

Transcript for Innovations and TBI Waiver Appendix K Webinar
April 21st, 2020
4:30 - 5:30pm

Presenters:

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Mya Lewis, NC Department of Developmental Disabilities
Kenneth Bausell, IDD Manager, NC Medicaid

Hugh:

Good afternoon everyone. It is 4:30. Let's get started.

Thank you for participating in today's webinar about COVID-19, and the NC innovations and NC TBI waivers. This webinar is for providers. This is a repeat of the webinar originally held on April 7th. We apologize for any inconvenience. This forum is put on by the I/DD team from NC Medicaid and the NC division of Mental Health, Developmental Disabilities, and Substance Abuse Services. You'll hear from a team of experts from those divisions discussing recent updates to the waivers, and the response to COVID-19, and what those updates mean. We will then take your questions and the team of experts will respond to them. My name is Hugh Tilson. I'll be moderating today's forum. Before I turn it over to Mya, who will introduce herself and today's speakers, I'd like to just take a brief moment to thank everybody for making time to participate in today's webinar. Your work is really important. We hope that the information provided today will help you do that work a little bit better by understanding these important changes that will help you make navigating these trying times a little easier.

Next slide, please.

After the panelists provide their updates, we'll turn to your questions. We've learned from past forums that the presenters will often address your questions during the presentations. We'll have time to get to your questions. I encourage you to wait until the presenters are through with their presentations before submitting a question. If you are participating through the webinar, please submit your questions using the Q&A function on the black bar at the bottom of the screen. It's that Q&A function on the black bar on the bottom. If you are on the phone, we can't take your question. You can submit questions for response later to bhidd.covid.qs@dhhs.nc.gov. And that was on the announcement for this webinar.

Lastly, we'll record this webinar, make the slides, a written transcript of the webinar, and make the recording available to the public soon. Now let me turn it over to Mya. Mya, thank you so much.

Mya:

Thank you for that information.

Welcome everyone to the Appendix K webinar, and the focus of this webinar is for our providers. Thank you for participating, and please know that we will allow time at the end of the webinar for questions, and we will address those questions that come through the Q&A box.

Today with us on the call we have again the teams from the Division of Mental Health, as well as Medicaid. And so myself, Mya Lewis, on the call. We also have from DMH, LaToya Chancey, and from NC Medicaid we have LaCosta Parker, Michelle Merritt, and Kenneth Bausell, whose voice you will hear once I'm finished.

As a reminder, we want to make sure we respect the privacy of the individuals whom we serve. So if there are specific questions geared toward specific individual situations, we ask that you please hold those and email those so that we can address those individual nuances one on one. Also, I encourage if there are any families or individuals on the call, make sure that you reach out to your care coordinators, with your LME/MCO, to address and get support with those specific individual questions. Again, this webinar is geared toward providers. So we hope to hear those questions from providers during this time.

Next slide.

And I am going to turn it over to Kenneth. As a reminder this is a discussion about the North Carolina innovation, and the North Carolina waiver flexibilities that have been approved by CMS related to COVID-19 . These flexibilities were approved for both waivers. And we will provide a little more detail about what those flexibilities are. Alright, thanks. Kenneth, take it over.

Kenneth:

Okay, I hope everyone can hear me, and thanks for joining us today. And like Mya said, this presentation is on the North Carolina Innovations and North Carolina TBI waiver flexibilities that were approved by CMS related to COVID-19 through a process known as the Appendix K. And simply put, an Appendix K is just a way to ask for changes when there is a disaster. And the purpose of Appendix K for COVID, and for the Innovations waiver, and the TBI waiver, is to allow for services to be delivered in a more flexible way. Allow for people to get the services they need, and to allow for social distancing.

Please note, should the COVID-19 situation change, Medicaid could consider asking for additional flexibilities or revising the Appendix

Ks. And we are actually in the process of looking at a second wave for some other types of changes that we want to make. And for more information on Appendix K in general, you can Google CMS and disaster kit, and it will pull up some information about Appendix K as well as some other waiver authorities that can be used for Medicaid services when you are able to have a disaster, or when a disaster happens.

Next slide.

