Missouri Alliance for **HOME CARE**

2420 Hyde Park, Suite A, Jefferson City, MO 65109-4731 ▪ (573) 634-7772 ▪ (573) 634-4374 Fax

October 1, 2020

Please find information related to the following:

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Federal Short-Term Spending Measure Contains Good News for Home Care & Hospice

On Wednesday September 30th, the Senate approved a Continuing Resolution (CR), a short-term funding measure, averting a shutdown and providing government funding into December, and several provisions in the CR are helpful for home care and hospice. Key among these is relaxations on how the Centers for Medicare & Medicaid Services (CMS) is to recoup payment of the Medicare Accelerated and Advanced Payments. The new plan will delay recoupment for one full year and stretch the recoupment schedule across 29 months. Recoupment per claim would be set at 25 percent for the first 11 months, then 50% for the following six months. The interest rate would also be dropped from 10.25 percent to 4 percent.

In other Medicare provisions, the legislation extends funding for Medicare outreach, and steadying of Part B premiums.

Officially known as the State Health Insurance Assistance Programs (SHIP), this program serves as a resource for Medicare beneficiaries and those nearing eligibility to assist with outreach, enrollment assistance, and education on the Medicare benefit.

Because of the COVID-19 pandemic and funds for the Medicare Accelerated and Advanced Payments being drawn from the Part B trust fund there is fear that Medicare beneficiaries could be exposed to large premium increases to offset those unexpected expenses. The CR will steady those rates and allow for a minimal increase, estimated as a monthly premium surcharge of $3 for most seniors.

For Medicaid the CR provides extension for two home and community-based services (HCBS) programs: Spousal Impoverishment protections and the Medicaid Money Follows the Person program. Spousal Impoverishment protections prevent an incentive that favors institutional care settings in the Medicaid program. Under current law, qualifying for Medicaid for HCBS services could result in a person in question's spouse impoverished. This program allows the spouse to maintain a certain amount of assets without impacting Medicaid eligibility. The alternative would be either the afflicted spouse taking residence in an institutional setting or the couple electing for divorce. Money Follows the Person provides funding to state Medicaid programs to apply towards steps and measures that enable a beneficiary to maintain independence at home that would otherwise be eligible for a nursing home.

MedPAC Finds Pandemic Devastated Nursing Homes, Assisted Living Facilities

The Medicare Payment Advisory Commission (MedPAC) recently reconvened for a series of sessions in their continued efforts to optimize the Medicare program. Leading off the September meeting was a session focused on the effects of the COVID-19 pandemic on the Medicare program. As expected, the MedPAC found the pandemic to have negative effects on beneficiaries' access to care, as well as providers' costs and revenues.

The Commission found that 80 percent of COVID-19 deaths were aged 65 and older, with 40 percent of decedents residing in nursing homes or assisted living facilities. Many beneficiaries declined or delayed care. The final effect of declined and delayed care is not known yet.

Specific to home health, MedPAC found a large decline in volume of services in the first quarter of 2020 of 20 – 30 percent. The volume of services began an upward recovery in later April, and by late June the sector returned to 95 percent pre-pandemic levels. For comparison, skilled nursing facilities experienced a 10 percent decline in volume from January through May, which continued into June. It is possible that pre-pandemic volume levels do not return.

In addition to decreased patient volume, providers were also exposed to increased costs that included additional protective personal equipment and cleaning costs. Home health agencies were able to offset decreased revenues caused by lower visit occurrence and volume of episodes, by reducing staffing costs. Other post-acute care settings were not able to offset losses to the same degree given the nature of institutional overhead. As other stability measures, MedPAC cited the provider relief funds, paycheck protection program, and the Medicare advanced payments as additional means providers were able to utilize to offset losses and maintain operations throughout the pandemic.

CMS Revises Instructions for Submission of No Pay RAP

The Centers for Medicare & Medicaid Services (CMS) revised Change Request (CR) 11855 to update the Service Date reporting on the claim and some remarks.

