DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, Hawaii 96709-0190

April 23, 2020

MEMORANDUM

MEMO NO.
QI-2015

TO: QUEST Integration (QI) Health Plans

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: COVID-19 PANDEMIC ACTION PLAN FOR QI HEALTH PLANS– PART III

The purpose of this memorandum is to operationalize the waivers and flexibilities that Department of Human Services, Med-QUEST Division (DHS/MQD) has received or requested specific to the Appendix K process and offers additional guidance to the QI-2009 and QI-2014 memorandums, which outline a pandemic action plan for QI health plans. The goal of the pandemic action plan is to maintain the health and safety of the QI members and health plan personnel, and the continued access to necessary services during and through the Public Health Emergency (PHE) that was declared by the Secretary of the Department of Health and Human Services on January 31, 2020. Note that for the Appendix K flexibilities only, they are in effect beginning March 1, 2020 and shall remain in effect through February 28, 2021.

What is Appendix K?

In times of emergency such as the COVID-19 pandemic, states which operate Home and Community-Based Services (HCBS) can apply for approval of "Appendix K: Emergency Preparedness and Response" in order to activate the necessary flexibilities available under the Medicaid. Hawaii's Appendix K application for the COVID-19 emergency was approved by the Centers for Medicare and Medicaid Services (CMS) on April 8, 2020 and is retroactive to March 1, 2020 and continues in effect through February 28, 2021.

These flexibilities are available only for the duration of a federally declared disaster. All services and programmatic changes taken through an approved Appendix K must be based on situations

that arise from the emergency and are temporary in nature. Service changes for participants must be directly related to the COVID-19 emergency and the flexibilities under Appendix K are only authorized for the duration of the emergency.

The purpose of these operational guidelines is to provide guidance on how to implement changes that will be in effect for the duration of the declared COVID-19 emergency. Health plans will work closely with members, families, and providers to ensure coordination and communications.

HCBS Final Rule Regulations

In order to comply to national recommendations for social distancing and to minimize the spread of infection during the COVID-19 pandemic, MQD suspends the HCBS settings requirement 42 CFR 441.301(c)(4)(vi)(D) that members are able to have visitors of their choosing at any time.

Service coordinators will not be required to modify the service plan during the period of the emergency. Health plans shall ensure that members health, safety, and psychological wellbeing are maintained in the provider setting.

Providers shall apply visitation limits/restrictions and have a process for properly screening and implementing infection control as recommended by the Centers for Disease Control and Prevention (CDC) guidelines at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Conflict of Interest

MQD provides exceptions for case management entities to provide direct services when appropriate when health plan service coordination is not accessible or limited in a regional area. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity to provide case management and/or develop person-centered service plans and also provide HCBS. The health plans shall ensure that safeguards for service delivery, billing, proper documentation, and record keeping will apply to these entities.

Level of Care (LOC)

Evaluation and Re-evaluation Process

Health plans cannot delay initial LOC evaluation. The initial LOC evaluation may be conducted remotely via telehealth in lieu of face-to-face visits for new members needing HCBS services that are practicing social distancing.

The LOC reevaluation will be extended for 6 months from the date of the current LOC expiration. MQD will work with Health Services Advisory Group (HSAG) to extend upcoming

reevaluations on a month to month basis until the conclusion of COVID-19 pandemic. The health plan service coordinator shall document the reason for the extension and the projected date in which the LOC will be able to be completed.

Services

"At Risk" Services for Members Diagnosed with COVID-19

MQD is waiving the limits on the number of hours of HCBS and the requirements to qualify for the following services for members diagnosed with COVID-19 and who are at risk of deteriorating to the institutional level of care (the "at risk" population). This includes:

1. Service limitation of ten (10) hours per week Personal Assistance Level I.
2. Functional points requirements for Personal Assistance Level I/Level II and Private Duty Nursing.
3. Service authorization limits on amount, duration, and frequency.

Continued Access to Services

The health plan shall not disenroll a member from HCBS. The health plans shall maintain current authorization levels. The service coordinator will provide monthly monitoring to ensure the service plan continues to meet the members' needs. Monthly monitoring may be done using telehealth that meets privacy requirements. The service coordinator shall reevaluate the plan of care when the period of emergency ends.

Modification to Person-Centered Planning and Processes

Service coordinators may use telehealth that meets privacy requirements in lieu of face-to-face meetings to conduct Health and Functional Assessments (HFA) to develop or update service plans, per Health and Human Services privacy guidelines at https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf
Service plan modifications to timeframes or processes are as follows:

1. Updates to the service plan may be approved with a retroactive approval date for service needs identified to mitigate harm or risk directly to COVID-19 impacts.
2. The use of electronic signatures that meets privacy and security requirements will be added as a method for member or legal guardian signing the service plan to indicate approval of the plan. Service may be delivered while pending signature to be returned to the service coordinator, whether electronic or by mail.

