Public Comments:
End of the Appendix K Coverage and ADM Revisions to 06-ADM-01R, 21-ADM-02R, 21-ADM-03R, 23-ADM-08

<table>
<tr><th colspan="2">Public Comments</th><th>Draft Responses</th></tr>
<tr><td colspan="2">Related to Remote Technology ADM (21-ADM-03R) – Supported Employment (SEMP) (2023 ADM -09)</td><td></td></tr>
<tr><td>1.</td><td>Concerned that phone calls with an individual now count as delivery of telehealth services even though a phone call is not “face to face.” I would ask that phone calls not be considered for telehealth purposes. Community-Based Prevocational Services (CBPV) and SEMP services often result in phone calls with clients to discuss service delivery schedule or “next steps” towards their employment goals which has been an acceptable form of communication for many years.</td><td>Per the Administrative Directive Memorandum, 21-ADM-03R, page 2: "Remote service delivery, for the purposes of this ADM refers to an electronic method of service delivery, including any two-way, real-time communication technology that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)." According to this definition, phone calls meet the definition of a telehealth modality. The HCBS 1915 (C) waiver also states that Prevocational, Pathway to Employment and SEMP services can be remotely delivered through the telephone or other technology in accordance with HIPAA.

SEMP, Pathway to Employment, and Community-Based Prevocational Services provided via remote technology directly to the person (i.e., direct services) must be listed in the Life Plan and reflected in the Staff Action Plan and meet the other requirements of 21-ADM-03R. However, providers can call individuals over the phone as an incidental component of service delivery to check-in with participants as allowed in the service definition or in emergency circumstances without meeting the requirements of 21-ADM-03R. This is different from phone calls that involve teaching/training with the staff that are considered telehealth.

In SEMP, Pathway to Employment and Community-Based Prevocational Services, examples of incidental calls to individuals include:
• reminding the individual about a job interview;
• reminding the individual to wash their uniform;</td></tr>
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		• informing the individual of job schedule changes; • learning about the individual's work schedule so the staff know when to visit sites; • checking in to see if there are any unforeseen challenges; and • scheduling upcoming service activities. Emergency phone calls include helping the individual trouble shoot an unexpected, non-regular problem at the work site. All services on behalf of a person (indirect services) in SEMP, Pathway to Employment, and Community-Based Prevocational are those services that do not directly involve the person served. For example, a call made to a supervisor at the work site by the staff person is an indirect service and the requirements of 21-ADM-03R do not apply. OPWDD will provide additional guidance regarding telehealth and these specific services.
2.	I am writing to you to express my concern and frustration regarding the end of Appendix K and now having to code and identify phone calls to the people we support in our SEMP programs differently. SEMP providers have provided this service for years without having to do anything other than classify it as an indirect service. Why do we have to do something different with a service we have been providing for years? Please take SEMP out of this Appendix K.	Please refer to the response for #1 and the distinction between direct and indirect services related to employment services and the need for billing modifiers/procedure codes and the classification of phone services as a telehealth modality. Remote service delivery cannot be the only modality used on a long-term basis in delivering services to Waiver participants. This is to ensure that remote service delivery does not isolate the person from the community or from interacting with people without disabilities. The distinct billing identifiers and modifiers for remote and regular service delivery will serve as an electronic record for OPWDD to provide assurance to the Centers for Medicare & Medicaid Services (CMS) that remote

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		service delivery is not the only modality used for delivering services to Waiver participants. The Appendix K authority for the 1915(c) HCBS waiver ended on 11/11/2023 but SEMP is identified in the current 1915(c) HCBS waiver as one of the services that can be remotely delivered through the telephone or other technology in accordance with HIPAA. As such, the assurances to CMS regarding the use of remote technology as outlined above must be met.
3.	SEMP is a program where we do not see every person every day. The way to communicate is through the telephone, as it is with any business. Not only do program staff call the person receiving services, but they call us as well. To ask them to go through an evaluation bi-yearly to assess their ability to call their job coach is not treating them as an equal in the workplace to use the telephone the same way as everyone else.	Please refer to the responses for #1 and #2 and the distinction between direct and indirect services related to employment services and the need for billing modifiers/procedure codes. As listed in the requirements of 21-ADM-03R, after the initial evaluation, it is the Care Manager's responsibility to ensure "that the continued use of technology for remote service delivery is reviewed and reaffirmed by the planning team every six (6) months or with each semi-annual Life Plan review." A new evaluation is not required every 6 months unless there are substantive changes in the person's life circumstances or a change in preference. If the provider has concerns related to remote service delivery, it is the provider's responsibility to notify the Care Manager.
4.	There are thousands of people enrolled in SEMP programs throughout New York State who all use the telephone to communicate. The amount of administrative work this will entail to administer and track for both the SEMP programs and the CCOs is time that could be spend more valuably. Not to mention the time the individual in the program needs to spend to be evaluated.	Please refer to the responses for #1, #2, and #3 above.

