

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-14-26  
Baltimore, Maryland 21244-1850



**Disabled and Elderly Health Programs Group**

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May 18, 2020

Judy Mohr Peterson, PhD  
Med-Quest Division Administrator  
State of Hawaii, Department of Human Services  
601 Kamokila Blvd, Suite 506A  
Kapolei, HI 96707

Dear Dr. Judy Mohr Peterson,

We are writing to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Hawaii's request to amend the following 1915(c) Home and Community-Based Services (HCBS) waiver with the Emergency Preparedness and Response Appendix K in order to respond to the COVID-19 pandemic:

WAIVER TITLE	CMS AMENDMENT CONTROL NUMBER
Hawaii 1915(c) Home and Community Based Services for People with Intellectual and Developmental Disabilities (I/DD Waiver)	HI.0013.R07.06

The amendment that the state has requested in this Appendix K are additive to the Appendix K approved March 27, 2020 and are effective from March 1, 2020 through February 28, 2021, and apply in all locations served by the individual waivers for anyone impacted by COVID-19.

We have included the approved Appendix K pages with this correspondence. Please utilize the waiver management system for HCBS waivers for any further amendments to these waiver programs other than Appendix K.

If you need assistance, feel free to contact Amanda Hill of my staff at 410-786-2457 or by e-mail at [Amanda.hill@cms.hhs.gov](mailto:Amanda.hill@cms.hhs.gov) or Mary Marchioni at 303-844-7094 or by e-mail [Mary.marchioni@cms.hhs.gov](mailto:Mary.marchioni@cms.hhs.gov).

Sincerely,

Alissa M.  
DeBoy -S

Alissa Mooney DeBoy  
Director

Digitally signed by Alissa  
M. DeBoy -S  
Date: 2020.05.18  
08:44:12 -04'00'

Enclosure

# 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. 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:       Hawaii      

B. Waiver Title(s): Hawaii 1915(c) Home and Community Based Services for People with Intellectual and Developmental Disabilities (I/DD Waiver)

C. Control Number(s): HI.0013.R07.06

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.

COVID-19 pandemic. This amendment is additive to the previously approved Appendix K and 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:** February 28, 2021

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:*

## 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]

**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. X 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]**

The timeframes for the submission of the CMS 372s and the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and notes that as a result the data will be unavailable for this timeframe in ensuing reports due to the circumstances of the pandemic.

## Contact Person(s)

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

**First Name:** Judy  
**Last Name:** Mohr Peterson, PhD  
**Title:** Administrator  
**Agency:** Hawaii Department of Human Services, Med-QUEST Division  
**Address 1:** 601 Kamokila Blvd.  
**Address 2:** Suite 506A  
**City:** Kapolei  
**State:** Hawaii  
**Zip Code:** 96707  
**Telephone:** 808-692-8085  
**E-mail:** jmohrpeterson@dhs.hawaii.gov  
**Fax Number:** 808-692-8087

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

**First Name:** Mary  
**Last Name:** Brogan  
**Title:** Administrator  
**Agency:** Hawaii State Department of Health, Developmental Disabilities Division  
**Address 1:** 1250 Punchbowl Street  
**Address 2:** Room 463  
**City:** Honolulu  
**State:** Hawaii  
**Zip Code:** 95813  
**Telephone:** 808-586-5840  
**E-mail:** Mary.brogan@doh.hawaii.gov  
**Fax Number:** 808-586-5844

## 8. Authorizing Signature

**Signature:**

**Date:** 5/13/2020

\_\_\_\_\_/S/\_\_\_\_\_  
State Medicaid Director or Designee

**First Name:** Pankaj  
**Last Name** Bhanot  
**Title:** Director  
**Agency:** Hawaii Department of Human Services  
**Address 1:** 1390 Miller Street  
**Address 2:** Room 209  
**City** Honolulu  
**State** Hawaii  
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**Fax Number** [Click or tap here to enter text.](#)