APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. 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 applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: **Connecticut**

B. Waiver Title(s): Acquired Brain Injury Waiver 2

C. Control Number(s):

CT.1085.R01.01

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.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.) CT is currently under a Stay Home Stay Safe executive order.

F. Proposed Effective Date: Start Date: March 16,2020 **Anticipated End Date: March 15,2021**

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus and is being implemented statewide

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

N/A

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.__X_ Access and Eligibility:

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

The state will temporarily permit an emergency increase in the individual cost limit for existing participants if needed to support such participants in the community safely during the emergency, and in order to avoid institutionalization. All modifications resulting in exceeding the individual cost cap are subject to prior authorization by Community Options clinical staff

ii.___ Temporarily modify additional targeting criteria.

[Explanation of changes]

b.___ Services

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

ii. _X_ 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]

The 18-hour daily limit on Companion Services will be temporarily suspended, with care manager approval, when necessary to support individuals safely in the community.

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. ___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]:

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

This authority is being requested under an 1135 waiver

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.

The state will temporarily permit family members to provide Companion Services provided they meet provider qualifications. Individuals on the OIG's excluded provider list remain excluded from payment.

d.___ 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.]

For ABI Group Day (Community Integration Agency Provider, Employment Services/Supports Agency Provider, Rehabilitation Hospital Outpatient Department Provider), Personal Care (Agency Provider), Respite (Agency Provider or Private Household Employee), ABI Recovery Assistant II (Rehabilitation Hospital Outpatient Department, Community Integration Services Agency, Certified Individual provider), ABI Recovery Assistant I (Rehabilitation Hospital Outpatient Department, Community Integration Services Agency, Certified Individual provider),Community Living Support Services (Agency or Rehabilitation Hospital Provider) , Companion (Agency Provider or Private Household Employee), Independent Living Skills Training (Agency Provider, Individual Private Provider, Rehabilitation Hospital Outpatient Department), and Substance Abuse Programs (Substance Abuse Diagnostic and Treatment Centers)rec, waive the initial premployment training requirement that providers have completed an approved training program concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or an Independent Living Center. The trainings(s) will still be available, and will be made available in a virtual format for providers, but will not be a prerequisite to providing services during the emergency period. Training would need to be completed within 60 days of the date of hire.

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.]

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

The state will allow assessments and reassessments to be conducted virtually, waiving the face-to-face assessment requirement.
The requirements for frequency of reassessments will be temporarily waived, and will be extended to a maximum of 3 months beyond the initial re-evaluation deadline.

f._X_ 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.]

In the event of staffing shortages, Companion Service (Agency and Private Household Employee) and Personal Care (agency)will be entitled receive payment at time-and-a-half when working over 40 hours per week, if such additional hours are necessary to support members in the community safely. A new rate is being developed that would permit a higher rate only for hours of service paid at time and a half. This is subject to departmental approval. The rate methodology for the overtime payments is consistent with currently approved rate methodology.

g. _ 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.]

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.]

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]

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]

Permit substitution of lower level staff in a service plan, such as substituting a Companion for a Homemaker or an ILST, or Companion or Homemaker for a Recovery Assistant, when necessary and in order to maximize use of available staffing resources.

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

a. ☒ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
   i. ☒ Case management
   ii. ☐ Personal care services that only require verbal cueing
   iii. ☐ In-home habilitation
   iv. ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
   v. ☒ Other *[Describe]:*

b. ☐

Companion Service: Permit Companion service to be provided electronically or telephonically for up to two hours per day

Add home-delivered meals

c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)

d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
    a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.
    b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
    a. ☐ Allow spouses and parents of minor children to provide personal care services
    b. ☒ Allow a family member to be paid to render services to an individual.
    c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

    d. ☒ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**
    a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.
    b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
    c. ☒ Adjust prior approval/authorization elements approved in waiver.
    d. ☒ Adjust assessment requirements
    e. ☒ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

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

First Name: Kathy
Last Name Bruni
Title: Director, Community Options
Agency: CT Department of Social Services
Address 1: 55 Farmington Ave.
Address 2: Click or tap here to enter text.
City Hartford
State CT
Zip Code 06105
Telephone: 860-424-5177

E-mail	Kathy.a.bruni@ct.gov
Fax Number	860-424-4963

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

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date: 3/24/20**

____***KateMcEvoy***_____
State Medicaid Director or Designee

First Name:	*Kate*
Last Name	*McEvoy*
Title:	Director of Health Services
Agency:	CT Department of Social Services
Address 1:	55 Farmington Ave
Address 2:	Click or tap here to enter text.
City	Hartford
State	CT
Zip Code	06105
Telephone:	860-424-5383
E-mail	Kate.mcevoy@ct.gov
Fax Number	860-424-4963

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 that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be 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):*	☐	Legally Responsible Person		Relative/Legal Guardian Only during the emergency situation

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 may 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; or (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.