After the original CR was released, NAHC went back to CMS to ask exactly how a home health agency should document on the claim those situations where a date could not be entered on line 0023 (the date of the first visit of the 30-day billing period) because the first visit did not occur within the first five days of the period. CMS responded that in these situations the home health agency may enter the first day of the period of care as the service date on this line when submitting a RAP for a subsequent period of care. This will prevent delaying the submission of the RAP for subsequent periods when the first visit in that period would be beyond the 5-day timeframe for a timely-filed RAP and will allow for the submission of RAPs for two 30-day periods of care immediately after the start of a 60-day certification period.

If the RAP that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty, the HHA enters information supporting the exception category that applied to the RAP. CR 11855 was updated to reflect that if the RAP that corresponds to a claim was originally received timely but the RAP was canceled and resubmitted to correct an error, the HHA enters remarks to indicate this condition, (e.g., "Timely RAP, cancel and rebill"). The HHA is to append modifier KX to the HIPPS code reported on the revenue code 0023 line. HHAs should resubmit corrected RAPs promptly (generally within 2 business days of canceling the original RAP). Remarks are otherwise required only in cases where the claim is cancelled or adjusted.

CMS Announces New Federal Funding to Support Transition from Nursing Homes to Community

The Centers for Medicare & Medicaid Services (CMS) announced on Wednesday, September 23, the availability of up to $165 million in supplemental funding to states currently operating Money Follows the Person (MFP) demonstration programs in 33 states. This funding will help state Medicaid programs jump-start efforts to transition individuals with disabilities and older adults from institutions and nursing facilities to home and community-based settings of their choosing.

"The tragic devastation wrought by the Coronavirus on nursing home residents exposes America's over-reliance on institutional long-term care facilities," said Administrator Seema Verma. "Residential care will always be an essential part of the care continuum, but our goal must always be to give residents options that help keep our loved ones in their own homes and communities for as long as possible."

"Home and community-based care is not only frequently more cost effective but is preferred by seniors and adults with disabilities seeking to maintain the dignity of independent living. This new federal investment will help states get our loved ones back home," she added.

Today's action is supported by new data that shows the need for this supplemental funding opportunity to accelerate states' MFP activities. According to a new report released by CMS today, MFP state grantees transitioned 101,540 Medicaid beneficiaries from institutional care to home-based and community services (HCBS) since the program started in 2007. However, last year, only 4,173 Medicaid beneficiaries were transitioned under the MFP program – a 46 percent decrease from 2018.

Thirty-three states (including the District of Columbia) that operate MFP-funded transition programs and plan to continue participating in MFP after this fiscal year are eligible to participate: Alabama, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Maryland, Maine, Minnesota, Missouri, Montana, North Carolina, North Dakota, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Washington, Wisconsin, and West Virginia.

Each state is eligible to receive up to $5 million in supplemental funding for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand HCBS capacity, such as:

- Assessing HCBS system capacity and determining the extent to which additional providers and/or services might be needed;
- Assessing institutional capacity and determining the extent to which the state could reduce this capacity and transition impacted individuals to more integrated settings;
- Provider and direct service worker recruitment, education, training, technical assistance, and quality improvement activities, including training people with disabilities to become direct service workers;
- Caregiver training and education;
- Assessing and implementing changes to reimbursement rates and payment methodologies to expand HCBS provider capacity and/or improve HCBS and/or institutional service quality;
- Building Medicaid-housing partnerships to facilitate access to affordable and accessible housing for Medicaid beneficiaries with disabilities and older adults; and
- Diversion strategies to prevent nursing facility admission.

In addition, states could use this funding opportunity to support HCBS planning and capacity building activities in direct response to the COVID-19 public health emergency, such as to plan and implement the use of telehealth for nursing facility transition activities that would normally be conducted in-person or to redesign service delivery models to reduce the risk of COVID-19 infection among MFP participants.

Supplemental budget requests under this funding opportunity will be accepted on a rolling basis through June 30, 2021. CMS will provide all eligible grantee states that currently operate a MFP-funded transition program, with additional information on this funding opportunity.

HCBS - Recent DSDS Memos

The Division of Senior & Disability Services (DSDS) has released many memos and/or Manual Updates over the last 2 months for HCBS providers. These notices are listed below in case any were overlooked.

