Alliance Questions Submitted to HCPF on 3.25.20

1. **Retainer Payments**
    a. Has there been any discussion around whether or not retainer payments will apply to other services in addition to SCC/SH? Services of particular concern include:
        i. Supported employment
        ii. Prevocational
        iii. Residential (e.g., if the person's family takes them home with them)
        iv. Massage & movement therapies (aren't these considered habilitative, and therefore fit w/in CMS guidance?)
    b. Can PASAs bill for retainer payments when the individual served declines services due to wish for social isolation? (We assume yes, but want to make sure)
    c. Has HCPF indicated whether or not they are considering allowing other providers outside of day programs (speech, movement, PT/OT, massage, etc) to bill for services approved in the PAR if the clients refuse telehealth AND in-person services? Lots of people are just dropping services.
    d. If we decided to call our clients to check on them and briefly socialize can we still bill for retainer payments? We are not billing for those phone calls.
2. **Administration/Billing**
    a. Will HCPF consider waiving the 240 TCM cap for this FY and indefinitely until this is all solved?
    b. Will HCPF/CDPHE protect providers from COVID-19 era claims being audited against non-COVID-19 requirements in the 7-year window for auditing claims? E.g., all the guidance and updates coming from regulatory agencies are not covered in regulation or billing manuals which are the basis for audits.
    c. If people want to go home to family, will family be able to be paid? If people want to go home to family and if family is not paid, will there be the ability to return to the agency post the pandemic without losing one's funding slot?
    d. For parents who still have to work, have a child with a disability and are on a waiver, and the child is out of school due to Covid-19, and the child is under the age of 12, can parents use respite services while the parent is working at this time?
    e. I know they are dealing with perhaps extending the time period on a person needing to receive a service within 30 days to maintain Waiver eligibility. A nuance to that is whether billing retainer units for a person would be sufficient to maintain eligibility?
    f. Alternative Delivery- of Services-
        i. Does this need to be documented in Service Plan or just documented in provider records, memo does not state Service Plan?
        ii. Since we cannot safely be out in community for SCC or truly accomplish SCC in any alternative delivery method, can we bill available SCC units as Spec Hab or do we need, in each and every case, to revise the Service Plan to re-allocate the units from SCC to Spec Hab – that re-allocation

will be hard to predict since the duration of this crisis is hard to predict. (We don't think this is necessary but want to make sure)

3. **Residential Questions**
    a. With many services previously done in group settings, even with the opportunity to provide the service in an alternate location due to a variety of reasons most individuals are receiving fewer services. This has shifted more of a burden to residential services. Has any thought been given to any temporary increases to services to support these providers? (i.e passing through the 6.2% FMAP to residential for just this period of time?)
    b. Can CDPHE/HCPF allow providers to go over census at GHs and PCAs in the case of need to isolate residents or deal with staffing shortages? If PCAs increase to 4 or more, can the GH licensing process be temporarily waived?
    c. Outings w/ parents/guardians: Unfortunately, we don't even know where the parents/guardians are going with the individual in service or who they are being exposed to, i.e. family members, friends, public outings, etc. When the parent/ guardian returns the individual back to the group home (or Host Home), how should we handle the situation knowing that the individual may have been exposed to the virus and potentially could introduce the COVID-19 into the group home (or Host Home Provider, who may have 1-3 individuals in there Host Home). Should we not allow the individual back in the setting knowing that the individual may have been exposed to COVID-19 and could potentially expose other vulnerable individuals within the group home or host home? (This could be communicated up front to the parent/guardian that if they remove the individual from the residential setting that the individual will not be allowed back into the residential setting.) Or, should we take extra precautionary screening processes prior to allowing the individual back into the residential setting?
    d. We have issued a letter to all Host Homes letting them know what steps our agency is taking to minimize the spread of COVID-19. We're hoping they take some of the same precautionary measures. As independent contractors, we don't want to cross the line in giving them demands. Are you giving Host Home Providers any special "guidance" for minimizing exposure outside of their house, especially since they are being paid with Medicaid dollars?
    e. We have a core group of DSPs staffing the group homes. This is the area I view as the greatest risk for virus spreading simply due to the number of staff and shifts required to safely operate the homes. Does the state recommend implementing a working quarantine? What would that definition be? How would we enforce it? (I.E. if a staff person goes out partying one night and posts pictures of themselves on social media, can we as an employer do anything about that?)
    f. Will there be a general protocol or recommendation from CDPHE/HCPF for responding to a COVID-19 diagnosis for an individual in a HH setting? ***(Also submitted to CDPHE)***
4. **Telehealth**

a. Can telehealth be expanded to Massage Therapy? Some providers would like to provide remote massage, video guided techniques, and send resources to families.
b. Do we know if HCPF plans to send guidance for SLS services and if we can utilize telehealth?
c. Will residential agencies have the liberty to do remote services and supports during this time and bill accordingly? (Presumably this would be in situations where the person lives in their own apartment and/or where 24/7 support/supervision is not required)

