

Medicaid Options for States During COVID-19: Considerations for Children and Youth with Special Health Care Needs

Association of Maternal & Child Health Programs • Georgia Health Policy Center

Background

The COVID-19 pandemic has required state Medicaid programs to quickly adapt to a new health care delivery landscape for millions of children, including children and youth with special health care needs (CYSHCN). With the economic downturn, growth in the program has soared. Over 2.7 million children nationally enrolled in Medicaid or the Children's Health Insurance Program (CHIP) during the eight-month period from March 2020 (the beginning of the public health emergency) to November 2020.¹ To respond to the crisis, the Centers for Medicare & Medicaid Services (CMS) created multiple [policy options](#) that states have used to institute critical modifications to their Medicaid programs during the public health emergency (PHE). Examples of these modifications have included addressing the pandemic-related needs of CYSHCN by transitioning in-person care to telehealth; implementing strategies to ensure continuous access to home health and other home- and community-based services for CYSHCN; and implementing other adaptive changes for related services, such as family caregiving. This fact sheet explores Medicaid policy options for states to meet the needs of CYSHCN during the PHE and discusses how future rollbacks of PHE modifications may affect CYSHCN populations.

Multiple Policy Options Help State Medicaid Programs Manage COVID-19

To increase and sustain access to health care services during the COVID-19 pandemic, states have utilized the following policy options to modify their existing state Medicaid plans to support CYSHCN populations:

- State Plan Amendments (SPA)
- 1135 Waivers
- 1915(c) Home- and Community-Based Services (HCBS) Waiver/Appendix K.²

Although the waiver most frequently used to provide care for CYSHCN is the 1915(c) HCBS Waiver/Appendix K, all states have employed a combination of Medicaid policy options to respond to COVID-19.

State Plan Amendments

Under normal circumstances, SPAs undergo a 90-day review and approval process after they are submitted to CMS. Once the SPA is approved, it becomes a permanent change to the state Medicaid plan. To address the states' need to rapidly modify and make temporary changes to their Medicaid programs during COVID-19, CMS developed a special SPA template. This template allows states to request multiple program changes simultaneously, including changes to Medicaid eligibility, enrollment rules, scope of benefits, and cost-sharing requirements. (See Table 1.) States can set time limits on their SPAs to align with the PHE period or another date prior to the end of the PHE. To date, all 50 states and the District of Columbia have applied for a temporary SPA or taken other administrative action to adjust their Medicaid program.

1135 Waivers

During the PHE, states may also use 1135 waivers to request CMS approval to increase access to care by relaxing requirements for providers to participate in the Medicaid program, suspending pre-approval requirements for services, lifting rules and restrictions on care settings, and altering provider reimbursement. To date, all 50 states and the District of Columbia have received approval for an 1135 waiver. The waivers are approved for 60 days, after which they can be renewed if the PHE is still in effect.

1915(c) Waivers/Appendix K

States can apply for a standalone "Appendix K" to amend existing 1915(c) waivers that govern the provision of HCBS under the Medicaid program. States use Appendix Ks during emergencies to make temporary changes in beneficiary eligibility rules, relax provider eligibility criteria, and implement more generous reimbursement policies for caregivers and HCBS services to support continuity of care. To facilitate changes to HCBS services during the pandemic, CMS released a COVID-19-specific Appendix K template. To date, all 50 states and the District of Columbia have an approved 1915(c) Appendix K.³ Appendix K authorities tied to the PHE are not linked to the end date of the PHE; instead, they follow the end date specified in the approved Appendix K.⁴

Table 1 highlights COVID-19 Medicaid policy options that benefit CYSHCN populations.