So the Appendix K timeframe. These flexibilities are effective March 13th, 2020 through March 12th, 2021. Or when COVID-19 resolves, whichever is first. So in the last few hurricanes, we have asked for Appendix K flexibilities in 90 day increments. For COVID-19 we asked for a full year of COVID-19 flexibilities because we do not have much experience with pandemics, or how COVID-19 will affect our state. We did not want to ask for flexibilities in 90 day increments, as it could cause some self-created tension points, and those self-created tension points could be exacerbated in the event that federal or state staff become ill with COVID-19. So again that is the reason we chose to go for a full year, which is the maximum amount of time an appendix Appendix K can be requested.

With that said, we will assess regularly and communication will come out when the NC Innovations and the TBI waiver flexibilities are no longer needed, and to determine the glide path. So again, we've asked for this for a full year, however if things begin to be solved sooner, these flexibilities might not extend for a full year. If we continue to have issues with COVID-19, then there may be some type of extension.

Next slide.

So for the next grouping of slides, we are really going to go through what specifically is in the Appendix K and what flexibilities are offered.

So the first one is one service per month. Beneficiaries who receive fewer than one service per month during this COVID-19 amendment period will not be subject to discharge. So waiver participants who do not use a waiver service during this amendment will not lose their ability to receive waiver services. As we know, in order to remain on the waiver, both innovations and TBI, you must use one regular waiver service per month. During this Appendix K timeframe, a person will not need to use one waiver service per month. However, if a person is not using one service per month, the care coordinator will reach out to monitor the person on a monthly basis.

The reason for this increase in monitoring is because we won't have the typical direct care check in with the person, and we want to be able to catch any changing health or non health support needs. So if we catch a changing support need, then it gives us the opportunity to address that changing support need because the person is not receiving services. Typically, the direct support professional at the provider agency, who's in the person's life on a daily basis oftentimes will see that change and be able to make recommendations, or request additional care. Because the service isn't occurring, then we want the care coordinator to be able to have that general oversight to catch changes as needed.

Next slide.

The next is to temporarily exceed service limitations. This allows for an increase in service hours from what is in the person centered plan, or the individual support plan, without prior authorization. Service limits in the ISP may be exceeded in the amount, frequency, and duration in the plan to meet the needs of the waiver participant who is impacted by COVID-19, and needs new waiver services. Additional services provided based on the member's needs, and that's an important point.

So, what does this all mean? This means ~~that~~ the amount of service, or how often the service happens. So again we're talking about the amount, frequency and duration. That's the amount of the service, and how often the service happens. Examples of this could be an increase in services during the typical school time, because school is now out. In this example, the increase could be community living supports, community networking or supported employment. Again going to those typical nonschool hours because school is now out on a different schedule. This could also be a shift from day supports group to day supports individual because there is no group available. And again going back to those additional services provided will be based on the member's needs. The reason for this justification for additional services should be documented, and this waiver of prior authorization is only during the time Appendix K is in effect. Documentation justification is needed as it is important to understand why these flexibilities were used, and to help us understand the effectiveness. It is also important to note that staff will be awake, and staff sleep is not reimbursable. So the same kind of rules around staff sleep.

Next slide.

So this is a just a continuation of no prior authorization. When services are increased without prior authorization, the provider agency will maintain the following elements:

- The reason for the increase in services.
- The current risks.
- The current services approved.
- Currently approved units.
- Increased services,
- and increased units.

The provider agency will provide this information to the LME/MCO in the way communicated by the LME/MCO to the provider networks. And again this is important for a number of reasons. It is important to capture so that we have an understanding of why additional are being provided. Again going back to the previous slide. It is important because it will give us a picture of what the overall COVID-19 response looked like, and it will also give us the opportunity to learn and apply that knowledge for future events, and in the event of audits. So we know that in the past couple of years we have had some physical disasters. So we want to be able to learn from each one of our disasters so that when these things happen, information can get out quicker. So responses and flexibilities that are the most useful can be used right away, and so that we are not reinventing the wheel. So we're really trying to use this as a learning environment.

The other aspect of the audits is really important too, because we know that there will be questions regarding the COVID-19 response, right? So we want to be able to provide information on how the flexibilities we are allowing for, or CMS is allowing us to allow for. How effective those have been, and how they are actually helping people having a better supported life.

Next slide.

So the next slide is service location and flexibilities. All of these flexibilities on these slides allow for social distancing, and for people to receive the services where they live. That is the general framework of the slide. It waives the requirement to attend the day supports provider location once per week. So we know that in the innovations waiver, and in the TBI waiver, you can have day supports predominantly in the community. However, once per week you have to basically touch the day supports facility. So, with this Appendix K we are waiving that because we don't want someone to have to go to the day supports facility with their staff, touch the location, and then go back into the community or home. Just, again, allowing for social

distancing and not forcing people to go into the community when that's not the best option.

