

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: Louisiana

B. Waiver Title:

New Opportunities Waiver, Residential Options Waiver, Children's Choice Waiver, Supports Waiver

C. Control Number:

LA.0401.R03.10
LA.0472.R02.07
LA.0361.R04.07
LA.0453.R03.06

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

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

These flexibilities will be utilized with the necessary flexibilities available in the COVID-19 Appendix K for this disaster.

Louisiana experienced severe storms and flooding as a result of Hurricane Laura and Hurricane Delta, which displaced a number of participants receiving services in the areas listed in Appendix K-1, H below. The total number of participants in the affected parishes was 12,995. Support Coordinators monitored and identified, through telephone and/or face-to-face contact, those who were directly affected and at risk. OCDD Central Office, with the assistance of Support Coordination Agencies, tracked the number of individuals in the affected areas, as well as number of individuals who evacuated, to where, and with whom. These numbers were reported daily to the State Emergency Operations Center.

There were no changes to the roles of state, local and other entities involved in approved waiver operations (see Appendix A of the approved waiver document for more information).

Temporary changes to service delivery methods include: exceeding duration of prior authorizations (extend PAs for POCs); modifying timeframes for LOC evaluations and/or re-evaluations and service plan development process (extend LOC evaluations and re-evaluations; & SCs contact participants at least monthly); expanding settings where services may be provided (participants can receive services in the home of their workers); providing services in out of parish or state settings; and modifying incident reporting requirements to ensure individual health and welfare and to account for emergency.

The changes addressed in this amendment will be added/adjusted to the currently approved Children's Choice (CC) Waiver (0361), New Opportunities Waiver (NOW) (0401) Supports Waiver (0453) Residential Options Waiver (ROW) (0472).

F. Proposed Effective Date: Start Date: August 27, 2020 **Anticipated End Date:** January 26, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of Hurricane Laura, Delta, and Zeta as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waivers to all individuals statewide impacted by Hurricane Laura, Delta and Zeta.

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. __x_ 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]

0401, 0472, 0453, 0361: Allow an increase to the maximum current number of Center-Based Respite hours per person from 720 per year to 4,320 hours for a period not to exceed 6 months.

This approval will be authorized by the state for only individuals whose homes were damaged or reached crisis due to Hurricanes Laura, Delta, Zeta.

Center-Based Respite is currently being utilized as emergency respite.

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]:

0401, 0472, 0453, 0361: -Allows Individual Family Support, Community Living Supports, Family Support services to be provided in a hotel, shelters, schools, etc. These services are to be provided where the participant is evacuated to. The prohibition which restricts direct support staff from providing waiver services in the home of the worker is modified for recipients in the affected parishes for this period. If overnight respite is utilized, the center based respite rate currently in place will be used.

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

0401, 0472, 0453, 0361: Allow services to be provided out of state and out of region as a result of evacuations caused by Hurricane Laura, Delta and Zeta. Services must be in the person-centered service plan. Services must be provided by a Louisiana Medicaid enrolled waiver provider. The provider is chosen by the individual. The individual will receive waiver services by direct support staff from the Louisiana Medicaid Waiver provider. OCDD remains responsible for the assurance of the health and welfare of the individual.

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

Virtual/remote/phone call visits in accordance with HIPAA requirements are provided to meet the requirements for:

- 10-day initial home visit
- Initial assessment
- OCDD waiver certification visits

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. ___ 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 Bennett
Title: Section Chief
Agency: Medicaid Program Support and Waivers
Address 1: P.O. Box 91030 Bin #24
Address 2: Click or tap here to enter text.
City Baton Rouge
State LA
Zip Code 70821
Telephone: 225-342-9846
E-mail Brian.Bennett@la.gov
Fax Number Click or tap here to enter text.

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

First Name: Julie
Last Name Hagan
Title: Assistant Secretary
Agency: Office for Citizens with Developmental Disabilities
Address 1: 628 North Fourth Street
Address 2: Click or tap here to enter text.
City Baton Rouge
State LA.
Zip Code 70821
Telephone: 225-342-0095
E-mail Julie.Hagan@la.gov
Fax Number Click or tap here to enter text.

8. Authorizing Signature

Signature:

Date: 10/6/20

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_____/S/_____
State Medicaid Director or Designee

| | |
|--------------------|--|
| First Name: | <i>Ruth</i> |
| Last Name | <i>Johnson</i> |
| Title: | Medicaid Director |
| Agency: | Bureau of Health Services Financing |
| Address 1: | 628 North Fourth Street |
| Address 2: | Click or tap here to enter text. |
| City | Baton Rouge |
| State | LA |
| Zip Code | 70821 |
| Telephone: | Click or tap here to enter text. |
| E-mail | Ruth.Johnson3@la.gov |
| Fax Number | Click or tap here to enter text. |

