

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: Delaware

B. Waiver Title: Delaware Diamond State Health Plan 1115 Demonstration Waiver

C. Control Number:

11-W-0036/4

D. Type of Emergency (The state may check more than one box):

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	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.

The COVID-19 pandemic has required all Delawareans to take dramatic emergency actions to slow the transmission of the virus from person to person and to preserve access to services. During 2020, Delaware elected to provide up to three 30-day episodes of retainer payments to state plan day service providers who provide personal care services under the state plan rehabilitative services benefit as defined under section 1905(a) of the Act in order to maintain capacity during the emergency. These retainer payments were approved as an amendment to the DSHP 1115 demonstration waiver on November 24, 2020.

This 1115 Attachment K (Appendix K) amendment elects the option described in the CMS SMD #21-003 to add up to three additional 30-day episodes of retainer payments for the same eligible providers of state plan day services in order to assist providers to be financially viable so that they can resume normal activities after the PHE. This amendment includes the CMS retainer payment guardrails as outlined in the CMS issued FAQs June 30, 2020.

This amendment aligns retainer payment authorities across the three types of eligible Division of Developmental Disabilities Services (DDDS) providers currently approved for retainer payments: (1) Eligible Lifespan 1915(c) Waiver providers; (2) Eligible Pathways Section 1915(i) providers and (3) Section 1905(a) State plan day service providers.

This amendment is additive to those previously approved and is proposed to be effective retroactive to January 1, 2021 through the end of the PHE.

Delaware estimates total computable expenditures in 2021 to be \$2,534,000.

F. Proposed Effective Date: Start Date: __Jan 1, 2021_____**Anticipated End Date:** No later than six months after the expiration of the PHE_____

G. Description of Transition Plan.

Not applicable

H. Geographic Areas Affected:

Entire State

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

Not applicable

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. ___ Services

i. ___ 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. ___ 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. ___ 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. ___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. ___ Temporarily modify provider qualifications.

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

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. ___ 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.]

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. X 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.]

Retainer Payments

Delaware requests expenditure authority to make retainer payments to providers of day services enrolled under the rehabilitative services benefit as defined under section 1905(a) of the Act in order to maintain capacity during the PHE.

As approved by CMS on November 24, 2020, during calendar year 2020, DDDS may make retainer payments for state plan day service providers whose attendance and utilization for the service drops by at least **50%** due to COVID-19 containment efforts. Retainer payments will be made at a percentage of the regular service rate using the CMS-approved methodology described in the waiver, not to exceed 75% of the regular rate. Retainer payment units are limited to average prior utilization for each member. The resulting payment will not exceed the total amount that the provider would have received had services been provided as expected. DDDS will use prior authorization and billing procedures to ensure that there are no duplicative payments.

The state will allow the provider to receive retainer payments for services that include up to three episodes of up to 30 consecutive days per beneficiary for personal assistance. The state assures a retainer payment will not exceed the payment for the residential habilitation services. The state will collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred or duplicate uses of available funding streams, as identified in a state or federal audit or any other authorized third-party review. The state will require an attestation from the provider that it will not lay off staff and will maintain wages at existing levels. For providers that had already laid off staff prior to June 30, 2020, in lieu of this attestation, the state will clarify via written policy that the provider may alternatively attest that the retainer payments it will bill to the state as a percentage of the regular payment take into account any staff layoffs that have already occurred and that the retainer payments reflect the provider's remaining fixed costs, including the cost of any staff that have not been laid off. The state will require an attestation from the provider that they had not received funding from any other sources, including but not limited to, unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE. If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped. If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

(New) During calendar year 2021, DDDS may make retainer payments for state plan day service providers whose attendance and utilization for the service drops by at least **25%** due to COVID-19 containment efforts. Retainer payments will be made at a percentage of the regular service rate using the CMS-approved methodology described in the waiver, not to exceed 75% of the regular rate. Retainer payment units are limited to average prior utilization for each member. The resulting payment will not exceed the total amount that the provider would have received had services been provided as expected. DDDS will use prior authorization and billing procedures to ensure that there are no duplicative payments.

The state will allow the provider to receive retainer payments for services that include up to three episodes of up to 30 consecutive days per beneficiary for personal assistance. The

state assures a retainer payment will not exceed the payment for the residential habilitation services. The state will collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred or duplicate uses of available funding streams, as identified in a state or federal audit or any other authorized third-party review. The state will require an attestation from the provider that it will not lay off staff and will maintain wages at existing levels. For providers that had already laid off staff prior to June 30, 2020, in lieu of this attestation, the state will clarify via written policy that the provider may alternatively attest that the retainer payments it will bill to the state as a percentage of the regular payment take into account any staff layoffs that have already occurred and that the retainer payments reflect the provider's remaining fixed costs, including the cost of any staff that have not been laid off. The state will require an attestation from the provider that they had not received funding from any other sources, including but not limited to, unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE. If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped. If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

Retainer payments will occur on a case by case basis when the provider is directly affected by COVID-19.

Retainer payments will not be authorized for a participant for units of service for which a provider is authorized to be paid for actual service delivery.

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]



Contact Person(s)

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

First Name: Kimberly
Last Name: Xavier
Title: Chief of Policy and Planning
Agency: Division of Medicaid and Medical Assistance
Address 1: 1901 N. DuPont Hwy
Address 2: Lewis Bldg
City: New Castle
State: DE
Zip Code: 19720
Telephone: 302-255-9628
E-mail: Kimberly.xavier@delaware.gov
Fax Number: Click or tap here to enter text.

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 by:

Date: 7/23/2021 | 4:07 PM EDT



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State Medicaid Director or Designee

First Name: *Stephen*
Last Name: *Groff*
Title: Director
Agency: Division of Medicaid and Medical Assistance
Address 1: 1901 N Dupont Highway
Address 2: Lewis Bldg
City: New Castle
State: DE
Zip Code: 19720
Telephone: 302-255-9626
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Fax Number: Click or tap here to enter text.

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 which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
Service Definition (Scope):			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>
		Agency. List the types of agencies:	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
		Relative/Legal Guardian	
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>
		Provider managed	



ⁱ Numerous changes that the state may want to make 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; (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.