

# 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.<sup>i</sup> This appendix may be completed retroactively as needed by the state.

## Appendix K-1: General Information

### General Information:

A. State: Iowa

B. Waiver Title:

Iowa HCBS AIDS Waiver; Iowa HCBS Elderly Waiver; Iowa HCBS Intellectual Disabilities Waiver; Iowa HCBS Waiver for Persons w/Physical Disabilities; Iowa HCBS - Brain Injury (BI) Waiver; Iowa HCBS Health and Disability Waiver

C. Control Number:

- IA.0213.R06.09
- IA.0299.R05.08
- IA.0345.R04.07
- IA.4111.R07.06
- IA.4155.R06.06
- IA.0242.R06.09

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

<input checked="" type="radio"/>	Pandemic or Epidemic
<input type="radio"/>	Natural Disaster
<input type="radio"/>	National Security Emergency
<input type="radio"/>	Environmental
<input type="radio"/>	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.

This Appendix K is in addition to Iowa's previously approved Appendix Ks. It is being submitted to implement the State's ARP 9817 spending plan.

**F. Proposed Effective Date: Start Date:** 1/27/20 **Anticipated End Date:** Six months after the expiration of the PHE.

**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, statewide, to all individuals impacted by the COVID-19 virus.

**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. \_\_\_ Access and Eligibility:**

**i. \_\_\_ Temporarily increase the cost limits for entry into the waiver.**

[Provide explanation of changes and specify the temporary cost limit.]

**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. \_\_\_ 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. \_\_\_ 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. \_\_\_ 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.**

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

**i. \_\_\_ Temporarily modify provider qualifications.**

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

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

**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].

To address the HCBS provider workforce shortages exacerbated by the COVID-19 public health emergency, Iowa will make one-time recruitment and retention payments in accordance with its Section 9817 ARP Spending Plan to HCBS Waiver providers delivering the following services solely on a FFS basis: Individual Consumer Directed Attendant Care (ICDAC) providers and HCBS Waiver Consumer Choices Option Employees (CCO) that meet the following criteria:

1. Provided services:

- Between July 1, 2020, and June 30, 2021; and
- Continued to provide patient care and has not permanently ceased providing patient care directly or indirectly through May 26, 2022.

2. With respect to Medicare, any state Medicaid program, and any Federal health care program, is not:

- Suspended or excluded from participation;
- Suspended from receiving payments; or
- Under any other sanction or penalty.

The State Medicaid Agency collected information on the total number of ICDAC providers, and the total number of CCO members employing direct care workers to identify the total number of FTEs eligible for distribution of funds. For purposes of calculating the amount to be distributed per FTE:

- ICDAC providers are considered 1 FTE.
- CCO employees providing self-directed personal care services, self-directed community supports, and employment or individual-directed goods and services are considered as 1 FTE.

The amount to be distributed per FTE = Total dollars/Total FTEs.

- Total dollars distributed to fee-for-service providers on May 26, 2022 were:
  - o FFS ICDAC amount distributed \$70,596.00 as allocated in the 9817 Plan
  - o FFS CCO amount distributed to Veridian Financial Services (VFS) \$4,498,534.00 as allocated in the 9817 Plan
- The amount to be distributed to each Individual CDAC provider applying for the funds = the calculated amount per FTE
- The amount to be distributed to each CCO member = the number of FTEs employed by the CCO member receiving a paycheck between December 2021 and March 2022, multiplied by the calculated amount per FTE

For CCO employees, the funds will be issued to, and managed by, the CCO Financial Management Service. The CCO participant employer retains the authority to determine how the recruitment and retention funds will be distributed to their employees and the amount to be distributed. CCO participant employers must distribute all the funds to their employees by March 31, 2024.

These payments will be reconciled by Iowa Medicaid for integrity of the investment in recruiting and retention. Information on payments made, including CCO participant's identifiable information and date of payment, will be collected and reconciled periodically.

**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]

## Contact Person(s)

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

**First Name:** Brian  
**Last Name** Wines  
**Title:** Program Manager  
**Agency:** Iowa Department of Human Services/Iowa Medicaid  
**Address 1:** 1305 East Walnut Street  
**Address 2:** Click or tap here to enter text.  
**City** Des Moines  
**State** Iowa  
**Zip Code** 50319  
**Telephone:** 515-321-6218  
**E-mail** bwines@dhs.state.ia.us  
**Fax Number** 515-725-1360

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

**First Name:** Jennifer  
**Last Name** Steenblock  
**Title:** Federal Compliance Officer  
**Agency:** Iowa Medicaid  
**Address 1:** 1305 East Walnut Street  
**Address 2:** Click or tap here to enter text.  
**City** Des Moines  
**State** Iowa  
**Zip Code** 50319  
**Telephone:** 515-782-1509  
**E-mail** jsteenb@dhs.state.in.us  
**Fax Number** 515-725-1360

## 8. Authorizing Signature

**Signature:** /S/

**Date:** 6/16/2022

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State Medicaid Director or Designee

**First Name:** Elizabeth  
**Last Name** Matney  
**Title:** Medicaid Director  
**Agency:** Iowa Medicaid  
**Address 1:** 1305 East Walnut Street  
**Address 2:** Click or tap here to enter text.  
**City** Des Moines  
**State** Iowa  
**Zip Code** 50319  
**Telephone:** 515-256-4640  
**E-mail** [ematney@dhs.state.ia.us](mailto:ematney@dhs.state.ia.us)  
**Fax Number** 515-725-1360



## 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:						
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>						
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):	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:		
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/>	Legally Responsible Person		<input type="checkbox"/>	Relative/Legal Guardian
<b>Provider Qualifications</b> (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):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed		



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<sup>i</sup> 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.