

# 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>1</sup> This appendix may be completed retroactively as needed by the state.

## Appendix K-1: General Information

**General Information:**

- A. State: \_\_\_\_\_ Michigan \_\_\_\_\_
- B. Waiver Title: MI Health Link Home and Community Based Services Waiver
- C. Control Number: MI.1126.01.04

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

<input checked="" type="checkbox"/>	<b>Pandemic or Epidemic</b>
<input type="checkbox"/>	<b>Natural Disaster</b>
<input type="checkbox"/>	<b>National Security Emergency</b>
<input type="checkbox"/>	<b>Environmental</b>
<input type="checkbox"/>	<b>Other (specify):</b>

**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.)

This additive amendment clarifies due dates of recertifications and allows for alternative methods of conducting the recertification assessments.

F. **Proposed Effective Date: Start Date: 03/01/2020 Anticipated End Date: Six months after the conclusion of the public health emergency.**

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

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.*

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

Because of the recommendation for social distancing and self-isolation for the population served, MDHHS extends any level of care determinations that will expire during the effective period of this appendix **for 12 months beyond the due date of the recertification.** Additionally, new evaluations **and re-evaluations that must be conducted** may be completed telephonically, via telehealth, or using video conferencing commonly available on smart phones in accordance with HIPAA.

**Contact Person(s)**

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

<b>First Name:</b>	Jacqueline
<b>Last Name</b>	Coleman
<b>Title:</b>	Waiver Specialist

<b>Agency:</b>	MSA, MDHHS
<b>Address 1:</b>	P.O. Box 30479
<b>Address 2:</b>	400 S Pine, 7 <sup>th</sup> Floor
<b>City</b>	Lansing
<b>State</b>	MI
<b>Zip Code</b>	48909-7979
<b>Telephone:</b>	517-248-1190
<b>E-mail</b>	<a href="mailto:colemanj@michigan.gov">colemanj@michigan.gov</a>
<b>Fax Number</b>	517-241-5112

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

<b>First Name:</b>	
<b>Last Name</b>	
<b>Title:</b>	
<b>Agency:</b>	
<b>Address 1:</b>	
<b>Address 2:</b>	
<b>City</b>	
<b>State</b>	
<b>Zip Code</b>	
<b>Telephone:</b>	
<b>E-mail</b>	
<b>Fax Number</b>	

## 8. Authorizing Signature

Signature: /S/

<b>Date:</b>	2/24/2021
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State Medicaid Director or Designee

<b>First Name:</b>	Kate
<b>Last Name</b>	Massey
<b>Title:</b>	Medicaid Director

<b>Agency:</b>	MSA, MDHHS
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