edwards, 2020). For these reasons, while the significant growth of telehealth represents a novel form of service delivery for HCBS for people with IDD,

it is critical for attention be paid to accessibility of telehealth to ensure it maximizes the access of people with IDD, as well as the technology disparities people with IDD face.

In addition, states commonly made changes to minimize provider and DSP instability. Not only did most states modify provider requirements to reduce administrative burdens and barriers, but they also expanded who could provide services, including case managers and family caregivers. Allowing family caregivers to be paid for provider services helps compensate for staff shortages, as well as produces better health outcomes (Matthias & Benjamin, 2008); doing so may be especially beneficial during a pandemic to minimize the number of supporters people with IDD needed to come in contact with. Paying family members to provide services can also help reduce the burdens associated with unpaid caregiving – the mechanism which the LTSS service system is largely built upon – including caregivers’ physical and emotional stress, poor health outcomes, and added financial costs (Gallanis & Gittler, 2012; Kunkel et al., 2003; Simon-Rusinowitz et al., 2005).

Almost all states also increased payment rates for services (90%) and implemented retainer payments (78%) to help keep providers in business and promote consistent, quality services for people with IDD. Retainer payments are beneficial to compensate for providers’ loss in revenue and increase in expenditures during the pandemic. For example, in April of 2020, 32% of IDD service providers reported lost revenue due to closing service lines (Avalere Health, 2020). Moreover, overtime payments for staff have cost the average provider a million dollars a year during the pandemic (ANCOR Foundation & United Cerebral Palsy, 2021). Both increased reimbursement rates and retainer payments can not only help providers maintain operations, as a result, they can also help ensure providers will be in business after the pandemic is over.

While increasing DSP wages is associated with reduced turnover (Pettingell et al., 2022) and was needed to compensate for DSPs' additional workload during the pandemic, when these temporary rate increases are removed, DSP turnover may increase, further exacerbating the systemic issue that is the DSP 'crisis' and in turn, hindering the quality of life of people with IDD (Friedman, 2018a, 2021b). It is also important to consider the implications of the modified staff qualification and training requirements on the quality of services and people with IDD's quality of life. Even prior to the pandemic, DSPs who provided the most support typically had the fewest qualifications, and there was little consistency in training guidelines or requirements across states (Hasan, 2013; Hewitt, 2014; National Direct Service Workforce Resource Center, 2013). Yet, staff training not only improves the quality of services, but also helps promote self-efficacy among DSPs, reducing burnout, and by extension, turnover (Hasan, 2013; Keesler, 2016).

Most states suspended people with IDD's HCBS Settings Rule right to have visitors of their choosing at any time. While this was likely done as a precaution to promote social distancing and reduce infection spread, doing so also contributed to increased loneliness and isolation among people with IDD, which can negatively impact people's mental health, especially during a traumatic and stressful time (ANCOR Foundation & United Cerebral Palsy, 2021; Embregts et al., 2022; Pettinicchio et al., 2021). In addition, from the Appendix K waivers, it was unclear if there were plans in place to fade these rights restrictions away as soon as was possible or if guidance given to providers on how best to do so.

While states made a wide number of amendments to their HCBS waivers for people with IDD during the pandemic, it was rare for states to expand people with IDD's opportunities for self-direction. While more research is needed to determine why so few states expanded self-

direction during the pandemic, we theorize that states may have not prioritized self-direction either because of administrative burden and/or because they assumed self-direction would conflict with health and safety during the pandemic. However, it is important to note that self-direction is not only associated with more choice and control, but also with improved health and quality of life outcomes (Gross et al., 2013; Heller et al., 2012; Swaine et al., 2016). The lack of expansion of self-direction may also be due to low expectations about the abilities of people with IDD; in fact, while most HCBS waivers allow self-direction, even prior to the pandemic, states only aimed to have 10% of people with IDD receiving HCBS self-direct (Friedman, 2018b). While fewer formal mechanisms for self-direction were expanded, the expansion of paying family caregivers may have helped increase the choice-making opportunities of people with IDD (San Antonio et al., 2006). Yet, people with IDD's ability to hire support staff outside of formal provider agencies using self-direction could have also helped compensate for DSP shortages.

