Missouri Alliance for **HOME CARE**

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Please find information related to the following:

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HHS Revises Provider Relief Fund Reporting Requirements

The U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), announced the latest Provider Relief Fund (PRF) application period has been expanded to include provider applicants such as residential treatment facilities, chiropractors, and eye and vision providers that have not yet received Provider Relief Fund distributions. HHS also announced it will be updating its most recent PRF reporting instructions to broaden use of provider relief funds.

Reporting Requirements Update
HHS is committed to distributing PRF funds in a way that is fast, fair, simple and transparent. In September, HHS published final reporting guidance to set expectations for PRF payment recipients. In providing this guidance, HHS also updated its Frequently Asked Questions (FAQs) to clarify that for purposes of relief payments for lost revenues attributable to COVID-19, recipients must submit information showing a negative change in year-over-year net patient care operating income. This definition sought to balance fairness and establish guardrails to restrict some providers from receiving distributions that would make them more profitable than they were before the pandemic.

As providers, provider organizations, and members of Congress familiarized themselves with the reporting requirements, HHS received feedback from many voicing concerns regarding this approach to permissible uses of PRF money. In response to concerns raised, HHS is amending the reporting instructions to increase flexibility around how providers can apply PRF money toward lost revenues attributable to coronavirus. After reimbursing healthcare related expenses attributable to coronavirus that were unreimbursed by other sources, providers may use remaining PRF funds to cover any lost revenue, measured as a negative change in year-over-year actual revenue from patient care related sources.

A policy memorandum on the reporting requirement decision can be found here - PDF*.

The amended reporting requirements guidance can be found here - PDF.*

Governor Calls Special Session On COVID-19 Funding

Gov. Parson has called a special session of the General Assembly for the legislature to make supplemental appropriations for the state's COVID-19 response beginning Thursday, November 5, 2020.

Since the General Assembly passed the FY 2021 budget in May, additional federal funding has been made available to the state, including funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The supplemental budget will provide access to this funding, which is intended to appropriate additional resources to respond to COVID-19.
The supplemental budget contains funding for several items, including the School Nutrition Services Program, the Emergency Solutions Grant Program for homelessness prevention, job training grants, and child support payments, among others.

As a reminder, MAHC successfully advocated and received $20 million in relief funding for Home & Community Based Services providers. The deadline for these providers to submit invoices to access their allocated funds is November 15th.

Azar Extends Public Health Emergency

HHS Secretary Alex Azar extended the COVID-19 Public Health Emergency (PHE) for an additional 90 days. The PHE, which would have ended on October 23, is now extended to January 23, 2021, unless there is a further extension. Because Section 1135 waivers generally expire when the underlying emergency/disaster declaration terminates, the extension will impact the termination dates of 113 waivers currently in place. However, Appendix K termination dates are not affected by the extension.

Click here to see the PHE renewal notice.

GAO Report: Home Care Rule Led to Difficulty Accessing Care, Not Higher Pay

(from NAHC Report)

The Home Care Rule, created by the Department of Labor in 2015 to extend wage and overtime provisions to home care workers, resulted in patient difficulty accessing care, the end of some services, and limits on working hours for home care aides, but did not result in higher pay for those workers, according to a new report from the Government Accountability Office (GAO).

With home care jobs expected to grow by 40 percent over the coming decade to meet the demands of the "Silver Tsunami," the GAO set out to discover what impact the DoL regulation known as the Home Care Rule — which extended Fair Labor Standards Act (FLSA) minimum wage and overtime protections to more home care workers — has had on home care workers, patients, and programs since 2015. The GAO compared home care workers' hours and earnings to workers in similar jobs before and after the

