pennsylvania
DEPARTMENT OF HUMAN SERVICES

March 25, 2021

To: Service Coordinators and Providers in the Act 150 Program

Subject: Temporary Changes to the Act 150 Program - Revised

The Centers for Medicare & Medicaid Services (CMS) approved temporary changes to the OBRA and Community HealthChoices (CHC) 1915(c) waivers beginning March 6, 2020 in response to the COVID-19 pandemic. Approval of these changes is covered under Appendix K, Emergency Preparedness and Response, which states may use during emergency situations to request amendments to their approved waivers. These changes address potential staffing shortages and the need for service provision not included in approved service descriptions to ensure participant health and safety needs can be accommodated for the duration of the COVID-19 statewide emergency. The duration of the approval may be extended depending on the length of the declared emergency. The Office of Long-Term Living (OLTL) extended the same flexibilities to the Act 150 Program.

In response to continued fluctuation in COVID-19 cases, OLTL submitted an amendment to Appendix K to CMS in January 2021. The purpose of the amendment was to extend the effective date, allowing some flexibilities to continue until six months after the end of the federal public health emergency. CMS has approved the amendment. This guidance rescinds and replaces the Act 150 guidance dated January 15, 2021. Additionally, this guidance clarifies flexibilities that remain available until six months after the end date of the federal public health emergency, or another date determined by OLTL. The federal public health emergency is set to expire on April 21, 2021; however, it's possible the federal government will decide to extend the emergency beyond April. Please use this public health emergency website link to see the current and future public health emergency declarations related to COVID-19.

The changes outlined below provide flexibilities for Service Coordinators and providers as they work with participants who may be facing disruption in services due to COVID-19. The flexibilities outlined below will not apply to all participants and should not be considered across-the-board changes that must be implemented for each participant. **These flexibilities must be evaluated on a case-by-case basis in coordination with the Service Coordinator and the OLTL Participant Services Review Unit.** Service Coordinators should contact RA-PWURGENTREVIEW@pa.gov for service plan issues related to the Appendix K flexibilities.

Guidance for Determining Whether the Amendments in Appendix K Apply

All changes authorized by Appendix K, as explained below, may only be implemented for participants impacted by COVID-19. The following questions can be used to determine whether requests and authorizations will be covered under Appendix K:

What change occurred for the participant as a result of COVID-19?

a. Was the participant receiving services in a setting that closed?

b. Has the participant tested positive for COVID-19 that requires relatives to render services when direct care workers are unwilling or unable to render services while the participant remains positive for COVID-19?

c. Has the participant's caregiver or a person with whom they live tested positive for or exhibited symptoms of COVID-19?

d. Has the participant's direct care worker tested positive for or exhibited symptoms of COVID-19?

e. Is the participant's direct care worker isolating at home or quarantined due to exposure to someone who tested positive or exhibited symptoms of COVID-19?

f. Is the participant's direct care worker unable to render services due to caring for a child or children due to closure of schools or day care programs as a result of COVID-19?

g. Is the participant's direct care worker unable to render services due to caring for a family member who tested positive for or exhibited symptoms of COVID-19?

h. Is the provider unable to provide staffing at pre-COVID-19 required levels due to overall shortages of staffing and inability to secure additional staff?

General Billing Guidance

On February 20, 2020, the Centers of Disease Control and Prevention (CDC) issued official diagnosis coding guidance for health care encounters related to COVID-19.

Based on this guidance, when services are related to COVID-19, providers must use the following ICD-10-CM billing codes –

Z03.818 - *Encounter for Observation for Suspected Exposure to Other Biological Agents Ruled Out*, for claims where there is a concern about a possible exposure to COVID-19.

Z20.828 - *Contact with and (Suspected) Exposure To Other Viral Communicable Diseases*, where there is an actual exposure to someone who is confirmed to have COVID-19.

Example #1: If a participant without COVID-19 requires more than 29 days of respite service in a licensed facility, due to lack of informal supports, e.g., a spouse is suspected of having been exposed to COVID-19, the provider must use **Z03.818** in addition to the primary diagnosis code used when billing for HCBS services.

Example #2: If a participant who does not have symptoms of COVID-19 requires more than 29 days of respite service in a licensed facility because their spouse has tested positive for COVID-19, the provider must use **Z20.828** in addition to the primary diagnosis code used when billing for HCBS services.

- Providers must bill the applicable procedure and place of service codes and include the appropriate COVID-related ICD-10 diagnosis code, in addition to the primary diagnosis code, to indicate service, setting or staffing exceptions that are approved in Appendix K.
- When temporary Appendix K changes are implemented as a precautionary measure to protect a participant, even when there is no concern for possible exposure, providers must use **Z03.818** in addition to the primary diagnosis code used when billing for HCBS services.
- Where a participant is exposed to or tested positive for COVID-19, providers must use **Z20.828** in addition to the primary diagnosis code when billing for all HCBS services, not just those approved in Appendix K.
- For services provided on or after March 6, 2020, providers should resubmit any claims that are not in compliance with this billing guidance.
- Providers must contact the participant's Service Coordinator to communicate changes to services or settings.
- If a provider decides to change their business practice, e.g., modifying staffing ratios, limiting services or suspending services, the provider must contact OLTL's enrollment team at RA-HCBSEnProv@pa.gov before making the change.

Waiver Services

For the following services, service limitations are temporarily lifted during the COVID-19 emergency declaration:

- **Personal Assistance Services (Agency and Participant-Directed)** – Normally, some family members can provide Personal Assistance Services, with exceptions.

