



**Appendix K: Emergency Preparedness and Response
Operational Guide
for the
Adult Autism Waiver**

Version 1.0¹

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¹ This guide will be updated as additional clarification is developed.

Table of Contents

I.	Overview	3
II.	Purpose and Usage	3
III.	Scope	4
IV.	Effective Dates.....	4
V.	Billing Logic and Documentation	4
VI.	Guidance for Determining Whether Appendix K Applies	6
VII.	Emergency and Temporary Requirements in the Adult Autism Waiver	7
	Process for Level of Care.....	7
	Day Habilitation – Service Definitions and/or Limits	8
	Family Support – Service Definitions and/or Limits.....	9
	Nutritional Consultation – Service Definitions and/or Limits.....	9
	Residential Habilitation (Community Homes and Life Sharing) Service Definitions and/or Limits	10
	Respite – Service Definition and/or Limits	13
	Specialized Skill Development: Behavioral Specialist and Systematic Skill Building – Service Definitions and/or Limits	14
	Specialized Skill Development: Community Support – Service Definitions and/or Limits	15
	Supports Coordination – Service Definition and/or Limits.....	16
	Temporary Supplemental Services - Service Definitions and/or Limits	17
	Therapies (Counseling) – Service Definitions and/or Limits.....	19
	NEW SERVICE: Shift Nursing – Service Definition and/or Limits	20
	Provider Qualifications.....	25
	Payment to Family Members.....	26
	Participant-Centered Planning and Service Delivery	26
	Participant Safeguards – Incident Management	27
	Rates, Billing and Claims and Supplemental or Enhanced Payments.....	28

I. Overview

In response to Coronavirus (COVID-19), Pennsylvania submitted Appendix K to the Centers for Medicare and Medicaid Services (CMS) requesting specific amendments to the approved 1915(c) waivers during this emergency. Appendix K was approved by CMS on March 18, 2020.

The population served through Pennsylvania’s Office of Developmental Programs (ODP) may be particularly vulnerable to COVID-19 due to:

1. underlying health conditions such as higher levels of diabetes and cardiovascular disease than the general public;
2. reliance on support from others for activities of daily living;
3. deficits in adaptive functioning that inhibit ability to follow infection control procedures;
4. receipt of care in congregate facility-based settings. ODP currently has approximately 56,000 individuals enrolled for services with approximately 36,000 of those individuals receiving services through one of ODP’s approved 1915(c) waivers.

Pennsylvania manages four (4) 1915(c) waivers; Person/Family Directed Support, Community Living, Consolidated (i.e. Intellectual Disability/Autism [ID/A]) and Adult Autism Waivers (AAW). *There are approximately 2,400 individuals currently on the waiting list who live with family and whose primary caregivers are over age 60. Family caregivers falling ill with COVID-19 may also result in an increased need for emergency services.*

The Office of Developmental Programs has created a [Coronavirus \(COVID-19\) Updates webpage](#) for stakeholders to stay up-to-date with updates and resources from ODP. This guide will be posted to this webpage.

II. Purpose and Usage

The purpose of this document is to provide operational guidance to specific temporary and emergency amendments granted under Appendix K by CMS. It is intended to be a guide for ODP, Supports Coordination Organizations, and Providers to ensure adherence to the conditions of the emergency amendments approved in Appendix K and provide specific guidance on process, documentation, and health and safety measures.



This icon indicates a notification requirement or an incident requirement.



This icon indicates additional documentation related to changes contained in Appendix K.

III. Scope

This operational guide applies to services rendered under the Adult Autism Waiver. The changes in this operational guide are only to be implemented for participants impacted by COVID-19. Participants may be impacted due to staffing shortages, a COVID-19 diagnosis for the participant or a participant's housemate or caregiver, and closures of service locations (residential homes, Day Habilitation service locations, etc.). Requirements in the current approved waiver must be followed for any requirement not listed in this guide.

IV. Effective Dates

The changes identified in this operational guide are effective starting March 11, 2020 and will continue to be in effect until an end date is provided by ODP. Needed changes covered in this document can be made effective retroactively to March 11, 2020, but not prior to this date.

Once the end date of Appendix K is determined, all changes made to implement Appendix K must end. As all changes in this operational guide are specific to COVID-19 impacts, and Appendix K will only end when there are no longer widespread impacts caused by COVID-19, there will no longer be a need for participants to maintain service changes allowable through Appendix K. As such, changes made to ISPs to revert services back to levels prior to being impacted by COVID-19 will not be subject to fair hearing and appeal requirements.

V. Billing Logic and Documentation

ODP acknowledges not all billing scenarios can be identified during the COVID-19 response. On February 20, CMS provided direction to states on ICD-10-CM billing codes related to COVID-19. Based on this guidance, ODP will be utilizing "Z03.818 medical diagnosis code" for claims when something is "out of the ordinary" and it is likely that reconciliation or adjustment will be needed. When services have been impacted by COVID-19, ODP recommends providers include the Z03.818 medical diagnosis code in addition to the regular diagnosis code on PROMISE claims utilizing the following logic in order of preferred method:

1. The service on the ISP is correct or a critical revision is made that reflects the service that was rendered. **(Do not use the diagnosis code Z03.818 on a claim.)**
 - A critical revision to the ISP is required to add Temporary Supplemental Services.

2. The service on the ISP is correct or a critical revision is made that reflects the service that was rendered, but the service was rendered in accordance with Appendix K. **(Include the diagnosis code Z03.818 on Field 21.B of the claim)**
 - Services that are provided remotely or via telephone.
 - Residential Habilitation services rendered beyond the home's approved program capacity.
 - More than 50 hours per week of Community Support, Supported Employment, Day Habilitation, and Small Group Employment is provided to meet the needs of participants.
 - More than 40 hours per week of a service is rendered by a relative or legal guardian.
 - Respite is rendered in a location that is not enrolled and qualified to render the Respite service (examples: private ICFs/ID or a residential location).
 - Shift Nursing is added to a plan.