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5.	Telehealth services have been utilized as a service modality prior to the PHE. The requirement to follow the processes identified within this ADM will create on-going inefficiencies for all, including CCOs, agency providers and the people being supported. In addition, the ADM outlines that this option should not be utilized as an exclusive, long-term service delivery option. I want to clarify that that the "long-term" use is only discouraged if it is coupled with the "exclusive" delivery option. In supporting people with their employment goals, this modality is absolutely necessary.	Please refer to the responses for #1, #2, and #3 above. Remote technology cannot be utilized exclusively on a long-term basis. As described in 21-ADM-03R, the use of remote technology to deliver services is determined through a person-centered planning process and is initiated per the person's request. The use of this modality may be part of an individual's service plan along with in-person services as described in their Life Plan.
6.	OPWDD should amend 21-ADM-03R to apply to SEMP services only in those situations where an individual has asked to receive exclusively remote delivery of all SEMP services as a long-term service delivery option.	As described in the responses above, remote service delivery cannot be the only modality used on a long-term basis in delivering services to Waiver participants. This is to ensure that remote service delivery does not isolate the person from the community or from interacting with people without disabilities. As described in 21-ADM-03R, page 3: "Remote service delivery may also be used as part of an individual's service delivery plan, along with in-person services, as described in their Life Plan."
7.	Under the revised guidance, providers would be required to seek Care Manger/CCO approval to provide remote services that were permitted, without exception, prior to COVID. For example, calling a SEMP participant to prepare for a job interview, counseling a person about the impact of work on their benefits, or troubleshooting an issue at the work site, must now be approved by the Case Manager, every six months. We see that the Q&A document, in the answer to question 29, reads that email, phone calls and text messages do not fit the definition of telehealth but since telephones and smart phones were listed as telehealth	The Care Manager/CCO does not approve remote services. Rather as described in 21-ADM-03R, after the initial evaluation, it is the Care Manager's responsibility to ensure "that the continued use of technology for remote service delivery is reviewed and reaffirmed by the planning team every six (6) months or with each semi-annual Life Plan review." A new evaluation is not required every 6 months unless there are substantive changes in the person's life circumstances or a change in preference. Please refer to the responses for #1 and #2 regarding the distinction between direct and indirect services related to employment services and requirements to use a billing modifier and procedure code as well

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	devices in the evaluation document, I am seeking clarity on that issue.	as the inclusion of phone calls as a telehealth modality. Upon further consideration, #29 and #32 in the Question & Answer document were revised and the corrected information has been distributed. For the purposes of telehealth, the use of a telephone **does** meet the definition of two-way, real-time communication technology, and may be used as a means to deliver telehealth services. Email and text messages do not fit this definition.
8.	The telephone has been in existence since 1876. All people have the right to use a phone without being "assessed" to do so. Use of the phone is an efficient, normalized, and standard way of conducting business and life. It is a normal way to communicate, to maintain relationships and convey information. SEMP staff routinely have used the phone to support individuals well before "telehealth" was even in existence. What benefit comes from tracking a SEMP/staff's use of the phone? This is not a responsible way to utilize Medicaid dollars. It is reasonable to believe that an employed individual is capable of using the phone. The varying ways to capture this information within the many electronic health records is no small task which will result in cost to modify, training and extra time to input billing information. And again, to what end? I would like to suggest that we treat our employed individuals with the dignity and respect they deserve and not consider the use of the phone as telehealth and therefore do not subject them to assessments, modified Life Plans and monitored phone use. New York State is an employment first state however steps like this can potentially have the opposite effect. Making it more difficult for a provider to provide supports by instituting unnecessary regulations can reduce the chances of success.	Please see the responses to #1, #2, and #3 above. As described in these responses, the purpose of monitoring the use of telehealth modalities, including phone calls, to deliver SEMP and other waiver services is to ensure that person is not isolated from the community or from interacting with people without disabilities. The distinct billing identifiers and modifiers for remote and regular service delivery will serve as documentation for OPWDD to provide assurance to the Centers for Medicare & Medicaid Services (CMS) that remote service delivery is not the only modality used for delivering services to Waiver participants.

