Missouri Alliance for **HOME CARE**

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Please find information related to the following:

- **Home Health Value-Based Purchasing (HHVBP) Model Expansion** *(from NAHC Report)*
- **Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Suspended Through March**
- **Lost Fundraising Revenues May Count as Patient Care Costs under Provider Relief Fund** *(from NAHC Report)*
- **CDC Provides Strategies for Optimizing Glove Supply**
- **CMS Expansion of Hospital without Walls Presents Opportunities for Home Health, Hospices**
- **Recent HCBS Memos**
- **REMINDER - EVV Attestation Forms for All Personal Care Services Providers Was Due January 1, 2021**

Home Health Value-Based Purchasing (HHVBP) Model Expansion

The U.S. Department of Health and Human Services (HHS) is announcing that HHS Secretary, Alex M. Azar, II, has approved the expansion of the Home Health Value-Based Purchasing (HHVBP) Model. The HHVBP expansion would be implemented through rulemaking no earlier than January 1, 2022.

Tested by the Centers for Medicare & Medicaid Services (CMS) Innovation Center, the HHVBP Model began its first performance year in 2016. The CMS Office of the Actuary has certified, based on its independent assessment of the model's performance over the first three years of the Model, that an expansion would reduce, or not result in any increase in, net Medicare spending.

The Secretary has also determined that an expansion of the HHVBP Model would likely improve quality of care for Medicare beneficiaries, without denying or limiting coverage or provision of benefits to Medicare beneficiaries. These combined determinations, coupled with the actuarial certification, meet the criteria set by Section 1115A(c) of the Affordable Care Act to allow the Secretary to expand the model through rulemaking.

For more information, please visit https://innovation.cms.gov/innovation-models/home-health-value-based-purchasing-model.

For questions, please call the helpdesk at (844) 280-5628 or email HHVBPquestions@cms.hhs.gov.

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Suspended Through March

The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the payment adjustment percentage of 2% applied to all Medicare Fee-For-Service (FFS) claims from May 1 through December 31. The Consolidated Appropriations Act, 2021, signed into law on December 27, extends the suspension period to March 31, 2021.

Lost Fundraising Revenues May Count as Patient Care Costs under Provider Relief Fund

Since creation of the Provider Relief Fund (PRF) under the *CARES Act*, the Department of Health & Human Services (HHS) has issued numerous clarifications related to the PRF and its allowed uses. In the latest series of updates, HHS has provided a clarification related to fundraising losses, indicating that lost fundraising revenues, grants or donations may be included in the calculation of lost revenues attributable to coronavirus if those sources are used to fund patient care services.

Following is the exact wording of the FAQ that HHS has posted online at the following website: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/provider-relief-fund-general-info/index.html?language=es#pr-overview

"Should providers include fundraising revenues, grants or donations when determining patient care revenue? *(Added 12/4/2020)*

- To calculate lost revenues attributable to coronavirus, providers are required to report revenues received from Medicare, Medicaid, commercial insurance, and other sources for patient care services. Other sources include fundraising revenues, grants or donations if they contribute to funding patient care services."

For your convenience, *NAHC Report* is providing below copies of all of the FAQs that were added or updated as part of the most recent round of PRF FAQ clarifications, which occurred on December 4, 2020.

Terms and Conditions

What if my payment is greater than expected or received in error? *(Modified 12/4/2020)*

- If HHS identifies a payment made in error, HHS will recoup the erroneous amount. If a provider receives a payment that is greater than expected and believes the payment was made in error, the provider should contact the Provider Support Line at (866) 569-3522 (for TYY, dial 711) and seek clarification.

Auditing and Reporting Requirements

Will HHS provide guidance to certified public accountants and those organizations that providers will rely on to perform audits? *(Added 12/4/2020)*

- Yes. Providers who received $10,000 or more in aggregate Provider Relief Fund payments will need to submit a report on how they used the PRF payment, and for more information on how to accurately fill out these reports, please refer to Post-Payment Notice of Reporting Requirements (November 2, 2020) – PDF and Provider Relief Fund Auditing and Reporting Requirements FAQs. Some providers will also be subject to Single Audit requirements. Additional relevant guidance will be posted as an Addendum to the 2020 Compliance Supplement, which is available at the Office of Federal Financial Management's website.