  On a case-by-case basis, temporarily, spouses, legal guardians, and persons with power of attorney may serve as paid direct care workers.

  These situations **must** be reviewed by OLTL on a case-by-case basis. Service Coordinators should contact RA-PWURGENTREVIEW@pa.gov to request this flexibility. This flexibility is only available when scheduled workers are not available due to COVID-19 and the participant's emergency backup plan cannot be implemented. Spouses, legal guardians and persons with power of attorney will be allowed to serve as paid direct care workers only until a replacement

direct care worker is in place and in no case beyond the duration of the COVID-19 emergency declaration.

This temporary flexibility does not apply in circumstances where a participant or their representative refuses services due to COVID-19 safety concerns despite the direct care worker(s) being available to provide services.

Under the participant-directed model, spouses, legal guardians and persons with power of attorney must be enrolled as direct care workers through Public Partnerships, LLC (PPL) and undergo criminal background checks and child abuse clearances as required by law.

Level of Care Assessments and Needs Assessments/Reassessments

- **Initial Level of Care Assessments using the FED** – may be conducted remotely using phone or video conferencing; the face-to-face requirement is temporarily waived.

- **Annual Reassessments, including the needs assessment and level of care** – may be conducted remotely using phone or video conferencing; the face-to-face requirement is temporarily waived. Reassessments may be conducted remotely using phone or video conferencing at the participants choice or when the Service Coordinator and/or participant identified that risk factors may be present.

  Annual reassessments, including the needs assessment, that were delayed beyond the 365th-day must be completed no later than December 31, 2020, which is 6 months after the issuance of the June 26, 2020 transition plan.

  Service Coordinators must receive education and training from the Service Coordination Entity on how to evaluate individual risk factors and protect themselves from potential exposure according to the guidance issued by the CDC and the Department of Health.

  Annual Reassessments, including the needs assessment, may be conducted face-to-face when possible. Service Coordinators should maintain safe behavioral practices as defined by the CDC and the Department of Health when doing so.

- **Comprehensive Needs Reassessments** – may be conducted remotely using phone or video conferencing when a participant's needs change, when the participant requests a reassessment, or following trigger events.

Service Coordinators must receive education and training from the Service Coordination Entity on how to evaluate individual risk factors and protect themselves from potential exposure according to the guidance issued by the CDC and the Department of Health.

The qualifications for the individuals conducting these assessments will not change.

Individual Service Planning/Service Coordination

- **Monitoring of the Individual Service Plan (ISP)** – Service Coordinators may monitor participants and ISPs remotely by telephone where face-to-face contacts are usually required. Service Coordinators are encouraged to contact participants frequently to ensure participants' needs are being met during the COVID-19 emergency declaration.

- **Service Planning Meetings and Plan Development** – may be conducted entirely using telecommunications. Members of the planning team, determined at the discretion of the participant, may also participate remotely using phone or video conferencing.

Retainer Payments to Address Emergency Related Issues

- **Personal Assistance Services** – During the COVID-19 emergency, retainer payments to direct care workers in agency and participant-directed models may be made when the participant is hospitalized, absent from their home, or in isolation and unable to receive services due to COVID-19. Personal Assistance Services retainer payments may not exceed 15 days – the number of days for which OLTL authorizes a payment for "bed-hold" in nursing facilities. Retainer payments will not be available when another reasonably equivalent assignment is made available to a direct care worker or when the worker is laid off and collecting unemployment.

  Billing Guidance:

  - Providers must bill the applicable procedure code (W1792, W1793, W1793 TT, or W1900) and must only be billed with the COVID-19 ICD-10 diagnosis code Z20.828.
  - Providers should bill for the scheduled hours during the time the participant is hospitalized or absent from their home. For example, if the participant is hospitalized for COVID-19 and was scheduled for 5 hours of Personal Assistance Services for 8 of the 15 consecutive calendar days, the provider would bill for 40 hours (5 hours x 8 days).

Documenting what actions were taken and maintaining evidence for why actions were taken.

In addition to notifying OLTL, providers and Service Coordination Entities should document any changes to their operations as a result of COVID-19 and maintain evidence to support why the changes were made. Doing so will help demonstrate the basis for an action. In general, evidence that should be maintained includes, but is not limited to:

- **Orders or notices from Federal, State, and local authorities that support changes to operational procedures.**

- **Correspondence and other records demonstrating inability to meet required staffing ratios or response times.** Example: Provider's employees are unable to report to work due to COVID-19-related reasons. Provider attempts to secure temporary staff from other staffing agencies, but each agency reports that they too are experiencing staff shortages. As a result, Provider is out of compliance with required staffing ratios. Provider should maintain documentation of employee unavailability and retain copies of correspondence with each of the staffing agencies to demonstrate that all possible efforts were made to secure enough staff.

- **Records demonstrating changes made in staffing or location of service provision.** Example: Provider temporarily closes its Structured Day Habilitation Program and reassigns staff to provide services to participants in their homes. The provider should retain a copy of this notice, documentation of staff reassignments and steps taken to ensure reassigned staff have required training to ensure health and safety support of the participant.

- **Document all services performed to include but not limited to:**
  - Participant name
  - Participant date of birth
  - Date of service
  - Services performed
  - Start and stop times of the services performed
  - Diagnosis
  - Individual performing the services
  - Service location

- **Providers should maintain fiscal records in accordance with 55 Pa. Code §§ 52.15 and 1101.51 to document service delivery and claims submissions.**