3. The service on the ISP does not reflect the service/staffing ratio that is being rendered, but a similar service is authorized on the ISP and the provider bills to help support cash flow. **(Include the diagnosis code Z03.818 on Field 21.B of the claim.)**

During this crisis, health and safety activities for individuals and families are paramount. **Retroactive authorizations** to March 11, 2020 can be made to remove barriers between HCSIS authorizations and providers rendering a service. Providers should contact the Supports Coordinators to discuss the need for retroactive authorizations. ODP's Bureau of Support for Autism and Special Populations is available for technical assistance when major changes are discussed or if there are concerns about requests.

Supports Coordination Organizations are not required to use these ICD-10 codes.

Providers must document what actions were taken and maintain evidence for why actions were taken:

- Medical records. Example: Individual #1 tests presumptively positive for COVID-19. The provider relocates Individual #1 and suspends his participation in all activities with housemates until medically cleared by a physician. The provider should maintain copies of the positive test result and medical clearance to support the relocation and suspension of participation.
- Correspondence and other records demonstrating inability to meet required staffing needs. Example: Provider A's provider-employed DSPs are unable to report

to work due to COVID-19-related reasons. Provider A attempts to secure temporary staff from multiple staffing agencies, but each agency reports that they too are experiencing staff shortages. As a result, Provider A is out of compliance with required staffing needs. Provider A should retain copies of correspondence with each of the staffing agencies contacted to demonstrate that all possible efforts were made to secure enough staff.

VI. Guidance for Determining Whether Appendix K Applies

All changes contained in this operational guide may only be implemented for participants impacted by COVID-19. The following questions can be utilized 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 Day Habilitation services in a licensed facility that closed?
 - b. Was the participant diagnosed with COVID-19 that requires relatives to render services when direct support professionals are unwilling to render services while the participant is contagious?
 - c. Was the participant's caregiver or a person with whom they live diagnosed (presumptive or confirmed) with COVID-19?
 - d. Was the participant's direct support professional diagnosed (presumptive or confirmed) with COVID-19?
 - e. Is the participant's direct support professional isolating at home or quarantined due to exposure to someone diagnosed (presumptive or confirmed) with COVID-19?
 - f. Is the participant's direct support professional unable to render services due to caring for a child(ren) due to closure of schools or day cares as a result of COVID-19?
 - g. Is the participant's direct support professional unable to render services due to caring for a family member diagnosed with 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?
 - i. Is the participant's family refusing to allow direct support professionals into their home as part of social distancing?
- Is the change requested covered in this operational guide? If not, please contact the Regional Office Representative in ODP's Bureau of Support for Autism and Special Populations.

Given the rapid response that will be necessary to ensure participant health and welfare and to avoid delays while waiting for approval and authorization of ISP changes in HCSIS, documentation of verbal approval or email approval of changes and additions to individual plans will suffice as authorization. More information can be found under the operational guidance for Appendix D.

VII. Emergency and Temporary Requirements in the Adult Autism Waiver

Waiver Reference: Appendix B-6-f
Process for Level of Care
<p>Appendix K Requirement(s):</p> <ol style="list-style-type: none"> 1. When ICF/ID or ICF/ORC level of care is evaluated, it is not required that a physician recommend, certify, or verify that the individual should receive the level of care furnished through the waiver. 2. Level of care recertification can be extended from 365 days of the initial evaluation and subsequent anniversary dates to 18 months from initial evaluations and subsequent anniversary dates.
Operational Guidance:
<ol style="list-style-type: none"> 1. To reduce the need to visit a doctor’s office, individuals will not be required to obtain the results of a medical evaluation to <u>be determined eligible for enrollment in the AAW or level of care recertification</u>. Administrative Entities (AEs) will determine initial level of care for enrollment in a waiver through the other 3 criteria listed in the waiver: <ol style="list-style-type: none"> 1. Verification of diagnosis of intellectual disability or autism spectrum disorder. 2. Certification by a Qualified Developmental Disability Professional (QDDP) that the individual has impairments in adaptive behavior based on the results of a standardized assessment. 3. Documentation that substantiates that the individual has had these conditions of intellectual and adaptive functioning deficits which manifested during the developmental period which is from birth up to the individual’s 22nd birthday. 2. ODP’s Bureau of Supports for Autism and Special Populations will conduct the level of care re-evaluation using the results of the most recent SIB-R to determine if the individual continues to require an ICF/ID or ICF/ORC level of care. Supports Coordinators do not need to take any further action. <p>ICD-10 codes discussed in Section V are not required for these changes.</p>

Day Habilitation – Service Definitions and/or Limits

Appendix K Requirement(s):

1. The requirement to provide services in community locations a minimum of 25% of participant time in service is suspended.
2. Suspend requirements for allowing visitors (providers may prohibit/restrict visitation in-line with CMS recommendations for long term care facilities). The modification of this right is not required to be justified in the ISP.
3. Day Habilitation may be provided in private homes.
4. Minimum staffing ratios as required by licensure, service definition, and ISP may be exceeded due to staffing shortages.

Operational Guidance:

1. No changes need to be made to the ISP to implement the suspension of the requirement that participants be given the choice to spend 25% of their time in community locations. Variances are not required to be completed when the 25% threshold is not achieved.
2. Requirements for visitors in licensed facilities where Day Habilitation may be provided are not addressed in this document at this time as all of these facilities were required to close effective March 17, 2020. Additional information about the closure of these facilities can be found in ODP communication 20-022.
3. ODP encourages Day Habilitation providers to continue to support participants in their homes during the closure of licensed Day Habilitation facilities and many community locations. Day Habilitation may be provided in the following private homes:
 - Homes owned, rented or leased by the participant, the participant’s family or friends.
 - Licensed and unlicensed Life Sharing homes.