Table 1. Adapting Medicaid Flexibilities to CYSHCN Populations during COVID-19				
	SPA	1135	1915(c) Appendix K	Implications
<i>Eligibility</i>				
<ul style="list-style-type: none"> Expand Medicaid coverage to optional populations Modify income eligibility criteria Relax eligibility requirements (application deadlines, proof of residency) 	●			States have the option to expand Medicaid eligibility to additional groups. For example, states can expand eligibility to uninsured individuals regardless of income and others who would not qualify for Medicaid in ordinary circumstances (e.g., undocumented immigrants and children). States can use this option to provide emergency care, including treatment for COVID-19 through the end of the PHE.
<i>Beneficiary Enrollment</i>				
<ul style="list-style-type: none"> Streamline and simplify the Medicaid application process Simplify and extend deadlines for renewals Extend presumptive eligibility to other groups beyond those that are income eligible 	●			The continuous coverage requirement, authorized by the Families First Coronavirus Response Act (FFCRA), provides states with enhanced Medicaid funding for retaining Medicaid beneficiaries enrolled as of March 18, 2020 through the end of the PHE. This reduces churn that would usually occur during periodic eligibility determinations. These changes apply to children insured through CHIP as well. Presumptive eligibility determinations can facilitate early access to health care services. It also ensures provider reimbursement for the care provided.
<i>Premiums/cost-sharing</i>				
Eliminate cost sharing, enrollment fees, copayments, deductibles, and coinsurance in Medicaid and CHIP	●			This provision can include co-pays for specialty medical providers who support CYSHCN. This reduces financial burdens on families during the PHE.
<i>Benefits</i>				
<ul style="list-style-type: none"> Remove benefit restrictions such as service limits and prior authorization Extend existing prior authorizations 	●	●	●	For CYSHCN who may need specialty care, these provisions reduce burden on the provider and caregiver. CYSHCN populations can more easily access care without disruption. The removal of minimum use requirements allows waiver-enrolled individuals to remain enrolled and to restart services when they feel it is safe to do so.
<ul style="list-style-type: none"> Remove requirements on minimum use of services 			●	

(continued)

Table 1. Adapting Medicaid Flexibilities to CYSHCN Populations during COVID-19

	SPA	1135	1915(c) Appendix K	Implications
<i>Telehealth</i>				
<ul style="list-style-type: none"> Expand telehealth coverage and access Cover audio-only services Allow additional providers to bill for telehealth services, including occupational therapists, speech therapists, and behavioral health therapists, as well as specialty care physicians Expand sites of care to include the patient's home or other non-clinical settings 	●	●		<p>Audio-only telehealth visits can be offered in rural areas where high-speed Internet is unavailable or very limited. Other services can be provided via telehealth, such as early intervention services, behavioral health, physical therapy, occupational therapy, and speech therapy.</p> <p>Most states have expanded this option to allow patients to receive telehealth services from home. This strengthens access to care, especially for CYSHCN who may be particularly vulnerable to COVID-19 or who have mobility issues.</p>
<i>Payment</i>				
<ul style="list-style-type: none"> Increase provider payment rates 	●			<p>A state may contractually require their Medicaid managed care plans to pay an enhanced minimum fee schedule for pediatric primary care providers. States may give retainer payments to some 1915(c) waiver providers as well.</p>
<ul style="list-style-type: none"> Offer retainer payments to support providers 		●	●	
<i>Provider Enrollment</i>				
<ul style="list-style-type: none"> Permit the use of out-of-state providers Temporarily relax service setting/location requirements Allow expanded enrollment to include new provider types 		●	●	<p>This provision increases access to specialty care provider in other states (e.g., behavioral health and other therapies) for children, especially in rural and/or underserved areas. To reduce the health risks of nonfamily members in the home during the PHE, family caregivers can be reimbursed for providing personal care services, which are typically provided by home health aides.</p> <p>This provision also offers states the opportunity to temporarily suspend occupational licensing laws for high-demand health care professions such as nurses and nurses' aides.</p>

Sources:

Kaiser Family Foundation. (2021). [Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19](#)

Georgia Health Policy Center. (2020). [Options for State Medicaid Programs During COVID-19 Emergency](#)

Georgetown University Center for Children and Families. (2020). [Approved 1135 Waivers and State Plan Amendments for COVID-19](#)

Kaiser Family Foundation. (2021). [Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic](#)

American Medical Association, Advocacy Resource Center. (2020). [State Policies on Access and Coverage During COVID-19](#)

National Academy for State Health Policy. (2020). [State Medicaid Strategies to Maintain Access to Care for Children with Special Health Care Needs during the pandemic](#)

Manatt Health. (2020). [Supporting Children and Youth with Special Health Care Needs During COVID-19](#)

National Conference of State Legislatures. (2020). [COVID-19: Occupational Licensing During Public Emergencies](#)

State Experiences with Appendix K Waivers to Meet the Needs of CYSHCN Populations During Covid-19

Several states have leveraged Medicaid Appendix K waivers to temporarily modify existing waiver programs that serve CYSHCN. Below are approaches that Maryland, Michigan, New York, North Dakota, Oregon, Texas, Washington, and Wisconsin have adopted during the PHE.

