HUMAN SERVICES DEPARTMENT

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Special COVID-19 Letter of Direction #12-1

Date: **November 23, 2020**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division**

Subject: **Community Benefit Waivers Approved in Appendix K, Effective March 12, 2020 Repeal and Replace Special COVID-19 LOD 12**

Title: **Community Benefit Appendix K**

The purpose of this Letter of Direction (LOD) is to provide guidance and directives to the Centennial Care 2.0 Managed Care Organizations (MCOs) for modification of services and program standards related to the national public health emergency associated with the 2019 Novel Coronavirus (COVID-19) outbreak. The purpose of these changes is to assure the continuation of essential services to Medicaid patients without disruption or delay while following Centers for Disease Control and Prevention (CDC) direction to maximize social distancing for the duration of the public health emergency.

The following waivers related to the Centennial Care Community Benefit (CB) were requested by HSD and approved by CMS effective March 12, 2020.

1. Flexibility to allow CB providers, in consultation with the state's licensing agency, to provide services in alternative settings including settings that are licensed for other purposes (i.e. residential using a day program facility) or unlicensed settings (i.e. hotels, schools, churches and/or permanent or temporary shelters) for residential or day programming in an effort to mitigate COVID-19 spread. Please see LOD #31 for telehealth billing guidelines. The following CB services are included:

   Occupational Therapy for Adults:
   - Face-to-face visits may be provided by telehealth option or phone visits. This includes assessment, monitoring or follow up. All interactions will be documented.
   - Trainings and return demonstrations may be done by telehealth or phone as needed.

   Physical Therapy for Adults:
   - Face-to-face visits may be provided by telehealth option or phone visits. This includes assessment, monitoring or follow up. All interactions will be documented.

- Trainings and return demonstrations may be done by telehealth or phone as needed.

Speech and Language Therapy for Adults:

- Face-to-face visits may be provided by telehealth option or phone visits. This includes assessment, monitoring or follow up. All interactions will be documented.
- Trainings and return demonstrations may be done by telehealth or phone as needed.

Customized Community Supports:

- Community Customized Supports can be provided in the home.

Behavior Support Consultation:

- Face-to-face visits may be provided by telehealth option or phone visits. This includes assessment, monitoring or follow up. All interactions will be documented.
- Trainings and return demonstrations may be done by telehealth or phone as needed.

Private Duty Nursing for Adults:

- Face-to-face visits may be provided by telehealth option or phone visits. This includes assessment, monitoring or follow up. All interactions will be documented.
- Trainings and return demonstrations may be done by telehealth or phone as needed.

2. Allow legally responsible individuals (LRIs) such as a spouse to provide personal care services (PCS). The MCOs are directed to report the total number of LRIs that provided Agency-Based Personal Care (ABCB) PCS in the prior month. The MCOs will report data for May 2020 on June 30, 2020 and will report data for June 2020 on July 15, 2020. Ongoing monthly reporting will be due on the 15th day of each month. If the 15th day falls on a weekend or holiday, the report is due on the first following business day. Reporting will be provided via email to Tallie Tolen at Tallie.tolen@state.nm.us.

In addition, the MCOs will work together to survey all PCS agencies to determine how many members have paid PCS caregivers who are related family members, regardless of household status. This data is due to HSD no later than August 15, 2020. The MCOs are directed to work with FiServ to ensure that this data element is captured in the Authenticare system for future reporting to HSD.

3. Allow provider enrollment or re-enrollment with modified risk screening elements such as suspending fingerprint checks or modifying training requirements as needed to all HCBS service providers. New Mexico providers must conduct employee abuse registry screenings and document that screening has occurred. (See Special COVID-19 LOD #6- Care Coordination and Other In-Home Services and Community Benefits)

4. Suspend the Nursing Facility Level of Care (NF LOC) redetermination for impacted members for the duration of the COVID-19 emergency. MCOs will continue to perform NF LOC assessments and submit NF LOC determinations as they are completed. MCOs will continue their processes to

ensure that prior authorizations for PCS, nursing facilities, and other long-term services and supports are in place. (See Special COVID-19 LOD #6)