In addition, relatively few states utilized emergency authorizations to expand access and eligibility for their IDD waivers; in fact, only 12 states increased cost limits, 6 states modified targeting criteria, and 2 states expanded the number of unduplicated people their waivers serve. A few states also suspended people with IDD's HCBS Settings Rule rights to choose where and with whom they lived. Given the significant infection and mortality rates of people with IDD in congregate settings (Chidambaram, 2022; Li, 2020), especially institutions, this seems like a missed opportunity to help people with IDD move from institutions to community-based settings during the pandemic. Since HCBS waivers are more cost effective than institutions (Braddock et al., 2017), moving people with IDD to HCBS would not be cost prohibitive, and, therefore, likely not a reason for the lack of expansion. Perhaps states hesitated to expand the access and eligibility for HCBS IDD waivers due to a lack of community infrastructure to support people

with IDD long-term, including after Appendix K waivers ended. In fact, as of 2020, 464,000 people with IDD were waiting for HCBS services (The Henry J. Kaiser Family Foundation, n.d.), highlighting the continued need to expand and strengthen the community infrastructure for people with IDD.

### **Implications for Policy and Practice**

Prior to the COVID-19 pandemic, HCBS for people with IDD, while a critical mechanism, was underfunded, disjointed, and fractured (ANCOR Foundation & United Cerebral Palsy, 2021). While the pandemic has been extremely trying for people with IDD and taxing for the IDD service system, changes to service provision, such as the introduction of technology and the need to compensate the temporary closure of day programs, allowed many people with IDD to receive creative, person-centered services in ways never seen before (ANCOR Foundation & United Cerebral Palsy, 2021; Bradley, 2020; Scheffers et al., 2021).

Yet, Appendix K waivers are *temporary* amendments to state HCBS waivers. Many of the amendments to HCBS IDD programs found in this study are scheduled to revert to pre-pandemic operations 6 months after the Public Health Emergency (PHE) is terminated, unless approved by other authorities or implemented into the states' actual 1915(c) waivers. Given the changes made using Appendix K waivers aimed to promote the access, continuity, and quality of HCBS, we believe it would be beneficial for many of the changes made to waivers via emergency authorizations, such as introduction of telehealth, expansion of paying family caregivers, increased reimbursement rates for DSPs, and increased flexibility in service provision, to continue.

### **Limitations**

When interpreting the findings from this study, a number of limitations should be noted. The aim of this study was to examine how states changed their HCBS waivers using emergency authorizations during the COVID-19 pandemic; these data do not indicate if, or, how these changes affected the quality of life or quality of services of the people with IDD receiving HCBS. However, we believe this would be a fruitful area of future study. Given differences in population could not be determined, HCBS waivers that combined people with IDD with other populations were not included in this study. States may amend their Appendix K waivers multiple times; our analysis was of the cumulous changes states made between the beginning of the pandemic and our data collection (April 7, 2022). As the pandemic is ongoing, states may choose to amend, expand, or roll back these changes between when our data collection ended and the end of the pandemic.

### **Conclusion**

The COVID-19 pandemic significantly impacted the HCBS IDD service system. Accordingly, during the COVID-19 pandemic, states made a large number of emergency amendments to their HCBS waivers for people with IDD using Appendix K waivers. These changes ranged from expanding where services could be provided to modifying provider qualifications, to increasing payment rates. The temporary changes made to HCBS IDD waivers aimed to ensure people with IDD's access to services and the quality of those services were maintained. It is important to ensure quality HCBS continue for people with IDD during the pandemic and well beyond.