Supporting participants in private homes may require a change to the ISP to identify the billing procedure codes with the proper staff ratio.

Additional guidance about how Day Habilitation staff may be utilized to support people in private homes and communities, including in Residential Habilitation settings, can be found in ODP communication 20-022.



NOTIFICATION REQUIREMENT FOR 1 THROUGH 3: When implementation of any of the requirements listed above require changes in currently authorized staffing ratios, the provider must notify each participant’s Supports Coordinator so that these

changes can be added and authorized in the ISP. The provider must inform the Supports Coordinator when these services will start or were implemented due to an emergency, which cannot be prior to March 11, 2020.

Family Support – Service Definitions and/or Limits

Appendix K Requirement(s):

1. Family Support may be provided using remote/tele support when this type of support meets the health and safety needs of the participant, including behavioral health needs.

Operational Guidance

1. When Family Support is provided using remote support or support via telephone, the provider is responsible for determining if this type of support will meet the health and safety needs of the participant. Billing for this service may only occur when licensed provider staff are actively engaging with participants and/or family members via technology or over the phone.



NOTIFICATION REQUIREMENT: Providers must notify each person's Supports Coordinator, if services need to be added to the plan or additional units are required to implement this change. They must inform the Supports Coordinator when these services will start or were implemented due to an emergency, which cannot be prior to March 11, 2020.

Nutritional Consultation – Service Definitions and/or Limits

Appendix K Requirement(s):

1. Nutritional Consultation may be provided using remote/tele support when this type of support meets the health and safety needs of the participant, including behavioral health needs.

Operational Guidance

1. When Nutritional Consultation is provided using remote support or support via telephone, the provider is responsible for determining if this type of support will meet the health and safety needs of the participant. Telephone consultation is allowable regardless of the distance between the provider and the participant. Billing for this service may only occur when the licensed dietician-nutritionist is actively engaging with participants via technology or over the phone.

The initial assessment required for ongoing services may be completed via video conferencing (such as FaceTime, Skype, Zoom, etc.)



NOTIFICATION REQUIREMENT: Providers must notify each person's Supports Coordinator, if services need to be added to the plan or additional units are required to implement this change. They must inform the Supports Coordinator when these services will start or were implemented due to an emergency, which cannot be prior to March 11, 2020.

Residential Habilitation (Community Homes and Life Sharing) Service Definitions and/or Limits

Appendix K Requirement(s):

1. Service can be provided in licensed or unlicensed settings.
2. Service definition limitations on the number of people of served in each home may be exceeded.
3. Maximum number of individuals served in a service location may be exceeded to address staffing shortages or accommodating use of other sites as quarantine sites.
4. Prior written authorization through the use of the Residential Habilitation Request Form is suspended.
5. Each participant's right to choose with whom they share a bedroom is suspended. The modification of this right is not required to be justified in the ISP.
6. Suspend requirements for allowing visitors (providers may prohibit/restrict visitation in-line with CMS recommendations for long term care facilities). The modification of this right is not required to be justified in the ISP.
7. Residential Habilitation services may be rendered by relatives or legally responsible individuals when they have been hired by the provider agency authorized on the ISP.
8. Minimum staffing ratios as required by licensure, service definition and individual plan may be exceeded due to staffing shortages.
9. Participants that require hospitalization due to a diagnosis of COVID-19 may receive Residential Habilitation in a hospital setting when the participant requires these services for communication, behavioral stabilization and/or intensive personal care needs. Residential Habilitation can be provided in a hospital as long as it is medically necessary for the participant to be hospitalized due to a diagnosis of COVID-19.

Operational Guidance:

1. Providers enrolled in the Consolidated or Community Living waivers to provide Residential Habilitation and Life Sharing can enroll in the Adult Autism Waiver to provide these services in either *licensed* or *unlicensed* settings. To enroll in the AAW,

contact the AAW Provider Enrollment Mailbox at ra-pwbasprovenroll@pa.gov to be provided with instruction on an expedited enrollment process.

2 & 3: For Residential Habilitation – Community Homes, the number of people receiving services in each licensed or unlicensed home may not exceed 8 or the capacity listed on the certificate of occupancy, whichever number is lower. For Life Sharing, the number of people receiving Life Sharing services may not exceed 2.

To implement this change, providers are not required to notify ODP when there is a change to the number of people served in the home due to COVID-19. This applies for increases in the number of people served in a home to address staffing shortages or using homes as quarantine sites. This also applies to decreases due to a person's medical or hospital leave due to COVID-19 or when a person stays with family or friends due to COVID-19 (also known as reserved residential capacity).



NOTIFICATION REQUIREMENT: Providers must notify each person's Supports Coordinator when there are plans to move the person to another home, or when emergency relocation is necessary. The Supports Coordinator will then notify the person's Regional Office Representative of ODP's Bureau of Supports for Autism and Special Populations to ensure that there are no concerns about the relocation.

4. If an individual needs to begin receiving Residential Habilitation, including Life Sharing, during this time, the Supports Coordinator does not need to complete or submit the Residential Habilitation Request Form if the service is needed due to a diagnosis or circumstances related to COVID-19.



NOTIFICATION REQUIREMENT: Before adding Residential Habilitation, including Life Sharing, to an individual's ISP, the Supports Coordinator should contact the Regional Office Representative of ODP's Bureau of Supports for Autism and Special Populations, except in emergency situations where an individual's health and safety is at risk. Notification to BSASP in these circumstances must be done as soon as possible.