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9.	Regarding SEMP Services: A large amount of SEMP services are/ can be done virtually- either by phone, text, email, or virtual platforms. While the explanation of "live time, 2-way communication" was provided as a description for remote services- it seems that in today's world, texting someone or calling them is simply everyday communication. I question if it should be considered remote.	Please see the responses to #1, #2, and #7 above.
10.	There are approximately 8,000 persons currently receiving SEMP across New York State, so that CCOs would need to approve SEMP telehealth services 16,000 times per year. CCOs strive to provide quality services but it is unlikely that they will be able to consistently and reliably meet this challenge. Turnover in Care Managers has been a challenge for providers, and failure to include this service in a Life Plan, or to not document it properly, could pose serious billing and Office of the Medicaid Inspector General (OMIG) challenges. We believe that by their very nature, SEMP services provided in the community, consistent with Olmstead, should be excluded from the telehealth guidance.	Please see the responses to #1, #2, and #3 above. OPWDD has established these standards to ensure compliance and quality measures are being met as required by the Centers for Medicare & Medicaid Services (CMS). CCOs have procedures in place to address the continuity of workflow regarding Care Manager turnover. The provision of SEMP services in the community is consistent with the Olmstead Act requirement to provide community-based services to persons with disabilities. Care Managers/CCOs are not approving that SEMP services are delivered by telehealth. Rather, it is the individual's choice to have their SEMP (or other eligible waiver services) delivered via this modality and the Care Manager/CCO is reviewing this on a regular basis to ensure that it continues to be the person's preference.
11.	One noteworthy concern is the inherent complexity of our work, wherein staff frequently engage in numerous telehealth calls with participants to schedule appointments. Given that our clientele also receives various waiver services from multiple agencies, it is not always feasible for us to be fully informed about concurrent services. For these reasons, we are seeking clarification to this language surrounding the three noted services and if phone calls are still being considered as "indirect" service, as the alternative could leave organizations vulnerable in audits. While we currently	Please see the responses to #1 and #10 above.

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	manage this process internally for in-person services, such as signing individuals out of day habilitation programs for job interviews, the prospect of having to extend this procedure to every phone call would be daunting.	
12.	The 21-ADM-03R indicates that telehealth/remote services cannot be a long-term service delivery option. Phone/text is necessary long-term for the coordination and provision of service for most SEMP participants. How do you reconcile this incompatible requirement given the reality of how SEMP services are provided?	To clarify, per 21-ADM-03R, pages 2 and 3: "Remote technology cannot be an **exclusive**, long-term service delivery option. Remote technology is available under certain conditions for time-limited periods to allow for continuity of services when in-person service delivery is not possible (e.g., during recovery from an accident/illness). **Remote service delivery may also be used as part of an individual's service delivery plan, along with in-person services**, as described in their Life Plan."
13.	If an Employment Specialist participates in a virtual meeting (ex. Zoom) that was initiated/setup by another party (ex. Care Manager, Employer, or Participant) and directly engages with the participant during this meeting, is it considered "telehealth"?	OPWDD agrees that this specific example would meet the definition of telehealth as described in 21-ADM-03R, page 2: "Remote service delivery, for the purposes of this ADM refers to an electronic method of service delivery, including any two-way, real-time communication technology that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)." Participating in planned virtual meetings with the individual and others for teaching/training purposes is typically not considered incidental unless it is a one-time emergency meeting. Corresponding Life Plans and Staff Action Plans need to meet the requirements as listed in 21-ADM-03R.
14.	What are the implications for the SEMP provider if the Care Manager fails to complete the telehealth evaluation every six months?	Please refer to #3 above. After the initial evaluation by the Care Manager, it is the Care Manager's responsibility to ensure that the continued use of technology is reviewed and reaffirmed every six months or at semi-annual Life Plan reviews. A new evaluation is not required every 6 months unless there are substantive changes