Modify target populations and scope of coverage

- Maryland relaxed eligibility criteria for children with autism spectrum disorder, to allow participants who would have aged out of the program at 21 or who no longer meet technical eligibility criteria to remain in the program. The state also suspended service limits on respite care, family consultation, and intensive individual support services. In addition, the Appendix K authorizes extra in-home and community services to waiver beneficiaries as schools reopen, to minimize disruptions.
- Texas and Wisconsin paused disenrollment of beneficiaries and program transitions via Appendix K waivers.
- Texas permitted beneficiaries over the age of 21 to remain in the STAR Kids Medically Dependent Children Program and suspended the release of any individuals from waiver waiting lists.
- Wisconsin suspended all involuntary disenrollment from their Children's Long-Term Support Waiver Program.

Relax service limitations and prior authorization requirements

- Michigan suspended time limitations on respite services; relaxed local service limitations for transportation; suspended limits on the number of sessions per day available for home care training; and suspended limits on monthly "units" of community living supports services under the state's Children's Waiver Program (CWP) for Children with Serious Emotional Disturbances.
- New York modified its CWP to allow beneficiaries to exceed service limits for community habilitation, day habilitation, respite care, adaptive and assistive equipment, caregiver/family support and services, nonmedical transportation, and palliative care.
- North Dakota simplified the process for case managers and service managers seeking authorization of additional hours of in-home support and respite services for beneficiaries enrolled in the following state programs: Medically Fragile Children, Children's Hospice, and Autism Spectrum Disorder.
- Washington state authorized additional hours of respite to caregivers and modified the scope of services in the Children's Intensive In-Home Behavior Support program. To reduce

children's exposure to non-family members, providers offering respite services can perform out-of-home tasks that are typically the responsibility of the primary caregiver, allowing caregivers to remain at home during respite hours. Under its Appendix K, Washington also extended transportation services, allowing beneficiaries to be transported to the home of another family member. In addition, the Appendix K allows the remote delivery of all services when a child or young adult cannot travel due to COVID, and eases requirements for pre-authorization of necessary assistive technology (e.g., tablets and phones) to facilitate the delivery of remote services.

Expand services settings, including out-of-state service delivery

- Michigan relaxed service setting requirements to deliver care in a provider's home or other setting to accommodate beneficiaries displaced from their home due to COVID. Specifically, the state's Appendix K waiver authorizes the delivery of respite services in a beneficiary's home, the home of another contact, adult foster care home, or other approved facility in the state.
- New York now permits providers to render HCBS services in alternative environments when waiver beneficiaries are displaced from their homes, and to deliver respite services via telehealth or other remote methods when feasible.
- Washington state beneficiaries can receive respite care services and positive behavior support services in hotels, shelters, churches, alternate living facilities, or in the home of a direct care staff member.
- Similarly, Maryland has relaxed service settings for care. Therapeutic services and other programs can be integrated for delivery in a beneficiary's home.
- In North Dakota, case managers can request approval to provide in-home support or respite services in alternative settings to keep beneficiaries safe. In addition, beneficiaries can receive respite, skilled nursing, hospice, and palliative services out of state if they need to relocate due to COVID.

Modify provider qualifications, provider types, and approved vendors

- Wisconsin relaxed provider eligibility to expand the pool of available providers for CYSHCN. The Appendix K also expanded access to assistive technology and transportation services by allowing beneficiaries to use general retailers to obtain technology and communication aides and adding "transportation network companies" as an approved transportation service provider.
- Washington state eased rules on vendors that can be approved for purchasing specialized equipment, supplies, and assistive technology. The state allowed contracted positive behavior support providers to deliver respite care.

- North Dakota is using its Appendix K to authorize relatives of waiver beneficiaries to provide services while temporarily suspending certain training requirements. The state is allowing out-of-state providers to offer hospice services for the North Dakota Children's Hospice program.

Modify requirements for level of care (LOC) evaluations and person-centered service plan development

Appendix Ks have also allowed states to extend service approval periods and temporarily suspend face-to-face meeting requirements to conduct annual service assessments and develop individual care plans.

- New York is allowing waiver assessments to be conducted over the phone or remotely and has temporarily suspended HCBS and LOC eligibility determination re-assessments. The state's Appendix K waives face-to-face service requirements for health home providers. Services can be coordinated and delivered via telehealth to prevent delays or disruptions to care. Text from New York's Appendix K demonstrates how management assessments can be flexible during the pandemic:

"If the person has immediate care management needs, for example, the person requires assistance with [accessing] the pharmacy or accessing food and other basic needs, delivery of school supplies and schoolwork connectivity, the case manager should ensure a frequency of contact sufficient to keep the person healthy and safe."

