Division of TennCare

MEMO

DATE: May 13, 2020

TO: Home and Community-Based Services Providers of Residential, Personal Care, Adult Day Care, Employment, and Community Integration Support Services in CHOICES and Employment and Community First CHOICES
TennCare Health Plans

FROM: Patti Killingsworth, Chief of LTSS

CC: William Aaron, Chief Financial Officer
Keith Gaither, Director of Managed Care Operations

SUBJECT: **CONDITIONS OF PAYMENT for COVID-19 Payment Flexibilities**

The purpose of this memo is to provide additional detail regarding conditions of payment for *temporary* COVID-related payment flexibilities announced last week that TennCare plans to implement in the CHOICES and Employment and Community First CHOICES programs (some only upon approval by the Centers for Medicare and Medicaid Services or CMS).

Each type of payment flexibility has associated conditions of payment as described in last week's memos.

The attachment to this memo provides additional detail regarding how these conditions will be applied in order to meet expectations of our federal partners regarding the purpose and intent of these payments, while also seeking to apply these conditions fairly and practically in light of how the public health emergency has evolved and impacted your daily operations.

We have also sought to expedite the flow of funds to providers and tominimize any administrative burden associated with receiving these payments, including attestation processes related to conditions of payment and billing processes.

The attachment includes additional information regarding billing processes and further describes how attestations will be accomplished. **Please review this information carefully. Note in particular that submission of claims and/or acceptance of payment for these COVID-related payment flexibilities constitutes the provider's attestation that all applicable conditions of payment will be met.** It is your responsibility to notify each MCO with whom you are contracted or not present for payment (or allow to be presented for payment) any claims for which conditions of payment will not be met, as described in the attachment.

All COVID-related payments are subject to audit and recoupment if it is determined that conditions of payment were not met. TennCare intends to work with our partners to design audit processes that will help to safeguard fiscal accountability while also minimizing administrative burden for your agency.

Again, we hope these payments signal how much the State values the critical services you provide to Tennesseans and their families. We are grateful for your continued commitment to this important work.

Payment Flexibility	Conditions of Billing/Payment	Condition Terms	Attestation/Validation Process
***Temporary* rate increase** for home and community-based **residential and personal care services** in CHOICES and ECF CHOICES effective 3/13-5/12/20	• Agree to continue to pay staff at current wage/salary levels • Commit to continuing service delivery both during and beyond the COVID-19 public health emergency	Because the *temporary* rate increases are applied retrospectively (effective 3/13/20), staffing changes may have occurred as a result of the public health emergency (PHE) *before* rate increases (and conditions of payment) were announced. Accordingly, this condition will be applied as follows. **If a provider has reduced wage/salary levels**: By June 1, 2020, the provider must restore wage/salary levels of currently employed staff to *at least* the amount they were paid prior to March 13, 2020 (the wage/salary can be higher, but not lower than the wage/salary rate as of March 12, 2020). Payroll records shall be provided if requested to validate this condition. **If a provider has laid off or furloughed staff:** By June 1, 2020, the provider must offer return to employment, earning *at least* the wage/salary amount they were paid prior to March 13, 2020 (the wage/salary can be higher, but not lower than the wage/salary rate as of March 12, 2020). The provider will be deemed to satisfy this condition even if laid off or furloughed staff decline such offer. Payroll records and return to employment offers/responses shall be provided if requested to validate this condition. The provider must continue providing the currently authorized level of services to CHOICES and ECF CHOICES members, as applicable, during and after the PHE, subject to member needs and preferences. In addition, the provider must resume the provision of any services that have been placed on hold or reduced during the PHE—again, subject to member needs and preferences. (There is no obligation to continue or resume services a member no longer needs or wants to receive from the provider.)	Providers were notified of the conditions of payment via memo on May 4, 2020, May 7, 2020, and May 13, 2020. The May 13, 2020 memo advised that MCOs will begin adjusting claims to include temporary rate increases for the specified dates of service beginning next week. TennCare directs MCOs to add the "DR" (Disaster Related) condition code during the claims adjudication process to each adjusted claim to denote that the claim is impacted by these temporary COVID-related payment flexibilities and conditions. A provider who is not able to comply with these conditions of payment and is therefore not eligible for the payments must notify all MCOs with whom the provider is contracted in writing *immediately* that conditions will not be met, so that payment adjustments will not be made. If a provider receives payment before notifying the MCO(s) that such conditions will not be met or falls out of compliance with the terms of these conditions, the provider must promptly return the payments to the MCO. **A provider's acceptance of payment for these temporary rate increases constitutes the provider's attestation that all applicable conditions of payment will be met.** Payments are subject to audit and recoupment if it is determined that conditions of payment were not met. Audit processes may include (but are not limited to) review of provider payroll records, return to employment offers/responses, PCSPs, MCO authorizations (including reductions or holds on such authorizations), claims, referrals, and gaps in care data.