HCBS 10-20-01 Online HCBS Referral Form

The Home and Community Based Services (HCBS) Manual has been revised to reflect updates to Policy 4.05 Intake and Prescreen Process and 8.00 Appendix 3, HCBS Referral Form (HCBS-1). Providers are encouraged to submit new HCBS referrals online in lieu of email or fax using the new HCBS Referral Form.

Please refer to HCBS 10-20-01 and the revised policies at:

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

Policies – https://health.mo.gov/seniors/hcbs/hcbsmanual/

Any questions should be directed to the Bureau of HCBS Intake and PCCP via email at HCBSIntakeAndPCCP@health.mo.gov.

Level of Care Transformation (LOC) Update

Please refer to INFO-09-20-04 at https://health.mo.gov/seniors/hcbs/infomemos.php.

Questions regarding this memorandum or the LOC Transformation should be directed to the Bureau of HCBS Systems and Data Reporting via e-mail at: LOCTransformation@health.mo.gov.

General Health Evaluations (Semi-Annual) Authorized Nurse Visits

Please refer INFO-09-20-05 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.

Mid-Month Authorizations

The Home and Community Based Services (HCBS) Manual has been revised to reflect updates to Policy 4.20 Person Centered Care Planning and Maintenance Process.

Please refer to HCBS 09-20-04 and the revised policies at:

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.

Participant Choice Statement Updates

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

- 4.00 2a Participant Choice Statement Form and Instructions CDS/Agency/ADC
- 4.00 2b Participant Choice Statement Form and Instructions RCF/ALF

Please refer to HCBS 09-20-03 and the revised policies at:

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

Policies – https://health.mo.gov/seniors/hcbs/hcbsmanual/

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

CDS Regulation Draft – House Bill 1682 Informal Vendor Comment

Please refer to INFO-09-20-03 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.

Legal References for Adverse Action Update

The Home and Community Based Services (HCBS) Manual has been updated to include a legal reference in Chapter 5.00 Appendix 1.

Please refer to HCBS 09-20-02 and the revised policy at:

Policy – https://health.mo.gov/seniors/hcbs/hcbsmanual/

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

Updates to Adverse Actions Policy and Legal References for Adverse Action

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

- 5.00 Adverse Action
- 5.00 Appendix 1 Legal References for Adverse Action

Please refer to HCBS 09-20-01 and the revised policies at:

Policies – https://health.mo.gov/seniors/hcbs/hcbsmanual/

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

Consistent Care Plan Authorizations - Dietary vs Meals/Dishes

Please refer to INFO 09-20-01 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

Consumer Directed Services Tax Information Documentation Requirements

The Home and Community Based Services (HCBS) Manual has been updated to include the addition of an appendix, Consumer Directed Services Tax Information.

Please refer to HCBS 08-20-01 and the appendix at:

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

Policy Manual – https://health.mo.gov/seniors/hcbs/hcbsmanual/

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

HCBS Regional Structure

Please refer INFO-08-20-01 HCBS Regional Structure at https://health.mo.gov/seniors/hcbs/infomemos.php.

CMS Seeks Input on Quality Measures for HCBS

The Centers for Medicare & Medicaid Services (CMS) has issued a request for Information(IRFI) seeking public input on a draft set of recommended quality measures for Medicaid-funded home and community-based services (HCBS).

CMS and states have worked for decades to support the increased availability and provision of high quality HCBS for Medicaid beneficiaries. HCBS provide individuals who need assistance (such as personal care, homemaker services, and adult day health services) the opportunity to receive services in their own homes or in the community as opposed to institutional settings.

HHS, states, and other entities have taken a number of steps over the past decade, in particular, to strengthen the capacity of states and the federal government to monitor, oversee, and improve the quality and effectiveness of services and to assure beneficiary health and safety. However, notable gaps and challenges related to HCBS quality remain. In particular, a 2016 NQF report commissioned by the Department of Health and Human Services (HHS) on "Quality in Home- and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement" indicates that, "HCBS lacks any standardized set of quality measures…[and] consensus as to what HCBS quality entails." The report recommends that HHS develop "a core set of standard measures for use across the HCBS system, along with a menu of supplemental measures that are tailorable to the population, setting, and program."