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		in the person's circumstances or a change in their preferences. Life Plans are subject to quality/fiscal reviews and any corrective actions deemed appropriate.
15.	Communication via phone/text with an individual has always been a billable SEMP service. Nearly all SEMP participates receive "remote" services, which will now require the Care Manager to complete an evaluation every six months. This will be an onerous process. Will OPWDD consider an exception for SEMP given the frequency of remote "telehealth" services?	Please refer to #1 and #3 above.
	Related to Remote Technology ADM (21-ADM-03R)	
16.	The regulation of not being able to bill for both services if speaking with someone on the phone and then see them in person the same day is counterintuitive to how the program can work. For example, an individual calls with an issue, then the SEMP staff goes to the worksite to meet with them to assist to resolve the issue. This is the natural flow of providing SEMP services.	Please refer to 21-ADM-03R, page 6: "In some cases, a person might receive both telehealth and face-to face services on the same date. However, only one claim per rate code can be submitted by a provider on a given day that accounts for the total documented service duration. Therefore, in these cases, the claim submitted for the date must include the above referenced procedure code [Procedure code, T2025] and modifier [Modifier, GT] for the entire claim, as only one claim per rate code can be submitted by a provider on a given day that accounts for the total documented service duration." When separate sessions of service delivery occur on the same day – the total duration of services is 'rolled-up' and submitted as a single claim/day. If the phone call is deemed service delivery and more than an incidental phone call, a billing modifier and procedure code would be added to the total hours in the same billing code for that day.

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17.	To consider speaking with someone's residence or parent as not telehealth but speaking directly with the person on the telephone as telehealth promotes a non-person-centered approach.	Please see the response to #1.
18.	Considering that numerous organizations rely on software companies for documentation maintenance, the introduced modification introduces a time constraint. The memorandum was disseminated on 10/24/2023, setting an implementation deadline of 11/11/2023, allowing a mere 14 business days to address these alterations with programmers. Furthermore, if the adjustments do, in fact, differ across various waiver services, it complicates the programming requests, leading to increased complexity and time consumption. In the now, the software company we are working with is now disallowing phone calls to be billed if another waiver service is in place, indicating that the software companies may also be confused as to what is being asked of them to create in terms of these changes.	The existing rate codes and billing processes should continue to be used while the software company works on updates. Once the billing software is ready, previously submitted claims for services delivered on or after November 11, 2023 can be adjusted to include the billing modifiers.
Related to Day Habilitation ADM (06-ADM-01R) - Mealtime		
19.	Regarding Day Hab., the half hour during lunch is one of the busiest, most staff intensive parts of the day. In addition to the social skill building that can be accomplished at mealtime, many program participants are at increased risk for choking, and as evidenced by the Justice Center's review, choking incidents, some resulting in death, are preventable with an adequate number of trained staff on duty.	Effective November 12, 2023, with the end of the Appendix K authority, billing rules regarding lunch during Day Habilitation service provision will return to the rule in 06-ADM-01R. For both Group Day Habilitation and Supplemental Group Day Habilitation the program day duration is defined as the length of time the provider delivers face-to-face Group Day Habilitation services to the person. Time spent during mealtime cannot be counted toward the program day duration.

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		The Day Habilitation rate methodology draws from a provider's reported costs of service delivery to establish the amount that the provider is paid for each full or half unit billed. These reported costs include the cost of staff supervising and assisting during lunchtime. In short, while the time staff spend during lunch does not 'count' toward the program day duration, these staffing costs are reflected in the rate that the provider is able to bill.
20.	During mealtime we need to make sure all staff are alert and present, ensuring everyone is eating safely. Staff are responsible and diligent to make sure the correct food and liquid consistencies are met for each person. We serve people that require all 6 food consistency categories to prevent choking as identified in OPWDD choking prevention initiative. This is the hardest time of the day for staff. These critical supports revert to being unpaid with the ending of Appendix K, mandating that mealtimes cannot count toward a billable day. Mealtime should be counted as billable time. There is no substitute for the supports provided by our staff during meals for vulnerable individuals who require them. Mealtime should not be excluded from the program day. OPWDD saw fit to change this during the PHE, and it should be one of the flexibilities continued in order to support the programs in their continued provision of services to the whole person. If not for all, perhaps OPWDD would entertain a billable lunch for individuals who's increased/enhanced mealtime needs are documented in the life plan.	Please refer to the response for #19.