5. When increasing the number of people served in a home, accommodations should be as comfortable and dignified as possible. While each individual's right to choose with whom they share a bedroom is suspended, providers are still encouraged to help participants exercise rights to the fullest extent possible. Providers are responsible for talking with each person who will be required to share a bedroom to discuss their concerns, how privacy will be afforded and how choices will be negotiated. Requests

such as sharing a bedroom with someone of the same sex must be honored. An unrelated child and adult may not share a bedroom.

6. Additionally, although requirements for visitors are suspended, providers *must* still facilitate personal relationships between each participant and persons of their choosing via cell phones/telephones and other technology (text, mail, Skype, sending photo graphs or videos, email, FaceTime, Alexa, Facebook Portal, etc.). Providers are expected to make every effort to support non-face to face contact between participants and their family and friends. The Department does not consider limiting visitors against an individual's wishes to be a violation of the individual's rights IF the visitation is limited to prevent the spread of COVID-19. Everyone in Pennsylvania is being asked to limit contact with others to prevent the spread of COVID-19. As such, limiting visitors against an individual's wishes to prevent the spread of COVID-19 does not need to be entered as a rights violation in Enterprise Incident Management (EIM). Limiting visitors for any reason not related to COVID-19 IS a rights violation and must be reported in EIM.
7. Relatives and legally responsible individuals who render Residential Habilitation must receive training on the participant's ISP for whom they are rendering these services, including training on the Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP). Training on the ISP must consist of basic health and safety support needs for that participant including but not limited to the fatal four.

When this service is rendered by relatives or legally responsible individuals, the provider agency authorized to render the Residential Habilitation is responsible for ensuring that services are provided as authorized in the ISP and that billing occurs in accordance with ODP requirements.

Additional guidance regarding training requirements can be found in the section pertaining to Provider Qualifications.

8. ODP continues to encourage ISP teams to use person-centered thinking skills to discuss each participant's risk factors and ways to mitigate those risks including what technology, environmental, and staff supports will be provided to mitigate those risk(s) during specific activities and situations. The emphasis and conversation is around why the supports are being provided; not the number of hours and people, but the reason why staff are there.



INCIDENT REQUIREMENT: Providers must report any incidents in which staffing shortages result in an alleged failure to provide care. Please see information contained in Appendix G below.

9. When services will be provided during the hospitalization of a participant, the provider can continue to bill the Residential Habilitation service as long as a minimum of 8 hours of non-continuous care is rendered within a 24-hour period beginning at 12:00 a.m. and ending at 11:59 p.m. The provider is responsible for talking with hospital personnel about whether the hospital will allow the provision of services and follow any hospital requirements for doing so.



DOCUMENTATION REQUIREMENT: Service notes must be completed for the participant that demonstrate how the service is being used for communication, behavioral stabilization and/or intensive personal care needs.

Respite – Service Definition and/or Limits

Appendix K Requirement(s):

1. Respite limits may be extended beyond 30 times the day unit rate per ISP plan year without requesting an exception in order to meet the immediate health and safety needs of participants, including behavioral health needs.
2. Respite services may be provided in any setting necessary to ensure the health and safety of participants.
3. Room and board are included in the fee schedule rate for Respite in a licensed Residential Habilitation setting.
4. Room and Board would be included in the fee schedule for settings used in response to the emergency.

Operational Guidance



NOTIFICATION REQUIREMENT FOR 1: The AAW Request for an Exception of an Established Service Limit form does not need to be completed when a participant requires Respite totaling more than 30 units of day respite in a period of one fiscal year. Providers must notify each participant's Supports Coordinator when he or she needs an increase in the number of day units of Respite currently authorized on the ISP.

2. Respite services may be provided in a setting/service location that is not currently enrolled or qualified to render services when the setting/service location is owned by a provider that is enrolled and qualified to render Respite services in another location. Example: A provider owns a residential home or private ICF/ID where they would like to render Respite. The provider is already enrolled and qualified to render Respite in a different service location. The provider can use the currently enrolled service location to render services in the residential home or private ICF/ID that is not currently enrolled and qualified to render Respite services.



NOTIFICATION REQUIREMENT: To implement this change, the provider must notify the participant's Supports Coordinator to add the Respite service and/or the service location in the ISP, if it is not already included on the ISP. While the ISP will not reflect the actual location where Respite is provided, the provider must notify the Supports Coordinator where Respite will be provided.



DOCUMENTATION REQUIREMENT: The service note must reflect where the Respite is actually provided.

Specialized Skill Development: Behavioral Specialist and Systematic Skill Building – Service Definitions and/or Limits

Appendix K Requirement(s):

1. Behavioral Specialist and Systematic Skill Building services may be provided using remote/tele support when this type of support meets the health and safety needs of the participant, including behavioral health needs.
2. Participants that require hospitalization due to a diagnosis of COVID-19 may receive Behavioral Specialist and Systematic Skill Building services in a hospital setting when the participant requires these services for communication, behavioral stabilization and/or intensive personal care needs.

Operational Guidance

1. When Behavioral Specialist or Systematic Skill Building services are provided using remote support or support via telephone, the provider is responsible for determining if this type of support will meet the health and safety needs of the participant. Billing for the direct component of each of these services may only occur when direct support professionals are actively engaging with participants via technology or over the phone. Providers can continue to bill indirect Behavioral Support and Systematic Skill Building as currently approved in the waivers.



NOTIFICATION REQUIREMENT: Providers must notify each person's Supports Coordinator, if services need to be added to the plan or additional units are required to implement this change. They must inform the Supports Coordinator when these services will start or were implemented due to an emergency, which cannot be prior to March 11, 2020.

2. Behavioral Specialist and Systematic Skill Building can be provided in the hospital as long as it is medically necessary for the participant to be hospitalized due to COVID-19. The provider is responsible for talking with hospital personnel about whether the hospital will allow the provision of services and follow any hospital requirements for doing so.