Day supports, support employment, community living support, and/or community networking can be provided in the individual's home, the direct care staff's home, or the residential setting. And again, when we are talking about residential settings, we are talking about the residential settings that are listed in our clinical coverage policy, and in the Innovation and TBI waivers. Those are typically group homes or alternative family living homes.

Furthermore, direct care services may be provided in a hotel, a shelter, church, or alternative facility, a setting or the home of a direct care worker, because of COVID related issues. So again, it's kind of redundant to the point above it, but it does allow for the services to be in different types of settings. So hotels, shelters, churches... things like that.

As we all know, people receive their community network and supportive employment in the community. When services are being conducted in the home, we want activities to be similar to what is being worked on, or typically being worked on in the community. But a complete redo of the short-term goals or long term goals is not necessary. Again, this is important because we know that if you are doing community networking, that's going to be in an integrated setting. We know if you are doing supportive employment, that's going to be work in an integrated setting. If those services are being conducted in the home because of COVID-19, we expect that the same kind of overarching philosophy of the goals are going to be done. However, they could pivot from being those employment or integrative support type goals. So, again, the general feeling of the service would be done in the home. But we don't want the provider agencies to have to do a complete revision of all of the services and the goals.

Next slide.

Respite flexibilities. This one is a little bit more straightforward. It allows respite to be provided when a family is out of state due to evacuation or displacement. It also allows out-of-home respite to be provided in excess of 30 days on a case-by-case basis. Importantly as well ~~information~~ is that if the out-of-home respite provider is outside of 40 miles from the North Carolina border, the North Carolina Medicaid and/or the LME/MCO will need a provider agreement with the out-of-state per Olmstead. That is kind of just the technical information that we need based on Olmstead. For a background about out-of-home respite, and why we have to waive this, is that out of home respite is typically not allowed to be provided over 30 days

because that would indicate that the person does not need or meet ICF/IID levels of care and is not benefiting from the habilitation component of the service. So that's why we typically don't have respite occurring over 30 days, or out-of-home respite occurring over 30 days. With this COVID-19 situation, out-of-home respite may be the most appropriate service to keep the person healthy and safe. And therefore that is why we are waiving it.

Next slide.

The next slide deals with temporarily permitting payments for services rendered by family, caregivers or legally responsible individuals. And for these next few slides that really deal with this payment to family, caregivers, relatives, or legally responsible individuals. It only applies to the Innovations waiver. This part does not apply to the TBI waiver. It allows for relatives of adult waiver beneficiaries (adult Innovations waiver beneficiaries) to reside in the home and out of the home to provide services prior to the background check and training for 90 days. This includes supported living.

The background check will be completed by the agency as soon as possible after the service begins, and training will occur as soon as possible without leaving the beneficiary without necessary care. If the background check demonstrates the individual should not continue working with the participant long-term, the individual will be immediately determined unqualified to render services. And here, when we say allowed relatives of adult Innovations waiver beneficiaries, we also mean that could be a relative who is the employee of record. It could be a relative who is the managing employer for the agency of choice. It could be a relative who is a guardian. It could be a relative who is a parent. And it could be a relative who is a representative who is linked up with that EOR. So again some important points are;

- Even if we do not have the background checks right away, the background check will be completed by the agency as soon as possible.
- Training will occur as soon as possible. As soon as we are able to do it, start getting training going. And if the background check shows the relative should not continue working, that individual will immediately stop working.

It is also important to note that if the relative has not started working yet, and the background check shows that the relative should not continue working with the individual, the relative should not work with the individual at all. Relatives providing services must be 18 or older with a high school diploma or equivalency.

If someone has a college degree from an accredited college or university, they can show about deployment/transcript in lieu of the high school diploma. And the reason being is that if you are going to an accredited college or university, you have to have a high school diploma or equivalency before you access that level of education. With all that said, it is recommended that a relative residing in the home of the beneficiary provide no more than 40 hours per week of service to the person. This must be reported to the LME-MCO, but does not require approval by the LME MCO. If over 40 hours are needed to be provided by relatives residing in the home of the beneficiary, then the provider must maintain justification on the individual's needs, and why there is no other qualified provider.

