



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

April 16, 2021

MEMORANDUM

MEMO NO.  
QI-2107

TO: QUEST Integration (QI) Health Plans  
Community Case Management Agencies (CCMAs)

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

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

The purpose of this memorandum is to operationalize the unwinding of some of the waiver flexibilities that the Department of Human Services, Med-QUEST Division (DHS/MQD) has allowed specific to the Appendix K and implemented in QI memoranda QI-2009 and QI-2015. MQD provides guidance for health plans and providers to resume in-person services as required in the QI contract prior to the Public Health Emergency (PHE), while maintaining the health and safety of QI members, providers, and health plan personnel during the PHE period that was declared by the Secretary of the Department of Health and Human Services on January 31, 2020.

The health plan must establish a reopening plan using the framework described in this memorandum to resume operations in accordance with the QI contract. This plan shall target the resolution of quality-of-care issues based on the extended period of no in-person contact, and consider the following safety practices and higher levels of safety precautions currently prevalent in the state:

- Improved availability of PPE,
- Improved understanding of, and level of comfort with, PPE usage,

- Widespread completion of COVID vaccination, especially those aged 75+, and
- Over twelve months of no in-person contact with service coordinators and community case managers (for some members).

Member is used in this memo to describe the member themselves or their authorized representative.

### Member Assessments

The health plan shall resume in-person interactions with members for assessments and re-assessments. Assessments and re-assessments may be conducted using telehealth and telecommunications technology only if an in-person interaction is not an option and should only be used on an exception basis. In-person interactions with members using appropriate safety precautions is the current expectation. Where possible, members at greatest risk and need should be prioritized to receive in-person interactions before members at lower risk and need.

The health plan must document the reason for conducting an interaction using a technology option. Prior to using technology for an interaction, consent shall be obtained and documented from the member and documented in the member's record. Acceptable technology options for conducting an assessment include: Telehealth, telephonic, and video technology commonly available on smart phones. The technology used must ensure privacy and security of all information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). If the member is unable to communicate using the agreed upon technology option, interactions may be completed through communication with an authorized representative who is familiar with the member's needs.

The timeframes for completion of the assessment and re-assessment shall continue in accordance with the current contract terms. However, any delays in assessments or re-assessments due to the PHE or state/local mandates shall be documented in the member's record.

Members requesting an increase or change of services during the PHE shall be re-assessed prior to service authorization.

### Plan of Care

The Plan of Care is a generic term that is referred to as the 'Service Plan' in the RFP-MQD-2014-005 contract and the 'Health Action Plan' in the subsequent RFP-MQD-2021-008 contract. For the purposes of this memorandum, plan of care shall refer to both terms and any subsequent term used that refers to a document that at minimum identifies the services available to a member.

The health plan shall obtain a signature by the member to acknowledge the approval of the person-centered plan of care per 42 CFR 441.301.

Services may be delivered before an in-person visit allows the plan of care to be signed by the member if an acknowledgement form has been completed by the health coordinator which documents the member's temporary approval of the plan of care. Acceptable methods for documenting member's acknowledgement include: Written approval via electronic message, or verbal approval via telephonic or video conference. The health plan health coordinator signature on the acknowledgement form may be used as an attestation to the member's temporary approval of the plan of care, and this temporary approval shall be in effect for no more than 30 days. See Attachment 1 for an example of an acknowledgement form. The technology used to obtain approval of the plan must ensure privacy and security of any information in accordance with HIPAA. If the member is unable to communicate using the agreed upon technology option, plan of care approval may be obtained from an authorized representative.

The timeframes for plan of care development and revisions continue in accordance with the current contract terms. However, any delays in the development or revisions to the plan of care due to the PHE or state/local mandates shall be documented.

Services during the PHE cannot be terminated or decreased if it affects the Member's Medicaid eligibility pursuant to 42 CFR 433.400.

#### Home and Community-Based Services (HCBS) Settings Requirements

The health plan shall ensure that the HCBS providers identified in the statewide transition plan are allowed flexibilities related to the implementation of the HCBS settings (Community Care Foster Family Home, Expanded-Adult Residential Care Home, Assisted Living Facility, Adult Day Health, and Adult Day Care) requirements to minimize transmission of infection. The following HCBS settings requirements include:

- 42 CFR 441.301(c)(4)(vi)(D), Member right to have visitors of their choosing at any time
- 42 CFR 441.301(c)(4)(vi)(B)(2), Member right to choose roommate or bedroom arrangement

These flexibilities allow HCBS providers to establish visitor and new admission pre-screening practices, in addition to other practices intended to minimize the transmission of infection, in accordance with the Centers for Disease Control and Prevention (CDC) recommendations for long-term care community residents at <https://www.cdc.gov/coronavirus/2019-ncov/community/retirement/residents.html>.

When health and safety precautions are implemented that may affect the member's freedom of choice and full access to the community, the health plan shall document that modification in the service plan in accordance with 42 CFR 441.301(c)(4)(vi)(F).

### Transportation Services

The health plan shall obtain the transportation vendor's written agreement that services are delivered using safe practices in accordance with CDC recommendations (<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/using-transportation.html#RideShare>). The same written agreement requirement applies to home care providers/CCFFH providers that use their personal vehicles to transport members. These include, but are not limited to:

1. Proper use of masks for driver and all passengers.
2. Practicing physical distancing by
  - a. Limiting the number of passengers in vehicle
  - b. Avoiding shared rides where multiple passengers are picked up that are not in the same household
  - c. Sitting in the back seat in larger vehicles such as vans, so you can remain at least 6 feet away or as far as possible from the driver. When possible, passenger should be sitting in the rear seat diagonally from the driver
3. Practicing hand hygiene and sanitizing surfaces in between rides
4. In-vehicle ventilation
5. Limiting eating and drinking during the ride

If you have any questions, please contact Jon Fujii at [jfujii@dhs.hawaii.gov](mailto:jfujii@dhs.hawaii.gov)

Attachment 1

**Plan of Care Update and Choice of HCBS Acknowledgement Form \***

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_ Health Plan: \_\_\_\_\_

Authorized Representative Name (optional): \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

**Member/Authorized Representative who agreed to the Plan of Care**

- I agree with this plan of care and participated in the development of my plan goals.
- I understand my right to choose providers and my rights as a member of the health plan.
- I agree with the services and agree to participate in the home and community-based program.
- I was educated on how to report abuse, neglect, exploitation, and critical incidents.

**HCBS Member Only**

I have been offered the option of Self-Directed Care:

- I Accept Self-Directed Care
- I Decline Self-Directed Care

HCBS Member Communication Method:

- Telephone: Verbal Consent
- Written: Email/Text Consent

**Member/Authorized Representative**

I will be given a copy of this acknowledgement form either by mail or email

Member/Authorized Representative Communication Method:

Mail: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health Coordinator Attestation to the Above**

Health Coordinator Name: \_\_\_\_\_

Health Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*This acknowledgment form shall expire after 30 days from the attestation date.