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): | | | | |
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| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | |
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| Provider Specifications | | | | |
| Provider Category(s) (check one or both): | <input type="checkbox"/> | Individual. List types: | <input type="checkbox"/> | Agency. List the types of agencies: |
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| Specify whether the service may be provided by (check each that applies): | | <input type="checkbox"/> Legally Responsible Person | <input type="checkbox"/> | Relative/Legal Guardian |
| Provider Qualifications (provide the following information for each type of provider): | | | | |
| Provider Type: | License (specify) | Certificate (specify) | Other Standard (specify) | |
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| Verification of Provider Qualifications | | | | |
| Provider Type: | Entity Responsible for Verification: | | Frequency of Verification | |
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| Service Delivery Method | | | | |
| Service Delivery Method (check each that applies): | <input type="checkbox"/> | Participant-directed as specified in Appendix E | X | Provider managed |
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| 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): | | | | |
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| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | |
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| Provider Specifications | | | | | |
| Provider Category(s) (check one or both): | <input type="checkbox"/> | Individual. List types: | | <input type="checkbox"/> | Agency. List the types of agencies: |
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| Specify whether the service may be provided by (check each that applies): | | <input type="checkbox"/> | Legally Responsible Person | <input type="checkbox"/> | Relative/Legal Guardian |
| Provider Qualifications (provide the following information for each type of provider): | | | | | |
| Provider Type: | License (specify) | | Certificate (specify) | Other Standard (specify) | |
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| Verification of Provider Qualifications | | | | | |
| Provider Type: | Entity Responsible for Verification: | | | Frequency of Verification | |
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| Service Delivery Method | | | | | |
| Service Delivery Method (check each that applies): | <input type="checkbox"/> | Participant-directed as specified in Appendix E | | <input checked="" type="checkbox"/> | Provider managed |
| 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): | | | | | |
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| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | |
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| Provider Specifications | | | | | |
| Provider Category(s) (check one or both): | <input type="checkbox"/> | Individual. List types: | | <input type="checkbox"/> | Agency. List the types of agencies: |
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| Specify whether the service may be provided by (check each that applies): | | <input type="checkbox"/> | Legally Responsible Person | <input type="checkbox"/> | Relative/Legal Guardian |
| Provider Qualifications (provide the following information for each type of provider): | | | | | |

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| Provider Type: | License <i>(specify)</i> | Certificate <i>(specify)</i> | Other Standard <i>(specify)</i> | |
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| Verification of Provider Qualifications | | | | |
| Provider Type: | Entity Responsible for Verification: | | Frequency of Verification | |
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| Service Delivery Method | | | | |
| Service Delivery Method <i>(check each that applies):</i> | <input type="checkbox"/> | Participant-directed as specified in Appendix E | X | Provider managed |
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| 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): | | | | |
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| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | |
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| Provider Specifications | | | | |
| Provider Category(s) <i>(check one or both):</i> | <input type="checkbox"/> | Individual. List types: | <input type="checkbox"/> | Agency. List the types of agencies: |
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| Specify whether the service may be provided by <i>(check each that applies):</i> | <input type="checkbox"/> | Legally Responsible Person | <input type="checkbox"/> | Relative/Legal Guardian |
| Provider Qualifications <i>(provide the following information for each type of provider):</i> | | | | |
| Provider Type: | License <i>(specify)</i> | Certificate <i>(specify)</i> | Other Standard <i>(specify)</i> | |
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| Verification of Provider Qualifications | | | | |
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| Provider Type: | Entity Responsible for Verification: | | Frequency of Verification | |
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| Service Delivery Method | | | | |
| Service Delivery Method (check each that applies): | <input type="checkbox"/> | Participant-directed as specified in Appendix E | <input checked="" type="checkbox"/> | Provider managed |
| 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): | | | | |
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| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | |
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| Provider Specifications | | | | |
| Provider Category(s) (check one or both): | <input type="checkbox"/> | Individual. List types: | <input type="checkbox"/> | Agency. List the types of agencies: |
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| Specify whether the service may be provided by (check each that applies): | | <input type="checkbox"/> | Legally Responsible Person | <input type="checkbox"/> |
| | | | | Relative/Legal Guardian |
| Provider Qualifications (provide the following information for each type of provider): | | | | |
| Provider Type: | License (specify) | Certificate (specify) | Other Standard (specify) | |
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| Verification of Provider Qualifications | | | | |
| Provider Type: | Entity Responsible for Verification: | | Frequency of Verification | |
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| Service Delivery Method | | | | |
| Service Delivery Method (check each that applies): | <input type="checkbox"/> | Participant-directed as specified in Appendix E | <input checked="" type="checkbox"/> | Provider managed |

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| Service Specification | | | | |
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| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | |
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| Provider Specifications | | | | |
| Provider Category(s) (check one or both): | <input type="checkbox"/> | Individual. List types: | | |
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| Specify whether the service may be provided by (check each that applies): | <input type="checkbox"/> | Legally Responsible Person | <input type="checkbox"/> | Relative/Legal Guardian |
| Provider Qualifications (provide the following information for each type of provider): | | | | |
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| Provider Type: | License (<i>specify</i>) | Certificate (<i>specify</i>) | Other Standard (<i>specify</i>) |
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| Verification of Provider Qualifications | | | |
| Provider Type: | Entity Responsible for Verification: | | Frequency of Verification |
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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.