

## COVID-19 Emergency Guidance

In order to protect the health, safety, and welfare of Home and Community Based Services (HCBS) participants, the Division of Senior and Disability Services (DSDS) has provided an outline for programmatic flexibility in delivery of services due to the COVID-19 pandemic. Providers should use professional judgement and current staff capacity to decide what programmatic flexibility may be necessary in order to ensure participant welfare.

### Assessments/Reassessments Updated 12/30/20

Effective immediately, all assessments completed by DSDS or Type 27 providers shall be conducted via telephone. This measure is being put in place in order to minimize any unnecessary exposure to those we serve, many of whom fall into a COVID-19 high risk category. Before an assessment is completed with a participant, DSDS staff or Provider 27 reassessors shall attempt to verify the participant's identity by asking their date of birth and last four (4) digits of their Social Security Number. If an individual refuses to give the information, this should be documented in case notes. Please do not document the participant's social security number in the case notes.

Type 27 Providers shall follow existing claims procedures to be reimbursed for reassessments completed via telephone.

At this time, required forms and other necessary documents shall be discussed with HCBS participants or their designee via telephone. The Physician notification form (HCBS-11) does not need to be completed at this time. Participant or authorized representative acknowledgment shall be accepted verbally by telephone for all required documents/forms. The blank documents/forms do not need to be uploaded into Web Tool. Case note documentation for verbal signatures must contain three parts:

- List of forms reviewed "via phone"
- Acknowledgment of understanding by the participant or authorized representative
- Agreement to a verbal signature

No mailings are necessary at this time unless specifically requested by the participant or their designee.

Self-direction determination may also be conducted via telephone. Assessors should only utilize the Self-direction Questionnaire via telephone. Adverse action should only be sent for those that are obviously impaired.

If Type 27 Providers are unable to complete reassessments due to staffing shortages or other issues, providers shall notify the appropriate Person Centered Care Planning (PCCP) team in a timely manner.

PCCP Teams: <https://health.mo.gov/seniors/homecomservices/pdf/BHCS-EvalTeam.pdf>

### Service Delivery

As health care providers, HCBS providers are expected to continue delivering services as authorized to participants at this time.

#### Safety

Providers of Home and Community Based Services are encouraged to review COVID-19 safety precautions and transmission information on the [DHSS website](#).

In an effort to protect Missouri's most vulnerable populations, providers of in-home service providers are reminded to screen staff to ensure they are free of communicable diseases per the code of state regulations. Staff who have signs and symptoms described in CDC guidance should **not** report to work.

In the event a participant is confirmed or presumed to be COVID-19 positive, the provider shall continue providing care as needed while following CDC guidance for precautions. Providers should evaluate all available options, including the use of family members or friends, in the event a participant's needs cannot be met. If there is still a need for services after this evaluation, please contact the appropriate [Person Centered Care Planning \(PCCP\)](#) team.

### Tasks

Providers may limit service delivery to essential services if needed due to staffing shortages or in order to limit exposure to COVID-19. If a provider limits service delivery, they should coordinate directly with participants to best meet their needs and preferences regarding care plan delivery. For example, a participant may prefer to limit exposure to personal care aides and therefore agree to a temporary reduction in services.

Providers able to meet the needs of participants may deliver any necessary tasks within the total authorized unit limit, even if the specific tasks are not listed on the current care plan. The Person Centered Care Planning (PCCP) team should only be notified if an INCREASE in total units is needed as it is anticipated there will be a high volume of requests during this period.

For state plan personal care participants (agency-model and consumer-directed) receiving services in their home, providers also have the option to conduct telephone checks for participants. The telephone checks should be used to ensure the health, safety and welfare of participants refusing services due exposure risk or in instances where there are staffing limitations. These services are in addition to and not in lieu of telephone nurse visits discussed below.

Documentation should be kept for each telephone check and should be made available upon request from the State. An [example form](#) developed by fellow providers is attached for optional use.

Effective for dates of service on and after August 01, 2020, the following changes are made for health and welfare checks:

- Up to five (5) hours or 20 units per month of currently authorized units of personal care may be utilized for each participant to complete health and welfare checks (units above the current authorization level are no longer approved);
- Health and welfare checks are required to be billed under the participant's current authorization for basic personal care procedure code T1019 for agency model personal care or T1019U2 for consumer directed personal care.
- Procedure codes T1019SC for agency personal care and T1019U2SC for CD services are no longer covered.