This could lead to a relative, or a combination of relatives providing over 56 hours of service. This, of course, would need to be safe and the best interest of the individual. And that staff/relative would need to work with the provider agency. When we have situations that a relative is newly providing services, the managed care organization, or LME-MCO, is going to monitor these services, by the relative, monthly. This monthly monitoring is in concert with our current practice and how we monitor relatives providing services.

Also if a person who utilizes supportive living decides to move back to the family home, they would use community living supports once they go back to their family home, if the relative decides to pick up those hours.

Next slide.

Again, this is continued.

Regarding relatives rendering services or providing service, and only applies to the North Carolina Innovations waiver. Relatives of adult waiver beneficiaries may provide community living supports, community networking, day supports, support employment and supportive living. The MCO will provide an increased level of monitoring for services delivered by relatives and legal guardians. Again, that's going to be that monthly monitoring. Care coordinators will monitor through telephonic monitoring, documentation review. And this is being done to ensure payment is made only for services rendered, and if the services are furnished in the best interests of the individual.

Other important parts to this is that this only applies to Innovations. And it only applies to adult waiver beneficiaries. We are working on the second wave of the appendix K. And that will include the recommendation to make relatives of non adult waiver beneficiaries being able to provide services. We will have to work with CMS to see if that's approvable. But that's something that we're working towards.

Next slide.

So how will the relative get paid for this work? Relatives providing services will work through a self-directed option. That could be an agency of their choice, or it could be through an employer of record. Or a provider agency to bill for the services rendered. Again the relative of the adult waiver beneficiary will get linked up to a self-directed option, or a provider agency, and then they will begin filling those services. The relative of the adult waiver beneficiary will complete the needed service grid documentation as evidence that services were rendered. Again that goes back to some of that documentation review that the care coordinator will do to ensure that services were provided. The service grid information will be completed. Relatives providing the services must be 18 years or older, and having a high school diploma or equivalency. As we talked about in the previous slide, if you have a college degree from an accredited university or college, then it could show that diploma or transcript.

If we can go to the next slide.

The next section is to temporarily modify provider qualifications. This allows the providers' existing staff to continue to provide services for 90 days when CPR, first aid, and crisis prevention/De-escalation recertification has lapsed. What this means is that if there is existing staff, and those existing staff are having a lapse in their CPR or first-aid or crisis prevention De-escalation certification, then those can be pended for 90 days. This applies to community living support, crisis services, community networking, day supports, respite, residential supports, supported living and employment. So again typically those services that work more on a one-to-one, or a group to staff services. Staff should come into compliance with that CPR, first aid, or crisis prevention training as soon as possible after Appendix K flexibilities expired. Again this allows for existing staff to continue to provide services when they have a lapse in those certificates, and this only applies to existing staff. At this time this does not apply to staff who are newly hired.

The reason that we chose to move forward with this, is because we do not want people to begin losing staff or have staff not be able to provide services during COVID because they cannot get training. Because it would not be in the best interest of the individual or the staff to go to those group trainings. With all of that said some of these trainings can be done online too. And some provider agencies will choose to have the majority of these done online. Of course, the CPR part of it needs to be in person.

The next is to temporarily modify processes for level of care evaluations, or re-evaluations. So annual reassessments of level of care that exceed this 60 day approval requirement beginning on March 13 2020, will remain open, and services will continue for three months to allow sufficient time for a care coordinator to complete the annual reassessment paperwork. What this is talking about is the level of care that someone needs to meet in order to maintain the Innovations or TBI waiver .

We want to make sure that again we do not have any bureaucratic processes that are forcing people to get paperwork signed that does not allow for social distancing. With all of that said, additional time may be awarded on a case-by-case basis when conditions from COVID-19 impede the process. Annual reassessments of level of care may be postponed by 90 calendar days to allow for sufficient time to complete annual reassessments, and accompanying paperwork. Simply stated, the annual reassessment of level of care will remain open. Services will continue for three months to allow for the care coordinated to complete the annual reassessment, and additional time may be given on a case-by-case basis. That is just a little bit simpler but for all the words.

Again, why we are doing this is that we want to allow for social distancing, and account for the fact that many offices are closed. It may be difficult to get some of the paperwork done.

Next slide.

Payment for services in an acute care hospital or short-term institutional stay. This has an Innovations component, and then the next slide will have the TBI component. So community living supports may be provided in an acute care hospital or short-term institutional stay, when the waiver participant is displaced from home because of COVID-19, and the waiver beneficiary needs direct assistance with activities of daily living, behavioral supports, or communication supports on a continuous and ongoing basis, and such supports are not otherwise available in those settings.

