Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Network Communication Bulletin #223

To: All Providers

From: Khristine Brewington, MS, LCMHCS, LCAS, CCS, CCJP
VP of Network Management

Date: June 13, 2022

Subject: Tailored Plan Webinar 101, Special Bulletin COVID-19

SPECIAL BULLETIN MEDICAID TRANSFORMATION

TAILORED PLAN WEBINAR 101

AHEC Tailored Plan 101 Webinar Series and Flexibilities ending for CAP-DA and CAP-C, registration details below:

NEW SERIES BEGINS JUNE 16, 2022

Join NC Medicaid Chief Medical Officer, Dr. Shannon Dowler, for the June Back Porch Chat on Thursday, June 16 from 5:30-6:30 p.m. This chat is the first in a series of monthly webinars that will build over the next six months to ensure that all of us are ready for launch of Tailored Plans in December 2022!

Register for the series

This webinar series occurs the third Thursday of each month and is designed to support all Medicaid providers, practice managers, quality improvement professionals, care coordinators and other leaders within your practice to help you prepare for the launch.

The June 16 chat will include critical background you need to be ready for launch, including:

- key aspects of the Tailored Plan program and the history of how we got here,
- what your patients should know now, and
- what providers of all types should be doing now to prepare!

Tailored Plan 101: Ready, Set, Launch Series Schedule

- **June 16, 2022** - Tailored Plan 101 Series Part 1: Preparing for Tailored Plan
- **July 21, 2022** - Tailored Plan 101 Series Part 2: Integrating Behavioral Health and Physical Health, Tailored Care Management and Advanced Medical Home
- **Aug. 18, 2022** - Tailored Plan 101 Series Part 3: Transitions of Care, Network Adequacy & Readiness
- **Sept. 15, 2022** - Countdown to Tailored Plan Launch: Who is Who
- **Oct. 20, 2022** - Countdown to Tailored Plan Launch: Health Plan Accountability and Reporting
- **Nov. 17, 2022** - Ready Set Launch: What ifs of Tailored Plan Launch, Quick Reference Guides, Practice Supports

Don't miss this opportunity to get important and timely information! The latest schedule, registration and information on previous webinars, including the recording, slides, and transcript are available on the AHEC Medicaid Managed Care website.

SPECIAL BULLETIN COVID-19 #250

Planning for the Transition out of the Appendix K Public Health Emergency for CAP/C and CAP/DA Waivers

In March 2020, NC Medicaid implemented policy flexibilities that temporarily changed how the Community Alternatives Program for Children and Disabled Adults (CAP/C and CAP/DA) Home- and Community-Based Services (HCBS) waivers would be executed during the COVID-19 public health emergency (PHE). The flexibilities were administrative changes made to the CAP/C and CAP/DA business rules, processes and policies.

Given the scientific approach to reducing outbreaks and spread of the virus and the implementation of preventive measures to combat infections and illnesses, DHB will be initiating a dialogue with CAP stakeholders on the transition back to normal business operations as a proactive approach to winding down of some of the CAP flexibilities. During these dialogues, risk mitigation strategies for health, safety, and well-being will be addressed.

The flexibilities implemented in the CAP waivers were through an emergency planning document called an Appendix K were effective March 13, 2020, and remains effective through the duration of the PHE and six months after the expiration of the PHE. The additional six-months allowed after PHE expiration serves as a runway for states to smoothly transition back to the normal business operations of the waivers. This transition could include some portions of the flexibilities included in Appendix K when approved in an amended waiver application.

The CAP flexibilities are listed below, communicated in SPECIAL BULLETIN COVID-19 #143 and desktop tools provided to Case Management Entities (CME) in 2020. The first item for discussion will be reinstating face-to-face monitoring and assessment visits with CAP beneficiaries and their families. Separate sessions will be held with case management entity (CME) supervisors and case managers, and waiver beneficiaries and their families. The key recommendations and takeaways from these sessions will assist with creating a transition plan to reinstate face-to-face visits.

CAP Flexibilities Transition Project Plan

Goal: Meet with stakeholders to identify a risk mitigation strategy to efficiently wind down the CAP flexibilities no later than six months from the expiration of the federal PHE.

