HUMAN SERVICES DEPARTMENT
Michelle Lujan Grisham, Governor
Kari Armijo, Acting Secretary
Lorelei Kellogg, Acting Medicaid Director

Letter of Direction #98

Date: **August 3, 2023**

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

From: **Lorelei Kellogg, Acting Director, Medical Assistance Division**

Subject: **MCO Requirements Regarding the Expiration of the Public Health Emergency (PHE) for COVID-19**

Title: **Expiration of the PHE**

The Centers for Medicare and Medicaid Services (CMS) has notified the Human Services Department (HSD), Medical Assistance Division (MAD) that the Public Health Emergency (PHE) expired May 11, 2023. 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 ending of the PHE associated with the 2019 Novel Coronavirus (COVID-19) outbreak, while ensuring the continuation of services is not affected by the end of the PHE.

CHANGES IN COVERAGE POST PHE:

1. **Homebound Vaccination Program:** During the PHE, MAD implemented a program that allowed Ground Ambulance providers to serve the homebound population in their communities. The service provided included a screening and COVID-19 vaccine administration. The last date of coverage for this service was May 11, 2023.

2. **Special COVID-19 LOD #1 Expedited Claims Payment and Reporting**- Post PHE will return to the current timeframes outlined in Contract:

   Current Timeframes 4.19.1.6 Paying Clean Claims in a timely manner.

3. **Special COVID-19 LOD #2 Guidance for Hospitals using Alternate Care Sites**- This flexibility ended on May 11, 2023.

4. **Special COVID-19 LOD #3 Provider Network and Out-of-Network Requirements-**

   a. **Provider Revalidations/Turn Around Documents, Site Visits and Fingerprint-based criminal background checks -** HSD will resume provider site visits, fingerprint-based criminal background checks and revalidation activities effective May 11, 2023. CMS is allowing states an extended period to complete these required activities; the time frame will be the length of PHE plus 6 months. Affected provider

records will be updated with the new determination date in case the provider has not submitted the required documents or complied with one of the requirements.

b. **Expired License-** Temporary suspension to require providers to submit proof of continued licensure or certification will end on May 11, 2023. Providers with an expired license or certificate will receive a notice to submit the required document within 60 days of the date of the notice. Failure to meet this requirement will result in termination of the provider's enrollment with NM Medicaid.

c. **Provisionally enrolled providers-** Effective May 11, 2023, a termination status will be applied to providers identified as provisionally enrolled. HSD is inviting provisional providers to participate as NM Medicaid providers on a permanent basis. HSD invites these providers to enroll as NM Medicaid participating providers at the following link: https://nmmedicaid.portal.conduent.com/webportal/enrollOnline

d. **Non-Network Providers-** HSD gave temporary permission to register non-network providers located in New Mexico and the bordering states. Effective May 11, 2023, a termination status will be applied to providers identified as non-network. HSD invites these providers to enroll as NM Medicaid participating providers at the following link: https://nmmedicaid.portal.conduent.com/webportal/enrollOnline

5. **Special COVID-19 LOD #4 COVID-19 MCO Guidance for Fair Hearings-** This flexibility has ended as of May 11, 2023.

6. **Special COVID-19 #5 Member and Provider Communication Protocols-** This flexibility has ended on May 11, 2023.

7. **Special COVID -19 #6-1 In-Home Services & Community Benefits-** These flexibilities have ended as of May 11, 2023.

8. **Special COVID-19 LOD #7 Special Requirements for Pharmacy and Waiver of Signature-** Effective May 11, 2023, HSD will no longer allow shortened durations between medication refills.

   a. For 30-day prescriptions, early medication refills may return to the MCOs pre-COVID thresholds and processes that were in place.

   b. For 90-day prescriptions, early medication refills may return to the MCOs pre-COVID thresholds and processes that were in place.

   c. Restrictions on early medication refills of controlled substances for drug classes III-V may return to pre-COVID thresholds and processes which were in place by the MCO. Class II opioids must have a 90% utilization for an additional prescription. A pharmacy with access to dispensing information through a chain store or linked database, or that is notified of early refills or other dispensing of drugs through a point-of-sale system, is responsible for assuring the refill meets the criteria by verifying the dispensing history available, including the drug monitoring program database.

   Signature Requirements: HSD gave temporary permission to waive signatures for Durable Medical Equipment and prescriptions through point-of-sale transactions allowing "COVID-19" or substantially similar language on a prescription or receipt of services on the counseling log. Effective May 11, 2023, the patient's or their representatives' signature must be obtained.

9. **Special COVID-19 LOD #8-3 Testing and Treatment Services and Code-**

    a. New Billing Codes for Testing – This flexibility ended on May 11, 2023.
    b. Claims Processing- This flexibility ended on May 11, 2023.
    c. Drive-through Testing/Screening-sunsets. This flexibility ended on May 11, 2023.