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Table 1  
*Appendix K Waivers for HCBS 1915(c) IDD Waivers*

State	Applicable IDD waivers	# Appendix K waivers	Effective date	End date
Alabama	AL0001, AL0391	5	1/27/2020	6 months after PHE
Alaska	AK0260, AK0262, AK1566	7	3/11/2020	6 months after PHE
Arkansas	AR188, AR936	6	3/12/2020	7/1/2022
California	CA0336, CA1166	8	2/4/2020	6 months after PHE
Colorado	CO0007, CO0293, CO0305, CO4180	14	3/10/2020	6 months after PHE
Connecticut	CT0426, CT0437, CT0881, CT0993	8	3/16/2020	6 months after PHE
Delaware	DE0009	5	1/27/2020	6 months after PHE
District of Columbia	DC0307, DC1766	5	3/11/2020	6 months after PHE
Florida	FL0867, FL40205	4	1/27/2020	6 months after PHE
Georgia	GA0175, GA0323	6	3/1/2020	6 months after PHE
Hawaii	HI0013	8	3/1/2020	6 months after PHE
Idaho	ID0076	3	1/27/2020	6 months after PHE
Illinois	IL350, IL464, IL473	3	1/27/2020	6 months after PHE
Indiana	IN0378, IN0387	10	3/1/2020	6 months after PHE
Iowa	IA0242	4	1/27/2020	6 months after PHE
Kansas	KS224, KS476	5	1/27/2020	6 months after PHE
Kentucky	KS0314, KS0475	5	3/6/2020	6 months after PHE
Louisiana	LA0361, LA0401, LA0453, LA0472	4	1/27/2020	6 months after PHE
Maine	ME0159, ME0467	8	3/1/2020	6 months after PHE
Maryland	MD0023, MD0339, MD1466, MD1506	9	3/1/2020	6 months after PHE
Massachusetts	MA0826, MA0827, MA0828, MA40207	5	3/1/2020	6 months after PHE
Michigan	MI0167, MI4119	3	3/1/2020	6 months after PHE
Minnesota	MN061	15	1/27/2020	6 months after PHE
Mississippi	MS0282	3	3/1/2020	6 months after PHE
Missouri	MO0178, MO0404, MO0841, MO4185	5	1/27/2020	6 months after PHE
Montana	MT0208	7	1/27/2020	End of PHE
Nebraska	NE0394, NE4154	6	3/6/2020	3/5/2021

Nevada	NV0125	5	1/27/2020	6 months after PHE
New Hampshire	NH0053, NH0397	3	3/1/2020	6 months after PHE
New Mexico	NM0173, NM0448, NM1726	6	1/27/2020	6 months after PHE
New York	NY0238	3	3/7/2020	3/31/2021
North Carolina	NC0423	6	3/13/2020	6 months after PHE
North Dakota	ND0037, ND0842	5	3/1/2020	6 months after PHE
Ohio	OH0231, OH0380, OH0877	5	1/27/2020	6 months after PHE
Oklahoma	OK0179, OK0343, OK0351, OK0399	16	1/27/2020	6 months after PHE
Oregon	OR0117, OR0375, OR40194	5	3/11/2020	6 months after PHE
Pennsylvania	PA0147, PA0235, PA0324, PA0354, PA0593, PA1486	21	1/27/2020	6 months after PHE
South Carolina	SC0237, SC0676	4	1/27/2020	6 months after PHE
South Dakota	SD0044, SD0338	7	1/27/2020	6 months after PHE
Tennessee	TN0128, TN0357, TN0427	3	3/13/2020	6 months after PHE
Texas	TX0110, TX0221, TX0281, TX0403	7	3/13/2020	End of PHE
Utah	UT0158, UT1666	4	1/27/2020	6 months after PHE
Virginia	VA0358, VA0372, VA0430	6	3/12/2020	6 months after PHE
Washington	WA0409, WA0410, WA0411, WA1186	11	1/27/2020	6 months after PHE
West Virginia	WV0133	6	3/12/2020	6 months after PHE

*Note.* PHE = Public Health Emergency.