The supplemental service provided in the hospital will not exceed 30 consecutive days, however there may be more than one 30 day period. Room and board is excluded.

So for that second bullet, this can occur for 30 consecutive days, then there will be a break, and if it is still needed there could be an additional 30 days. So, say the 29th day was a Friday, the service can be provided. Let's say it is the 30th day (Friday), that service could be provided. If the 31st day is a Saturday, no services will be provided. If needed, that service could pick back up on the following day and start that next 30 day period.

With that said, hospital regulation should be noted and observed because COVID-19 is infectious. There may be times when hospitals do not want additional people brought into their settings because that can cause a larger spread of the infection.

Next slide.

This is our TBI difference. Again, our TBI waiver and Innovations waiver have similar structures. However, they do have different services and supports. So the TBI waiver difference is that life skill training for behavioral intervention, and personal care may be provided in the acute care hospital or short-term institutional stay. And again, there has to be 30 days -- it cannot be more than 30 consecutive days but there may be more than one 30 day consecutive period. So again it could be the same break and starting back up. Life skill training is more of a rehabilitative focused service that also has behavioral components. And personal care is more of a service that assists with ADLs, communication, things like that. So, again, it's still the activities of daily living, behavioral supports or communication supports.

The supports would not be otherwise available in the hospital or the short-term institutional setting.

If you can go to the next slide.

I will let you look at that one briefly. We had a little bit of a lapse but this is the life skills TBI difference. Very similar information.

If you can go to the next slide.

So the next slide deals with retainer payments to address emergency related issues. And the purpose of retainer payments is to support direct support professionals/Staff. And support provider agencies during COVID-19. We know that staffing is an issue outside of the COVID-19 situation, and we do not want to come out of the situation and face a reduced staff paradigm.

Retainer payments with appendix K include retainer payments to direct care workers to address emergency related issues. Retainer payments cannot be provided from more than 30 consecutive days, there may be more than 30 consecutive day period. So again very similar to the acute care slide, there has to be at least a one day break. So again if you have services on a Friday, the 30th day, and the 31st day services cannot be provided or billed with retainer payments. And if still needed, it could come back up and start another 30 day consecutive period. The state will implement a distinguishable process to monitor payments to avoid duplication of billing. And that's just what we have to do in order to show that we are not having duplication

of billing in the sense that we are having multiple retainer payments being paid for one individual for the same services. As well as if a relative is a provider (as we will get on to in the next slide), providing the service, we want to make sure that we are distinguishing the retainer payment from the services that are actually being provided.

We are already on the next slide.

Retainer payments are for direct care providers who normally provide services that include rehabilitation and personal care, but are currently unable to due to the complications experienced during the COVID-19 pandemic. Due to the waiver participant being sick, COVID-19, or the waiver participant is sequestered and/or quarantined based on the local state[indiscernible] and medical requirements/orders. And when we were working with CMS, how "sequestered" is being interpreted by CMS and by the state is that it means our state's stay-at-home order would count as sequestering. We need to have that process to monitor retainer payments. So that would be through the use of distinct modifiers. And retainer payments cannot be made for respite.

With all that said, that is a lot of information. If a waiver participant is sick with COVID-19, that does not mean that the person has to have a positive test. It means a person can be symptomatic with COVID-19 based on criteria identified by the North Carolina division of Health and Human Services, and issued guidance related to COVID-19. This also means that a person could turn down staff because there is a stay-at-home water. This also means that a sick staff person could be covered because of a stay-at-home order, again going back to bed sequestering equaling state stay-at-home.

The only services that are available for retainer payments are services that include personal care, and/or habilitation, and that is why respite is not included. And for the innovations waiver, these services are community living supports, community networking, day supports, residential supports, supported living, and supported employment. For the TBI waiver, the covered services for retainer payments are personal care, community networking, day supports, supported living, and supportive employment.

Actually, cross out supportive living from the TBI waiver because that is not a TBI waiver service.

Also to clarify, as we talked about life skill training being able to be provided in acute care settings, and short-term institutional stays. CMS or the centers for Medicare and Medicaid services provide guidance that life skills training could not be used for retainer payments for the TBI waiver, because it does not include habilitation,

or personal care because it is more of a rehabilitative service that does not fall into this retainer payment situation.

More clarifying information regarding retainer payments. Retainer payments may only be made for innovations waiver services or TBI waiver services as they are currently authorized in the individual support plan. Retainer payments are for primary staff that provide regular scheduled services that are unable to deliver those services. And staff identified as backup staff are not eligible for retainer payments. So again it has to be a staff that is actively working these hours.