### Referrals/Care Plan Change Requests **Updated 12/30/20**

Please submit new referrals using the [Online Home & Community Based Services Referral Form](#) or by sending an [HCBS-1 Form](#) to [HCBSCallCenterReferrals@health.mo.gov](mailto:HCBSCallCenterReferrals@health.mo.gov). Please only use one route (online or e-mail) per referral. Please submit requests for care plan changes using the [Provider Communication Form](#) to [PCCP@health.mo.gov](mailto:PCCP@health.mo.gov). This is an effort to preserve the phone line for participants and others who have no other means to initiate referrals or requests.

Due to an exceptionally high number of referrals and requests, there may be a delay in processing. Referrals and requests are prioritized by immediacy of need and date received. Please keep in mind that submitting duplicate or multiple referrals or requests for the same participant will result in a processing delay for all parties involved. DSDS will be in contact with all appropriate persons to complete the referral/request. HCBS providers should reference Cyber Access Web Tool to check on the status of referrals/requests. Thank you for your patience as we work diligently to process all referrals and requests as soon as possible.

### Non-Emergency Medical Transportation (NEMT)

In the event that NEMT is unavailable to provide transportation to medical appointments due to staffing shortages, the HCBS provider or the participant's family/friend may complete this task and request mileage reimbursement through NEMT for this purpose.

### Stay at Home Order/Curfew

Certain areas of the state are enforcing stay at home orders (shelter in place) or curfew restrictions. Health care providers are not subject to stay at home orders/curfews when delivering essential health care services, this includes in-home and CDS providers. Please continue to provide HCBS to participants. All provider staff are encourage to carry this exemption letter to avoid any potential care interruptions. If you are unable to print the letter, we encourage you to take a photo of it on your phone to have with you.

Health care providers unable to gain access to participants due to building restrictions should use this letter in these instances too. If the letter does not allow the provider to gain access to the participant, please notify [LTSS@Health.mo.gov](mailto:LTSS@Health.mo.gov). Include as much detail as possible, including:

- Participant name and DCN
- Date of attempted visit
- Name and address of housing
- Type of housing if known
- Name of individual denying access and any available contact information

### Staffing Shortages

It is anticipated some providers may be unable to continue serving a participant due to staffing shortages. If a provider is unable to continue providing care to a participant to meet their essential needs and the participant does not have a backup plan, the provider shall contact the [PCCP team](#) immediately, so the state can address the participant's needs.

Electronic Visit Verification (EVV) – Flexibility expires December 31, 2020 due to federal mandate for EVV implementation effective January 1, 2021. For more information regarding the changes associated with EVV visit the Department of Social Services [EVV page](#).

EVV exception documentation will not be required as providers may not have time to set up/train new participants and aides in order to provide care in a timely manner. Additionally, EVV requirements may be waived for shopping/errands as providers may need to assist multiple participants at one time.

## **Caregiver Requirements**

### Eligible Caregivers

Flexibility for agency-model providers: Family members (spouse and legal guardian excluded) may be eligible to be hired as an aide to provide care. Family members (absent the exceptions above) will only be allowed to provide services if he/she **does not reside in the same residence** if no other caregiver is available. A family member is defined in regulation as a parent, sibling, child by blood, adoption or marriage (stepchild), spouse, grandparent or grandchild. Any family members outside of this definition that live in the home may provide care as an aide. Any non-related individuals living in the home may provide care as an aide. Family Care Safety Registry (FCSR) filing is still required (see below for further guidance).

### Training /Oversight/Evaluations

All training and annual oversight visit requirements will be suspended. Providers are expected to train each individual on the person-specific needs of each participant they will begin serving via telephone or other means. Employee evaluations have also been suspended.

### Family Care Safety Registry (FCSR)

The state will waive the requirement for the FCSR background check to be returned prior to the start of the individual providing care as it is anticipated there may be a delay in background check processing. The provider shall file the FCSR request prior to the aide providing care, and the aide/attendant may begin providing care immediately. If a potential aide/attendant requires a Good Cause Waiver, the state will waive the requirement for the waiver to be returned prior to the individual providing care. Providers shall only make this exception for crimes that are typically waived with the Good Cause Waiver.

## **Nurse Visits**

### Qualifications

Graduate Nurses may be hired to complete Authorized Nurse Visit tasks. Family Care Safety Registry filing is still required (see above for further guidance).

### General Health Evaluations

At this time, GHEs may be conducted via telephone or tele-monitoring. Required and other necessary documents shall be discussed with HCBS participants or their designee via telephone. Participant or designee acknowledgement shall be accepted verbally and documented in the HCBS Web Tool. The GHE shall continue to be uploaded to the Web Tool.

