

# 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.<sup>1</sup> 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: Missouri

B. Waiver Title(s):

Aged and Disabled Waiver Adult Day Care Waiver Independent Living Waiver
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C. Control Number(s):

MO.0026.R08.01 MO.1021.R01.02 MO.0346.R04.02
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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.

As of March 30, 2020, Missouri had 903 confirmed cases of COVID-19 and anticipates this number to increase. The population served through Missouri's Department of Health and Senior Services, Division of Senior and Disability Services (DSDS) may be particularly vulnerable to infection and resulting illness due to: (1) Many of the participants receiving these services have co-morbid medical conditions; (2) underlying health conditions such as higher levels of hypertension, diabetes and cardiovascular disease than the general public; (3) reliance on support from others for Activities of Daily Living; (4) deficits in functioning that inhibit ability to follow infection control procedures; and (5) dependence upon care to remain in a community setting. Missouri seeks temporary changes to the 1915(c) waiver to accommodate potential issues with staffing shortages and the need for service provision outside of approved service descriptions to ensure participant health and safety needs can be accommodated for the duration of the emergency.

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

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

The state is following CDC and the state's Department of Health and Senior Services guidelines, which can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/index.html> and <https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/>

## 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. X 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]

- Exceed limitations of 100% of the cost cap for Adult Day Care recipients in need of additional care due to the emergency when adult day care is not an option due to closure or risk of exposure. The cost cap may only be exceeded to provide respite services up to the amount of authorized adult day care services when documented guidance is provided by the authorizing state agency.
- Flexibility to deliver services not prior authorized by the state in order to ensure timely delivery of services.
- Flexibility to deliver personal care services not in accordance with a service plan approved by the state on an emergent basis or under the constraints of availability of staff as impacted by the COVID-19 pandemic .

**iii. \_\_\_ X 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]:

- Respite services may be provided in any setting necessary such as state alternative care facilities (hospital overflow), hospitals, and emergency shelter locations (including hotel or other arrangements as necessary to isolate individuals) to ensure the individual's health and safety needs can be met. Room and board is not included.

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

**c. X 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.

Family members must be employed by or contracted with a MHN contracted provider. Family members who do not live in the same residence and are not legally responsible individuals, spouses or legal guardians, may provide services when no other caregiver is available. This will be extremely critical due to staffing shortages but also in situations where a participant may be exposed to or diagnosed with COVID-19 and the family member is the only willing individual to provide services.

These individuals must receive training on the participant's needs and care plan for whom they are rendering these services.

When these individuals render a waiver service, the provider agency authorized to render the service is responsible for ensuring that services are provided and that billing occurs in accordance with billing and service documentation requirements.

Family Care Safety Registry (FCSR) filing is still required but services can begin before results are returned. If a Good Cause Waiver is required, staff can still begin services for participants, excepting a finding reported by the FCSR listed in Section [192.2495.6](#).

**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.]

All direct care staff training, orientation, and eligibility requirements are temporarily waived in anticipation of the need to bring staff on quickly to deliver care. All staff will be trained specific to the participant they are serving and their current needs. The training will include all information regarding abuse, neglect and exploitation of participants and the importance of reporting fraudulent activities to the State. The participant will be informed of their rights and responsibilities as a service recipient of HCBS.

Provider in-home visits for supervisor oversight related to staff performance and review of certain tasks being performed in person in the home is temporarily waived as providers should focus on oversight related to care and participant needs at this time. The provider is still responsible to ensure staff are conducting job duties accurately and according to all HCBS programmatic rules and regulations.

Regarding background checks, Family Care Safety Registry (FCSR) filing is still required but services can begin before results are returned. If a Good Cause Waiver is required, staff can still begin services for participants, excepting a finding reported by the FCSR listed in Section [192.2495.6](#).

**ii. X Temporarily modify provider types.**

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

Adult day care providers may provide respite as needed due to ADC closure or participants at high risk concerned about exposure, etc. The state will provide specific direction to ADCs regarding the delivery of this 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]**

The HCBS Intake Center will no longer be conducting pre-screen determinations for initial assessment of nursing facility Level of Care (LOC). HCBS Intake Center staff shall be reallocated to assist in determination of initial assessment of LOC and person centered care plan changes.

All assessments completed by DSDS or designated providers assessors shall be conducted via telephone. Required forms and other necessary documents shall be discussed with HCBS participants or their designee via telephone.

**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.]

N/A

**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.]

Providers may limit service delivery to essential services if needed due to staffing shortages or in order to limit exposure to COVID-19. If a provider limits service delivery, they should coordinate directly with participants to best meet their needs and preferences regarding care plan delivery. For example, a participant may prefer to limit exposure to personal care aides and therefore agree to a temporary reduction in services.

Providers able to meet the needs of participants may deliver any necessary tasks within the total authorized unit limit, even if the specific tasks are not listed on the current care plan. The state will ensure the person-centered service plan is modified to allow for additional supports/and or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended as soon as possible to ensure that the specific service is delineated accordingly to the date it began to be received. The care coordinator must submit the request for additional supports/services, as well as the date the verbal consent was provided, no later than 30 days from the date the service begins. The state is allowing verbal consent by telephone for signatures as authorized by Section 1135 authority.

