Missouri Alliance for **HOME CARE**
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Please find information related to the following:

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NAHC to Congress: Minimum Wage Hikes Must Not Outpace Reimbursement Rates - MAHC Signs onto Letter *(from NAHC Report)*

On February 9th, the National Association for Home Care and Hospice sent a letter to leaders in Congress of both parties, outlining recommendations as legislators consider an increase in the minimum wage to $15 per hour.

Twenty-eight state home care and hospice associations joined NAHC in signing the letter.

An increase to the federal minimum wage has long been a challenging issue for home care and hospice providers, as they seek to balance the need to properly reward the indispensable work of caregivers with inadequate payment rates that make it difficult to maintain any profit margin.

Some state Medicaid programs reimburse less than $15 per hour for personal care services, meaning the provider would in effect be paying itself to provide care. Taking into account other employment-related costs, such as training, supervision, various administrative functions, and taxes further demonstrates the pressures home care agencies are under, and the need for adequate payment rates.

In the letter NAHC acknowledges the need to compensate the home care workforce fairly for their valuable work while positioning providers to stay competitive for staff. As a recommendation NAHC urges Congress to increase payment rates from federally funded programs in conjunction with an increase to the minimum wage as a means to offset agencies increased labor cost.

In addition, NAHC recommends that a tax credit or subsidy be created for the consumer of service so that they are positioned to maintain the level of care they need.

Labor Dept. Issues Stronger Workplace Guidance on Coronavirus *(from NAHC Report)*

The U.S. Department of Labor recently announced that its Occupational Safety and Health Administration has issued stronger worker safety guidance to help employers and workers implement a coronavirus protection program and better identify risks which could lead to exposure and contraction. President Biden directed OSHA to release clear guidance for employers to help keep workers safe from COVID-19 exposure.

"Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace" provides updated guidance and recommendations, and outlines existing safety and health standards. OSHA is providing the recommendations to assist employers in providing a safe and healthful workplace.

"More than 400,000 Americans have died from COVID-19 and millions of people are out of work as a result of this crisis. Employers and workers can help our nation fight and overcome this deadly pandemic by committing themselves to making their workplaces as safe as possible," said Senior Counselor to the Secretary of Labor M. Patricia Smith. "The recommendations in OSHA's updated guidance will help us defeat the virus, strengthen our economy and bring an end to the staggering human and economic toll that the coronavirus has taken on our nation."

Implementing a coronavirus protection program is the most effective way to reduce the spread of the virus. The guidance announced today recommends several essential elements in a prevention program:

- Conduct a hazard assessment.
- Identify control measures to limit the spread of the virus.
- Adopt policies for employee absences that don't punish workers as a way to encourage potentially infected workers to remain home.
- Ensure that coronavirus policies and procedures are communicated to both English and non-English speaking workers.
- Implement protections from retaliation for workers who raise coronavirus-related concerns.

"OSHA is updating its guidance to reduce the risk of transmission of the coronavirus and improve worker protections so businesses can operate safely and employees can stay safe and working," said Principal Deputy Assistant Secretary for Occupational Safety and Health Jim Frederick.

The guidance details key measures for limiting coronavirus's spread, including ensuring infected or potentially infected people are not in the workplace, implementing and following physical distancing protocols and using surgical masks or cloth face coverings. It also provides guidance on use of personal protective equipment, improving ventilation, good hygiene and routine cleaning.

OSHA will update this guidance as developments in science, best practices and standards warrant.

This guidance is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of existing mandatory safety and health standards. The recommendations are advisory in nature, informational in content and are intended to assist employers in recognizing and abating hazards likely to cause death or serious physical harm as part of their obligation to provide a safe and healthful workplace.

Under the Occupational Safety and Health Act of 1970, employers are responsible for providing safe and healthful workplaces for their employees. OSHA's role is to help ensure these conditions for America's working men and women by setting and enforcing standards, and providing training, education and assistance. Learn more about OSHA.

Home Health – BinaxNOW Antigen Test Kits Re-Order Form

Home Health agencies can click here to access the link for re-ordering the BinaxNOW Antigen Test Kits.

If you are a new user, the form will direct you to complete a new application for tests rather than just re-ordering. The link for the initial application for each user type is within the above re-order link.