Can my organization get an extension to the submission due date for audits conducted under 45 CFR Part 75? *(Modified 12/4/2020)*

- Yes. The Office of Management and Budget (OMB) in OMB M-20-26, Extension of Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations, dated June 18, 2020, provided non-Federal entities extensions beyond the normal due date to submit 2019 audit year reports. Please see the OMB website for more details. Commercial organizations with questions about their ability to obtain extensions should email HRSA's Division of Financial Integrity at SARFollowup@hrsa.gov.

Use of Funds

At the bottom of page 1 of the reporting requirements announcement in PDF, Step 2 states "PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to patient care lost revenues, net of the healthcare related expenses attributable to coronavirus calculated under step 1." Is the underlined language still applicable under the reporting requirements notice that HHS posted on October 22, 2020? *(Modified 12/4/2020)*

- No, healthcare related expenses are no longer netted against the patient care lost revenue amount in Step 2. A revised notice was posted to remove this language.

Overview

Who is eligible to receive payments from the Provider Relief Fund? *(Modified 12/4/2020)*

- Provider Relief Fund payments are being disbursed via both "General" and "Targeted" Distributions.

To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in 2019, be a known Medicaid and CHIP or dental provider and provide or provided after January 31, 2020

diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.

- A description of the eligibility for the announced Targeted Distributions can be found here. U.S. healthcare providers may be eligible for payments from future Targeted Distributions. Information on future distributions will be shared when publicly available. All providers retaining funds must sign an attestation and accept the Terms and Conditions associated with payment.

Miscellaneous

Should providers include fundraising revenues, grants or donations when determining patient care revenue? *(Added 12/4/2020)*

- To calculate lost revenues attributable to coronavirus, providers are required to report revenues received from Medicare, Medicaid, commercial insurance, and other sources for patient care services. Other sources include fundraising revenues, grants or donations if they contribute to funding patient care services.

CDC Provides Strategies For Optimizing Glove Supply

Forbes recently published an article on the world's largest glove manufacturer shutting down more than half of its factories after a large number of its workers tested positive for COVID-19. As this may have an effect on supply chain integrity for healthcare providers, please review the Centers for Disease Control and Prevention's Strategies for Optimizing the Supply of Disposable Medical Gloves resource.

CMS Expansion of Hospital without Walls Presents Opportunities for Home Health, Hospices

Amid the rising number of COVID-19 cases and hospital capacity nearing or beyond its maximum in many areas of the nation, the Centers for Medicare & Medicaid Services (CMS) expanded its Hospitals Without Walls program to allow hospitals to care for patients in their home instead of the hospital.

The Hospitals Without Walls program was implemented at the beginning of the current COVID-19 Public Health Emergency (PHE). Under this program hospitals can provide hospital services in other healthcare facilities that would not otherwise be considered to be part of a healthcare facility; or can set up temporary expansion sites to help address the urgent need to increase capacity to care for patients.

This most recent expansion of the program allows the hospitals to care for patients needing acute inpatient care in their home instead of the hospital. The expansion is an individual waiver (not a blanket waiver) of the requirement for hospitals to have nursing services provided on premises 24 hours a day, 7 days a week and the immediate availability of a registered nurse for care of any patient. Hospitals wishing to participate in the program must apply for the waiver.

The waiver is for patients meeting acute inpatient care who need at least daily rounding by a physician and medical team. They must be admitted to the program from the emergency room or inpatient hospital setting and initially have been seen by a physician or advance practice provider (APP). The physician or APP must then visit and evaluate the patient at least daily. This visit can be performed remotely if appropriate. There must also be at least two in-person visits by clinicians each day. There must be at least one in-person or remote visit with a Registered Nurse (RN) who develops a nursing plan consistent with hospital policies. If the RN determines it is clinically appropriate, the in-person visits can be with Mobile Integrated Health (MIH) paramedics without RN on-site care.