Through this RFI, CMS seeks input on sets of specific questions related to measure development and selection along with input the draft set of recommended measures for Medicaid-funded HCBS that is intended for voluntary use by states and other entities.

Comments are due October 19, 2020 and are to be submitted electronically to HCBSMeasuresRFI@cms.hhs.gov.

Provider Relief Fund Reporting Requirements Released

The following was written by William T. Cuppett, CPA, of The Health Group.

The Department of Health & Human Services (HHS) has finally issued general reporting requirements for the use of Provider Relief Funding. This document provides information on provider reporting guidelines, including intent, use of funds, and data elements requested. The purpose of the notice is to inform Provider Relief Fund (PRF) recipients that received one or more payments exceeding $10,000 in the aggregate what they will be required to report as part of the post-payment reporting process. **It is significant that lost revenues will be based on net patient care operating income (revenues less direct patient care expenses). This was expected by many observers.**

Recipients will report their use of PRF payments by submitting the following information:

1. Healthcare related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare related operating expenses.
2. PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to lost revenues, represented as a negative change in year-over-year net patient care operating income (i.e.,patient care revenue less patient care related expenses for the Reporting Entity, net of the healthcare related expenses attributable to coronavirus calculated under 1 above. Recipients may apply PRF payments toward lost revenue, up to the amount of their 2019 net gain from healthcare related sources. Recipients that reported negative net operating income from patient care in 2019 may apply PRF amounts to lost revenues up to a net zero gain/loss in 2020.

If recipients do not expend PRF funds in full by the end of calendar year 2020, they will have an additional six months in which to use remaining amounts toward expenses attributable to coronavirus but not reimbursed by other sources, or to apply toward lost revenues in an amount not to exceed the reported 2019 net gain.

Reporting Entities that received between $10,000 and $499,999 in aggregated PRF payments are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed sources (e.g., payments received from insurance and/or patients, and amounts received from federal, state or local governments, etc.) in two aggregated categories (direct patient care expenses are reported in the determination of net operating revenue, discussed above).

Recipients who received $500,000 or more in PRF payments are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed sources, in greater detail as follows:

- General and Administrative Expenses Attributable to Coronavirus – The actual G&A expenses incurred over and above what has been reimbursed by other sources:
    - Mortgage/Rent: Monthly payments related to mortgage or rent for a facility.
    - Insurance: Premiums paid for property, malpractice, business insurance, or other insurance relevant to operations.
    - Personnel: Workforce-related actual expenses paid to prevent, prepare for, or respond to the coronavirus during the reporting period, such as workforce training, staffing, temporary employee or contractor payroll, overhead employees, or security personnel.
    - Fringe Benefits: Extra benefits supplementing an employee's salary, which may include hazard pay, travel reimbursement, employee health insurance, etc.
    - Lease Payments: new equipment or software leases
    - Utilities/Operations: Lighting, cooling/ventilation, cleaning, or additional third-party vendor services not included in "Personnel".
    - Other General and Administrative Expenses: Costs not captured above that are generally considered part of overhead structure.

- Healthcare Related Expenses Attributable to Coronavirus, over and above what has been reimbursed by other sources:
    - Supplies: Expenses paid for purchase of supplies used to prevent, prepare for, or respond to the coronavirus during the reporting period. Such items could include personal protective equipment (PPE), hand sanitizer, or supplies for patient screening.

- Equipment: Expenses paid for purchase of equipment used to prevent, prepare for, or respond to the coronavirus during the reporting period, such as ventilators, updates to HVAC systems, etc.
- Information Technology (IT): Expenses paid for IT or interoperability systems to expand or preserve care delivery during the reporting period, such as electronic health record licensing fees, telehealth infrastructure, increased bandwidth, and teleworking to support remote workforce.
- Facilities: Expenses paid for facility-related costs used to prevent, prepare for, or respond to the coronavirus during the reporting period, such as lease or purchase of permanent or temporary structures, or to modify facilities to accommodate patient treatment practices revised due to coronavirus.
- Other Healthcare Related Expenses: Any other actual expenses, not previously captured above, that were paid to prevent, prepare for, or respond to the coronavirus.