OIG Adds 2 Home Health Items to Work Plan *(from NAHC Report)*

The Office of Inspector General (OIG) has announced two new items of interest to home health members. One is an audit of home health telehealth services during the COVID-19 public health emergency (PHE) and the second is a report on the challenges faced by home health agencies in responding to the PHE and the strategies used to respond.

Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency
The declaration of a public health emergency (PHE) on March 13, 2020, in response to the COVID-19 pandemic, allowed the Centers for Medicare & Medicaid Services (CMS) to take proactive steps to support the response to COVID-19 through the use of section 1135 waivers. By means of this authority, CMS waived certain requirements in order to expand Medicare telehealth benefits to health care professionals who were previously ineligible, including physical therapists, occupational therapists, speech language pathologists, and others. CMS also amended regulations to allow home health agencies to use telecommunications systems in conjunction with in-person visits. The amended regulations state that:

1. the use of technology must be related to the skilled services being furnished, and
2. the use of technology must be included in the plan of care with a description of how the technology will help achieve goals without substituting for an in-person visit.

OIG will evaluate home health services provided by agencies during the COVID-19 public health emergency to determine which types of skilled services were furnished via telehealth, and whether those services were administered and billed in accordance with Medicare requirements. OIG will report as overpayments any services that were improperly billed.

This report is expected to be delivered during FY2021.

Home Health Agencies' Challenges and Strategies in Responding to the COVID-19 Pandemic
Home health agencies (HHAs) have faced unprecedented challenges to providing care during the COVID-19 pandemic. Reported challenges include, but are not limited to, procuring necessary equipment and supplies, implementing telehealth to treat patients remotely, and addressing staffing shortages. However, the full spectrum of these challenges, including how challenges have evolved over time, is unknown. HHAs have used strategies to address these challenges, but the array of strategies and the extent to which HHAs found them helpful are also unknown.

This nationwide study will provide insights into the strategies HHAs have used to address the challenges presented by COVID-19, including how well their emergency preparedness plans served them during the COVID-19 pandemic.

This report is expected to be delivered during FY2022.

The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections. Projects listed in the Work Plan span the Department and include the Centers for Medicare & Medicaid Services (CMS), public health agencies such as the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH), and human resources agencies such as Administration for Children and Families (ACF) and the Administration on Community Living (ACL). OIG also plans work related to issues that cut across departmental programs, including State and local governments' use of Federal funds, as well as the functional areas of the Office of the Secretary of Health & Human Services (HHS). Some Work Plan items reflect work that is statutorily required.

Providers can see all active OIG Work Plan items for home health agencies and hospices, of which there is a fair number, by going to the OIG Active Work Plan Items webpage and entering their provider type in the search bar.

HHS Announces Provider Relief Fund Reporting Update *(from NAHC Report)*

The U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), announced on Friday, January 15, that it will be amend the reporting timeline for the Provider Relief Fund Program (PRF) due to the recent passage of the *Coronavirus Response and Relief Supplemental Appropriations Act*. Consequently, PRF recipients will now be required to submit their reporting requirements on their use of these funds later than previously announced.

PRF recipients may begin registering for gateway access to the Reporting Portal where they will ultimately submit their information in compliance with the new reporting requirements HHS is issuing.

The PRF Reporting Portal is now open for registration and is available here: https://prfreporting.hrsa.gov/s/.

The updated reporting requirements are HERE. A redline comparing the updated reporting requirements to the November 2020 version is HERE.

Reporting Portal Update & Registration Launch
Beginning last summer, HHS began outlining comprehensive reporting instructions that would apply to recipients of PRF funds that received payments exceeding $10,000 in aggregate. HHS previously planned to open the Reporting Portal based on this previously released information by January 15, 2021, with the first deadline for submissions on February 15, 2021. In late December, however, Congress passed the *Coronavirus Response and Relief Supplemental Appropriations Act*, which added another $3 billion in funding to the PRF program and included language specific to reporting requirements. HHS has been working to update the PRF reporting requirements to be consistent with this new law. HHS wanted to give recipients ample time to familiarize themselves with the updated reporting requirements well in advance of required submission deadlines.

HHS is encouraging all PRF recipients that have received aggregate PRF payments that exceed $10,000 to establish a reporting account by registering at the newly enabled PRF reporting website.