It is also important to note that the employee who is being retained will not be eligible for unemployment for those specific hours in the agreement. And relatives as direct support professionals will be eligible to get retainer payments if they were providing services on or before March 13, 2020. And more information will come out regarding retainer payments from the state and the LME-MCOs .

Another important aspect to retainer payments, is that a relative as a direct support employee can theoretically get retainer payments as well if the individual who they are providing service to had to go to a different setting or to a hospital. Those relatives as direct support professionals will be providing services on or before 3/13/2020. So, If that relative started providing these services in the COVID-19 flexibilities, they would not be eligible for retainer payments. However if they are providing services for the appendix K, they could.

Next slide.

So the next slide is dealing with care coordination monitoring flexibilities. There is a lot of words on the screen. But the simplest way to put it, is that monthly and quarterly care coordination monitoring will occur telephonically in individuals who do not receive at least one service per month will receive monthly monitoring. So again, their monitoring will go up based on the information that we talked about earlier in the slide show. Relatives who begin providing services for the individual on the waiver, they will also begin getting that telephonic monitoring monthly as well.

Next slide.

The next slide is regarding LME/MCO flexibilities that fall outside of Appendix K but I believe are important. So, effective immediately, LME/MCOs may temporarily implement desk reviews, including the use of videos of the site for managing on-site [Indiscernible] reviews and

new admissions to unlicensed alternate family living homes. Typically someone from the LME-MCO had to go out and physically see the sites. So we are saying right now that these could be done through desk reviews, which include the use of video for the site.

We have also received information about qualified professionals, and how they supervise/monitor their direct care staff. That supervision of direct care staff by the qualified professionals is not dictated by the North Carolina Innovations waiver or Innovations policy, as well as the TBI waiver for the TBI waiver policy. Supervision and monitoring is determined by the individualized supervision plan established by the provider, required by 10NCAC27G- 0104, and 10NCAC27G-0204. So if a provider agency needs to adjust face-to-face supervision with a director staff, then a qualified professional should update the supervision plan to allow for telephonic or visual supervision. We wanted to just get that general information out, because it does fall outside of the innovations and TBI waiver and therefore it is not dictated by Appendix K .

Next slide.

This is our last slide. It is regarding Supports Intensity Scale(SIS) assessments. An innovations waiver beneficiary and/or their guardian may elect to waive the support intensity scale assessment during the COVID-19 amendment period. And the SIS assessment will need to be completed after the COVID-19 crisis has ended. So again, because SIS assessments typically happen with groups of people altogether, we want to give that option that people do not have to have the Supports Intensity Scale assessment during this time period.

Alternatively though, SIS assessments may be completed virtually using the video platform, or telephonically. If an Innovation waiver beneficiary is due for a SIS assessment during the COVID-19 amendment period, the beneficiary or their guardian will receive communication from the LME-NCO regarding the option to complete the SIS assessment through a video platform, telephonically, or they may elect to waive the assessment until the COVID-19 amendment period ends. An individual or family could put the SIS assessment off until this COVID-19 crisis has ended and then they will get the SIS assessment. Or, they could do it through a video platform telephonically to get it done now, to get the information and to use it. And to really be able to get to a place where they can utilize the assessment. We worked on that language with AAIDD, which are the individuals who have developed the SIS. So this information is in concert with them.

Next slide.

So now we are done. We will have some time for questions. We want to give a special thank you to all of you for all the support you provide, and all the work that you do for beneficiaries and families of the Innovations waiver on the TBI waiver. We also want to thank the direct support professionals who continue to make the system work, as well as thanking their families who support them and do so much good work as well. We want to thank our LME-MCO partners for their continued dedication to operationalize these flexibilities. So that's the end of our presentation. And we will take some questions.

Hugh:

Great!

As a reminder you can submit questions using the Q&A function on the black bar at the bottom of the screen.

We have a lot of technical questions. Trying to filter through some of these.

One question that came up is about a second appendix K being sent. When will that be sent to CMS?

Kenneth:

We are working on finishing up the second wave of the Appendix K now. Hopefully that will go to CMS either at the end of the week, or next week. We will provide information to CMS to get their general feedback. And then we will make the submission. We will work with them to get an approval. As all of you know, we submitted the Appendix K on March 13, 2020. It took a little bit of time to get a formal approval. A lot of information is going to CMS with a lot of back-and-forth kind of questions. We want to make sure the information we give to them is as clean as possible. If there are any technical types of language that we would need to include, that we do that. We are working to try to complete that now.