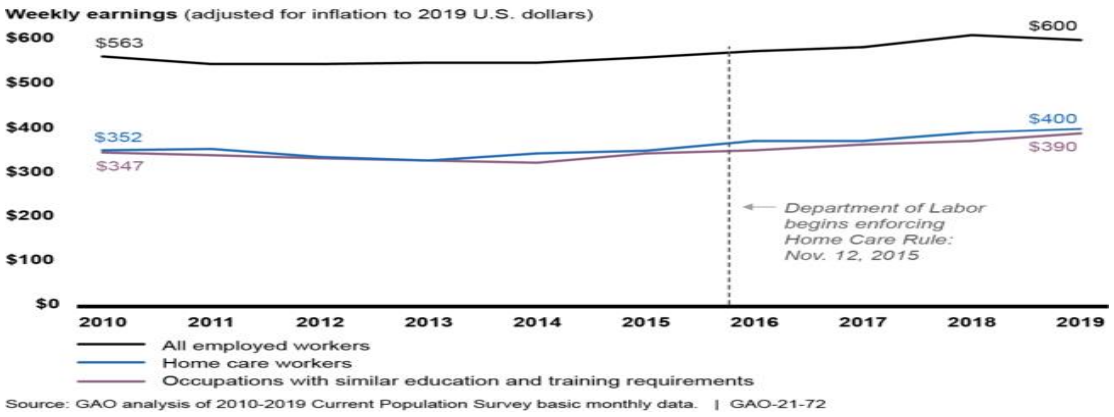
regulation took effect. GAO analyzed 2010 through 2019 national survey data on workers' hours and wages; interviewed stakeholders from the different groups affected, DOL officials, and home care program officials from three states selected based on variation in their Medicaid programs and minimum wage levels; and reviewed studies on state strategies to implement the Home Care Rule.

What GAO Found

Many states responded by limiting workers' hours in their Medicaid programs to avoid overtime costs. The GAO report cites Oregon, where new home care workers provided via Medicaid were limited to 40 hours per week. What's more, some states altered delivery of home care services in their Medicaid programs by doing things like discontinuing some services, such as live-in care. Some states did not make these changes.

The GAO found that home care workers were more likely to work full-time after the rule, but their pay did not increase relative to similar workers. "Some provider agencies restricted workers' hours to limit overtime costs, though this can result in the need to hire more workers, leading to increased costs of recruiting, training, and scheduling," wrote the GAO.

GAO's analysis of national survey data found that home care workers, when compared to occupations with similar education and training requirements, were more likely to work full-time but did not earn significantly higher earnings following the Home Care Rule (see figure). Many stakeholders GAO spoke with described ongoing challenges consumers face in obtaining home care services, such as difficulty finding workers to hire.



Source: GAO analysis of 2010-2019 Current Population Survey basic monthly data. | GAO-21-72

"The GAO report validates the concerns that NAHC expressed regarding the effective elimination of the "companionship" exemption under the Fair Labor Standards Act," said NAHC President William A. Dombi, in reaction to the report. "Neither workers nor consumers benefited to any degree by requiring home care employers to pay overtime without any additional remedial actions. The GAO analysis shows that workers' pay has not increased, patients have more difficulty accessing care, state Medicaid programs are restricting the hours an individual can work, and home care programs have been eliminated because of this ill-advised rule change. NAHC strongly supports better compensation for the invaluable home care aide workforce. However, this rule change caused more harm than good because state Medicaid programs have not stepped up with improved payments and no consumer protections have been instituted, such as tax credits, to offset higher costs of care for the private pay patient.

Perhaps now policy makers will take the necessary steps to improve care access and to achieve respectful wages to caregivers."

You may read the full GAO report **HERE**.

CDC Expands its Definition of Who is at Risk for COVID Infection

The Centers for Disease Control and Prevention (CDC) recently updated its coronavirus guidelines to significantly expand the population of people deemed to be at risk for infection.

Anyone in "close contact" with an infected person is regarded as a person at risk for infection, but the CDC previously defined that as someone who spent at least 15 consecutive minutes within six feet of someone with a confirmed case of coronavirus. Now, **CDC defines close contact as a person who was within an infected individual for a total of 15 minutes over a 24-hour period**.

That means the number of people deemed to be at risk will almost certainly increase, with potentially significant implications for workplaces, mass transit, and health care workers.

In a report also issued Wednesday, the CDC found a 20-year-old prison employee became infected with coronavirus after interacting with people who subsequently tested positive. In this case there were a total of 22 interactions, totaling 17 minutes during the employee's eight-hour work shift.