The updated reporting requirements released do not apply to funds from: Nursing Home Infection Control, Rural Health Clinics Testing, and COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment and Vaccine Administration for the Uninsured recipients. While there is currently no deadline for providers to establish a reporting account in the newly enabled Reporting Portal, all providers will be required to complete this first step in order to advance and fulfill their reporting requirements once HHS announces the new deadline to do so. Provider support and call center resources are currently limited but will be more available to answer providers' questions once the second phase for reporting submissions is announced.

More information about the new reporting requirements and portal registration can be found here.

Johnson & Johnson Publishes White Paper on The Impact Of COVID-19 On Nursing

As part of the Johnson & Johnson commitment to support front-line health care workers, and in partnership with the American Nurses Association and American Organization for Nursing Leadership, J&J recently shared a white paper exploring findings from a market research study on how COVID-19 is impacting the nursing profession.

CMS Answers Key Home Care Questions *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has provided the following responses to several outstanding questions submitted by the National Association for Home Care & Hospice (NAHC). NAHC submitted the questions after receiving requests for clarification on these issues from its membership.

Question #1
There is confusion based on the regulations below. Section 424.22(a)(v) (A)(2) states that a NP, PA, or a CNS may conduct the F2F encounter when collaborating with certifying physician whether in a facility or in the community. However, 424.22(a)(v) (C) (1) and (2) seem to limit who may conduct the F2F

encounter when an NP, PA, or CNS is certifying beneficiaries admitted to home health from the community. Section (C) reads as though the NP, PA, or CNS may only conduct the F2F encounter if they are the certifying practitioner. These sections are conflicting and seem to prohibit NPPs who are not certifying but are working in collaboration with a certifying physician to conduct the F2F encounter for beneficiaries admitted to home health from the community.

- 424.22(a)(v)(A) and (C)

(A) The face-to-face encounter must be performed by one of the following:

1. The certifying physician (as defined at §484.2 of this chapter) or a physician, with privileges, who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.
2. The certifying nurse practitioner (as defined at §484.2 of this chapter), certifying clinical nurse specialist (as defined at §484.2 of this chapter), or a nurse practitioner or a clinical nurse specialist who is working in accordance with State law and in collaboration with a physician or in collaboration with an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.
3. A certified nurse midwife (as defined in section 1861(gg) of the Act) as authorized by State law, under the supervision of a physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.
4. A certifying physician assistant (as defined at §484.2 of this chapter) or a physician assistant under the supervision of a physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

(B) The face-to-face patient encounter may occur through telehealth, in compliance with section 1834(m) of the Act and subject to the list of payable Medicare telehealth services established by the applicable physician fee schedule regulation.

(C) The face-to-face patient encounter must be performed by the certifying physician or allowed practitioner unless the encounter is performed by:

1. A certified nurse midwife as described in paragraph (a)(1)(v)(A)(4) of this section.

2. A physician, physician assistant, nurse practitioner, or clinical nurse specialist with privileges who cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner.

CMS Response: The statute states only that the certifying physician must document that the physician or NPP has had a face-to-face encounter prior to certification. It does not prevent a community-based physician from conducting the F2F, when he/she is not the certifying physician. Therefore, this would not limit the F2F (conducted by a community physician or allowed NPP) to only the certifying physician or allowed practitioner. We will consider proposing conforming regulation text changes in future rulemaking to make this clear.

In their response, CMS is referring to the statutory language from the CARES Act. A provision in the CARES Act replaced a section in the Social Security Act at 1814(a)(2)(C), which eliminated the requirement that the certifying physician himself or herself, or an NPP collaborating with the certifying physician, had a face-to-face encounter with the beneficiary. The revised statutory language permits a certifying practitioner to document that any allowed practitioner has conducted the F2F encounter regardless of whether they are the certifying practitioner or collaborating with certifying practitioner.

1814(a)(2)(C)

"and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that prior to making such certification the physician must document that the physician himself or herself , or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician, has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary; "

CARES Act

by striking ", and, in the case of a certification made by a physician" and all that follows through "face-to-face encounter" and inserting ", and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after the date of the enactment of the (CARES Act), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or physician assistant has had a face-to-face encounter"

Although CMS recognizes the change in the statute for the home health F2F encounter, it is unclear whether the MACs have received any instructions regarding CMS' position. NAHC is seeking information from the MACs.