Hugh:

Great.

Have some questions about telehealth. Can respite be provided by telehealth?

Let's start with that one.

What innovation services can be provided with FaceTime telephonic means?

Kenneth:

We are actually still working on the telephonic kind of mechanisms for innovation services being provided. More guidance coming out regarding that. We do know from CMS that respite cannot be done telephonically. However we are working to see if we need to submit anything additional to determine what services could theoretically be done through innovations telephonically. We do know that in order for a service to be provided telephonically, through innovations, if it is one of those services that is more of a direct care service, the person would need to be able to benefit from queuing. And it would have to be indicated clinically for that individual. We would have some individuals on the Innovations waiver for those direct care services that may not benefit from the telephonic provision of services based on our current understanding with CMS. We are working on trying to get more information out around that.

Hugh:

Have some questions about billing. When can we expect more information about retainer payments? Let's start with that.

Kenneth:

Right now I would suggest reaching out to your LME-MCO. Your LME-MCO is the one who is operationalizing retainer payments. They are working on that now. And then more information regarding the generalized framework for retainer payments will be coming out through a Medicaid bulletin or a joint communication bulletin.

Hugh:

Will that include modifiers for the retainer? Will the LME-MCOs have standardized processes for providers to submit invoices and claims for retainer payments?

Kenneth:

Retainer payments are going to be done in one of two ways. The first way is using two modifiers. So that would be the CR modifier and the XU modifier which will be attached to the billing. The second way would be through an invoice process. Because it takes a little bit of time to get modifiers loaded up to the systems. Some LME/MCOs may use an invoice process before they have those modifiers ready to go, in order to get the retainer payments operationalized quickly.

Hugh:

I am looking through the questions.

Mya:

Hugh?

Hugh:

Yes.

Mya:

While you are looking through the questions, we have a question posed regarding retainer payment for state-funded services. And if those individuals are eligible?

To answer that question. Retainer payments in this discussion are only pertaining to those innovation waiver and TBI waiver services. Only Medicaid waivers. Retainer does not pertain to state-funded IDD services. Thank you.

Hugh:

We have a question about relatives determined to be unqualified to render services. Would they be denied for all services retroactively, or only after the date of the determination? [That] may be too technical.

Kenneth:

What is in the Appendix K right now is that there is going to be the background check as soon as possible. If it is known that the individual should not have been providing services, that is an issue. If the background check comes back later and shows that the person should not be, sometimes there are delays, but that's a different situation. I think that the best thing to do is to work with your LME/MCO when you become aware that the relative should not be providing services.

Hugh:

Related to LME/MCOs. Flexibilities are for a full year. Can an LME/MCO give three months authorization or should we strictly follow authorizing services for the year?

Kenneth:

As stated in the beginning of the webinar, Appendix K flexibilities right now are for a full year, however, the reason why we get a full year was because we have not experienced a global pandemic before. Or a pandemic that hit North Carolina. We do not know yet how COVID-19 will resolve. We have some promising data about how social distancing is working. We have other areas in the country and the world who are beginning to ease restrictions. So it may make sense for LME-MCOs to think about things in 90 day chunks, because if things start to resolve, we may shut down some of those Appendix K flexibilities before the full year. As we talked about in the beginning as well, if things start to resolve sooner, we will determine what that glide path would look like to get back to our normal policies.

Hugh:

Do you know whether there will be rate increases in services such as community living and supports?

Kenneth:

That will probably be a better question for the LME/MCOs. So the LME/MCOs have rate setting authority for the Innovations and the TBI waiver services. I know that some LME/MCOs have increased their rates for certain services. So that would be best asked of your LME/MCO.

Hugh: [long pause]

I am still here, I am just processing all of these.

Are all LMEs doing retainer payments?

Kenneth:

Correct.

So LMEs are working on operationalizing retainer payments.

Hugh:

If we already laid off staff, can we use retainer to bring them back?

Kenneth:

I think that may be a little bit too much of a technical question. As we talked about on the slide. A person cannot get retainer payments and unemployment [benefits] for that segment. Theoretically, if

someone was no longer taking on unemployment, they could utilize retainer payments.

Hugh:

If community networking is provided at home, does it require a modifier when billed outside of flexibility services [Indiscernible] provided in a person's home?