5. **Non-Residential Services**
    a. What can be considered "alternative locations" for day services? Specifically, can SCC services be provided in the individual's home?
    b. Should homemaker services still be provided in the home if families choose to continue these services, and if so, how?
        i. Some providers are asking the CCBs to ask the individuals/families that receive homemaker services to provide their own cleaning supplies so when the provider comes in to clean, the provider isn't taking their mops and brooms and such into multiple houses and increasing the possibility of cross contamination from one home to the next. Is this an appropriate role of the CMA? (It seems families should have these supplies on hand, but providers are stating that the families either don't or won't provide their own cleaning supplies to avoid possible contamination.)
    c. What is the expectation for providing SLS services with only mentorship being approved for phone/video (groceries, med apts, etc.) if an individual is diagnosed with COVID-19? Who is responsible for setting up the contingency plan?
    d. We are looking for guidance on hands-on Personal Care (although it probably also applies to personal care tasks in residential settings) from the recent Operational Memo (OHM 20-023). We're being told there are no service modifications, but we're also being told that all services must be provided using social distancing. We haven't figured out how to bathe someone from 6 feet away yet. The CDC and CDPHE are also recommending not using masks if both the caregiver and client are apparently well. Some guidance around how best to protect personnel and clients during essential hands-on care would be really helpful.
        i. Also along the lines of "no modifications" to Personal Care and Homemaker, we're wondering why there isn't the ability to do prompting for tasks via telephone or web conferencing? There seem to be opportunities for clients to continue to get needed support in these areas while not exposing either client or employee.
    e. Job Coaching/Supported Employment: Many businesses have laid people off that have one-to-one job coaches and the provider can no longer support that job coaching position. Will there be any relief for agencies who rely upon these revenues as employment opportunities for people with IDD decline?

6. **Workforce**
    a. U.S. Families First Coronavirus Response Act is causing many providers to ask how they will pay for employees that take leave, especially if they are furloughed.

Is the state planning to offer any relief? Otherwise, providers may not have a choice but to fire employees, so they can get unemployment.

b. Can the state waive its references requirements for new hires to help providers cover staffing shortages?
c. Some states are shutting down background screening and fingerprinting because they're considering new hires "non-essential". As we work through plans to onboard staff without physical contact via technology and other resources, my concern is what will happen in CO if/when those agencies stop their services. We expect that we'll see a sharp rise in applicants due to other companies closing day programs, restaurants, etc. We want to be sure we can get these people onboarded when that happens. Not an issue at the moment, but I do fear it will come soon and wanted to put that on your radar.
d. Essential Personal
i. It is our understanding IDD providers are covered under the March 22 Order guidance, and Denver. However, because the stay-at-home orders are being released at the local level, some providers are unclear if they are (or will be) covered. Do you have any guidance on this? ***(Submitted to CDPHE as well.)***
ii. In light of the shifting stay at home orders, etc., what services does HCPF consider essential vs. ones that should probably not be provided at this time? For example, what about respite for CES?

7. **Other**:
a. Any idea what is going to happen with EVV? Will it be postponed or delayed?
b. How will the state ensure that funds from the 6.2% FMAP increased get passed through to providers to help them cover unreimbursed costs? If this results in rate increases for services, can HCPF ensure that level 7 rates receive a commensurate increase as other rates?

FYI- Families First Coronavirus Response Act- You will likely get questions. We are working with our federal association and contractors to learn more and provide guidance.

- Does paid sick leave apply to people who have to self-isolate due to traveling to the mountain communities?
- When will we know if we are considered Health Care Workers and which workers will this include? Will behavior services be included since they work directly with the clients and families? *US DOL will be making this determination, but it is a big issue for CO IDD providers!*
- Would defining us as "healthcare workers" under federal wage and hour laws require a HCPF rule change?
- Would paid sick leave have to be continuous? For example, if we could get staff who were symptomatic enough for telehealth work to cover 20 hours, could paid leave cover the other 20? And continue this for 4 weeks to fully use that benefit?
- Per FFCRA, related to expanded FMLA provision, it states that after the first ten days of this leave, an employee will receive ten remaining weeks of leave paid at a rate not less than two-thirds of the employee's regular rate where qualified. For this can an employer

require the employee to use emergency sick leave or other paid time off in conjunction to cover unpaid leave portion?

- Related to FFCRA, for employees who have been furloughed and are not actually working or "clocking hours", where their situation may qualify for either the emergency paid sick leave or expanded FMLA impacted by COVID-19, would they be able to have these benefits?