DOCUMENTATION REQUIREMENT: When services are provided during hospitalization, service notes must be completed for the participant that demonstrate how the service is being used for communication, behavioral stabilization and/or intensive personal care needs.

Specialized Skill Development: Community Support – Service Definitions and/or Limits

Appendix K Requirement(s):

1. Community Support, when provided alone or in combination with Day Habilitation, Small Group Employment, and Supported Employment may be provided in excess of 50 hours per week without requesting an exception in order to meet the health and safety needs of participants.
2. Community Support may be provided using remote/tele support when this type of support meets the health and safety needs of the participant, including behavioral health needs.
3. Participants that require hospitalization due to a diagnosis of COVID-19 may receive Community Support in a hospital setting when the participant requires these services for communication, behavioral stabilization and/or intensive personal care needs.

Operational Guidance



NOTIFICATION REQUIREMENT FOR 1: The AAW Request for an Exception of an Established Service Limit form does not need to be completed when a participant requires more than 50 hours per week of Community Support, Day Habilitation, Small Group Employment, and Supported Employment due to an increased need for Community Support related to COVID-19. Providers of Community Support must notify each participant's Supports Coordinator when he or she needs an increase in the services currently authorized on the ISP.

2. When Community Support is provided using remote support or support via telephone, the provider is responsible for determining if this type of support will meet the health and safety needs of the participant. Billing may only occur when direct support professionals are actively engaging with participants via technology or over the phone.



NOTIFICATION REQUIREMENT: Providers must notify each person’s Supports Coordinator, if services need to be added to the plan or additional units are required to implement this change. They must inform the Supports Coordinator when these services will start or were implemented due to an emergency, which cannot be prior to March 11, 2020.

3. Community Support can be provided in the hospital as long as it is medically necessary for the participant to be hospitalized due to COVID-19. The provider is responsible for talking with hospital personnel about whether the hospital will allow the provision of services and follow any hospital requirements for doing so.



DOCUMENTATION REQUIREMENT: When services are provided during hospitalization, service notes must be completed for the participant that demonstrate how the service is being used for communication, behavioral stabilization and/or intensive personal care needs.

Supports Coordination – Service Definition and/or Limits

Appendix K Requirement(s):

1. Allow remote/telephone individual monitoring by Supports Coordination where there are currently face-to-face requirements.
2. Individual Support Plan team meetings and plan development may be conducted entirely using telecommunications.

Operational Guidance

1 & 2. Effective immediately and until further notice, ODP is NOT PERMITTING SCOs to conduct and SC activities in-person with individuals/families/caregivers (i.e. individual monitoring, ISP meetings, etc.). For the safety of everyone, SCOs should use phone or video conferencing solutions. The only exception would be if there are significant health and safety concerns and the only possibility to address is via an in-person visit.

SCOs are expected to schedule team meetings via conference call or similar technology.

For individual quarterly monitoring that would have typically been required to be conducted face-to-face, the SC must continue to evaluate and record the answers to all of the questions on the SC monitoring tool, to the best of his or her ability.

The Scales of Independent Behavior-Revised (SIB-R), Quality of Life Questionnaire (QOL.Q), and Parental Stress Scale (PSS) do not need to be completed prior to developing the initial ISP or annual review plan. These assessments should be completed at the next face-to-face meeting with the individual and adjustments to the ISP based on the outcomes of those assessments can be completed through a critical revision or general update.

The PRE should continue to be completed by the Supports Coordinator or Behavioral Specialist prior to the submission of the ISP.

The ISP signature form should be completed at the next face-to-face visit with the individual. A service note detailing why the date on the ISP signature form does not align with the meeting date should be completed.

If an individual is newly enrolled in the AAW or awaiting the completion of the initial ISP, the SC may develop an interim ISP to get services started before the full ISP is developed. An interim ISP includes only the completion of the following sections of the ISP:

- Medial Information: Current Health Status - This includes any known medications, health concerns, etc. This is meant to be an overview until the full ISP is completed.
- Health and Safety: General Health and Safety Risks
- Health and Safety: Supervision Care Needs
- Goals – a goal will need to be connected to each service. Objectives are not required.
- Service Details

An interim ISP is temporary. The interim ISP is used to get services initiated until a more detailed service plan can be finalized. The interim ISP cannot be used for more than 45 days.

ICD-10 codes discussed in Section V are not required for these changes.

Temporary Supplemental Services - Service Definitions and/or Limits

Appendix K Requirement(s):

1. Temporary Supplemental Services can be exceeded beyond 540 hours in a twelve-month period to address the increased needs of individuals affected by the epidemic/pandemic or increased number of individuals served in a service location.
2. Temporary Supplemental Services may be rendered by relatives or legally responsible individuals when they have been hired by the provider agency authorized on the ISP.
3. Participants that require hospitalization due to a diagnosis of COVID-19 may receive Temporary Supplemental Services in a hospital setting when the participant requires these services for communication, behavioral stabilization and/or intensive personal care needs.

Operational Guidance

1. The need to exceed the service limit to assure the participant's health and safety should be identified by the ISP team.



NOTIFICATION REQUIREMENT: The Supports Coordinator must notify the Regional Office Representative of ODP's Bureau of Supports for Autism and Special Populations (BSASP) via email with the participant's name, reason for the service, reason for the service limit to be exceeded (if applicable), and length of time service will be needed (if known).

BSASP will review the situation with the Supports Coordinator (and through service notes) on a regular basis to review the continued need for Temporary Supplemental Services.

2. Relatives and legally responsible individuals who render Temporary Supplemental Services must receive training on the participant's ISP for whom they are rendering these services, including training on the Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP). Training on the ISP must consist of basic health and safety support needs for that participant including but not limited to the fatal four.

