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): Children's Hospice

C. Control Number(s):
ND.0834.R02.02

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:** 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 Respite hours on the service plan - these could be increased by a verbal approval from the State. The Service 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 to include possible out of state, then the services of Respite/ Skilled Nursing/ Hospice/ and Palliative may be temporarily provided to the individual within the new temporary environment. Case Managers 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 not be provided in a facility-based setting.

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 to complete temporary services to move a child out of state. Case Manager will be responsible to ensure the Hospice Agency is licensed within state of parent's choice and can meet current level of care of child.
Case Managers 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.
Receiving out of state Hospice agency must enroll with ND Medicaid as per approved 1135 waiver.

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.]

If waiver beneficiaries need to move out of state due to Covid 19, providers of out of state Hospice services must meet enrollment qualification as stated in waiver and enroll in ND Medicaid as approved with in the 1135 waiver.

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:	Respite
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Child must be residing in their legally responsible care givers home and service of respite must occur within this home. Respite can provide temporary relief to the legally responsible care giver in order for the care giver to possibly but not be limited to accompanying other siblings to daily activities, provide relief for brief periods of time and complete all ADL's and IADL's for the child. This service will only be authorized when listed on the service plan as a need. These are hours the family can use in conjunction with the Home Health Aide (not a waiver service). These hours may also be authorized if family is receiving home health services through state plan – they will not be scheduled during same times. Respite is defined as taking total care of child for a short period of time (not overnight). The legal caregiver will be able to attend to other siblings, family members, take care of self needs or other tasks. The service plan would state respite being used and number of hours per month. Service auths are approved for three month time. So they are approved four times a year.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Limited to 76 hours per year for identified child. This must be stated on Service Plan. Service auths are approved for three month time. So they are approved four times a year.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Hospice Agency
				Home Health Agency
				Medicaid enrolled agency that has certified CAN's on their staff.

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)*
Hospice Agency	Licensed Hospice agency within the state of North Dakota as per Chapter 23-17.4	individual providing the service must minimally have a CNA certificate.	

Home Health Agency	Certified as a Home Health Care provider per chapter 23-17.3	individual providing the service must minimally have a CNA certificate.	
Medicaid enrolled agency that has certified CAN's on their staff.		Individual providing the service must minimally have a CNA certificate.	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Hospice Agency	**Department of Health.**	**Annually**
Home Health Agency	**Department of Health**	**Annually**
Medicaid enrolled agency that has certified CAN's on their staff.	**Certification of CNA training completed/ dated.**	**every two years**

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

Service Specification	
Service Title:	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 concerning stages of dying, be able to complete assessments to determine what stage of death the identified individual is in to determine possible services, provide information on what to expect with the identified terminal illness, be the link of communication for the hospice primary physician and family, to assist with referral and support. Hospice Case Management services would provide a variety of activities such as intake, case planning, on-going monitoring, review of supports/services to promote quality, monitor outcomes, planning for and implementing changes in supports and services to reflect the changes of the progression of death and providing information on the right to appeal. In addition to these the hospice case manager would also be available day or night, by either phone or in person, to assist the family in dealing with the terminal illness or with complications brought on by a stage of dying. Hospice case Manager would ensure the plan and discussion was focused on the terminal illness and the outcome of death. They would encourage and show through example how to talk about death and how the emotions and fears effect everyday life of a family dealing with this outcome. This service would assure that support for individual /family requests fall within the scope of the program, while promoting reasonable health and safety. Hospice case management services would assist in the coordination of identifying multiple services both formal and informal and with obtaining and applying for identified services. This service would ensure goal 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 goal of the family. The Hospice Case manager will complete assessment in determination of where the individual is within the multiple stages of death and complete this assessment frequently to ensure the plan is current and beneficial to the family with authorized services.

Hospice case management services would ensure the review of rights are ~~signed~~ to include assistance of family being informed of their rights and to document the choice of services for individual/family at least quarterly this would include 1) review of progress, 2) satisfaction of services, 3) identify barriers and 4) discuss an action plan to resolve outstanding issues. Hospice case management services may consist of phone calls or accompany consumer to support agency, assisting with completing paperwork and any other assistance identified in service plan. Hospice case management services would be able to assist in crisis intervention services to include emergency planning -24 hour on call service. Hospice case management would also provide an emotional support and assistance to problem solving as needed.

This service can be authorized to be utilized during all other waiver services. This service will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan. The Hospice case manager cannot perform any other waiver service and is responsible to send the signed plans into the state program manager.

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

Hospice Case Management services can be used monthly. Hospice case manager cannot provide any other service within the waiver.

This service can be authorized to be utilized during all other waiver services.

This service will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan.

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

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)*
Agency	Registered nurse in the state of ND, working at a licensed Hospice agency within the state of North Dakota as per Chapter 23-17.4		Must be available to family at all times, must have strong understanding of the stages of death and be able to assess what stage the individual is in, must have strong communication skills, must have access to primary hospice physicians to be able to communicate changes in identified individuals heath status. must be able to enroll as a Medicaid provider within the MMIS system.
Individual	Registered Nurse in the state of North Dakota.		independently working yet able to meet all requirements of service definition for case management. Must be available to family at all times, must have strong understanding of the stages of death and be able to assess what stage the individual is in, must have strong communication skills, must have access to primary hospice physicians to be able to communicate changes in identified individuals heath status. must be able to enroll as a Medicaid provider within the MMIS system.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	North Dakota Board of Nursing. Department of Health.	Annually
Individual	North Dakota Board of Nursing.	Annually

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