NEW YORK STATE | Department of Health

October 1, 2020 Webinar on: COVID-19 Revised Appendix K Approved August 25, 2020

Traumatic Brain Injury (TBI) and

Nursing Home Transition and Diversion (NHTD) Waiver

October 2020

Appendix K Overview of Changes

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"Appendix K" for NHTD/TBI 1915(c) Waivers During COVID-19 Emergency

- The Appendix K for NHTD/TBI mirrors many of the provisions the Department included in its guidance to be immediately responsive to participants and providers during the initial days of the COVID-19 emergency and is available here.
- CMS approved New York's original Appendix K for NHTD/TBI on April 21, 2020 https://www.medicaid.gov/state-resource-center/downloads/ny-0444-0269-combined-appendix-k-appvl.pdf. Subsequent to the initial submission, CMS clarified several criteria. A revised submission of the Appendix K for NHTD/TBI was approved on August 25, 2020 https://www.medicaid.gov/state-resource-center/downloads/ny-0444-0269-combined-2-appendix-k-appvl.pdf.
  - **All the terms and conditions of the prior submission remain in place and all amended language from the previously submitted Appendix K is highlighted in the August 25, 2020 approved Appendix K.**
- The Appendix K provisions are in effect beginning March 1, 2020 and are anticipated to remain in effect through February 28, 2021.
- **The following slides summarize changes made to the April 21, 2020 approved Appendix K.**

Brief Description of Changes Made to Original Appendix K

- Per CMS instructions, language regarding CMS 372 submission timeframes has been amended.
- New York State (NYS) included CMS-mandated guardrails for providers seeking retainer payments on or after June 30, 2020.
- Consistent with CMS guidance, NYS amended the previously approved language allowing retainer payments for more than three 30 consecutive day periods to limit retainer payments to up to three 30-day episodes not to exceed a total of ninety (90) days.

Amended K-2-M Language Related to 372 Submission

- Amended language regarding 372 submission is below (found in section K-2-M of the August 25, 2020 approved Appendix K):
  - "The timeframes for the submission of the CMS 372s and the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data, for current reviews looking back at performance measures other than those identified for the Health and Welfare assurance and future look behind reviews at performance measures other than those identified for the Health and Welfare assurance. As a result, the current look behind data that would have been collected as well as future data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic."

Changes to Retainer Payment Conditions

As of the June 30, 2020 release of the CMS "COVID-19 FAQs for State Medicaid and CHIP Agencies" (found here: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf), States that allowed multiple periods of retainer payment in their Appendix Ks were required to add a limit to the number of periods a provider may receive retainer payment for each participant for each service and were also required to add additional guardrail language to the process. This additional guardrail language was dictated by CMS.

Changes to Retainer Payment Conditions

The new language added to the retainer payment section of the Appendix K includes:

- A limit of three, 30-day periods of consecutive Retainer Payment billing such that the provider may not request **nor bill for more than 90 separate days of retainer payment billing.**
- For any retainer payment billing requests authorized after June 30, 2020, providers will have to attest to the additional guardrails required and noted by CMS in their June 30, 2020, "COVID-19 FAQs for State Medicaid and CHIP Agencies" https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Retainer Payment Language

Changes are noted in red font:

"Upon approval by the RRDC, providers offering Home and Community Support Services (HCSS), Structured Day Program (SDP) services, Independent Living Skills Training (ILST), Community Integration Counseling (CIC) and Positive Behavioral Interventions and Support (PBIS) services may bill retainer payments at the providers' existing rate, not to exceed the hours approved within participant Service Plans. These services listed include personal care as a component (e.g., by supporting ADL/IADL skill training and activities). Any changes to a participant's existing Service Plan will require an addendum and prior approval from the RRDC. Alternative means to current service provision will require prior approval from the RRDC. The RRDC will confirm that every attempt was made to provide services through alternative means (telehealth/telephonic) before considering approval of retainer payments."

