

# 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: Mississippi

B. Waiver Title(s):

Traumatic Brain Injury/Spinal Cord Injury Waiver Independent Living Waiver Elderly & Disabled Waiver Assisted Living Waiver Intellectual Disabilities/Developmental Disabilities Waiver
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C. Control Number(s):

MS.0366.R03.04 MS.0255.R05.05 MS.0272.R05.06 MS.0355.R04.03 MS.0282.R05.03
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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.

This Appendix K is additive to the approved Appendix K. The change included is to extend the effective date of all flexibilities outlined in previously approved Appendix K's to six (6) months following the expiration of the public health emergency.

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: No later than six (6) months following the end 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. 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](https://msdh.ms.gov/msdhsite/_static/resources/2944.pdf).

## Contact Person(s)

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

**First Name:** Margaret  
**Last Name** Wilson  
**Title:** Nurse Office Director, Office of Policy  
**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)359-5248  
**E-mail** Margaret.Wilson@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:** Margaret  
**Last Name** Wilson  
**Title:** Nurse Office Director, Office of Policy  
**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) 359-5248  
**E-mail** Margaret.Wilson@medicaid.ms.gov  
**Fax Number** (601)359-9521

**8. Authorizing Signature**

**Signature:** /S/

**Date:** 1/15/2021

State Medicaid Director or Designee

**First Name:** Margaret  
**Last Name** Wilson  
**Title:** Nurse Office Director, Office of Policy  
**Agency:** Mississippi Division of Medicaid  
**Address 1:** Walter Sillers Building, Suite 1000  
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**City** Jackson  
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