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:__North Dakota_____

B. Waiver Title(s): Medically Fragile Children

C. Control Number(s):
ND.0568.R02.03

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:** Aug. 31, 2020

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.

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]

State Medicaid agency may approve an increase of In-Home Support hours on the service plan - these could be increased by a verbal approval from the State. The Case Manager would be responsible to get verbal approval from State Medicaid agency, followed by a confirming email and update the service plan within 30 days from the date the service was initiated.

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]:

If it is best for the individual to be relocated to a non-infected environment, then In-Home support would be available to the individual within the temporary new environment. Case Manager would obtain verbal approval, from the State with confirmation email to follow, of change of service location and update service plan within 30 days from the date the service was initiated.

Respite may be provided in a facility- based setting but would exclude room and board.

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

State Medicaid Agency may grant approval for out of state In-Home Support if family is temporarily relocated out of state during the emergency. Case Manager would be responsible to receive verbal approval from State Medicaid Agency followed by email confirmation and update the service plan within 30 days from the date the service was initiated.

Temporary out of state providers of In-Home Support service would be required to enroll with ND contracted fiscal agent.

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._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 relatives of waiver beneficiaries who reside in the home and out of the home to provide services prior to background check and training for 90 days. It is understood that the background check will be submitted by the agency within 30 days after the service begins and training will occur within 90 days of hire without leaving the beneficiary without necessary care.

The state is modifying provider standards for relatives to qualify as a direct worker while his/her background check and pre-employment screenings are in pending status. This allowance will be applied to participant-directed service (PDS) arrangements. Further, should a pending screening come back demonstrating concerns with the background check and/or pre-employment screening that would not allow the worker to continue employment long term that worker continues to be qualified until an alternative employee is identified unless the worker poses an immediate jeopardy to health, safety, and/or welfare of the participant (i.e. has tested positive for infectious disease) or is found to be guilty of past abuse, neglect, exploitation or violent felony and therefore is immediately unqualified.

Suspend training requirements for immediate family members and/or legal representatives providing services to waiver participants. As defined by the IRS, "immediate family member" includes a spouse, child, parent, grandparent, brother, sister, grandchild, stepparent, stepchild, stepbrother or stepsister of the participant.

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

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._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.]

Case managers may complete the person-centered service planning process using telephonic, videoconferencing, or web-based conferencing platforms that enable direct communication between the case manager and participant / participant's representative, in accordance with HIPAA requirements.

Person-Centered Service Plans (PCSP) that are due to expire within the next 60 days require case management contact to the participant using allowable remote contact methods to verify with the participant or representative that the current PCSP assessment and service, including providers, remain acceptable and approvable for the upcoming year. The state will verify by obtaining electronic signatures from service providers and the individual or representative, in accordance with the state's HIPAA requirements.

As requested, and/or necessary, modifications to the person-centered plan may be made, as driven by individualized participant's need, circumstance, consent, and reviewed on an individualized basis, without the input of the entire person-centered service team.

The Department will temporarily allow changes to be modified primarily by the case manager and participant/participant's representative – with signature from the provider to deliver modified services as documented in the updated plan. Physical signature to the plan can be obtained from third parties using remote transmission methods. The case manager may share forms requiring signature and receive documented signature consenting to a modified plan using fax or by sharing scanned documents via secured email. Consent may also be provided electronically via email. Electronic signature is also acceptable during the emergency period planning and development of modified person-centered service plans may be conducted using remote contact methods, in keeping with all other allowances for case management activities during the emergency period.

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 PCSP will be updated no later than 30 days from the date the service was initiated.

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]

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]*

   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:	Katherine
Last Name	Barchenger
Title:	State Autism Coordinator
Agency:	Department of Human Services - Medical Services Division
Address 1:	600 East Boulevard Ave Dept 325
Address 2:	Click or tap here to enter text.
City	Bismarck
State	North Dakota
Zip Code	58505-0250
Telephone:	701-328-4630
E-mail	kbarchenger@nd.gov
Fax Number	701-328-1544

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

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date: 3/28/2020**

_____/S/_____
State Medicaid Director or Designee

First Name:	*Caprice*
Last Name	*Knapp*
Title:	Director of Medical Services
Agency:	Department of Human Services – Medical Service Division
Address 1:	600 East Boulevard Ave Dept 325
Address 2:	Click or tap here to enter text.
City	Bismarck
State	North Dakota
Zip Code	58505-0250
Telephone:	701-328-1603
E-mail	cknapp@nd.gov
Fax Number	701-328-1544

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:	In-Home Support

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

Service Definition (Scope)**:**

In-Home Supports (IHS) enables a child who has a serious chronic medical condition to remain in and be supported in ~~their~~ family home and community. IHS is intended to support both the eligible child and the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. The eligible child must be living with a ~~legally~~ responsible caregiver. IHS benefits the eligible child by supporting their primary caregiver in meeting their unique medical needs. The primary care giver is supported in meeting the needs of their child within the routines of their family home and community: a)Training as identified in the Case Plan; b)Physical or verbal assistance to complete activities such as eating, drinking, toileting and physical functioning; improving and maintaining mobility and physical functioning; maintaining health and personal safety; carrying out household chores and preparation of snacks and meals; communicating, including use of assistive technology; learning to make choices, to show preference, and to have opportunities for satisfying those interests; developing and maintaining personal relationships; pursuing interests and enhancing competencies in play, pastimes and avocation; c)Involvement in family routines and participation in community experiences and activities. The eligible client will be supported in the home by staff hired by the family excluding legally responsible persons or individuals living in the same home as the consumer. The eligible client may also be supported in the home of the staff member hired by the family if the staff members home meet foster care licensure standards. This will not be a foster care placement, only the foster care standards will be used to assure health and safety welfare. Co-employers would be the family and an agency hiring the individual to work for family. Minimum requirements for a non-licensed provider would be 1) pass criminal background check, 2) over the age of 18, 3) not living in the home and 4) additional requirements identified on the individuals service plan.