    Everything else in Special COVID LOD #8-3 will continue.

10. **Special COVID-19 LOD #9-1 COVID Special Requirements for Prior Authorization and Cost-Sharing-** This flexibility has ended on May 11, 2023.

11. **Special COVID-19 LOD #11-1 Reporting Requirements and Replace Special COVID-19 LOD #11-** This flexibility ended on May 11, 2023.

12. **Special COVID-19 LOD #12-1 Community Benefits Appendix K-**
    The following waivers related to the Centennial Care Community Benefit (CB) were requested by HSD and approved by CMS effective March 12, 2020. These waivers will continue for 6 months after the end of the PHE, November 11, 2023.
    a. 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 Special COVID-19 LOD #13-1 for telehealth billing guidelines. The following CB services are included:
        i. 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.
        ii. 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.
        iii. 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.
        iv. Customized Community Supports:
            - Community Customized Supports can be provided in the home.
        v. 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.

vi. 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.

b. 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@nm.hsd.gov.

c. Modify incident reporting requirements which allow for weekly in lieu of daily reporting will be extended through November 11, 2023. The MCO is required 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

d. Modify incident reporting requirements which allow for weekly in lieu of daily reporting will be extended through November 11, 2023. The MCO is required 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.

e. 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.

f. 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:

i. A provider shall not bill retainer payments for one service if providing a similar service to the same member in the same time period;
ii. Retainer payments may not be billed when the member chooses to receive services through a different provider;
iii. 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;
iv. 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
v. 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 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.

13. **Special COVID-19 LOD #13-1 Telehealth:** Post PHE telehealth services will be covered as defined in NMAC 8.310.2-Health Care Professional Services. Telephone visits will continue to be allowed as they have been during the PHE, including in a member's home. This flexibility ends December 31, 2024.

14. **Special COVID-19 LOD #14 – COVID-19 Rate Increase for ALFs**- This flexibility ended on May 11, 2023.

15. **Special COVID-19 LOD #16-1 Non-DRG Hospital Inpatient Payment Rate Increases-** This flexibility ended on May 11, 2023.

16. **Special COVID-19 LOD #17 Non-Emergency Medical Transportation (NEMT) for Testing, Treatment and Isolation**. This flexibility ended on May 11, 2023. As of 5/12/2023 MCOs will no longer be required to ensure implementation of proactive identification strategies and transportation processes for Medicaid eligible recipients who are seeking COVID-19 testing, treatment, or isolation.

17. **Special COVID-19 LOD #18 Offsite for FQHCs, IHS and Tribal 638 Facilities, RHCs, and HBRHCs:**
    a. **FQHCs:** As of 5/12/2023 MCOs will no longer be required to reimburse for the collection of a specimen when the specimen is obtained at testing sites outside of the clinic environment as outlined in Special COVID-19 LOD #18. Entering condition code DR (disaster related) for billing on a UB-04 and appending modifier CR (catastrophe/disaster related) for billing on a CMS-1500 will no longer be required for FQHCs.
    b. **IHS and Tribal 638 Facilities:** Per CMCS Informational Bulletin (CIB) issued on October 4, 2021 offsite services provided by Indian Health Service (IHS) facilities, including those facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. No. 93-638 is allowed nine months after the PHE ends or February 11, 2024. Effective February 12, 2024, offsite services will only be allowed for Tribal 638 FQHCs in alignment with NMAC 8.310.4. See Supplement 21-04 Tribal FQHC Designation and Billing Guidance for more information on Tribal 638 FQHCs.
    c. **Freestanding Rural Health Clinics (RHC) and Hospital Based Rural Health Clinics (HBRHC):** As of 5/12/2023 MCOs will no longer be required to reimburse

for the collection of a specimen when the specimen is obtained at testing sites outside of the clinic environment as outlined in Special COVID-19 LOD #18. Entering condition code DR (disaster related) for billing on a UB-04 and appending modifier CR (catastrophe/disaster related) for billing on a CMS-1500 will no longer be required.

18. **Special COVID-19 LOD #19-1 COVID-19 Claims Waiver of Timely Filing for All Medicaid enrolled providers-** This flexibility ended on May 11, 2023.

19. **Special COVID-19 LOD #20 Surveillance Testing-** This flexibility ended on May 11, 2023.

20. **Special COVID-19 LOD #21 Provider Rate Increases and Claims Adjustments for dates of services April 1, 2020-June 30, 2020-** This flexibility ended on May 11, 2023.

21. **Special COVID-19 LOD #23 Temporary Hospital Payment Increases-** This flexibility ended on May 11, 2023.

Contact your Centennial Care 2.0 Contract Manager with any questions regarding this LOD.