Retainer Payment Language

Changes are noted in red font:

"Retainer payments cannot be provided for more than 30 consecutive days. There may be more than one 30 consecutive day period. The provider may only request for up to three (3), thirty (30) consecutive day periods per participant, not to exceed ninety (90) days. Consecutive days are those days that are eligible for billing. Retainer payments are for direct care providers who normally provide services that include habilitation and personal care, but are currently unable to due to complications experienced during the COVID-19 pandemic because the waiver participant is sick due to COVID-19; or the waiver participant is sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders. The state will implement a distinguishable process to monitor payments to avoid duplication of billing."

Retainer Payment Language

Changes are noted in red font:

"Providers may not seek retainer payments if they would exceed the number of hours in the approved service plan. Retainer payment requests authorized after June 30, 2020 will include a supplement to the prior attestation to include:

- All current billing requirements remain in place: retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred (or in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third-party review. Note that "duplicate uses of available funding streams" means accessing more than one PHE funding stream for the same purpose;
- While receiving retainer payments, the provider has not received relief from any other source(s), including, but not limited to, unemployment benefits and Small Business Administration loans, that would exceed revenue for the last full quarter prior to the Public Health Emergency (PHE);
- The provider will not lay off staff and will maintain wages at existing levels;
- If the provider received revenues from other sources that exceeds pre-PHE level income, retainer payments will not be available; and
- Funding is subject to a final reconciliation to include an evaluation of other sources of emergency funding including unemployment benefits and Small Business Administrative Loans and may require the recoupment of retainer payments if revenue exceeds the quarter prior to the PHE."

Retainer Payment Billing Process

- All pending requests for retainer payments received by the RRDC after June 1, 2020 were held pending the resubmission of the Appendix K.
- A revised *Monthly Retainer Payment Request Form* (that includes the *Supplemental Attestation*) was developed and requires that all requests not previously approved be re-submitted to the RRDC. This form includes the new guardrail language required by CMS. All providers must "attest" to the criteria included in the revised form when seeking additional payments.
- Providers must submit the September 2020 dated *Monthly Retainer Payment Request Form* (which includes the *Supplemental Attestation*) and sign the back of the form which includes the attestation.
- The retainer payment request packet must include the *Monthly Retainer Payment Request Form - Billing Dates* document which includes the dates the provider will bill for a retainer payment as well as the number of total billing days that the provider will claim for retainer payment.
- Retainer payment billing may only be used when a provider would have normally billed for the provision of services according to the schedule in the participant's plan.

Retainer Payment Billing Process

- Providers who have submitted retainer payment requests that were previously approved and who are not seeking any additional retainer payment billing must email their RRDC stating that they will not be submitting any new retainer payment requests and confirm in their email that they have not billed for more than 90 total retainer payment billing days.
    - If a provider **is** planning on submitting further retainer payment requests, they must submit a completed *Monthly Retainer Payment Request Form - Billing Dates* document for all previously approved retainer payment requests.
- Retainer payments may not exceed a total of 90 billing days. Retainer payment billing should indicate days that services would have been provided if not for the participant's illness, sequestration or quarantine based on local, state, federal and/or medical requirements/orders related to COVID-19.
- Retainer Payment Billing and required forms may be subject to audit.

Retainer Payment Billing

- Retainer payment billing may not occur without prior approval by the RRDC. All required forms must be completed in full.
- All retainer payment billing must be made according to the proposed schedule included in the participant's service plan.
- If previous billing occurred for services provided through alternative means only and the provider now seeks retainer payments for the same date of service, the claim must be resubmitted. Upon approval of the request for retainer payments, the provider will resubmit the previously paid claim and adjust the billing accordingly. This will include the total number of units billed (alternative means + retainer payment). The amended claim should use delay reason code 3.

Contact the NYS Department of Health Waiver unit at:

waivertransition@health.ny.gov