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

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

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

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

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

Individual/Agency			The Family Support Services provider who are co-employers must be licensed as required in NDAC 75-04-01. (Co-employers would be family and agency both hiring the individual to work for family) through the state of North Dakota and must pass background check requirements as identified by the state. Providers of services must also meet the criteria identified in the participant's service plan.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Co-employee	Department of Human Services, Developmental Disabilities Unit	Annually

Service Delivery Method

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

Service Specification	
Service Title:	Program Manager or Case Management
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
This service would assist the individual /family by providing information, referral, and support to them. Case management services would provide a variety of activities such as intake, case planning, on-going monitoring and review of supports and services to promote quality and outcomes, and planning for and implementing changes in supports and services and right of appeal. This service would assure that support for individual/family requests fall within the scope of programs, while promoting reasonable health and safety. Case management services would assist in the coordination of identifying multiple services both formal and informal, along with obtaining/ applying for identified services. This service would ensure goals and needs are being met by ~~meeting~~ with the individual/family at least quarterly to review case plan and assure supports are successful in reaching the goals of the family. Case management service would ensure the review of rights are signed to include the assurance of family being informed of their rights and to document the choice of services for individuals requesting a HCBS waiver verses Institutional care. Case management services would meet ~~face to face~~ with individual/family at least quarterly; this would include 1) review of progress 2) satisfaction with services, 3) identify barriers and 4) discuss an action plan to resolve outstanding issues. Case management services may consist of phone calls or accompanying consumer to supports agency assisting with completing paperwork and any other assistance identified in case plan. Case management service would be able to assist in crisis intervention services to include emergency planning. Case management would also provide emotional support and assistance to problem solving as needed. Case Management could also assist / participate in individual educational planning (IEP) process. Case Management would support/ educate families on the Self-Directed Supports program.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
If Case Management Services are determined a need by the participant and family, service will be provided monthly to the family. This service does not meet the required use of a waiver service per quarter to remain on the waiver."	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Individual		Case management	

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

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

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

Agency	Holds a bachelor's degree in any of the following: social work, psychology, nursing, occupational therapy, physical therapy, child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreational therapy or human resources and administration and management. Or Holds a master's degree counseling or doctorate in medicine		Must have strong communication skills. Must have personal licensures up to date. Must be able to enroll as a Medicaid provider. Must have a criminal background check completed.

Agency	bachelor's degree in social work, psychology, nursing, occupational therapy, physical therapy, child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreation therapy, or human resources administration and management. A master's degree in counseling or a doctorate in medicine will also meet requirements.	A Qualified Mental Retardation Professional (QMRP) A person who has as least one year of direct care experience working with persons with a mental illness or developmental disability; is a doctor of medicine or has a bachelor's or master's degree in one of the following fields: social work, psychology, nursing, occupational therapy, physical therapy, child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreation therapy, or human resources administration and management. A master's degree in counseling or a doctorate in medicine will also meet	Requires knowledge, skills and abilities generally acquired and developed through formal education resulting in an undergraduate degree, extensive training, and /or relevant experience in work of an equivalent type and complexity. A moderately high degree of interpersonal skill is required to be able to communicate with and motivate others in the satisfactory performance of duties and responsibilities. The Ability to access the program ASSIST and to navigate said program. Ability to have contract with the fiscal agent for the spend down budget. Must have the ability to travel to the family's home throughout the state, as needed but at least quarterly. Must not have a conflict of interest in providing services to this population. Must be able to provide these services to the family at the same or less than rate.

		requirements. Show knowledge and understanding of Self-Directed Support program.	
Individual	Holds a bachelor's degree in any of the following: social work, psychology, nursing, occupational therapy, physical therapy, child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreational therapy or human resources and administration and management. Or Holds a master's degree counseling or doctorate in medicine		Must have strong communication skills. Must have personal licensures up to date. Must be able to enroll as a Medicaid provider. Must have a criminal background check completed.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	Central Office Program Manager	yearly

Agency	Upon making application to the position of Case Manager the Human Resource Management Services a Division of the Office of Management and Budget, reviews and verifies the qualifications listed on the application. Those individuals that meet the requirements are then forwarded onto the interviewing team. Upon selection of appropriate individual: references are checked, if criminal history check is needed this is also completed.	Case Managers are subject to annual review of job performances and continued ability to meet qualifications for position. This review is completed by Program Administrator and is kept in the Case Manager's personnel file. NDAC Chapter 4-07-10 covers the requirements for performance management and evaluations. 4-07-10-04: Each agency, department, and institution shall use the criteria in one or the other of the following performance management program types: 1. Individual-based performance. a. Performance reviews are conducted at least annually. b. Performance reviews are based on individual job-related requirements. c. A standard form or approach is used. d. Performance standards, or goals and objectives are used. e. The review includes a review of past performance. f. The review includes a discussion of how performance may be improved or how an employee's skills may be developed. 2. Team-based performance. a. Performance reviews are conducted at least annually. b. Performance reviews are based on overall team performance and how the

		employee functions as part of a team. c. The emphasis of the program is on improving the quality of a service or product, constantly improving systems and processes, and on preventing problems and eliminating them. d. The program provides guidance for the education, training, and self-improvement of the employee.
Individual	Central Office Program Manager	yearly

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	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.