# APPENDIX K: Emergency Preparedness and Response

## Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

# Appendix K-1: General Information

## General Information:

**A. State: Oregon_____**

**B. Waiver Title:** Aging and People with Disabilities

**C. Control Number:**
OR.0185.R06.03

**D. Type of Emergency (The state may check more than one box)**:

| | |
|---|---|
| x | **Pandemic or Epidemic** |
| O | **Natural Disaster** |
| O | **National Security Emergency** |
| O | **Environmental** |
| O | **Other (specify):** |

**E. Brief Description of Emergency.** *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

1) nature of emergency: The Oregon Health Authority has identified several counties in Oregon with presumptive positive cases of COVID-19. COVID-19 is spread from person-to-person through droplets in the air and on surfaces that people touch. This situation is unfolding quickly and the risks for individuals that are aging or experiencing disabilities are high. Aging and People w/ Disabilities (APD) is committed to ensuring the health and safety of the people we serve.

2) number of individuals affected and the state's mechanism to identify individuals at risk: All participants in the APD program, under the 1915 (c) waiver are at risk of exposure or contracting COVID-19.

3) roles of state, local and other entities involved in approved waiver operations:
The roles of state, local, and other entities involved in approved waiver operations are defined in Appendix A in section A-1 and 2.

4) expected changes needed to service delivery methods, if applicable:
See Below

**F. Proposed Effective Date: Start Date: 3.1.2020_Anticipated End Date: 2.28.2021**

**G. Description of Transition Plan.**

Waiver participants will transition to emergency service status as soon as it becomes evident that they are impacted by the COVID-19 outbreak. This will be evidenced by contraction of COVID-19 by the waiver participant, their provider or their housemate, local quarantines, or other guidance of isolation or precautionary measures issued by local or federal health departments.

**H. Geographic Areas Affected:**

All

**I. Description of State Disaster Plan (if available)** ***Reference to external documents is acceptable*****:**

State declaration of the state of emergency: https://www.oregon.gov/gov/Documents/executive_orders/eo_20-03.pdf
Oregon Office of Emergency Management: https://storymaps.arcgis.com/stories/6c96b225a8424992b56e59400a30dab4

## Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

### Temporary or Emergency-Specific Amendment to Approved Waiver:

***These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.***

**a.___ Access and Eligibility:**

**i.___ Temporarily increase the cost limits for entry into the waiver.**
[Provide explanation of changes and specify the temporary cost limit.]

N/A

**ii.___ Temporarily modify additional targeting criteria.**
[Explanation of changes]

N/A

**b._X__ Services**

**i._ __ Temporarily modify service scope or coverage.**
[Complete Section A- Services to be Added/Modified During an Emergency.]

**ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.**
[Explanation of changes]

**iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).**
[Complete Section A-Services to be Added/Modified During an Emergency]

**iv. _X__Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:**
[Explanation of modification, and advisement if room and board is included in the respite rate]:

As directed by APD, provide monthly case management services to eligible individuals in any setting the participant is located in.

**v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver).** [Explanation of changes]

**c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver**. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

N/A

**d._X__ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).**

**i.__X_ Temporarily modify provider qualifications.**

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

APD provides monthly case management services to eligible individuals. Staff must be classified as a case manager or higher (which has degree and experience requirements). APD requests waiving the classification requirement for staff unless the service includes a LOC evaluation or re-evaluation.

This provision will sunset within 90 days after the conclusion of the emergency. Where the extension of the waiver of provider determinations falls outside of the expiration date of the Appendix K, the state will submit either an amended Appendix K or a simple waiver amendment.

**ii.___ Temporarily modify provider types.**

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

**iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.**

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

N/A

**e. _X__Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements).** [Describe]

Allow for LOC re-evaluations to be extended to the end of this Appendix K period.

Allow LOC evaluations or re-evaluations to be completed by alternate communications methods in lieu of face to face, such as telehealth as directed by APD, in accordance with HIPAA.

**f.___ Temporarily increase payment rates**

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

**g._X__ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.**

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

Allow person-centered service plan development completion by methods other than face to face such as telehealth as directed by APD, in accordance with HIPAA.

Person-centered service plans that are due to expire within the next 30 days require case management contact to the participant or representative to verify if the current plan adequately meets their needs. If the participant or representative determines that the plan remains acceptable, the current plan will be considered certified. The state will verify by obtaining electronic or written signatures from service providers and the individual or representative, in accordance with the state's HIPAA requirements
Changes, including the amount, duration and scope of the service, will be updated in the person-centered service plans within 30 days from the date the service was initiated.

**h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances**. [Explanation of changes]

**i.___ 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.**

[Specify the services.]

**j.___ Temporarily include retainer payments to address emergency related issues.**

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

**k.___ Temporarily institute or expand opportunities for self-direction.**

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

N/A

**l.___ Increase Factor C.**
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

N/A

**m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program].** [Explanation of changes]

## Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the request:

| | |
|---|---|
| **First Name:** | Dana |
| **Last Name** | Hittle |
| **Title:** | Deputy Medicaid Director |
| **Agency:** | Oregon Health Authority |
| **Address 1:** | 500 Summer St NE |
| **Address 2:** | |
| **City** | Salem |
| **State** | Oregon |
| **Zip Code** | 97301 |
| **Telephone:** | 503-945-6491 |
| **E-mail** | Dana.Hittle@state.or.us |
| **Fax Number** | (503) 945-5872 |

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

| | |
|---|---|
| **First Name:** | Mike |
| **Last Name** | McCormick |
| **Title:** | Interim Director- Aging and People w/ Disabilities |
| **Agency:** | Oregon Department of Human Services |
| **Address 1:** | 500 Summer St NE |
| **Address 2:** | |
| **City** | Salem |
| **State** | Oregon |
| **Zip Code** | 97301 |
| **Telephone:** | 503-945-6229 |
| **E-mail** | Mike.R.McCormick@dhsoha.state.or.us |
| **Fax Number** | |

## 8. Authorizing Signature

**Signature:**
**_____/S/_____**
State Medicaid Director or Designee

| | |
|---|---|
| **Date:** | **4/28/2020** |

| | |
|---|---|
| **First Name:** | Lori |
| **Last Name** | Coyner |
| **Title:** | State Medicaid Director |
| **Agency:** | Oregon Health Authority |
| **Address 1:** | 500 Summer St NE |
| **Address 2:** | |
| **City** | Salem |
| **State** | Oregon |
| **Zip Code** | 97301 |
| **Telephone:** | 503-947-2340 |
| **E-mail** | Lori.a.coyner@dhsoha.state.or.us |
| **Fax Number** | 503-373-7327 |

# Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

| Service Specification | | | | |
|---|---|---|---|---|
| Service Title: | | | | |
| *Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:* | | | | |
| Service Definition (Scope)**:** | | | | |
| | | | | |
| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | |
| | | | | |

| Provider Specifications | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)***:** | ☐ | Individual. List types: | ☐ | Agency. List the types of agencies: |
| | | | | |
| | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| Specify whether the service may be provided by *(check each that applies):* | x | Legally Responsible Person | x | Relative/Legal Guardian |

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| | | |
| | | |
| | | |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ☐ | Participant-directed as specified in Appendix E | ☐ | Provider managed |

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority.

States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.