Objectives

1. Through a workgroup survey, solicit participation from CAP/C and CAP/DA managers, supervisors, case managers and beneficiaries, beneficiaries' family members and HCBS providers to engage in small workgroup discussion once per month.
2. Engage monthly with identified workgroup participants about successes and barriers of the CAP flexibilities to develop best practice recommendations for policy changes and timeframe to transition to permanent program business processes and rules.
3. Implement and execute a CAP Flexibilities Transition Plan that corresponds with the PHE expiration timeline for the CAP waivers.

CAP/C AND CAP/DA WAIVER FLEXIBILITIES FOR THE MANAGEMENT OF THE PHE

Case management

- Covers monthly telephonic contact with waiver participant and quarterly telephonic contact with service providers to monitor PHE service plan, other essential case management needs, and initial and annual telephonic assessments of level of care and reasonable indication of need.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: The coverage of a one-time purchase order process for each approved service to promote an on-demand quick procurement when the goods and service items listed in the Appendix K are readily available in retail. The purchase order may include the participant being given a check made out directly to the provider (that the provider must endorse), a purchase account at the retailer where the participant and the provider both sign (the invoice is submitted to the case manager for verification), or the designation of a VISA card number assigned specifically to a waiver participant for on-line procurement of approved services, arranged by the case manager. The VISA card will not be given to the individual. The case manager will document the VISA card number and the associated PIN.

Participant goods and services

- Covers disinfectant wipes, hand sanitizer and disinfectant spray for certified nursing assistants or personal assistants who can continue to render in-home, pediatric and/or nurse care to a waiver participant. Covers facial tissue, thermometer and specific colored trash liners to distinguish dirty linen of infected household member(s) to prevent spread.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 # 22]: The coverage of three cloth face coverings for the waiver participant to promote compliance with the mask mandate made effective on June 26, 2020, by Governor Cooper. The flexibilities also cover a tablet or smartphone for identified waiver participants to promote telephonic/electronic engagement with service providers for telehealth, monitoring and linkage. It is restricted to individuals who do not have access to tablets or smartphones through the State Plan. The approval of a smart device does not include minutes or data in addition to what is included in the initial device purchase. Also covered is non-medical transportation to Adult Day Health programs when transportation is needed and not available through the Adult Day Health program.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: A one-time purchase order process for each approved service to promote an on-demand quick procurement when the goods and services are available in retail.

Training/Education/Consultive Services

- Covers training for the paid worker on the use of personal protective equipment (PPE) and other identified training needs specific to the care needs of waiver participants to prevent the spread of COVID-19.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: A one-time purchase order process for each approved service is permitted to promote an on-demand quick payment of training/education/consultative services.

In-home care, pediatric nurse aide, personal care assistance and congregate care

- Services are not required to be used on a monthly basis. Services approved in the service plan may be rendered in various amounts, frequencies, durations and settings, but no less than what has been approved in the service plan. Covers payment to in-home care, pediatric nurse aide, personal care assistance and congregate care to a non-live-in close relative or legally responsible person for waiver participant whose hired worker is not able to render the service because of impact from COVID-19.
- [No updated flexibilities were added to this service from SPECIAL BULLETIN COVID-19 #22.]

Community transition

- Covers a less than 90-day institutionalized Medicaid beneficiary experiencing COVID-19 symptoms who can safely transition to home- and community-based placement using HCBS services.
- [No updated flexibilities were added to this service from SPECIAL BULLETIN COVID-19 #22].

Meals

- Covers one lunch meal per day for aged and disabled adults participating in CAP/DA who are approved to receive meal preparation and delivery and their meal delivery services are suspended due to COVID-19.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: The coverage of a home-delivered meal when a waiver participant is assessed to need a meal during the public health emergency. This service may cover one food delivery meal (e.g., Uber Eats, DoorDash, Grub Hub, frozen meal or similar service) per day.

Home accessibility and adaption

- Covers germicidal air filters.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: A one-time purchase order process for each approved service to promote an on-demand quick procurement when the germicidal air filters are available in retail.