5. Continue all care coordination activities using telephonic visits, or, if the capacity exists for the member and MCO, virtual visits. Care coordination activities that normally require an in-home visit with face-to-face member interaction include initial, annual, and semi-annual Comprehensive Needs Assessments (CNAs); semi-annual and annual in-person touch points; transition of care three-day in-home assessments; and NF LOC determinations for community benefits. (See Special COVID-19 LOD #6)

6. Modify incident reporting requirements, including the suspension of the requirement to conduct a neglect investigation of any incident of deviation in staffing as outlined in a comprehensive care plan. The critical incident will need to be reported to HSD and the MCO will be responsible to talk to the Member and Provider regarding staffing. The MCO should update the back up plan as needed. For Members with family/natural supports, a report would not go to APS, only Members with no supports would warrant a report to APS.

7. Modify incident reporting requirements, including suspension of the requirement to submit an incident report for Abuse Neglect and Exploitation for any deviation in staffing as outlined in a comprehensive care plan and/or back-up plan, unless the Member does not have natural supports. If this requirement is suspended, providers must report any incidents in which staffing shortages result in a failure to provide care via the Critical Incident Portal.

8. Allow for payment for services for the purpose of supporting waiver participants by allowing CB PCS in an acute care hospital or short-term institutional stay when the services are not already part of the required services for which the acute care hospital is responsible. The payments may only be made for up to 30 consecutive days.

9. Provide retainer payments for approved personal care services. Up to three episodes of 30 days may be reimbursed. There must be a break in between episodes. Each episode must be documented separately. MCOs are expected to pay retainer payments at 100% of contract PCS rates.

When billing for retainer payments, providers must use the correct PCS procedure code (99509 or T1019) with the modifier 52. The MCOs will also bill their encounters with this modifier.

Within 5 business days of the effective date of this LOD, the MCOs will notify providers on how to bill for retainer payments and ensure that:

Retainer payments will not be authorized when a provider is providing services and will only occur on a case-by-case basis when a member is directly impacted by the emergency, i.e., sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders. In addition:

a. A provider shall not bill retainer payments for one service if providing a similar service to the same member in the same time period;

b. Retainer payments may not be billed when the member chooses to receive services through a different provider;
c. Retainer payments will not be made if the member receives the same service from a different provider within the same time period, e.g. on the same day if a daily service, or within the same week if a weekly service;
d. The provider shall continue to submit claims for all services that are provided, and therefore are not eligible to be billed as retention payments; and
e. The provider shall pass retainer payment funds to caregivers to maintain staffing levels during the Federal PHE.

The MCOs will work with the Self-Directed Community Benefit (SDCB) Fiscal Management Agency (FMA) to ensure that retainer payments are implemented in a similar manner for the SDCB program.

CMS released New FAQs-Released June 30, 2020 COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies. The MCOs must ensure that they are following the guidance as described in pages 23-25. The June 30, 2020 FAQs are attached to this LOD.

The MCOs must work with their contracted PCS agencies to ensure that the guardrails as described below and in the June 30, 2020 FAQs are met before issuing retainer payments to providers.

- The MCOs must limit retainer payments to 100% of the contracted PCS rate and ensure recoupment if other resources, once available, are used for the same purpose.
- The MCO must 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 in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third party review. Note that "duplicate uses of available funding streams" means using more than one funding stream for the same purpose.
- The MCOs must require an attestation from the provider that it will not lay off staff, and will maintain wages at existing levels for the duration of the Federal PHE.
- The MCOs must 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 Federal PHE, or that the retainer payments at the level provided by the MCO would not result in their revenue exceeding that of the quarter prior to the Federal 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.

The MCOs must maintain evidence and/or require their contracted agencies to maintain evidence to be provided in the event of an audit.

The MCOs will collaborate to align billing processes to the extent possible for providers to bill retainer payments.

This COVID-19 Letter of Direction will sunset when the Human Services Department determines that the outbreak of the 2019 Novel Coronavirus (COVID-19) associated with the national public health emergency has been contained.