Kenneth:

Not at this time.

The LME-MCOs do operationalize our waiver services. So if they are trying to track those in a certain way they may ask you to do a modifier. But from a state level, if a service is being done in the person's home, or if there are any of the flexibilities, the LME-MCOs are going to have to report on those. There may be some usages of modifiers.

Hugh:

Are retainer payments available for B-3 services?

Kenneth:

Currently retainer payments only available for 19-C Innovation services, and 19-15 C TBI waiver services. We are currently working internally to determine how retainer payments could be utilized for B-3 services, however that's not a closed issue yet. More will come out on B-3 services and retainer payments.

Hugh:

Is there a requirement for LME-MCOs to monitor on-site long-term location supports, LTVS? Can they go telephonic or desk review?

Kenneth:

Can you repeat what that service is?

Hugh:

LTVS. Long-term Vocational Supports?.

Kenneth:

Mya, can you take that one.

Mya:

If we are talking about the monitoring of the service by the LME. Not the provider agents, but the LME. Then we are following the flexibilities around the care coordination monitoring that's happening on the Appendix K for those state-funded services. So that telephonic connecting and interacting with the individual or family from LME monitoring appropriate for state-funded long-term services and support.

Now, there is also a question about supervision and provider supervision of the staff. That supervision is based on the provider's individualized supervision plan for your staff. If you have updated your supervision plan for staff to include telephonic monitoring, and follow-up, then that would be appropriate. But your provider monitoring of staff is based on what your providers individualized plan is for those individuals.

Hugh:

Can staff providing residential support in a group home also bill for DSC and SC during the appendix K?

Kenneth:

Can you repeat the question? Can group staff also bill for supportive employment? Is that the question?

Hugh:

[thinking] A series of letters. DS, CN AND SE.

Kenneth:

Okay. Okay, got it.

Can a residential provider bill for day supports(DS), community networking(CN) and supportive employment(SE)?

Theoretically, yes they could. As you know, not all residential settings have those services in their contract. So you'll want to reach out to your LME-MCO regarding contract flexibilities and/or if there is an invoice process. But that periodically could happen.

Hugh:

Is there a lower age limit for relatives to provide waiver services?

Kenneth:

The age limit remains at 18.

Hugh:

Any flexibilities for medication administration training?

Kenneth:

Not at this time.

Hugh:

Not all MCOs have released information regarding retainer payments. What are your expectations, and do they have a deadline for publishing this information?

Kenneth:

We will continue working with LME-MCOs regarding retainer payments. I think it is important to note that we have only done retainer payments in our state during two different hurricanes in the eastern part of the state. So there has been a lot of work going into how to operationalize retainer payments. You will be seeing more information coming out soon.

Hugh:

Can AFL providers provide day supports, community networking, and support employment to the beneficiary in their home?

Kenneth;

The primary AFL staff cannot at this time provide those services to the individual in their home. But another staff could. With our second waiver of appendix K, we are asking to waive the requirement that primary providers cannot provide any other service. That is what we are working on with our second wave of Appendix K.

Hugh;

If the members are receiving supported living level III and [indiscernible] support is providing night supervision, can the provider still bill the one unit for the day since the hours of service were provided?

Kenneth:

Can you repeat the question?

Hugh:

I'll try.

If a member is receiving supportive living level III, and a natural support is providing night supervision, can the provider bill the one unit for the day since the hours of service were provided?

Kenneth:

If the supported living service was being provided, that supportive living service could be billed.

Hugh:

Okay. We have a number of other questions that are even more technical than this. I think what I am going to do is forward them to you all, so you can respond directly to those who have submitted them. Since we're almost out of time, what I would like to do is thank everybody for making time for this webinar. And to thank you all that were panelists for your great presentation and your expertise, and all the work you are doing not just tonight but to make these changes, and making this process better for everybody. So let me thank you for that. And let me turn it back over to you all for any final and closing words to the people who are on the line.

Kenneth:

Again, thanks everybody for being on this call with us. We apologize for the issue last Tuesday. We will work to get this recording and this information posted. Again we just want to thank you all for the support you are providing to individuals who need that support. We also want to thank all the direct support professionals who continue to make our system work. We want to thank our LME-MCOs for their continued engagement, and work on this as well. We hope to have more information sharing time with you all. And to get more of your questions because that really helps us as we are trying to make people

able to have the supports that they need. Thank you all again for joining us.

[Event Concluded]