The prison employee wore a cloth mask, eye protection, and gown during all of these interactions, while the infected persons were mostly, but not always wearing masks.

This update comes at a time when 75 percent of the country is experiencing an increase in the number of COVID-19 cases.

Recommendations and Clarifications for HHAs on the No-Pay RAP *(from NAHC Report)*

Beginning January 1, 2021, home health agencies (HHAs) will be required to submit a request for anticipated payment (RAP) that will be paid at 0 percent, prior to each claim. The Centers for Medicare & Medicaid Services (CMS) finalized the No-pay RAP policy in the CY 2020 Home Health Prospective Payment System Rate Update rule. Although there is no payment assigned to the RAP, it still serves an operational role for the Medicare program by establishing the beneficiary's primary home health agency (HHA) in the Common Working File (CWF) in order to enforce the consolidated billing rules.

Because there is no payment assigned to the No-pay RAP, CMS has modified the criteria for submitting RAP beginning January 1, 2021 to require the following:

(1) The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented, as required in regulation at 42 CFR 484.60(b) and 42 CFR 409.43(d);

(2) The initial visit within the 60-day certification period must have been made and the individual admitted to home health care.

Additionally, for CY 2021, CMS established non-timely submission payment penalty when the HHA does not submit the RAP within 5 calendar days from the start of care date for the first 30-day period of care in a 60-day certification period and within 5 calendar days of the "from date" for the second 30-day period of care in the 60-day certification period.

This reduction in payment will be equal to a 1⁄30th reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the home health "from date" until the date the HHA submits the RAP. The penalty applies to outlier claims and low utilization payments adjustment (LUPA) claims. For LUPA 30-day periods of care in which an HHA fails to submit a timely RAP, no LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP. The payment reduction cannot exceed the total payment of the claim.

The 5-day submission time frame along with the late submission penalty has caused concern for many agencies. The current requirements for submitting the RAP entail a number of processes that must be conducted, such as, a complete plan of care that is sent to the physician, a comprehensive assessment including the OASIS in order to establish the POC and generate an accurate HIPPS code, and if the certification statement is included on the POC, all certification requirements are needed to be completed prior to submitting the RAP. Therefore, although CMS has modified the criteria for submitting the RAP beginning on January 1, 2021 many HHAs will need to modify agency operations and the electronic health record (EHR) in order to accommodate the revised criteria. 2021.

In discussions the National Association for Home Care & Hospice (NAHC) has had with several large vendor organizations it is evident that the vendor community is working to assist HHAs with this transition in RAP submission criteria. However, agencies should be proactive in addressing with their vendor any concern they have regarding what actions are taking place to prepare for the No-pay RAP submission changes

The following questions may be helpful when working with your vendors.

1. Has the vendor modified the workflow within the EHR to permit the RAP to be submitted in accord with the new criteria and within 5 days beginning on January 1, 2021?
2. If your vendor has not completed the updates, when will they be completed?
3. How will the agency's current back office operations need to be altered?
4. Will the agency have access to reports for compliance analytics and management?
5. What is the anticipated learning curve for staff to learn the EHR and operations?

Following are clarifications on several other policy issues related to the CMS No-pay Rap policy.

- The count for the 5-day time frame begins with the "from" date on the RAP as day 0. In the Medicare Claims Processing Manual, chapter 10, 40.1, CMS states "… within 5 calendar days after the From date of a HH period of care."
- HHAs may report any valid HIPPS code on the RAP and claim, the amount paid on the claim will be paid based on inputs from the Medicare system and not the HIPPS code reported on the claim.

- CMS will permit the "from" date on the RAP to be the services date associated with revenue code 0023. This will prevent delaying the submission of the RAP for subsequent periods, including recertification episodes, when the first visit in that period would be beyond the 5-day timeframe.
- CMS is revising the claims processing system removing the edit to not require that allow the first service date on the RAP to not have to match the first service date on the claim.