When this service is rendered by relatives or legally responsible individuals, the provider agency authorized to render the Temporary Supplemental Services is responsible for ensuring that services are provided as authorized in the ISP and that billing as well as claim and service documentation occurs in accordance with ODP requirements.

3. Temporary Supplemental Services can be provided in the hospital as long as it is medically necessary for the participant to be hospitalized due to COVID-19. The provider is responsible for talking with hospital personnel about whether the hospital will allow the provision of services and follow any hospital requirements for doing so.



DOCUMENTATION REQUIREMENT: When services are provided during hospitalization, service notes must be completed for the participant that demonstrate how the service is being used for communication, behavioral stabilization and/or intensive personal care needs.

Therapies (Counseling) – Service Definitions and/or Limits

Appendix K Requirement(s):

1. Therapy (counseling) may be provided using remote/tele support when this type of support meets the health and safety needs of the participant, including behavioral health needs.
2. Participants that require hospitalization due to a diagnosis of COVID-19 may receive therapy (counseling) in a hospital setting when the participant requires these services for communication, behavioral stabilization and/or intensive personal care needs.

Operational Guidance

1. When Therapy (counseling) is provided using remote support or support via telephone, the provider is responsible for determining if this type of support will meet the health and safety needs of the participant. Billing for this service may only occur when licensed provider staff are actively engaging with participants via technology or over the phone.



NOTIFICATION REQUIREMENT: Providers must notify each person’s Supports Coordinator, if services need to be added to the plan or additional units are required to implement this change. They must inform the Supports Coordinator when these services will start or were implemented due to an emergency, which cannot be prior to March 11, 2020.

2. Therapy (counseling) can be provided in the hospital as long as it is medically necessary for the participant to be hospitalized due to COVID-19. The provider is responsible for talking with hospital personnel about whether the hospital will allow the provision of services and follow any hospital requirements for doing so.



DOCUMENTATION REQUIREMENT: When services are provided during hospitalization, service notes must be completed for the participant that demonstrate how the service is being used for communication, behavioral stabilization and/or intensive personal care needs.

NEW SERVICE: Shift Nursing – Service Definition and/or Limits

Shift Nursing has been added as a service in the Adult Autism Waiver while Appendix K is in effect.

Service Definition:

Shift Nursing is a direct service that can be provided either part-time or full-time in accordance with 49 Pa. Code Chapter 21 (State Board of Nursing) which provides the following service definition for the practice of professional nursing: "Diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

Shift nursing for participants is generally not available through Medical Assistance Fee-For-Service or Physical Health Managed Care Organizations. Home health care, which is defined as a rehabilitative nursing component, is the only service available in the participant's home through Medical Assistance.

Shift Nursing services may only be funded for participants through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the participant's insurance or insurance limitations have been reached. A participant's insurance includes Medical Assistance (MA), Medicare and/or private insurance.

This service may be provided at the following levels:

- Basic - Staff-to-individual ratio of 1:2.
- Level 1 – Staff-to-individual ratio of 1:1.

Participants authorized to receive Shift Nursing services may not receive the following services at the same time as this service: Respite (15-minute or Day); the Systematic Skill Building and Community Support components of Specialized Skill Development; Day Habilitation, Therapies, and Nutritional Consultation. Shift nursing may be provided as a discrete service during the provision of residential habilitation, including life sharing to ensure participant health and safety needs can be met.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Provider Specifications:

Shift Nursing can be provided by an individual nurse or a Nursing Agency.

Provider Qualifications (Individual Nurse):

Nurses must meet the following standards:

1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.
2. Have a signed ODP Provider Agreement on file with ODP.
3. Complete standard ODP required orientation and training,
4. New providers demonstrate compliance with ODP standards through completion of self-assessment and validation of required documentation, policies and procedures.
5. Have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.
6. Have Workers' Compensation Insurance, in accordance with state statute.
7. Be trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.
8. Comply with Department standards related to provider qualifications.

Individual nurses must meet the following requirements:

- Be a Registered Nurse (RN) or Licensed Practical Nurse (LPN).
- Comply with Title 49 Pa. Code Chapter 21.
- Nurses with a waiver service location in a state contiguous to Pennsylvania must comply with regulations comparable to Title 49 Pa. Code Chapter 21.

Provider Qualifications (Nursing Agencies):

Agencies must meet the following standards:

1. Have a waiver service location in Pennsylvania or a state contiguous to Pennsylvania.
2. Have a signed ODP Provider Agreement on file with ODP.
3. Complete standard ODP required orientation and training,
4. New providers demonstrate compliance with ODP standards through completion of self-assessment and validation of required documentation, policies and procedures.
5. Have Commercial General Liability Insurance.

6. Have Workers' Compensation Insurance, in accordance with state statute.
7. Ensure that staff (direct, contracted, or in a consulting capacity) have been trained to meet the needs of the participant which includes but is not limited to communication, mobility and behavioral needs.
8. Comply with Department standards related to provider qualifications.

Nurses working for or contracting with agencies must have criminal history clearances per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter 15.

Staff (direct, contracted, or in a consulting capacity) providing Shift Nursing services must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

Providers with a waiver service location in Pennsylvania must comply with Title 49 Pa. Code Chapter 21.

Providers with a waiver service location in a state contiguous to Pennsylvania must comply with regulations comparable to Title 49 Pa. Code Chapter 21.

Operational Guidance

Providers enrolled to provide Shift Nursing in the Consolidated, Community Living, or P/FDS waivers can enroll in the Adult Autism Waiver to provide Shift Nursing using an expedited enrollment process. To enroll in the AAW, providers should contact the AAW Provider Enrollment Mailbox at ra-pwbasprovenroll@pa.gov to be provided with instruction on an expedited enrollment process.