- Michigan authorized the extension of annual care determinations through the end of the Appendix K approval period and relaxed timelines for submitting Individualized Education Programs (IEPs) from schools, LOC evaluations, and other service-related assessments. The state also expanded the use of telehealth services for developing and modifying person-centered service plans between care coordinators and waiver beneficiaries.
- Maryland, North Dakota, Oregon, Washington, and Wisconsin have relaxed the rules requiring face-to-face evaluations, assessments, and patient meetings. Case managers can now conduct assessments and service planning remotely via telephone or other telehealth technologies.

Increase payment rates, authorize payments for family caregivers, and issue retainer payments

To support the safe delivery of care and sustain providers through the COVID-19 pandemic, many states have used Appendix Ks to modify payment rules in their waiver programs serving CYSHCNs.

- Michigan authorized a rate increase (not to exceed 50 percent of current rates) for community living supports, personal care, overnight health and safety services, and

respite services. The state also approved payments for support services in alternative settings such as acute care hospitals and short-term institutional settings where these services are not typically delivered.

- Oregon increased payment rates for direct nursing services for its Medically Involved Children's Waiver.
- Washington state increased reimbursement rates for residential habilitation providers, respite providers, and skilled nurses serving beneficiaries in the Children's Intensive In-Home Behavior Support program.
- Several states are allowing family caregivers and legal guardians to receive reimbursement for the provision of services during the PHE.
- Maryland and Wisconsin are reimbursing caregivers for the delivery of intensive individual support services and personal care of beneficiaries.
- Appendix Ks are also supporting retainer payments to health care providers and facilities. Maryland, New York, and Wisconsin authorized retainer payments to providers offering habilitation services to compensate them for COVID-related no-shows. Retainer payments for personal care services that cannot be provided due to safety concerns were also covered in Maryland, New York, and Oregon.

Future Considerations

Rapid Medicaid adaptations have mitigated the challenges of the PHE for CYSHCN populations. The phasing out of COVID adaptations will have an undeniable impact on these children and their families. States may consider transforming temporary SPA actions to permanent SPAs and leveraging permanent 1915(c) waiver/Appendix K approvals beyond the current PHE. States will likely analyze the benefit of maintaining these temporary measures against the availability of resources to sustain these policy changes after the national PHE ends. As states advance their planning for the end of the PHE, they will need to monitor the various approaches to resumption of normal operations and the potential impacts on CYSHCN and their families, which may not be fully understood for years to come.

CMS issued guidance in December 2020 to clarify expectations for how states should handle the transition back to 'normal' operation once the national PHE ends. CMS recommends that states review individual policies to determine whether each one should terminate before the formal end of the PHE, be extended temporarily, or be extended permanently (based on CMS approval). An additional recommendation is to design a phased approach to this transition process to allow time for states to comply with federal requirements (e.g., timeliness of eligibility redeterminations).

States must develop protocols for communicating changes in Medicaid policy once the PHE has ended. This is critically important for families with CYSHCN, given the potential impact that policy changes could have on quality of life, caregiver strain, and health outcomes. The CMS guidance provides detailed information on which changes to COVID-19 flexibilities would require advance notification to beneficiaries. As the end of the PHE approaches, stakeholders will need to engage in policy analysis, communications, and support for families and providers to successfully navigate Medicaid policy for CYSHCN populations in the post-pandemic era. ■



Funding

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), under grant number U1XMC31656 “Supporting Maternal and Child Health Innovation in States” (award totaling \$2,000,000). The content and conclusions are those of the author and should not be construed as the official position or policy of, nor are they an endorsement of HRSA, HHS, or the U.S. Government.

End Notes

¹Centers for Medicare & Medicaid Services; Center for Medicaid and CHIP Services. (2021). [October and November 2020 Medicaid and CHIP Enrollment Trends Snapshot](#)

²Georgia Health Policy Center. (2020). [Options for state Medicaid programs during COVID-19 emergency](#)

³Kaiser Family Foundation. (2021). [Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19](#)

⁴Centers for Medicare & Medicaid Services (2020). [Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Operations Upon Conclusion of the COVID-19 Public Health Emergency](#)

© Association of Maternal & Child Health Programs. Reproductions for education-only use under Creative Commons Attribution-Noncommercial-No Derivatives 4.0 International License. creativecommons.org/licenses/by-nc-nd/4.0

Association of Maternal & Child Health Programs
1825 K Street NW | Suite 250 | Washington, DC 20006
amchp.org