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: MS

B. Waiver Title(s): Independent Living Waiver

C. Control Number(s):

MS.0255.R05.02

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.)

F. Proposed Effective Date: Start Date: March 1, 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. The state will implement additional flexibilities requested as needed at DOM's discretion based on the severity of the pandemic.

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's pandemic disaster plan is available at https://msdh.ms.gov/msdhsite/_static/resources/2944.pdf.

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.__X_ 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. _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. ___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._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.

Temporarily allow Personal Care Services to be provided by the family members provided they are not legally responsible for the person to include individuals living in the home with the participant.

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.]

Allow flexibility on expiring state issued identification, training, background checks, etc. at DOM's discretion throughout the pandemic. Flexibilities include temporarily waiving/delaying requirements for full 40 hour training, state issued ID, TB skin test, physical exam, CPR and first aid certification. To ensure ongoing quality of care and safety, new provider staff or those due for recertification of credentialing will be required to complete training on infection control, proper transferring techniques, and Vulnerable Person's Act, will be required to complete a HCBS Provider Health Self-Attestation form, and will be required to have a name only background check with results that do not preclude them from providing care in accordance with state law.

ii._X__ Temporarily modify provider types.

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

Allow qualified personal care provider agencies to provide personal care in addition to individual personal care providers.

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]

Allow authority to delay the completion of recertifications throughout the pandemic and/or the authorization to complete them telephonically where appropriate in accordance with HIPAA requirements.

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 instances where an agency provider is used to provide personal care, a higher rate, not to exceed 25% of the current rate, may be paid to account for agency overhead costs.

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.]

Allow any face to face/home visits including quarterly plan reviews to be completed telephonically, if needed, in accordance with HIPAA requirements. Case Managers will still be required to complete monthly contacts with participants/caregivers by phone to ensure services are received as authorized.

h._X_ 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]

Allow for any follow up related to critical incident reports to be completed telephonically, as needed, in accordance with HIPAA requirements.

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._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]

DOM will waive the requirement that a participant must be terminated from the waiver if he/she is not available for services after 30 days; however, participants will still receive monthly monitoring by Case Managers to assure health and welfare.

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
   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]*

Allow qualified personal care provider agencies to provide personal care services in addition to individual personal care attendants.

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:	Paulette
Last Name	Johnson
Title:	Nurse Office Director, Office of Long Term Care
Agency:	Mississippi Division of Medicaid
Address 1:	Walter Sillers Building, Suite 1000
Address 2:	550 High Street
City	Jackson
State	Mississippi
Zip Code	39201
Telephone:	(601)359-6141
E-mail	Paulette.Johnson@medicaid.ms.gov
Fax Number	(601)359-9521

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

First Name:	Anita
Last Name	Naik
Title:	Office Director, Office of Special Disability Programs
Agency:	Mississippi Department of Rehabilitation Services
Address 1:	1281 Highway 51 N
Address 2:	Click or tap here to enter text.

City	Madison
State	Mississippi
Zip Code	39110
Telephone:	(601)853-5230
E-mail	ANaik@mdrs.ms.gov
Fax Number	(601)853-5230

8. Authorizing Signature

Signature: **Date: 3/23/2020**

_____ /S/_____
State Medicaid Director or Designee

First Name:	Paulette
Last Name	Johnson
Title:	Nurse Office Director, Office of Long Term Care
Agency:	Mississippi Division of Medicaid
Address 1:	Walter Sillers Building, Suite 1000
Address 2:	550 High Street
City	Jackson
State	Mississippi
Zip Code	39201
Telephone:	(601)359-6141
E-mail	Paulette.Johnson@medicaid.ms.gov
Fax Number	(601)359-9521

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)**:**	

A nutritionally balanced meal delivered to the home of an eligible persons who is unable to leave his/her home without assistance, unable to prepare their own meals, and/or has no responsible caregiver in the home.

The purpose of home delivered meals is to:
1) Meet the nutritional needs of an individual in support of the maintenance of self-sufficiency and enhancing the quality of life;
2) Keep the person in his/her home rather than in an institution.

Minimum Program Requirements:
All service providers offering home delivered meals must adhere to the following requirements: Service Activities:
(A) Safety: Home delivered meals providers are required to ensure that food handling methods (preparation, storage, and transporting) comply with the Mississippi State Department of Health regulations governing food service sanitation.

(B) Supplies: The home delivered meals provider shall be responsible for providing at the minimum, the following service supplies with each individual meal:
1) Straw: Six inch individually wrapped (jumbo size)
2) Napkin: 13 inches by 17 inches
3) Flatware: Each individually wrapped package to contain non-brittle medium weight plastic fork or spoon and serrated knife with handles at least 3 1/2 inches long.
4) Carry-out tray: FDA approved compartment tray for hot foods.
5) Condiments: Individual packets of iodized salt and pepper shall be provided. Other condiments, individually packed, such as ketchup, mustard, mayonnaise, salad dressings, tartar sauce, shall be served when necessary to complete the menu.
6) Cups: Styrofoam cups, 4oz. with cover for cold foods to accompany carry-out trays.

(C) Transporting Equipment: Each home delivered meals provider must use transporting equipment designed to protect the meal from potential contamination, and designed to hold the food at a temperature below 45 degrees Fahrenheit, or above 140 degrees Fahrenheit, as appropriate.