Shift Nursing may be rendered by relatives or legally responsible individuals who meet the qualifications in the service definition.

ODP's Bureau of Supports for Autism and Special Populations will provide Supports Coordinators with a Services and Supports Directory for Shift Nursing. If the Supports Coordinator has identified in need for shift nursing in a county where a provider has not yet been identified, the SC should contact the AAW Provider Enrollment Mailbox at ra-pwbasprovenroll@pa.gov.

Determining the need for services:

The following additional questions should be used to establish a determination of need:

- Does this participant have an unstable airway that without immediate intervention could cause respiratory arrest (stop breathing)?
- Does this participant need clinical treatment that either requires the presence of a nurse or that can be taught to a lay person and monitored by a nurse?
- Does this participant have someone supporting him or her that can be taught treatment techniques and maintain equipment in a home program?
- Can care be safely and effectively administered in the home setting and life-supporting equipment be managed?

Shift Nursing services may only be funded through the waiver if documentation is secured by the SC that shows the service is medically necessary. The participant must be in need of support that that can only be provided by a registered nurse or licensed practical nurse. For more information on support that can be provided without a nurse, please refer to the Pennsylvania Department of Health’s guidance regarding non-skilled services/activities that can be performed by direct care workers at

<https://www.health.pa.gov/topics/Documents/Facilities%20and%20Licensing/HcAGuidance.pdf>

Providers must follow all guidance on service delivery previously issued by ODP for the delivery of Shift Nursing in the Consolidated, Community Living, or P/FDS waivers.

<i>Waiver Service</i>	<i>Unit</i>	<i>Rate</i>	<i>Staffing</i>	<i>Procedure Code</i>	<i>Modifier</i>
Shift Nursing - RN	15 min	\$15.78	1:1	T2025	TD
Shift Nursing - RN		\$8.06	1:2	T2025	TD, UN
Shift Nursing - LPN		\$11.41	1:1	T2025	TE
Shift Nursing - LPN		\$5.88	1:2	T2025	TE, UN



DOCUMENTATION REQUIREMENTS:

- An evaluation indicating the need for nursing services, specifying the need for services by a licensed registered nurse (RN) or a licensed practical nurse (LPN).
- Documentation, including the most recent nursing care plan, from the nursing service provider to confirm that nursing care continues to be appropriate.
- An emergency action and transportation plan consistent with the participant’s condition.

- Documentation that the nursing service is not covered by the participant's insurance.
 - **Participants whose *only* form of insurance is Medical Assistance:** Adults are not entitled to private duty nursing/shift nursing through the Medical Assistance program's fee-for-service or managed care delivery systems. The Medical Assistance program's Adult Benefit Package Chart indicates that home health care is the only service available in the individual's home with a nursing and/or therapy component. This chart is available at the end of OMAP Bulletin 99-15-05 which can be accessed at http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/c_172249.pdf. This chart should be printed and kept in each participant's file as documentation that private duty nursing/shift nursing is not available.
 - **Participants who have private insurance (in addition to Medical Assistance):** The SC and/or individual or family member should contact the private insurance to determine if this service is covered. The SC must document in a service note the name of the insurance carrier, the name of the person spoken to, and confirmation of one of the following:
 - The nursing service is not covered by the participant's insurance;
 - Nursing services have been denied by the insurance carrier; or
 - Insurance limitations for nursing services have been reached.

Lack of coverage for services and denials in writing must be requested from the insurance carrier, but the service can be added to the ISP and authorized with the verbal confirmation alone. When insurance carriers decline to provide written documentation, ODP will also accept one of the following (in addition to the verbal confirmation):

- A copy of the policy or some other written statement documenting that the service, item or amount requested exceeds the allowable service limit or that the service is not covered.
- Written confirmation of information received verbally from an insurance carrier that is sent to the insurance carrier, identifies the item or service in question, and requests that the insurance carrier advise the writer of any inaccuracy.

Provider Qualifications

1. To allow redeployment of direct support and clinical staff to needed service settings during the emergency, staff qualified under any service definition in the Adult Autism Waiver may be used for provision of any non-professional service under another service definition in C-1/C-3. Professional services exempt from this include; Supports Coordination, Therapies, Behavioral Specialist Services and Systematic Skill Building components of Specialized Skill Development, Nutritional Consultation, Family Support, and Shift Nursing.
2. All staff must receive training on any individuals' ISPs for whom they are providing support. Training on the ISP must consist of basic health and safety support needs for that individual including but not limited to the fatal four. In addition, if the participant has a Behavioral Support Plan and Crisis Intervention Plan, staff must be trained on the implementation of those plans.

Operational Guidance

1. ODP encourages providers to collaborate with another to ensure that individuals receive the services and support needed. To achieve this, providers can use direct support professionals who are qualified under a non-professional service to render another service. An example of this would be when a Residential Habilitation provider hires or redeploys staff who currently render Day Habilitation services to render Residential Habilitation services. While individual staff do not have to meet the qualification criteria to render a specific service, providers must be enrolled and qualified in HCSIS to render the service.
2. When this occurs, providers must ensure that staff receive training on each individual's ISP to whom they will render services, including the Behavioral Support Plan (BSP) and Crisis Intervention Plan (CIP). The training must include basic health and safety support needs for each individual including but not limited to the fatal four, communication, mobility, and behavioral needs.

For newly enrolled providers or new staff hired for any service during this time, the SPeCTRUM 2.0 training course can be completed within 30 days after the first date of service delivery.