Retroactive approval dates

- Allows retroactive approval dates to the effective date of the Appendix K when services are needed and the waiver beneficiary, caregiver or provider is impacted by COVID-19 and cannot complete the service plan.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: Allows a retroactive service approval date for up to 30 calendar days of the request during the activation of the Appendix K when services are needed and the waiver beneficiary, caregiver or provider is impacted by COVID-19 and cannot complete the service plan.

Telephonic contact

- Allows changing required quarterly face-to-face visits to a quarterly telephonic contact when waiver beneficiary, caregiver or the provider is directly impacted by COVID-19.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: Clarifies that only monthly and quarterly telephonic contact is permitted with waiver beneficiary, caregiver or the provider during the public health emergency.

Reassessment of need

- Allows extended date for annual reassessment of need (or level of care [LOC]) when the assessment cannot be conducted due to the waiver beneficiary, caregiver or provider being directly impacted by COVID-19.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22]: Permits the waiving of the annual LOC assessment to maintain continuous enrollment in the waiver through the duration of the public health emergency.

Retainer payments

- Allows the authorization of retainer payments to a direct worker in the amount, frequency and duration as listed on the currently approved service plan when a waiver participant or hired worker is directly impacted by COVID-19.
- [Newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22 through all the following bullet points]:
  - Only authorizes time-limited (maximum of three 30-billable-day periods) retainer payments to an essential worker in the amount, frequency and duration listed on the currently approved service plan when a waiver participant or hired worker is directly impacted by COVID-19.
  - To promote oversight to avoid duplication of billing of retainer payments, the oversight includes:
    - Individual workers are required to sign an attestation prior to claiming retainer payments in which they must attest to following the rules.
    - Retain their availability to the specified waiver participant to assist with activities of daily living (ADLs) and instructional activities of daily living (IADLs) that are consistent with an approved service plan when it is safe to return to the home.
    - Not file an unemployment claim while a retainer agreement is in progress.
    - Report to the waiver case manager the occurrence of a layoff by an employer when a retainer payment is executed.
    - Receive the maximum reimbursement rate or wages per the planned pay period for approved hours/units in an active service plan approved before the retainer agreement was initiated.
    - Agree to receive a maximum of three retainer agreements for one specified waiver participant.
    - Agree that the retainer agreement is only authorized when the waiver participant is sequestered and is not able to access needed services.

Provider organizations that accept a retainer payment agreement for a specified worker cannot receive duplicative payments and must adhere to the following requirements:

- The provider agency is not able to bill retainer payments on behalf of staff that are laid off.
- The provider agency's retainer payment claims must be adjusted to account for any layoffs if a staff member is laid off.
- [The newly updated flexibilities from SPECIAL BULLETIN COVID-19 #22 – This statement was added]: Clarifies the expanded HCBS listed in the Appendix K and the other waiver services

listed in the CAP/C and CAP/DA Clinical Coverage Policy may be extended as authorized by the State, within reasonable limits.

The following eight items remain the same as in SPECIAL BULLETIN COVID-19 #22.

- Home accessibility and adaptation. May exceed the waiver limit of $28,000, when determined necessary and qualifying conditions are met.
- Equipment, modification and technology. May exceed the waiver limit of $13,000, when determined necessary and qualifying conditions are met.
- Case management units. Allows additional monthly reimbursement of case management time when determined necessary as evidenced in case notes to manage needs of the waiver participant experiencing COVID-19 symptoms and ensure linkage to necessary resources.
- Participant goods and services. May exceed the $800 fiscal year limit, when determined necessary and qualifying conditions are met.
- Assistive technology. May exceed the CAP/C waiver limit of $28,000, when determined necessary and qualifying conditions are met.
- Training/education/consultative services. May exceed the $500 fiscal year limit, when determined necessary and qualifying conditions are met.
- Respite. May exceed the 720 in-home respite hours per fiscal year for in-home and coverage of 30 or more days in an institution, when determined necessary and qualifying conditions are met.
- Cost Limits. Allows the established cost threshold for waiver enrollment to be exceeded, based on averages, if the individual care needs are more than the waiver year cost neutrality projections.

Read the Official Bulletin

Any questions about this Communication Bulletin *that does not already have an email listed for questions from that specific section*, may be sent to the following email: NetworkManagement@TrilliumNC.org. These questions will be answered in a Q&A format and published on Trillium's website.