Alliance Questions Submitted to HCPF on 3.16.20

1. Will the state make allowances to extend due dates for annual trainings that pertain to groups? *E.g.,* QMAP and SAFETY CARE? We will need extensions in order to not bring people together in close quarters.
2. Will there be funding for our residential agencies to have people at home versus day program?
3. Can you provide spec hab or day services in the home if day programming is interrupted for individuals?
4. Will there be a stipend given if we are required to pay employees outside of the 4 approved sick days?
5. Will there be a general protocol or recommendation from CDPHE/HCPF for responding to a COVID-19 diagnosis for an individual in a HH setting?
6. What is the expectation for providing SLS services (groceries, med apts, etc.) if an individual is diagnosed with COVID-19? Who is responsible for setting up the contingency plan?
7. How does the CMS COVID-19 Emergency Declaration Health Care Providers memo apply? https://drive.google.com/file/d/1xbN_auzsQudsdMVgxb5xCoAhRHZ-2gVX/view
8. Will HCPF provide guidance for community-based and in-home services? This will likely lead to additional questions.
9. If we need to shut down how will billing be affected?
10. Is Colorado planning on submitting an "Appendix K" for each of the state's 1915c HCBS waivers to provide flexibility for the provision of services during the coronavirus outbreak?
11. Is HCPF giving any consideration to any type of emergency funding should we have to close day programs or group living situations, pay lots of overtime for staff, lose additional enrollments due to attrition, etc.?
12. Are there "Business Interrupted Funds" available to providers? Federal or State?
13. What options does a residential agency have if a client tests positive for COVID 19 and the host home refuses to let them return?
14. What do we do if staff in a group home refuse to work with folks or host home providers call and tell us they won't care for their clients anymore?
15. This will likely cause lots of capacity issues. For example, who is going to volunteer to do respite for someone who has or has been exposed to COVID-19? What flexibilities can help us address these shortages?
16. COVID-19 is causing clients to request telehealth sessions in increasing volumes but HCPF seems to be denying some services that were outlined in HB17-1094. Can we get some clarity/flexibility, as there is a high request for telehealth services?
17. Will this delay EVV implementation?
18. Retainer Payments:

a. Do providers bill the same rate for retainer payments?
b. Do retainer payments include transportation?
c. Do retainer payments include community connector day programs?
d. Will state retainer payments cover:
in home therapies (massage; music, etc)
in home personal care
employment services
transportation
Do retainer payments apply to supported employment?
Do retainer payments include behavior therapy services that were approved?
Will retainer payments apply to State fund day hab services?
e. The memo regarding retainer billing mentions that in order to bill there must be authorization and documentation in the service plan. Is there a process for getting this done?
f. The retainer payments say they must be authorized/documented in persons plan, however the response time of CCB's with those requests are concerning. Do we request and proceed as if it will be documented?
g. What type of documentation is required for the Service Plan for the retainer payment.
h. Does the retainer payment needed to be added into service plan as a retainer or billed as normal?
i. If we provide services in different locations do we still bill the current service in the individuals plan or do we need to request a revision and bill for what the service most clearly reflects? For example if we are providing Day Program services in the individuals home but they usually attend activities in the community and have SCC units, do we need to make a revision to bill Day Hab?
j. If client chooses to stay home (or HHP) chooses can we still bill retainer units?
k. I saw a memo indicating that retainer payments need to be written in the plan. How will this be tackled?

19. Can spec hab be provided in the home as an alternative service?
20. Will there be flexibility in spend down of Family Support dollars for this year since will not be used by end of year?
21. Telehealth
a. Is telehealth for behavior counseling approved?
b. Will we be allowed to support people without face to face contact if person is ill? Our agency plans to cook, shop, etc. for people as needed.
c. Can some SLS services be provided electronically?
d. Will the state make any allowances for tele-health music/movement therapy visits?
e. According to HCPF's policy team, music/movement therapy can be offered via telehealth per HB15-1029 and HB17-1094. HCBS seems to be communicating conflicting information though, so I'd like to see HCPF coordinate internally and communicate an aligned memo on this. Also, we are wondering if massage therapy can be offered via teletherapy, via parent education.

f. There was guidance that Medicaid behavior therapy codes could temporarily be utilized in a Telehealth format. Can we seek guidance on what this includes (parent treatment planning? Parent communication via email and phone? Creating home lessons? Data analysis?)

g. Has there been any guidance regarding Early Intervention Providers being able to do Telehealth or video for their visits? (CDHS)

i. we moved out EI providers to teletherapy...there was a little guidance sent out next week but I am wondering if we need to change PARS to reflect that mode of delivery in order to get paid. Waiting on an answer for that.

22. Can you please clarify the screening guidelines - are they for both day program and residential settings or just day program settings? What if admin and day program are in the same building - do we need to implement screening guidelines for all admin staff?
23. Really good point that it will become quite problematic if people told that if they live in an area of community transmission, they should not work, or should self- isolate. Future guidance there would be appreciated.
24. Is there a list of "community-based spread" communities? It's my understanding that most cases have known exposure or its under investigation. Haven't seen direction on this.