Portions of the GHE will not be able to be completed via telephone. Providers are encouraged to use professional judgment to discuss the participant's current condition and conduct a face-to-face visit, if necessary.

### Advanced Personal Care (APC) Evaluation

At this time, the Authorized Nurse Visit task Evaluate Advanced Personal Care may be conducted via telephone or tele-monitoring. Providers are encouraged to use professional judgment to determine whether a face-to-face visit or other appropriate follow up is needed.

### Medication Set Up

Note: This only pertains to Authorized Nurse Visits for Medication Set Up in the participant's home

The Center for Disease Control and Prevention (CDC) recommends individuals maintain a 14-day supply of medications. Where possible, the Medication Setup task through Authorized Nurse Visits may be expanded to allow for up to a 21-day supply of medications if the participant has this amount of medication supply on hand. (Please note: Pharmacies must adhere to current dispensary and prescription guidance and are not able to fill more than 2 weeks in advance.) DSDS encourages providers to assist in this effort in preparation for potential service delivery barriers.

### Authorized Nurse Visits

For all Authorized Nurse Visits, providers are encouraged to use professional judgment to determine whether a face-to-face visit is needed in order to complete the task. For example, if medications have been physically set up for two or three weeks, telephone or tele-monitoring can be used to check on clients on weeks that it is not necessary for the provider nurse to go to the home for medication set-up. There are no set time parameters on telephone visits however, every time the nurse is conducting a nurse visit no matter what the reason for the visit is, the nurse needs to be checking on the participant as a whole utilizing the sample triage form or something similar to it. It's important that since a nurse isn't going out into the home that the phone calls are thorough in order to ensure the safety and wellbeing of the participant.

## Adult Day Care

### General Guidance

Adult Day Care (ADC) Facilities are encouraged to remain open for as long as safely possible. At this time, there are no restrictions or directives for ADC Facilities to close in any location of the state.

In the event an ADC Facility anticipates closure, the ADC shall notify the appropriate [Person Centered Care Planning \(PCCP\)](#) team in order to effectively plan for participants' care. It is the responsibility of the ADC to communicate with the PCCP team regarding participants who do not have a backup plan in place to receive care due to the ADC closure. ADC Facilities shall also notify Shay Patterson, Licensure and Certification Manager, of temporary or permanent ADC closure as a result of COVID-19 via e-mail at [Shay.Patterson@health.mo.gov](mailto:Shay.Patterson@health.mo.gov).

ADC Facilities are encouraged to notify the appropriate [PCCP team](#) if there is capacity to take on additional participants.

### Transportation

ADC Facilities may choose to waive their transportation service and implement a drop-off/pick-up process throughout the COVID-19 outbreak. This decision is at the discretion of the ADC Facility.

### Respite Care

DSDS and the Department of Social Services, Missouri Medicaid Audit and Compliance (MMAC) have partnered to take steps to ensure continued service delivery to Adult Day Care (ADC) participants during the ongoing COVID-19 outbreak. Effective immediately, DSDS is extending the opportunity to ADC Facilities to provide Respite Care to participants who would ordinarily travel to an ADC facility, but are unable to do so due to COVID-19 concerns.

Respite Care services are maintenance and supervisory services provided to a participant in the individual's residence to provide relief to the caregiver(s) that normally provides the care. Respite may also include web based socialization activities and transportation for meal delivery.

Family members (spouse and legal guardian excluded) may be eligible to be hired to provide the respite. Family members (absent the exceptions above) will only be allowed to provide respite if he/she does not reside in the same residence, and he/she will only be allowed to provide respite if no other caregiver is available.

Respite time may be delivered equal to the currently authorized ADC hours. In explanation, ADC Facilities may bill for Basic Respite Care units up to the maximum of units authorized for ADC. For example, an ADC participant with 300 units of ADC services may receive up to 300 units of Respite Care. ADC Facilities shall only bill for services delivered.

ADC Facilities shall not bill for Basic Respite services for more than one (1) participant per one (1) caregiver for any period of time. If a caregiver is providing respite to two (2) or more participants simultaneously, the ADC Facility shall ensure claims do not exceed the total hours worked by the caregiver. For example, if Basic Respite is provided to two (2) participants simultaneously for 8hrs by one (1) caregiver, the facility shall only bill a total of eight (8) combined hours for both participants. For example, 4hrs per participant. Billing for 8hrs per participant (16hrs in an 8hr period) would result in double billing and would be subject to recoupment.