Lost Revenue – Reporting Entities provide will information used to calculate lost revenues attributable to coronavirus, represented as a negative change in year-over-year net operating income from patient care related sources. Once revenue information is provided, cost/expense impacts will be calculated based upon a calendar year comparison of 2019 to 2020 healthcare expenses to determine net operating income. Revenues and expenses include all lost patient care revenues and patient care cost/expense impacts.

Reporting on a Quarterly Basis – Revenues and expenses will be reported on a quarterly basis for the entire 2019 year and, potentially for the first two (2) quarters of 2020 if needed to support use of the PRF.

Non-Financial Data – Additionally, non-financial data will also be collected (per quarter) as follows:

- Personnel Metrics: Total personnel by labor category (full-time, part-time, contract, other; recipient must define), total re-hires, total new hires, total personnel separations by labor category.
- Patient Metrics: Total number of patient visits (in-person or telehealth), total number of patients admitted, total number of resident patients.
- Facility Metrics: Total available staffed beds for medical/surgical, critical care, and other beds.

Thanks again to William T. Cuppett, CPA, of The Health Group for this important update.

COVID-19 Nursing Home Commission Issues Final Recommendations; Addresses Issues Relevant to Hospice Care in Facilities

In response to the ongoing and widespread impact of the COVID-19 public health emergency (PHE) on nursing home residents throughout the country, the Centers for Medicare & Medicaid Services (CMS) authorized creation of an independent National Commission on Safety and Quality in Nursing Homes to address safety and quality in nursing homes in relation to the PHE that began its work in June. That work was finalized this week with public release on September 16 of a Final Report.

In response to an earlier call from the Commission for public input, the National Association for Home Care & Hospice (NAHC) submitted extensive comments to the Commission based on concerns expressed

by member hospice organizations and state associations. NAHC's comments were organized into six areas of concern:

- Access to hospice services
- Ability to provide technology-based visits
- Coordination of care
- Reduced referrals/discouraged hospice elections
- Meeting testing requirements

The Commission's work culminated in 27 recommendations and 100 action steps organized into 10 themes. Its recommendations center on the following issue areas:

- Testing and Screening
- Equipment and PPE
- Cohorting
- Visitation
- Communication
- Workforce Ecosystem: Stopgaps for Resident Safety
- Workforce Ecosystem: Strategic Reinforcement
- Technical Assistance and Quality Improvement
- Facilities
- Nursing Home Data

While nearly all of the key areas identified have some implications for hospice patients residing in facilities, recommendations and action steps in several of the areas were particularly relevant. NAHC's review of the final report identified the following elements as having strong relevance for hospice and linkages to NAHC's submission to the Commission:

TESTING AND SCREENING:

- Develop a decision tree that incorporates recommendations from Nursing home Reopening Recommendations for State and Local Officials, QSO-20-30-NH (May 18, 2020) and that communicates the most appropriate testing strategy for residents, staff, and visitors for baseline and iterative testing. This tree must be tailors for the community prevalence and other risk factors (e.g., staff travelling between nursing homes, residents receiving offsite care including dialysis) to encourage effective planning and intervention. It should explain what to do (e.g., cohorting, observations, transfer, additional testing) when a resident or staff member: (1) is exposed to an individual(s) known to have COVID-19; (2) is presumptively positive; (3) confirmed positive; or (4) refuses testing.

EQUIPMENT AND PPE:

- Establish national training requirements for infection control and use of PPE for all healthcare personnel, as well as other individuals with direct and indirect contact with residents.
- Tailor training modules for PPE utilization for administrators, residents, staff, contractors, essential care partners, and visitors.

COHORTING:

- Develop clear and concise guidance for cohorting; ensure guidance:

- Prioritizes resident social and emotional health and minimizes disruption of their daily routines.

