APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. 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 completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State:_Oregon_____

B. Waiver Title: Aging and People with Disabilities

C. Control Number:
OR.0185.R06.05

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.

This application is additive to the previously approved Appendix K dated 04/28/2020 and 06/23/2020. All changes from the originally approved documents were effective as of 03/01/2020.

F. Proposed Effective Date: Start Date: 3.1.2020_Anticipated End Date: Six months beyond the end date of the federal Public Health Emergency (PHE).

G. Description of Transition Plan.

H. Geographic Areas Affected:

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

Contact Person(s)

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

First Name:	Dana
Last Name	Hittle
Title:	Deputy Medicaid Director
Agency:	Oregon Health Authority
Address 1:	500 Summer St. NE
Address 2:	
City	Salem
State	Oregon
Zip Code	97301
Telephone:	(503) 945-6491
E-mail	dana.hittle@state.or.us
Fax Number	(503) 945-5872

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

First Name:	Mike
Last Name	McCormick
Title:	Interim Director – Aging and People with Disabilities
Agency:	Oregon Department of Human Services
Address 1:	500 Summer St. NE

Address 2:	
City	Salem
State	Oregon
Zip Code	97301
Telephone:	503-945-6229
E-mail	Mike.R.McCormick@dhsoha.state.or.us
Fax Number	

8. Authorizing Signature

Signature:

_____/S/_____
State Medicaid Director or Designee

Date:	2/12/2021

First Name:	Lori
Last Name	Coyner
Title:	State Medicaid Director
Agency:	Oregon Health Authority
Address 1:	500 Summer St NE
Address 2:	
City	Salem
State	Oregon
Zip Code	97301
Telephone:	(503) 947-2340
E-mail	lori.a.coyner@dhsoha.state.or.us
Fax Number	(503) 373-7327