Table 2

*Emergency Amendments to HCBS IDD Waivers*

Amendment	N	%
<b>ACCESS AND ELIGIBILITY</b>		
Increase cost limits for entry into the waiver	12	26.7%
Modify additional targeting criteria	6	13.3%
Increase unduplicated number of participants	2	4.4%
<b>ASSESSMENTS AND PERSON-CENTERED PLANNING</b>		
Modify processes for level of care re/evaluations	37	82.2%
Allow virtual/remote evaluations, assessments, and person-centered service planning meetings	32	71.1%
Allow extensions for reassessments/reevaluations up to a year	28	62.2%
Add electronic method of signing off on required documents	31	68.9%
Modify person-centered service plan development process	36	80.0%
<b>SERVICES</b>		
Add services to the waiver	23	51.1%
Add home-delivered meals	9	20.0%
Add medical supplies, equipment and appliances	6	13.3%
Add assistive technology	5	11.1%
Modify service scope or coverage	29	64.4%
Exceed service limitations or requirements	37	82.2%
Adjust prior approval/authorization elements approved in waiver	25	55.6%
<b>SETTINGS</b>		
Add remote/electronic service delivery	42	93.3%
Expand settings where services may be provided	42	93.3%
Allow for payment for services in acute care hospital or short-term institutional stay	31	68.9%
Provide services in out-of-state settings	14	31.1%
<b>PROVIDERS</b>		
Modify provider requirements	43	95.6%
Modify provider qualifications	42	93.3%
Modify provider types	15	33.3%
Modify licensure or other requirements	29	64.4%
Permit family caregivers/legally responsible individuals to be paid for providing services	28	62.2%
Authorize case management entities to provide direct services	13	28.9%
Institute/expand opportunities for self-direction	6	13.3%
<b>REIMBURSEMENT AND RATES</b>		
Increase payment rates	40	88.9%
Include retainer payments	35	77.8%
<b>SAFEGUARDS AND OVERSIGHT</b>		
Waive HCBS Settings Rule regulations about visitors	31	68.9%
Modify incident reporting requirements, medication management or other participant safeguards	31	68.9%
Other changes necessary to address imminent needs of waiver participants	43	95.6%







Table 3 (continued)

*State Changes to HCBS IDD Waivers*

Amendment	TX	UT	VA	WA	WV
<b>ACCESS AND ELIGIBILITY</b>					
Increase cost limits for entry into the waiver					
Modify additional targeting criteria					
Increase unduplicated number of participants					
<b>ASSESSMENTS AND PERSON-CENTERED PLANNING</b>					
Modify processes for level of care re/evaluations		X		X	X
Allow virtual/remote evaluations, assessments, and person-centered service planning meetings	X	X	X		
Allow extensions for reassessments/reevaluations up to a year	X	X	X		
Add electronic method of signing off on required documents	X	X	X		
Modify person-centered service plan development process		X		X	X
<b>SERVICES</b>					
Add services to the waiver		X		X	
Add home-delivered meals					
Add medical supplies, equipment and appliances					
Add assistive technology					
Modify service scope or coverage					
Exceed service limitations or requirements	X	X		X	X
Adjust prior approval/authorization elements approved in waiver	X	X			
<b>SETTINGS</b>					
Add remote/electronic service delivery	X	X	X	X	X
Expand settings where services may be provided	X	X	X	X	X
Allow for payment for services in acute care hospital or short-term institutional stay	X	X		X	X
Provide services in out-of-state settings				X	
<b>PROVIDERS</b>					
Modify provider requirements		X	X	X	X
Modify provider qualifications		X	X	X	X
Modify provider types		X		X	
Modify licensure or other requirements		X		X	X
Permit family caregivers/legally responsible individuals to be paid for providing services		X	X		
Authorize case management entities to provide direct services		X			
Institute/expand opportunities for self-direction					
<b>REIMBURSEMENT AND RATES</b>					
Increase payment rates	X	X	X	X	X
Include retainer payments		X	X	X	X
<b>SAFEGUARDS AND OVERSIGHT</b>					
Waive HCBS Settings Rule regulations about visitors	X	X	X		
Modify incident reporting requirements, medication management or other participant safeguards		X		X	
Other changes necessary to address imminent needs of waiver participants	X	X	X	X	X