There are additional requirements such as Immediate, on-demand remote audio connection with an Acute Hospital Care at Home team member who can immediately connect either an RN or MD to the patient and the ability to have In-home appropriate emergency personnel team to the patient's home within 30 minutes. Hospitals are required to submit monitoring data on a regular basis.

There is some speculation in the healthcare industry that this expansion may not be temporary. CMS did not specify its intentions for the duration of the program in any of its communications about the expansion.

The hospital is responsible for all services being provided under the waiver; however, the hospital is able to contract for the services. **Home health agencies, and possibly hospice providers, may be asked to contract or may offer to contract with the hospital for some of the required services which include nursing and physical, occupational and speech therapy.**

Recent HCBS Memos

Multiple HCBS memo's have been released over the past couple of weeks.

Updates to Policy Clarification Questions (PCQs) *(1-7-21)*

This memorandum is to inform Home and Community Based Services (HCBS) staff and stakeholders of updates to the Policy Clarification Questions (PCQs). Updates include:

- Assessment/Reassessment Section – Modified question 53.
- Electronic Visit Verification Section – Added question 16, modified questions 1-6 and questions 7-8, deleted question 11.

Home and Community Based Services Policy Clarification Questions – these updated PCQs can be located at: https://health.mo.gov/seniors/hcbs/pdf/pcq.pdf.

Please refer INFO 01-21-01 at - https://health.mo.gov/seniors/hcbs/infomemos.php

Any questions regarding this memorandum should be directed to Long Term Services and Supports via email at LTSS@health.mo.gov.

Updates to COVID-19 Emergency Guidance

Providers and DSDS staff should review all sections and resources identified as "Updated" or "New" for the latest guidelines. https://health.mo.gov/seniors/hcbs/covid-19-provider-info.php

Updated Sections:

- Assessments/Reassessments
    - Case note specifics for verbal signatures
- Service Delivery:
    - Referrals/Care Plan Change Requests
- Provider Operations
    - Addition of a Consumer-Directed Services flexibility

Any questions regarding this information should be directed to Long Term Services and Supports via email at ltss@health.mo.gov.

Updates to the Policy Clarification Questions (PCQs) *(12-21-20)*

This memorandum is to inform Home and Community Based Services (HCBS) staff and stakeholders of updates to the Policy Clarification Questions (PCQs).

Updates include:

- Advanced Personal Care (APC) Section – Added questions 31 & 32, modified question 28.
- Assessment/Reassessment Section – Added questions 21-53.
- Authorized Nurse Visits Section – Added questions 8-12.
- Consumer Directed Services Section – Added question 15.
- Consumer Directed Services Transportation Section – Added questions 15 & 16.
- Agency Model Personal Care Section – Added questions 12-14.
- Respite Care Section – Added question 3.
- Task Chart – Modified Catheter Hygiene section.

The PCQs can be located at: https://health.mo.gov/seniors/hcbs/pdf/pcq.pdf.

Please refer INFO 12-20-02 at https://health.mo.gov/seniors/hcbs/infomemos.php

Any questions regarding this memorandum should be directed to the Bureau of Long Term Services and Supports at LTSS@health.mo.gov.

Medicaid Income Information

This memo is related to the updated Medicaid income information to reflect changes to the Medicaid Income effective January 1, 2021.

Please refer to HCBS 12-20-01 and the revised policy at the links below.

- Policy – https://health.mo.gov/seniors/hcbs/hcbsmanual/
- Memorandum - https://health.mo.gov/seniors/hcbs/hcbsmanual/hcbsmemos.php

Any questions should be directed to the Bureau of Long-Term Services and Supports at LTSS@health.mo.gov.

HCBS Manual – Revisions to Reflect Recent Updates

The Home and Community Based Services (HCBS) Manual has been revised to reflect updates to the following policies:

- Policy 1.25 Electronic Visit Verification
- Policy 1.25 Appendix 1
- Policy 3.55 Independent Living Waiver
- Policy 4.00 Appendix 2a Participant Choice Statement (CDS, Agency, ADC)
- Policy 4.00 Appendix 2d Agency Model Participant Rights and Responsibilities
- Policy 4.00 Appendix 2e CDS Participant Rights and Responsibilities
- Policy 5.00 Adverse Action
- Policy 5.00 Appendix 1 Legal References for Adverse Action
- Policy 8.15 Provider Complaint Process

Please refer to HCBS 12-20-02 and the revised policies at the links below.

