

[illegible]

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

☐	Pandemic or Epidemic
☐	Natural Emergency
☐	National Security Emergency
☐	Environmental
☐	Other (specify):

D. Brief Description of Emergency: *In no more than one paragraph each*, briefly describe the nature of the emergency. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver. In this section summarize the flexibilities being requested.

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E. Proposed Effective Date: Specify the effective date. Indicate the end date (not to exceed one year from the effective date).

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F. Description of Transition Plan:

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G. Geographic Areas Affected:

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

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Appendix K-2: Temporary Emergency-Specific Amendment to Approved Waiver

Temporary Emergency-Specific Amendment to Approved Waiver:

These are changes that are directly related to the state's response to an emergency situation and 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

[Provide explanation of changes.]

b. ___ Services

i. ___ Temporarily modify service scope or coverage

[Complete Section A- Services to be Modified during the emergency. If the state wishes to temporarily allow for remote/telehealth delivery of services, complete K-2-b-ii below.]

Name of Services	Type of Change

ii. ___ Temporarily allow for remote/telehealth delivery of waiver services

[Specify the waiver service that can be delivered remotely/via telehealth. Check the assurance boxes.]

☐ The remote service will be delivered in a way that respects the privacy of the individual especially in instances of toileting, dressing, etc.

☐ The telehealth service delivery will facilitate community integration.

☐ The telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service may be rendered without someone who is physically present or is separated from the individual.

☐ The state will support individuals who need assistance with using the technology required for telehealth delivery of the service.

☐ The telehealth will ensure the health and safety of an individual.

iii. ___ Temporarily exceed service limitations (including limits on services as described in Appendix C-4) or requirements for amount, duration, or prior authorization to address health and welfare issues presented by the emergency

[Provide explanation of changes.]

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iv. ___ 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; assistive technology; non-medical transportation)

[Complete Section A-Services to be Added/Modified during the emergency.]

v. ___ Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) due to the emergency. Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Provide explanation of modification, and advisement if room and board is included in the respite rate.]

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vi. ___ Temporarily provide services in out-of-state settings (if not already permitted in the state's approved waiver)

[Check the assurance boxes below.]

☐	Provider qualifications in the approved waiver apply. If there are additional provider qualifications for out-of-state providers, specify them in the narrative section below.
☐	If there are any licensure or certification requirements for out-of-state providers, those out-of-state requirements must be met.

[In the narrative section, indicate if the state is using a different rate methodology for the out-of-state providers and provide information regarding the different rate methodology.]

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c. ___ Temporarily Permit or Revise Payment for Provision of Services by Relatives, Legal Guardians, and/or Legally Responsible Individuals

[Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the person-centered service plan, and the procedures that are used to ensure that payments are only 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 describe the changes in provider qualifications.]

ii. ___ Temporarily modify provider types

[Provide explanation of changes, list each service affected, and describe 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, a description of settings impacted, and the services provided in those settings.]

e. ___ Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements)

[Describe changes in processes and/or the revised timeframes in which the evaluations or re-evaluations will be completed. Note that any changes in the timeline for initial evaluations can only be authorized via section 1135. In addition, states may not extend the timeframes for re-evaluations beyond 12 additional months past when the level of care is due.]

f. ___ Temporarily increase payment rates or allow for supplemental payments

[Provide an explanation for the increase or supplemental payment. As necessary, list the provider types, the revised rates by service, the percentage of the rate increase 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 or supplemental payment varies by provider, list the rate or supplemental payment by service and by provider. Note that no room and board costs should be included in any changes, except as permitted for respite services in certain facilities.]

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. Note that any changes to exceed the one-year timeline required by regulation for the review of the person-centered service plan can only be authorized via a section 1135 waiver authority.]

h. ___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances

[Provide explanation of changes.]

i. ___ Temporarily allow payment for waiver services provided in an acute care hospital in accordance with section 1902(h)(1) of the Act, under the following conditions:

[Check the boxes below to affirm that the conditions are met for waiver services rendered in an acute care hospital. Also, in the text box below the conditions, specify the waiver services that can be provided by the 1915(c) HCBS provider when they are not duplicative of services available in the acute care hospital setting; how the 1915(c) HCBS will assist the individual in returning to the community; and whether there is any difference from the typically billed rate for these HCBS provided during an acute care hospitalization.]

- ☐ The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;
- ☐ The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;
- ☐ The HCBS must be identified in the individual's person-centered service plan; and
- ☐ The HCBS will be used to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

j. ___ Temporarily include retainer payments to address emergency related issues

[Describe the circumstances under which such payments are authorized for 1915(c) waiver providers of personal care services and/or habilitation services that includes a personal care component, including the limit on their duration. Retainer payments are only available for 1915(c) waiver providers furnishing personal care and habilitative services that include personal care as a service component for the lessor of the number of bed-hold days approved in the state plan or 30 consecutive days. Include the percentage of the current rate to be paid if the retainer payment is less than 100% of the service rate. Also, specify the process the state will utilize to monitor payments to avoid duplication of billing. Please note for states that use managed care delivery systems for these services, in addition to the Appendix K approval, approval of a state-directed payment will be necessary to effectuate retainer payments in Medicaid managed care plans. State directed payments must comply with the requirements of 42 CFR section 438.6(c) and other federal requirements, including section 71116 the Working Families Tax Cut legislation. Questions about state directed payments or preprint submissions should be directed to statedirectedpayments@cms.hhs.gov.]

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

[Complete the table below. For the number of additional participants for each waiver, please note that this number is over the state's approved Factor C.]

Waiver Title	Control Number	Requested Additional Number of Participants

[In the text box, explain the reason for the increase in Factor C.]

m. ___ Other Changes Necessary

[Note that changes must be in accordance with what is permissible under Medicaid 1915(c) statute/regulation.]

i. ___ 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

[Provide explanation of changes.]

ii. ___ Reporting requirements (e.g., 372, evidentiary reports)

[Provide explanation of changes.]

Contact Person(s)

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

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.

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.

Authorizing Signature

Signature:

Date:

State Medicaid Director or Designee

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.

Section A---Services to be Temporarily Added/Modified during an Emergency Response

Complete for each service added during a time of the 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:	
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	

<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
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>	☐	Individual. List types:	☐	Agency. List the types of agencies:
Specify whether the service may be provided by <i>(check each that applies):</i>	☐	Legally Responsible Person	☐	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>	☐	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.

PRA Disclosure Statement

The purpose of this form is for states to request an emergency response related amendment to an approved Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is ###. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.