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21.	Beyond the choking and prevention considerations, it is also crucial to ensure that people are able to access their food, especially for those with mobility deficits (fall risks), intellectual deficits, upper extremity contractures, decreased upper extremity strength or dexterity impairments (unable to open bags, containers, drinks, etc.). From a Behavioral Health perspective, it is also vital to consider individuals who do not understand the risk involved with eating food outside of their clinical recommendations. Direct Support Professionals (DSPs) play an essential role in knowing and monitoring people to ensure their safety is preserved. Therefore, we believe that not allowing meal periods to be counted towards a billable unit is contrary to the procedures and protocols listed above and indicates that mealtimes require no staff – which could not be farther from what is required. There is no other data point as demonstrable to the quality of care needed at lunchtime than the fact that the staff to individual at mealtime is 1 to 1 or 1 to 3, versus 1 to 5 during day programming.	Please refer to the response for #19.
22.	Transportation not included in billing is a hardship in the rural areas. Mealtime should be included in billing as this is the most optimal time for teaching/training for everyday living skills, socialization whether meals are in the IRA house or in the Community. Mealtime is one of the most staff intensive times of the day.	Transportation costs are updated annually in a provider's Day Habilitation rate based on the provider's reported costs in the Consolidated Fiscal Report (CFR). Please refer to the response for #19.
23.	Mealtime- if it will not be allowed for billing, define parameters for the deduction, how long do they have to be at program to require the mealtime deduction? How long does the deduction have to be?	OPWDD does not require that providers 'clock-in and out' for lunch time. To minimize the provider administrative burden each provider may establish typical lunchtime duration and 'back out' this time from the program day duration for each individual served.

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Related to Day Habilitation (21 ADM-02R) – Medically Frail		
24.	Medically Frail and Elderly- reinstitute the memo from 2010 allowing individuals for sporadic needs be able to receive day habilitation services in certified settings. There are many individuals who have temperature protocols due to medical conditions and cannot leave the home if the weather is too hot or too cold, if it is icy and they are afraid or falling, etc. (CH-R can be delivered in the home if they meet criteria, but there is still the caveat of 51% standard outside of the home).	Please refer to 21-ADM-02R, page 2 for the description of individuals who qualify for Community Habilitation-Residence (CH-R) services. When evaluating whether in-residence CH-R is appropriate for a person, the provider must plan for the delivery of these services to support the person's full access to the greater community. When there are extenuating circumstances preventing the person from receiving CH-R services in the community, these should be documented. Significant changes or concerns related to the delivery of CH-R services in the community should be discussed at person-centered reviews.
Related to Day Habilitation (06 ADM-01R) – Remote Technology		
25.	"Remote technology is available under certain conditions for time-limited periods to allow for continuity of services when in-person service delivery is not possible (e.g., during recovery from an accident/illness)." We interpret this language to mean that use of remote technology to deliver day services to a person residing in their private home (e.g., living with family, living in an uncertified setting) during periods where weather conditions make it not possible to provide in-person service delivery is allowable. A severe weather condition would be a time-limited period and fit the intent of the language of a "condition" in the ADM. There are many individuals supported and families who would greatly benefit from having this option available to ensure continuity of day services during times when the weather conditions do not allow for safe travel to bring the provider and individual together.	Such service delivery is allowed and OPWDD will amend 21-ADM-02R and 06-ADM-01R to clarify the allowability of the delivery of day habilitation services via remote technology in non-certified residences such as a person's family home.
26.	In reviewing the ADM's language, it appears to not address the individuals who live at home. By this omission, the ADM suggests that providers cannot use telehealth during inclement weather for	Such service delivery is allowed in non-certified settings such as private homes. OPWDD will amend 21-ADM-02R and 06-ADM-01R

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	individuals who live at home with family, even though the individual/family/care manager/team has chosen and decided this to be the best modality through which to provide services when such an event occurs. This decision would also be reflected in both the Life Plan and the Staff Action Plans. It is understood that individuals who live in a certified residence have staffing to address their specific needs, but individuals who live at home do not have such support and could benefit from remote delivery during inclement weather if the team so decides. Given this interpretation, the NY Alliance recommends that this ADM should be updated and reissued to address this type of scenario where the use of remote technology makes sense for individuals living at home.	to clarify that the delivery of day habilitation services via remote technology in non-certified residences is allowable.
27.	Day Hab participants who live at home with their families who are unable to physically attend programs due to inclement weather, and who request remote services as an alternative on those days, would benefit greatly and we hope this will be allowed in the updated guidance.	Please refer to the response for #26.