The provider is required to document the services and tasks that were actually delivered.

The annual person-centered care planning meeting may be completed telephonically. Person-Centered Service Plans that are due to expire within the next 60 days require person centered care plan team contact to the participant using allowable remote contact methods to verify with the participant or representative that the current assessment and services, including providers, remain acceptable and approvable for the coming year.

**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. X 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.]

For individuals hospitalized, a provider may bill waiver services to assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The services will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

**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.]

N/A

**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. X 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]**

The timeframes for the submission of the CMS 372s and the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and notes that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic.

## 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.  Add home-delivered meals

Allow up to two meals per day. Allow waiver of nutritional requirements if necessary and at the guidance of the state in situations where necessary.

- 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.

Family members who do not live in the same residence and are not legally responsible individuals, spouses or legal guardians, may provide services when no other care giver is available and must be employed by or contracted with a Medicaid HCBS contracted provider

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:** Glenda  
**Last Name:** Kremer  
**Title:** Assistant Deputy Director, Program Operations  
**Agency:** Missouri Department of Social Services, MO HealthNet Division  
**Address 1:** 615 Howerton Court  
**Address 2:** PO Box 6500  
**City:** Jefferson City  
**State:** Missouri  
**Zip Code:** 65102-6500  
**Telephone:** (573) 751-6962  
**E-mail:** [Glenda.A.Kremer@dss.mo.gov](mailto:Glenda.A.Kremer@dss.mo.gov)  
**Fax Number:** (573)526-4651

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

**First Name:** Jessica  
**Last Name** Bax  
**Title:** Division Director  
**Agency:** Missouri Department Health & Senior, Division and Senior Services  
**Address 1:** 912 Wildwood Dr.  
**Address 2:** PO Box 570  
**City** Jefferson City  
**State** Missouri  
**Zip Code** 65109  
**Telephone:** (573)526-8557  
**E-mail** Jessica.bax@health.mo.gov  
**Fax Number** (573) 522-3024

## 8. Authorizing Signature

**Signature:**

/S/

**Date:** 5/21/2020

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State Medicaid Director or Designee

**First Name:** Todd  
**Last Name** Richardson  
**Title:** Director  
**Agency:** MO HealthNet  
**Address 1:** PO Box 6500  
**Address 2:** Click or tap here to enter text.  
**City** Jefferson City  
**State** Missouri  
**Zip Code** 65102  
**Telephone:** (573) 751-6922  
**E-mail** [Leann.hager@dss.mo.gov](mailto:Leann.hager@dss.mo.gov)  
**Fax Number** (573) 751-6564

## 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: Home Delivered Meals

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

Service Definition (Scope):

Home Delivered Meal is a service to provide individuals with one (1) or two (2) meals per day. A unit of service is a meal. The meals are delivered to individuals who would require nursing facility level of care but for the provision of such services.

The utilization of Home Delivered Meals may not occur if another paid or natural support is required during the meal time.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No more than two (2) home delivered meals will be authorized for each day. The maximum limit of meals per week is 14.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Home Delivered Meals Provider

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
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<b>Home Delivered Meal Provider</b>			A provider of home delivered meals must comply with the requirements specified in 19 CSR 15-4.240 Nutrition Service Requirements, 19 CSR 15-7.010 General Requirements of All Service Providers, 19 CSR 15-7.060 Nutrition Service Standards, and the Older Americans Act, PL 114-144, as amended in 2016. If any of these requirements are waived or modified by the Administration for Community Living or state during COVID-19, providers of home-delivered meals shall adhere to current standards relative to these waivers. Providers must have a written contract with the Department of Health and Senior Services in order to enroll as a Home Delivered Meal (HDM) provider with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC).

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<b>Home Delivered Meals</b>	<b>Department of Health and Senior Services</b>	<b>Annually</b>

**Service Delivery Method**

<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
	<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>		<input type="checkbox"/>	

**Service Specification**

<b>Service Title:</b>	Basic Respite
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<b>Service Definition (Scope):</b>	
Basic Respite care services are maintenance and supervisory services provided to a participant with nonskilled needs in that individual's home because of the absence or need for relief of those persons who normally provide care for the participant. This service encompasses all the needs of a participant that might come up during the	

**Service Specification**

Service Title: Basic Respite

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*  
 service provision that fall under supervision, companionship and direct participant assistance, all the services that are required to maintain the participant in his/her home. Federal financial participation is not claimed for the cost of room and board within this service.

All respite providers, including the new provider type listed below may provide transportation to medical appointments when NEMT services are not available.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	X	Agency. List the types of agencies:
				Adult Day Care – licensed

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
	Required to be licensed by the Department of Health and Senior Services and must meet the requirements of State Statute 192, RSMo.		

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	<b>Department of Health and Senior Services – Division of Regulation and Licensure</b>	<b>Relicensure every two years</b>

**Service Delivery Method**

Service Specification				
Service Title:	Basic Respite			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
	<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>		<input type="checkbox"/>	




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<sup>i</sup> 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.