Expand Service Settings for Day Programs
MQD expanded settings where services may be provided for Adult Day Care and Adult Day Health. These services may be provided in members' homes, whether in a licensed or certified setting or a private home. The use of telehealth and telephonic services are permitted when possible and appropriate. When service is provided in a licensed or certified setting, the service cannot be provided by a member of the household. Please see Modification to Service Scope Day Programs for documentation and billing details.

Expand Service Settings for Home Care Services
MQD expanded settings where service may be provided for Personal Assistance Level I and Level II and Private Duty Nursing. In certain circumstances related to COVID-19 pandemic, alternative settings may include the home of a relative, hotel, etc.

Billing – Home care providers shall bill the health plans using the regular process and health plans shall process and pay these claims using regular claim payment system, but the providers shall use normally billed CPT/HCPCS code with CR modifier and use Place of Service (POS) 99 for Other. Health plan shall reimburse at the normal rate for billable services.
Health plan service coordinator shall

a. Not use face-to-face interaction but will use alternative communication modalities to continue interaction with member.
b. Conduct a needs assessment, take into consideration in home family supports or lack of, and need for an alternative service setting.
c. Discuss the benefits from the temporary alternative setting and settings options for services that can be provided during the public health emergency.
d. Document the member's decision whether to receive services in home or in a temporary alternative setting.
e. Ensure that the setting meets the needs of the member including but not limited to accessibility inside and outside of the setting, access to meals, and adequate supplies for providers to render personal care services.

Modification to Service Scope Day Programs (Adult Day Care and Adult Day Health)
MQD is recommending that all Medicaid members adhere to the Governors stay at home orders to prevent the spread of COVID-19, especially to those who are elderly and compromised by pre-existing conditions. Therefore, MQD recommends day program providers stop the physical attendance of Medicaid members into their facilities. MQD understands that health plan service coordinators are actively assessing the needs of members that have been affected by the closing of day programs.

MQD modified the service scope to allow services to be rendered beyond a "center-based" setting i.e., residential private home or licensed/certified home. The new scope language is underlined in table below.

From Appendix K: Section A

Service Specification	
Service Title:	Adult Day Care
Service Definition (Scope)**:**	
Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the member's service plan. Therapeutic, social, educational, recreational, and other activities are also provided as a regular adult day care service. <u>These services may be delivered in a center-based setting or in a residential setting, in certain circumstances related to the COVID-19 pandemic and is documented in the service plan. The program may conduct wellness calls and check-ins when member is absent due to medical or emergency circumstances. Wellness calls and check-in activities may include education to member and families, medication reminders for self-administration, and coordination for medically necessary appointments and transportation. Additional services may include but not limited to, delivery of essential items such as groceries and meals, translation, and family supports. The use of telehealth and telephonic services are permitted when possible and appropriate</u> Adult day care staff member may not perform health care related services such as medication administration, tube feedings, and other activities which require health care related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family member and professionals, such as an RN or LPN, from an authorized agency. <u>Family supports does not include home care services such as homemaker and personal care services as defined in HAR Chapter 11-700.</u>	
Service Title:	Adult Day Health
Service Definition (Scope)**:**	
Adult day health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community. Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse. In addition to nursing services, other components of adult day health may include emergency care, dietetic services, occupational therapy, physical therapy, physician services,	

pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech- language pathology, and transportation services. These services may be delivered in a center-based setting or in a residential setting, in certain circumstances related to the COVID-19 pandemic and is documented in the service plan. The program may conduct wellness calls and check-ins when member is absent due to medical or emergency circumstances. Wellness calls and check-in activities may include education to member and families, medication reminders for self-administration, and coordination for medically necessary appointments and transportation. Additional services may include but not limited to, delivery of essential items such as groceries and meals, translation, and family supports. The use of telehealth and telephonic services are permitted when possible and appropriate

Family supports does not include home care services such as homemaker and personal care services as defined in HAR Chapter 11-700.

With this flexibility, health plans may continue to authorize day program services to be delivered under the following conditions:

a. Health plan confirms the center-based day program is closed to Medicaid members due to the PHE.

b. Health plan may not reduce the authorized day program services during the PHE.

c. Health plan will communicate with the day program on the expansion of the service scope delivery and encourage in-home services provided via alternative communication modalities (to include FaceTime, Facebook Messenger, telephonic, etc.) to receive continued day program reimbursements. Remote services may include but are not limited to:

    1. The program may conduct wellness calls and check-ins.

    2. Wellness calls and check-in activities may include education to member and families, medication reminders for self-administration, and coordination for medically necessary appointments and transportation.