VISITATION:

- Emphasize that visitation is a vital resident right. Update and release consolidated, evidence-based guidance on safely increasing controlled, in-person visitation prior to federal Phase 3 reopening.
- Provide updated guidance on in-person visitation that immediately enables nursing home owners and administrators to adjust protocols and safely increase in-person visitation by essential care partners, compassionate care visitors, and ombudsmen based on emerging and established evidence. This CMS in-person visitation guidance should:
  - Restate the existing right to visitation and clarify modifications to this right for each phase of the pandemic.
  - Describe or restate minimum standards for visitor testing, training on and use of facial coverings and other PPE, temperature checks, physical distancing, visitor movement restrictions, post-visit disinfection, instructional signage, supervision and assistance from staff, and SARS-CoV-2 positive visits.
  - Outline how to adapt visitation policies based on local prevalence of COVID-19 cases internal and external to nursing homes.
  - Require nursing home owners and administrators to encourage residents to designate an Essential Care Partner that can visit in person when other visitors may not be allowed; when a resident is unable to do so, the legal surrogate could serve as an Essential Care Partner or appoint an alternate, such as a loved one.
  - Include a person-centered, consumer-driven definition of compassionate care situations (e.g., not limited to hospice care or last days or hours of life), along with criteria for assessing when compassionate care and extended end-of-life visitation by at least one visitor is appropriate.
  - Stress that ombudsmen may visit residents, and relay information to families and guardians, prior to federal Phase 3 reopening when they are able to observe infection prevention and control standards.

- Provide guidance on virtual visitation that specifies evidence-based protocols for acquiring, using, and safely sharing technology and communicative devices (e.g., cell phones tablets, webcams, other web applications/platforms) to safely facilitate virtual visitation. This guidance should:
  - Encourage safe sharing of sanitized technology that is readily accessible (e.g., large button phones) and available to residents (e.g., at the closest nursing station).
  - Provide learning resources about various technology tools that nursing home staff can use to communicate with residents, families and staff.
  - Include information on accessing and using low-cost, creative methods for maintaining contact between residents and their loved ones (e.g., messages through windows, Jitterbug flip phone, postcards).
- Continue to facilitate the sharing of ideas about virtual visitation options among nursing home owners and administrators.
- Encourage state agencies to approve applications for the use of civil money penalty (CP) funds for the purpose of providing communicative devices for virtual visitation.
- Amend 42 CFR Section 483.10 to include differentiated reference to compassionate care and hospice care under the residents' rights provision; define contingencies for emergencies.

COMMUNICATION:

- Increase specificity and expand breadth of guidance on communications between nursing home staff, residents and families.
- Define the type of information that nursing home staff are expected to communicate (e.g., specifics about a cohorting plan; transfer and discharge rights during phases of an emergency; visitation and/or connection options; options for residents to share feedback; screening/testing protocols and policies; COVID-19 cases and deaths).
- Define time-sensitivity of key messages (e.g., about transfers, discharge, hospitalization).
- Require an individualized communication plan as part of each nursing home resident's individual care plan, documenting preferred mode (e.g., recordings, letters, phone, video, in-person) and frequency of communication; with whom to engage (e.g., residents, providers, loved ones; one-on-one, small groups, or large groups); and action steps for missed communications.

CDC Study Suggests COVID-19 Mitigation Efforts Could Reduce Impact Of Flu

A new Centers for Disease Control and Prevention study suggests that social distancing and other measures to stop the spread of SARS-CoV-2 could help reduce the impact of flu this fall and winter in the U.S. if widely practiced. U.S. flu activity declined sharply within two weeks of the COVID-19 emergency declaration and widespread implementation of community mitigation measures, including school closures, social distancing and mask wearing. The decline also occurred in other Northern Hemisphere countries and the tropics, and Southern Hemisphere temperate climates have had virtually no flu circulation. The report adds, "Influenza vaccination for all persons aged >6 months remains the best method for influenza prevention and is especially important this season when SARS-CoV-2 and influenza virus might cocirculate."

Quality Reporting Program Tip Sheets and Training and Education Resources

The Centers for Medicare & Medicaid Services (CMS) has announced that the COVID-19 PR Tip Sheets are now available for the **home health quality reporting program** (HH QRP) and the **hospice quality reporting program** (HQRP).

The purpose of the tip sheets is to help providers understand the Centers for Medicare & Medicaid Services' (CMS) public reporting strategy for the quality reporting programs to account for CMS quality data submissions that were optional and exempted from public reporting during Q4 of calendar year 2019 and Q1 and Q2 of 2020 due to the COVID-19 public health emergency (PHE). The impact on CMS' Compare website refreshes is also outlined.