(D) Emergency Meals: Home delivered meal providers must have contingency plans to ensure that in the event of an emergency, enrolled persons will have access to a nutritionally balanced meal.

(E) Other requirements:
1) The provider must bring to the attention of the appropriate officials for follow-up any conditions or circumstances which place the person or the household in imminent danger.
2) Home delivered meals service providers must comply with all state and local health laws and ordinances concerning preparation, handling and service of food.
3) Home delivered meals service providers must have available for use, upon request, appropriate food containers and utensils for blind and individuals with limited dexterity or mobility.
4) All staff working in the preparation of food must be under the supervision of a person who will ensure the application of hygienic techniques and practices in food handling, preparation and services. This supervisory person shall consult with the service provider dietitian for advice and consultation, as necessary.
5) Home delivered meals service providers, where necessary and feasible, may use various methods of delivery. However, all food preparation standards set forth in this section must be met.
6) Only one hot meal may be delivered per day, such as under severe weather conditions, it will be permissible to leave additional nonperishable meals or food items for a person, not to exceed two meals a day or any other full nutritional regimen, provided that proper storage and heating facilities are available in the home, and the person is able to prepare the meal with available assistance.
7) Establish procedures to be implemented by staff during an emergency (fire, disaster) and train staff in their assigned responsibilities.
8) Keep a record of each person served a meal. If person, or designated caregiver, is not home at time of delivery, then meals should not be delivered. Meals, delivered to anyone other than the person or their caregiver, are not billable.
9) Documentation of services provided. Documentation of delivered meals must be kept and forwarded along with a copy of billing to the case manager on a monthly basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
One unit of service is one meal delivered. Two meals per day, seven days a week will be the maximum meal services allowed. The maximum number of meals that are billable per month is equal to two times the number of days in the month. Shelf-stable meals are provided to the homebound for designated holidays, weather or other emergencies, elections and various community events.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Qualified Vendor

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Qualified Vendor		All vendors must be certified through the Mississippi State Department of Health.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Qualified Vendors	Mississippi Department of Rehabilitation	Upon hire and as needed

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Service Specification	
Service Title:	Institutional Respite
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

Respite services are provided in Medicaid approved hospitals, nursing facilities, and hospital swing beds to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Federal financial participation is not to be claimed for the cost of room and board expect when provided as part of respite care furnished in a facility provided approved by the state that is not a private residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Institutional Respite – 90 days per year allowed. When the stay exceeds 30 consecutive days, the state has mechanisms in place to prevent duplicate billing for both institutional and HCB services.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Medicaid approved hospitals, nursing facilities,
				and hospital swing-beds.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Institutional Respite	Medicaid approved hospital, nursing facility, and hospital swing-bed		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Institutional Respite	Mississippi Department of Rehabilitation	Upon hire and as needed

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Service Specification	
Service Title:	Specialized Medical Equipment & Supplies
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

Specialized medical equipment and supplies to include devices, controls, or appliances which enable the participant to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These items must be specified on the plan of care. Personal protective equipment (PPE) may also be included in this service, and refers to protective gowns, gloves, facemasks or other equipment designed to protect the wearer from injury or the spread of infection or illness.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items. Also covered are durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be those items which are deemed as medically necessary for the individual client. Medicaid waiver funds are to be utilized as a payor of last resort. Request for payment must be made to other payors (i.e. Medicare, State plan, and private insurance) prior to submission of billing request to utilize waiver funds. All items shall meet applicable standards of manufacture, design and installation.

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

Each request for specialized medical equipment is evaluated by the Rehabilitation Counselor or Division of Medicaid (DOM) staff to determine if the equipment requested could benefit from an Assistive Technology (AT) evaluation and recommendation.

If the LTSS assessment determines that supplies and case management service are the only services needed by an applicant, the applicant would not meet waiver eligibility.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Specialty Medical

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Specialty Medical	N/A	N/A	Providers of specialized medical equipment and supplies under this home and community -based services waiver shall meet the following minimum qualifications: A)General Business Standards: a permanent local address & phone number, State of MS sales tax number, Federal I.D. number or social security number, Liability insurance B)General Service Standards: Manufacturer's guarantee or warranty must be honored as published, provide repair capability for products Providers should meet the following additional standards for custom in-house seating systems, powered mobility, three wheel scooters, and high-tech systems: Provide documented proof of attendance of training with seating & positioning, maintain a current list of power chair manufacturers represented, have on staff a technician certified as being trained to repair each power chair manufacturer represented, if offered by the manufacturer, maintain basic inventory of electronic parts to repair power chairs of manufacturers represented or demonstrate the capability to repair motors, modules, joysticks, and parts to repair the above, must be able to deliver and assemble all equipment to be ready for final adjustment and fitting, have and present at purchase all necessary manuals, warranties, and provide written warranties, and must be able to provide instruction in proper use and care of equipment. Must be capable to provide training in safe and effective operation of the equipment, as well as maintenance schedule as a component part of the purchase price; must have available a list of key contact personnel at various manufacturers for immediate technical support or special handling of specific needs including complete parts, manuals, and accessory catalogs along with updates and current technical service bulletins.
Verification of Provider Qualifications			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialty Medical	Mississippi Department of Rehabilitation	Upon hire and as needed

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.