    3. Additional services may include but not limited to, delivery of essential items such as groceries and meals, translation, and family supports.

d. Health plan service coordinator shall not use face-to-face in-person interactions but will use alternative communication modalities to continue interaction with member. These interactions are to:
    1. Conduct a needs assessment and take into consideration in-home family supports or lack thereof.

    2. Discuss the benefits from the temporary in-home services that can be provided by the day program during the public health emergency.

3. Document the member's decision whether to continue or substitute day program service and update the service plan accordingly. The health plan may modify authorizations to substitute day program service for Personal Care Level I provided by either an home care agency or self-direct provider.

Documentation – Day programs shall document the in-home service delivery in the member medical record as follows:

a. Member receiving the remote services
b. Worker delivering the remote services
c. Date, start time & end time of the remote service
d. Specific remote services delivered
e. Communication modality used

Billing – Day Programs shall bill health plans for the telehealth service delivery using the regular process and health plans shall process and pay these claims using regular claim payment system, but the following changes shall be made:

a. More than one call, telehealth check-in, or service may be conducted within a single day. Regardless of the number of contacts occurring each day, only one unit may be billed for each service day.
b. Service delivery shall use normally billed CPT/HCPCS code with GT and CR modifier and add POS 02.
c. Health plan shall reimburse at the normal rate for billable services.

Alternative Paid Supports using Self-Direct Option

The health plan shall pay for services rendered by family caregivers or legally responsible individuals for Personal Assistance Level I and Level II as an alternative to agency or independent and unrelated self-direct workers. The option to pay family caregivers or legally responsible individuals will decrease risk and limit the transmission of the virus to and from the greater community. This also ensures continuity of care for the medically needy population.

Service coordinator shall

a. Conduct a needs assessment using telehealth that meets privacy requirements in lieu of face-to-face meetings.
b. Discuss self-direct option of service delivery shall be discussed with the member to allow payment to any family caregivers or legally responsible individuals.
c. When the member agrees upon the self-direct option, the service coordinator shall document the changes in service plan.

The service coordinator may complete the service plan by use of e-signatures that meets privacy and security requirements. This will be added as a method for the member or legal guardian signing the service plan to indicate approval of the plan. Services may start immediately while waiting for the signature to be returned to the service coordinator, whether electronically or by mail.

Family caregivers or legally responsible individuals must enroll in self-direct option to receive reimbursements. The health plan shall

a. work with the member to ensure the employee enrollment packet is completed.
b. work with the family caregivers or legally responsible individuals to ensure the employer enrollment packet is completed.
c. streamline the self-direct enrollment process with the state allowed flexibilities that may include but not limited to waiving the training requirements, criminal history checks, and employment eligibility verification requirements.

Billing – Self-Direct providers shall turn in time sheets to the member/employer, the member/employer shall confirm services delivered and turn in verified time sheets to the health plans using the regular process, and health plans shall process and pay these claims using regular claim payment system.

Support Services in an Acute Care Hospital or Short-Term Institutional Stay

The health plan shall pay for Personal Assistance Level II service for the purpose of supporting a member in an acute care hospital or short-term institutional stay when necessary supports are not available in the setting when the member requires those services for communication and behavioral stabilization and such services are not covered in such settings. The member may have been admitted for COVID-19 related symptoms or related complications before initial positive diagnosis. These services may be provided at the request of the hospital, short-term care facility, or by the member and/or authorized representative only with facility approval. Health plan reimbursement for this service may not exceed the lesser of 30 consecutive days. Billing – Personal care providers shall bill the health plans using the regular process and health plans shall process and pay these claims using regular claim payment system, but the providers shall add on a CR modifier to each CPT/HCPCS code billed, add CR modifier, add POS 21 for Inpatient Hospital or POS 31 for Skilled Nursing Facility.

Providers

Expand of Provider Type and Qualifications for Service Delivery

The health plan may contract with an active provider type H1 (I/DD Waiver Provider) to perform similar service delivery for Personal Assistance Level I/Level II and Private Duty Nursing to expand provider network. The health plan must notify MQD to temporarily enroll the H1 provider into home care agency (24) or nursing agency (46) provider type. The health plan may

also contract with other home and community-based service providers, such as home-delivered meals providers, to expand their provider network. A temporary Medicaid Provider ID number will be issued, with an enrollment end date that will correspond with the public health emergency end date.

Licensure and Certification Requirements

For HCBS settings that are due for licensing/certification renewal, MQD is working with the Department of Health, Office of Health Care Assurance (OHCA) to extend the current licensure/certification for providers in emergent situations where the health and welfare of the member is at risk when there is no access to a licensed/certified provider in the regional area. This will expand the options for residential placement upon hospital discharge and in turn increase the hospital capacity to serve more severe emergency cases.