CMS announced in March 2020 that data for Q4 of calendar year 2019 was optional. Since the announcement was made after the due date for the data submission, most hospice and home health agency providers had already submitted the data for this period. Since the data submissions for this period were strong and met quality reporting standards CMS will include the data in measure calculations for the Compare website refreshes scheduled for October 2020 for home health and November 2020 for hospices.

CMS will not include for public reporting the Q1 and Q2 2020 data that was excepted. All four Compare refreshes scheduled for 2021 would include data from these excepted periods so CMS will freeze the Compare website during 2021. This means, CMS will hold the data constant (i.e., freeze the data). So following the October 2020 refresh for home health and the November 2020 refresh for hospice, the data publicly reported will be the same data as the last 2020 data. Stated another way, the publicly reported data will be frozen through the October 2021 refresh for home health and the November 2021 refresh for hospice. After these refreshes CMS plans to resume public reporting.

This change also impacts Provider Preview reports, Review and Correct reports as follows:

- After the last 2020 refresh, CMS will not issue Provider Preview reports for those refreshes that continue to display the constant or frozen data.
- The purpose of the Review and Correct report is for providers have access to quality measure data prior to the data correction deadline for public reporting. It includes data from the most current quarter "open" for data correction and data from the previous three quarters "closed" for data correction (frozen data).There will be no data available (open) to correct for Q1 2020 and Q2 2020.

Hospice providers will be able to confidentially review any data from Q1 and Q2 2020 that they chose to submit by viewing the Quality Measure reports available in their CASPER folders. CMS requires OASIS submission as a condition of payment. Because of this requirement, home health agencies were required to report OASIS during the exception period. This data will still be available to home health agencies for confidential review as well.

TRAINING AND EDUCATION/RESOURCES

HOSPICE

1. On Wednesday, August 5, CMS hosted the August 2020 HQRP Forum to present a new claims-based composite quality measure concept that CMS is considering including in the HQRP. During this webinar, Medicare-certified hospice providers and other hospice stakeholders heard from CMS's subject matter expert and the measure developer about the measure concept and shared ideas. Materials from this HQRP Forum, including a recording of the presentation, are now available in the Downloads section of the HOPE webpage.
2. CMS will host the Hospice Vendor call for Software Vendors and Developers on Thursday, September 17, 2020 from 3:00 pm to 4:00 pm ET. The agenda for the call and call in instructions can be found here. It appears that the new data specifications will be part of the items addressed on this call. The final version of the specifications will go into effect on January 1, 2021. The primary change for this version is the removal of Section O items. Specific questions vendors would like addressed during the call, should be sent to iQIES@cms.hhs.gov. Please include "HOSPICE VENDOR CALL" in the subject line. Questions must be e-mailed prior to 6:00 pm ET on Friday, September 11, 2020.
3. CAHPS Hospice Survey
    1. Updates to the Case-Mix Adjustment (CMA) Methods document which describes the CMA model, updated coefficients and means from Quarter 1 2018 to Quarter 4 2019 for CAHPS Hospice Survey is available. Click here to view or download the document that will permit a survey vendor or hospice to closely approximate the effect of case-mix adjustment on CAHPS Hospice Survey results.

2. The CAHPS Hospice Survey National Percentiles document for the upcoming public reporting period (first quarter of 2018 through the fourth quarter of 2019) is available here.
3. The CAHPS Hospice Survey state score document for the upcoming public reporting period (first quarter of 2018 through the fourth quarter of 2019) is available here.
4. The CAHPS Hospice Survey response rate for the public reporting period (first quarter of 2018 through the fourth quarter of 2019) is 32% which is consistent with previous reporting periods

HOME HEALTH

1. CMS is offering a web-based training course for those who are new to the Home Health (HH) Quality Reporting Program (QRP). This course is designed to provide a general overview of the program as well as a variety of links and resources for additional information. Click here to access the training. Specific topics include:
    1. Lesson 1: What is the Home Health Quality Reporting Program (HH QRP)?
    2. Lesson 2: The Outcome and Assessment Information Set (OASIS)
    3. Lesson 3: OASIS Data Submission
    4. Lesson 4: HH QRP Resources

Enhancing RN Supervision of Hospice Aide Services

The Centers for Medicare & Medicaid Services (CMS) recently released an MLN Fact Sheet, Enhancing RN Supervision of Hospice Aide Services. This fact sheet contains information about frequency and documentation requirements of registered nurses' (RN) supervisory visits. Learn how often RNs should visit patients in their homes to assess hospice aide's quality of care and services and documenting these visits to meet applicable CMS regulations and interpretive guidelines.