Payment Flexibility	Conditions of Billing/Payment	Condition Terms	Attestation/Validation Process
	For ECF CHOICES providers *only*: Commit to serve additional members as such services are needed by ECF CHOICES members and as funds are available to serve additional members beginning July 1, 2020	The ECF CHOICES provider will expand staff capacity as needed to accept new referrals to provide services to additional ECF CHOICES members.	
Retainer payments for **Adult Day Care (ADC)** in CHOICES and **Job Coaching, Supported Employment - Small Group (SE-SG), Integrated Employment Path (IEP), and Community Integration Support Services (CISS)** in ECF CHOICES effective 3/13-5/12/20	• Billable only for dates of service when the actual benefit was not provided and billed, and when alternative services were not authorized and billed by the provider • Agree to continue to pay all ADC, Job Coaching, SE-SG, IEP, and CISS staff at current wage/salary levels	A retainer payment may be billed for services that had been approved in the PCSP and were authorized to be delivered by the provider even if service authorizations have been reduced or placed on hold since the PHE commenced. The alternative services "exclusion" does not prohibit the provider from delivering other HCBS—authorized either before or after the PHE commenced. However, the provider may not bill a retainer payment if 1) the provider actually delivered the benefit and has sought or will seek payment for such service; OR 2) the provider is authorized to provide and has sought or will seek payment for the delivery of alternative HCBS on the same date of service for which the retainer payment is billed. Because the *temporary* rate increases are applied retrospectively (effective 3/13/20), staffing changes may have occurred as a result of the public health emergency (PHE) *before* rate increases (and conditions of payment) were announced. Accordingly, this condition will be applied as follows. **If a provider has reduced wage/salary levels**: By June 1, 2020, the provider must restore wage/salary levels of currently employed staff to *at least* the amount they were paid prior to March 13, 2020 (the wage/salary can be higher, but not lower than the wage/salary rate as of March 12, 2020). Payroll records shall be provided if requested to validate this condition.	MCOs will verify that the provider has not submitted a claim for the same service (without a DR condition code) for the date of service for which a retainer payment is made. MCOs will also verify that the provider has not submitted a claim for alternative HCBS (i.e., authorized in lieu of the service for which the retainer payment is billed) for the date of service for which the retainer payment is billed. Providers were notified of the conditions of payment via memo on May 4, 2020, May 7, 2020, and May 13, 2020. Providers may begin submitting claims for retainer payments upon notification by MCOs once the emergency 1115 waiver amendment is approved by CMS. Providers must include the "DR" (Disaster Related) condition code on each claim for a retainer payment to denote that the claim is impacted by these temporary COVID-related payment flexibilities and conditions. **A provider's submission of a claim for a retainer payment with the "DR" condition code constitutes the provider's attestation that all applicable conditions of payment will be met.** A provider who is not able to comply with the wage/salary condition of payment and is therefore not eligible for the payments must not submit claims for retainer payments. If a provider falls out of compliance with the terms of these conditions after receiving payment, the provider must promptly return the payments to the MCO. Payments are subject to audit and recoupment if it is determined that conditions of payment were not met. Audit processes may include (but are not limited to) review of provider payroll records, return to employment offers/responses, PCSPs, MCO authorizations (including reductions or holds on such authorizations), claims, referrals, and gaps in care data.

Payment Flexibility	Conditions of Billing/Payment	Condition Terms	Attestation/Validation Process
		If a provider has laid off or furloughed staff: By June 1, 2020, the provider must offer return to employment, earning *at least* the wage/salary amount they were paid prior to March 13, 2020 (the wage/salary can be higher, but not lower than the wage/salary rate as of March 12, 2020). The provider will be deemed to satisfy this condition even if laid off or furloughed staff decline such offer. Payroll records and return to employment offers/responses shall be provided if requested to validate this condition.	
	• Commit to resuming service delivery once the quarantine period has concluded	The provider must resume the provision of any service(s) for which the retainer payment is billed and paid that have been placed on hold or reduced during the PHE—subject to member needs and preferences. (There is no obligation to continue or resume services a member no longer needs or wants to receive from the provider.) Providers that have closed and do not intend to reopen are <u>not</u> eligible for these payments.	
	For ECF CHOICES providers *only*: • Commit to expanding capacity to serve additional members as such services are needed by ECF CHOICES members and as funds are available to serve additional members beginning July 1, 2020	The ECF CHOICES provider will expand staff capacity as needed to accept new referrals to provide services to additional ECF CHOICES members.	

Payment Flexibility	Conditions of Billing/Payment	Condition Terms	Attestation/Validation Process
COVID+ Residential Special Needs Adjustment (RSNA) and Personal Care Rate Differential (PCRD)	• Billable *only* if person receiving services is *confirmed* COVID-19 positive • Billable *only* for services provided during the period that the person requires isolation due to the COVID-19 diagnosis (based on CDC guidance) --Limited to 21 days except with physician order to continue at-home isolation up to no more than 30 days total • $5/hour hazard pay has been made to staff providing the service for each unit billed, supported by payroll records	***Confirmed* positive COVID-19** means the person has been tested for COVID-19, and the test was positive. The provider must have reported the person as confirmed positive COVID-19 in accordance with COVID-19 reporting processes set forth in the April 7, 2020 memo to HCBS providers. **Isolation** means that a person *confirmed* to have COVID-19 is separated from other people and his/her movement is restricted to prevent the spread of the disease. The provider is responsible for following CDC guidance as it relates to whether a person receiving services requires in-home isolation due to a COVID-19 diagnosis, such that hazard pay is appropriate, and for billing in accordance these limitations.	Billing will occur through a notification process to the member's MCO (rather than submission of claims). The MCO will process the payment directly, at point of claim. MCOs will verify that the person was reported ***confirmed* positive COVID-19** in accordance with COVID-19 reporting processes set forth in the April 7, 2020 memo to HCBS providers. The MCO may request additional information as needed to confirm the appropriate COVID+ RSNA, as applicable—specifically as it relates to whether dedicated 24/hour (round the clock) staffing with hazard pay is required. TennCare directs MCOs to add the "DR" (Disaster Related) condition code during the claims adjudication process to each claim for a COVID+ RSNA or PCRD to denote that the claim is impacted by these temporary COVID-related payment flexibilities and conditions. **A provider's acceptance of payment for these temporary rate increases, after notification to the MCO, constitutes the provider's attestation that all applicable conditions of payment will be met.** Payments are subject to audit and recoupment if it is determined that conditions of payment were not met. Audit processes may include (but are not limited to) review of provider payroll records, PCSPs, service notes, and other medical records.