The respite care rate is \$4.09 per 15 minute unit. For guidance regarding billing, see [INFO memo 03-20-04](#). Please be aware the procedure code in the memo contains the modifier, HB. Billing dates may not precede March 13, 2020. Please do not contact the PCCP team regarding billing or authorization related to this.

Through 4/9/20: Facilities shall bill each individual date of service on a separate line of the claim indicating the appropriate number of units for that date of service for the participant.

4/10/20 and After: From and through dates may be billed on an individual line on a claim indicating the total number of units for the time period for the participant. The from and through date may not exceed a calendar month and must not overlap previous dates already billed.

ADC providers also have the option to conduct telephone checks for participants in order to ensure their health, safety and welfare. (i.e. additional time to go over back-up plans, checking on symptoms prior to sending an aide, general questions related to resource needs during COVID-19 and the stay-at home order, and/or the participant is refusing services due exposure risk or there are staffing limitations so multiple phone checks are needed, etc.).

An example form developed by fellow providers has been attached for you to utilize if you choose but is not required. Telephone checks should be documented by the ADC by following normal timesheet guidelines. For task, indicate – telephone check.

Up to five (5) hours or 20 units per month of ADC telephone checks (within the currently authorized ADC amount) can be utilized for each participant to complete these vital checks. To bill for these additional units, providers shall bill procedure code S5150, modifiers SC and HB. The rate is \$4.59 per 15 minute unit. The codes can be billed from and through dates but must be in same calendar month. Billing dates may not precede March 13, 2020. As with all COVID-19 related emergency guidance, effective dates will be retroactive to the date of the emergency declaration by Governor Parson. Please do not contact the local PCCP team regarding billing questions.

## **Residential Care Facilities/Assisted Living Facilities (RCF/ALF)**

Due to CDC recommendations to restrict congregate dining related to the COVID-19 outbreak all HCBS participants residing in a RCF/ALF may receive an additional three (3) units of personal care dietary assistance per day. For those HCBS participants currently residing in an RCF/ALF who do not currently receive dietary assistance, three (3) total units of personal care dietary assistance per day shall be authorized in addition to the currently authorized care plan beginning March 13th, 2020 until either the lifting of the CDC recommendation or the end of the declared emergency, whichever is sooner. These additional units should be added and documented alongside other HCBS tasks on the participant's chart/normal daily documentation records utilized for personal care delivery. A brief note or other indication that 3 additional units of Dietary were provided to the participant with caregiver initials will suffice.

Please do not contact the PCCP regarding this increase. DSDS is centrally coordinating the process to authorize the additional dietary personal care units.

For guidance regarding billing, see [INFO memo 03-20-05](#). Please be aware the procedure code in the memo contains the modifier, U3 and SC. Billing dates may not precede March 13, 2020. Do not contact the PCCP team regarding billing or authorization related to this.

## Provider Operations

### General

Provider offices can close and staff may work remotely. Providers shall maintain phone availability to ensure participants, caregivers, and the Department are able to communicate with the provider regarding participant needs.

### Consumer-Directed Services **New**

With the passing of House Bill (HB) 1682, flexibility has been provided waiving the requirement of the annual face to face monitoring visits.

### Personal Protective Equipment (PPE)

Providers should contact their Local Public Health Association (LPHA) to request PPE once their normal supplier has been exhausted. PPE should only be used in appropriate normal circumstances or if a participant is positive for COVID-19 or under investigation for a positive diagnosis as supplies are limited.

See [DSDS webpage](#) for further PPE request information.

### Signature Requirements

Required forms/documents (i.e new employee paperwork, new participant paperwork, timesheets for services completed via phone, etc) may be signed via telephone. The information included in the forms shall be discussed and verbal signatures must be documented with the acknowledging party's name with documentation stating "via telephone." Tax related paperwork however, still requires a written signature. These documents may be mailed in order to obtain the signature.

## Adult Protective Services

Providers should explore all alternative options for participants refusing services before making a hotline to Adult Protective Services. Alternate services could include dropping of medications/meals at the door or telephone checks. Delivery of meals, medications and telephone checks in these circumstances are considered billable time. See above regarding telephone checks for additional details.

Please use the online reporting application for any non-emergent situations. This will allow the phone lines to stay open for those with emergencies during this difficult time. Access the online Adult Abuse & Neglect Hotline at [www.health.mo.gov/abuse](http://www.health.mo.gov/abuse).

## Questions

Due to high call volumes and DSDS staffing shortages, additional questions should be sent via email to [LTSS@health.mo.gov](mailto:LTSS@health.mo.gov).