Until further notice, if providers are unable to train new staff using the Standard Medication Administration Training Course, new staff may administer medications after they: (1) Complete ODP's Modified Medication Administration Training Course, available on [www.MyODP.org](https://www.myodp.org/course/index.php?categoryid=11) (<https://www.myodp.org/course/index.php?categoryid=11>). (2) Receive

training from the provider on the use of the provider’s medication record for documenting the administration of medication, and (3) Providers must retain record of staff’s completion of the Modified Medication Administration Training Course by retaining a copy of the certificate of completion. ODP will notify providers when the Standard Medication Administration Training Course is again the requirement.



DOCUMENTATION REQUIREMENT: Providers must document all training completed with staff, contractors or consultants.

ICD-10 codes discussed in Section V are not required for these changes.

Waiver Reference: Appendix C-2

Payment to Family Members

1. The limitation for a family member to deliver services no more than 40 hours in a seven-day period will be extended to 60 hours in a seven-day period.

Operational Guidance



DOCUMENTATION REQUIREMENT: When services are rendered by family members, the provider agency authorized to render the service is responsible for ensuring that services are provided as authorized in the ISP and that billing as well as claim and service documentation occurs in accordance with ODP requirements.

Waiver Reference: Appendix D

Participant-Centered Planning and Service Delivery

1. Given the rapid response that will be necessary to ensure participant health and welfare and to avoid delays while waiting for approval and authorization of individual plan changes in HCSIS, documentation of verbal approval or email approval of changes and additions to individual plans will suffice as authorization. Upon validation that a verbal or email approval was provided for requested changes, ODP may backdate authorizations in HCSIS for waiver services provided during the period of time specified in Appendix K.

Operational Guidance



NOTIFICATION REQUIREMENT: Providers are responsible for notifying the Supports Coordinator as soon as they become aware of any changes needed to participants’

ISPs. They must tell the Supports Coordinator the date that changes need to be implemented, which can be no earlier than March 11, 2020.



DOCUMENTATION REQUIREMENT: While email approval is preferred, when this is not possible Supports Coordinators must document verbal conversations with the Regional Office Representative of ODP’s Bureau of Support for Autism and Special Populations where approval is given. Documentation must include the date and name of the person with whom the verbal conversation occurred in addition to all relevant information about the participant and provider for whom the approval applies.

Written consent from the participant and written acknowledgement from the provider of changes made to an ISP using a critical revision are not required at this time.

Depending on the nature of the service that is or will be rendered, providers may be required to use ICD-10 codes discussed in Section V as enumerated throughout this **operational guide**. SCs do not need to use ICD-10 codes discussed in Section V for the changes in Appendix D.

Waiver Reference: Appendix G

Participant Safeguards – Incident Management

1. Suspension of requirements for allowing visitors to prevent the spread of COVID-19 is allowed and is not considered a rights violation. The modification of this right is not required to be justified in the ISP.
2. Suspension of requirements for right to choose who to share a bedroom with. The modification of this right is not required to be justified in the individual plan.

Operational Guidance

Many providers enter a neglect incident into Enterprise Incident Management (EIM) if the total number of staff on duty is lower than the total number of staff who are supposed to be on duty based on staffing needs specified in the individual plan. During the time that this provision of Appendix K is in effect, a neglect incident will NOT need to be entered into EIM if these circumstances exist as long as:

- a. The reason there are fewer staff on duty than what is specified is in the ISP relates directly or indirectly to COVID-19; and
- b. The individual receives all needed care.



INCIDENT REQUIREMENT: Providers must report any incidents in which staffing shortages result in an alleged failure to provide care, even if the staffing shortage is COVID-19 related.

1. The Department does not consider limiting visitors against an individual's wishes to be a violation of the individual's rights IF the visitation is limited to prevent the spread of COVID-19. Everyone in Pennsylvania is being asked to limit contact with others to prevent the spread of COVID-19. As such, limiting visitors against an individual's wishes to prevent the spread of COVID-19 does not need to be entered as a rights violation in Enterprise Incident Management (EIM). Limiting visitors for any reason not related to COVID-19 IS a rights violation and must be reported in EIM.
2. For Residential Habilitation including Life Sharing, each individual's right to choose with whom they share a bedroom is suspended. Providers are still encouraged to help participants exercise rights to the fullest extent possible. Providers are responsible for talking with each person who will be required to share a bedroom to discuss their concerns, how privacy will be afforded and how choices will be negotiated. Requests such as sharing a bedroom with someone of the same sex must be honored. An unrelated child and adult may not share a bedroom. Suspension of this right for purposes related to COVID-19 does not need to be entered as a rights violation in Enterprise Incident Management (EIM).

Waiver Reference: Appendix I

Rates, Billing and Claims and Supplemental or Enhanced Payments

1. The following rates may be increased to account for excess overtime of direct support professionals to cover staffing needs and to account for additional infection control supplies and service costs:
Residential Habilitation, including life Sharing, the Community Support component of Specialized Skill Development, Day Habilitation, Respite, and Shift Nursing.
2. Retainer payments may be provided for Day Habilitation.
 - a) Retainer payments may be provided in circumstances in which facility closures are necessary due COVID-19 containment efforts.
 - b) Retainer payments may be provided in circumstances in which attendance and utilization for the service location drop to below 75% of annual monthly average 7/1/19 to 2/28/2020.

c) Retainer payments will not exceed 75% of monthly average of total billing under the 1915(c) waivers.

Operational Guidance

1. There is no provider action necessary at this time relative to temporarily increased rates. It is anticipated that temporarily increased rates would be applied retroactively.
2. There is no provider action necessary at this time relative to retainer payments for Day Habilitation. ODP will perform necessary calculations and providers will receive monthly payments through gross adjustments. It is anticipated that providers will see their first retention payment prior to March 31, 2020.



NOTIFICATION REQUIREMENT: Providers should work with the SCOs to have plans updated in HCSIS as expeditiously as possible.