CMS Releases Clarifying Memo Regarding Emergency Preparedness Requirements *(from NAHC Report)*

The Quality, Safety, and Oversight Group (QSOG) of the Centers for Medicare & Medicaid Services (CMS) recently released memo QSO-20-41-ALL Guidance related to the Emergency Preparedness Testing Exercise Requirements- Coronavirus Disease 2019 (COVID-19). This memo provides guidance on meeting emergency preparedness testing requirements in light of many of the response activities associated with the COVID-19 Public Health Emergency (PHE).

CMS made changes in November 2019 to the emergency preparedness requirements for home health agencies and hospices as part of a final rule related to burden reduction. Specifically, CMS revised the emergency preparedness testing exercise requirements to allow for an exemption to the testing requirements during or after an actual emergency. If a provider experiences an actual natural or man-made emergency that requires activation of their emergency plan, inpatient and outpatient providers will be *exempt from their next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the actual event*. In light of the PHE, CMS is clarifying the testing exercise requirements to ensure that surveyors, as well as providers and suppliers, are aware of the exemption available based on activation of their emergency plans.

For providers of inpatient services which includes inpatient hospice facilities: The testing exercises were expanded to include workshops as an exercise of choice. However, these providers are still required to conduct two emergency preparedness testing exercises annually

For providers of outpatient services which includes home health agencies and non-inpatient facility hospices: These providers must continue to test their program annually, by participating in a community-based full-scale exercise (if available) or conduct an individual facility-based functional exercise every other year. In the opposite years off the full-scale exercise, the providers are required to conduct a testing exercise of their choice, which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator.

As stated above, the emergency preparedness regulations allow an exemption for providers or suppliers that experience a natural or man-made event requiring activation of their emergency plan. Many providers have activated their emergency plans due to the current PHE. Such facilities are exempt from the *next required full-scale community-based or individual, facility-based functional exercise*. Facilities must be able to demonstrate, through written documentation, that they activated their program due to the emergency. CMS requires facilities to conduct an exercise of choice annually for inpatient providers and every two years for outpatient providers (opposite the year of the full-scale or facility-based functional exercise). For the "exercise of choice," facilities must conduct one of the following:

- Another full-scale exercise;
- Individual-facility-based functional exercise;
- Mock disaster drill; or
- A tabletop exercise or workshop.

Facilities may need to conduct an exercise of choice following the current PHE if they were required to conduct such an exercise this year and did not already do so.

CMS gave the example that facilities may choose to conduct a table-top exercise (TTX) which could assess the facility's response to COVID-19. This may include but is not limited to, discussions surrounding availability of personal protective equipment (PPE); isolation and quarantine areas for screening patients; or any other activities implemented during the activation of the emergency plan. The emergency preparedness provisions require that facilities assess and update their emergency program as needed. Therefore, lessons learned and challenges identified in the TTX may allow a facility to adjust its plans accordingly. As a reminder, all providers and suppliers must continue to analyze their facility's response to and maintain documentation of all drills, tabletop exercises, and activation of their emergency plan. This would include documentation showing any revisions to the facility's emergency plan as a result of the after action review process.

CMS indicated that a future release of the State Operations Manual, Appendix Z will update the guidance, but they also included in this memo a surveyor worksheet. The worksheet summarizes the testing requirements and provides example scenarios for surveyors. It is also a useful tool in helping providers to assure compliance with the requirements.

Level of Care Transformation (LOC) Q&A Session

A memorandum has been issued by the Division of Senior & Disability Services regarding a Level of Care Transformation Q&A session.

Please refer to INFO-10-20-01 at https://health.mo.gov/seniors/hcbs/infomemos.php.

This memorandum provides Home and Community Based Services (HCBS) staff and stakeholders an update on the LOC Transformation project. DSDS is committed to providing information and answering outstanding questions pertaining to the LOC Transformation project. As part of this commitment, DSDS has collaborated with fellow provider and community stakeholder Elisa Pelham to address common questions. Questions have been posed and answered in a video format, accessible via the DSDS Provider Information Page. Please click here to view the Q&A session. This session addresses key questions regarding what to expect as LOC Transformation draws near, including population changes and other quality improvement initiatives associated with the project.

Questions or comments 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.