In November 2019 the Department of Health & Human Services (HHS) Office of the Inspector General (OIG) released a report that found that hospice registered nurses did not always (1) visit hospice beneficiaries' homes at least once every 14 days to assess the quality of care and services provided by hospice aides or (2) document the visits in accordance with Federal requirements. In this report, the OIG recommended that CMS promote hospices' compliance with the condition of participation standard that requires registered nurses to visit hospice beneficiaries' homes at least once every 14 days to assess the quality of care and services provided by hospice aides. This could include working with state survey agencies and accreditation organizations to increase emphasis on oversight of the requirement, education hospices about the requirements, and making the standard a quality measure. This recently released Fact Sheet appears to be in response to these recommendations.

Under the current Public Health Emergency (PHE) the 14-day aide supervisory requirement is waived and the requirement that a registered nurse make an annual onsite supervisory visit for each aide that provides services on behalf of the hospice is postponed; however, CMS encourages hospices to continue conducting the supervisory visits if possible. Hospices should review the Fact Sheet for reminders about the supervisory requirements and suggestions for documentation. Not completing the every 14-day aide supervisory visit has been a frequent Medicare survey deficiency for hospices as it is often in the top ten most frequently cited deficiencies. It seems that there are two issues with compliance for

hospices (1) scheduling of the aide supervisory visit and (2) proper documentation and follow-up of the visit. Many hospices have found that incorporating the supervision into every registered nurse visit is helpful in assuring the visit is made as well as for greater oversight of aide services and identifying any problems as soon as possible. Documentation must be in the medical record and should reflect not just that the supervisory was conducted, but also if the aide is:

- present or not present during the supervisory visit,
- following the plan of care for assigned tasks,
- creating successful interpersonal relationships with the patient and family supporting care,
- demonstrating competency with assigned tasks,
- following infection control procedures,
- reporting changes in the patient's condition, and
- respecting the patient's rights.

CMS Clarifies Hospice Election Statement and Election Statement Addendum

The Centers for Medicare & Medicaid Services (CMS) finalized in the Fiscal Year (FY) 2020 Hospice Wage Index and Payment Rate Update and Quality Reporting Update (final rule) an implementation date of October 1, 2020 for the modified election statement and election statement addendum requirements. There are many outstanding questions about the requirements and how compliance with this condition of payment will be assessed.

NAHC has been in touch with CMS on these issues and received confirmation from CMS representatives early this week that **the only financial penalty that should be imposed for the new condition of payment is when an addendum has been requested and there is not evidence in the medical record of the addendum being provided to the beneficiary/legal representative.**

CMS, the Medicare Administrative Contractors (MACs) and other reviewers should be looking for evidence on whether the addendum was requested, and if it was, evidence that the addendum was provided to the beneficiary/legal representative and that the beneficiary/legal representative signed the document. CMS told NAHC that it will not be looking to determine if the addendum was provided within the required number of days or if all content requirements are met.

CMS reiterated its intent for the election statement addendum is to improve transparency between the hospice and the beneficiary (or legal representative) and not to become another route by which to deny payment. Therefore, the condition of payment is met if there is a signed addendum (and any signed updates) in the requesting beneficiary's medical record with the hospice.

CMS has stated in comments that if the beneficiary/legal representative refuse to sign the addendum, the hospice should explain that signature is simply an acknowledgement of receipt and not indication of agreement with the contents of the addendum, and if the beneficiary/legal representative still refuse to sign, the hospice should document this in the record. While there are still outstanding questions about the modified election statement and addendum and the Immediate Advocacy process to be utilized should a beneficiary/legal representative contact the QIO with concerns about the addendum, providers will be relieved to know that financial penalties are not associated with all of the technical requirements of the addendum.