- Policies – https://health.mo.gov/seniors/hcbs/hcbsmanual/
- Memorandum - https://health.mo.gov/seniors/hcbs/hcbsmanual/hcbsmemos.php

Any questions should be directed to the Bureau of Long-Term Services and Supports at LTSS@health.mo.gov.

REMINDER - EVV Attestation Forms for All Personal Care Services Providers Was Due January 1, 2021

Section 12006(a) of the 21st Century Cures Act (Cures Act) mandated that states implement Electronic Visit Verification (EVV) for all Medicaid PCS by January 1, 2020. Missouri applied for and received a Good Faith Effort Exemption from the Centers for Medicare and Medicaid (CMS) to delay mandated use of EVV for one additional year. Effective January 1, 2021, the use of EVV is mandatory for all Medicaid PCS in Missouri. This applies to PCS provided under sections 1905(a) (24), 1915(c), 1915(j), 1915(k), and Section 1115 of the Social Security Act. Effective January 1, 2021, Medicaid participants cannot opt out of using the PCS provider's EVV system. Providers must submit notice to MMAC of any participants who refuse to use EVV after the effective date. Beginning January 30, 2021, Missouri Code of State Regulations (CSR) 13 70-3.320 will contain additional requirements for use of EVV for PCS services provided to Missouri Medicaid participants with a prior authorization, or care plan, as approved by the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS); or the Department of Mental Health (DMH), Division of Developmental Disabilities (DD). The new regulation was posted in the **Missouri Register** on 12/15/2020.

Although the new state regulation is not effective until January 30, 2021; the federal requirements under the Cures Act are effective January 1st and have not been waived or extended due to the COVID emergency. In addition to the services authorized by DSDS and DMH, PCS authorized by the Bureau of Special Health Care Needs and the Bureau of HIV, STD and Hepatitis of DHSS must be verified through use of an EVV system in order to comply with the CURES Act. In order to submit PCS claims, a provider's EVV system must verify the following:

- Type of PCS performed with details specific to tasks
- Identity of the individual receiving the service
- Identity of the individual providing the service
- Date the service was provided
- Time delivery of PCS began and ended
- Location where the service was delivered

The Missouri Medicaid Audit & Compliance (MMAC) unit created a one page, fillable **EVV Attestation Form**, which is available at **www.mmac.mo.gov.** PCS providers can submit one form for all their enrolled National Provider Identifiers (NPIs), as long as all NPIs are using the same EVV system. **All PCS providers need to take the following actions:**

- Prior to January 1, 2021, all PCS providers must submit an EVV Attestation Form to MMAC by emailing it to MMAC.EVV@dss.mo.gov.
- Any PCS provider that will not be using an EVV system by January 1, 2021, must submit written notice to MMAC.EVV@dss.mo.gov that date. Failure to utilize EVV is a Medicaid program violation that will result in administrative sanctions.
- Any PCS provider that is unable to utilize their EVV system for a specific Medicaid participant(s) due to a technology issue, must submit written notice to MMAC.EVV@dss.mo.gov by January 1, 2021. DSDS will locate another PCS provider offering EVV technology that works for the participant.
- PCS providers must report to MMAC any Medicaid participant(s) who refuses to utilize the provider's EVV system after January 1, 2021. The PCS provider should submit written notification to MMAC.EVV@dss.mo.gov. Medicaid claims submitted after January 1, 2021, for any participant that refuses to utilize EVV will be denied/recouped.

PCS providers who fail to submit an EVV Attestation Form to MMAC, or fail to provide notification of one of the circumstances listed above, will be subject to one or more administrative sanctions listed in 13 CSR 70-3.030(4). MO HealthNet has an **EVV website** with additional information, including EVV Fact Sheets for providers and Medicaid participants. DMH also has an **EVV website** with more information for providers delivering PCS to DD participants. Providers can email questions about EVV to Ask.EVV@dss.mo.gov