Question #2

I am assuming the section regarding private duty nursing under Medicaid was not changed to reflect NPPs ordering services since the statute was specific to home health services. I am receiving questions from members and want to be sure that is the case rather than an oversight.

- 440.80 Private duty nursing services.

Private duty nursing services means nursing services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided—
(a) By a registered nurse or a licensed practical nurse;
(b) Under the direction of the beneficiary's physician; and

CMS Response: The changes allowing allowed practitioners to certify and order services were made under Medicaid HH as well; however, we cannot speak to private duty nursing under Medicaid. Please

reach out to MMCO for advisement regarding this question. **NAHC has reach out to the Medicare and Medicaid Coordination Office for clarification.**

Question #3
I am seeking clarification on the intersection of the new home infusion therapy (HIT)supplier benefit and beneficiaries receiving hospice care. I understand that the professional services related to Part B infusion drugs are carved out of the home health benefit beginning 1/1/2021. There is confusion, however, regarding whether hospice providers are required to provide the professional services related to a Part B infusion drug under the hospice benefit billed under Part A or must a HIT supplier provide those service under Part B. The need for the drug in this case would be related to the terminal illness, for example, a morphine infusion for pain.

CMS Response: The 21st Century Cures Act only excluded home infusion therapy services from home health services. All infusion services related to the hospice patient's terminal illness and related conditions would remain covered under the Medicare hospice benefit.

MedPAC Recommends Home Health Rate Cut *(from NAHC Report)*

During their recent January 14-15 meeting, the Medicare Payment Advisory Commission (MedPAC) recommended to Congress a five percent base rate cut for home health services. The recommendations follows the base rate discussions held during MedPAC's previous meeting in December 2020.

Prior to the vote, commissioners received a presentation form MedPAC staff on the current state of the home health program. In 2019 Medicare home health spending totaled $17.8 billion. Approximately 11,300 certified providers participated in the program providing care to 3.3 million beneficiaries across 6.1 million episodes of care. Ninety-nine percent of Medicare beneficiaries live in a zip code serviced by at least one home health provider. The presentation further revealed an average profit margin of 15.8 percent, and an all payer profit margin nearing 6 percent.

MedPAC forecasts a 14 percent Medicare profit margin for 2021.

Concluding the presentation was a recommendation of a 5 percent base rate cut, consistent with what was discussed in the December meeting. This is estimated to result in between a $750 million – $2 billion in savings in 2022 and over $10 billion in savings over five years.

Following the presentation, a roll call vote among the commissioners was held resulting in unanimous approval of the 5% rate cut recommendation. This recommendation will be among a series that touch every aspect of the Medicare program. Combined, they will be presented to the Congress in March 2021.

MedPAC has consistently recommended rate reductions and other rate cuts to the home health program for years and for years NAHC has urged Congress to reject those recommendations. Accordingly, Congress has elected not to act on those recommendations. NAHC will continue to work with members of Congress to demonstrate that a rate cut of five percent would harm patients, as well as providers.

CMS Finalizes Definition of "Reasonable and Necessary" *(from NAHC Report)*

A definition of "reasonable and necessary" is part of the recently finalized rule, Medicare Program; Medicare Coverage of Innovative Technology (MCIT) and Definition of ''Reasonable and Necessary''.

This rule also establishes a Medicare coverage pathway to provide Medicare beneficiaries nationwide with faster access to new, innovative medical devices designated as breakthrough by the Food and Drug Administration (FDA). The Medicare Coverage of Innovative Technology (MCIT) pathway begins national Medicare coverage on the date of FDA market authorization and continues for four years. As part of this, the Centers for Medicare & Medicaid Services (CMS) will codify the definition of reasonable and necessary to align with the goals of MCIT.

CMS finalized that an item or service would be considered ''reasonable and necessary'' if it is:

1. safe and effective;
2. not experimental or investigational; and
3. appropriate for Medicare patients, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is—
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the patient's medical needs and condition;
    - Ordered and furnished by qualified personnel;
    - One that meets, but does not exceed, the patient's medical need; and
    - At least as beneficial as an existing and available medically appropriate alternative
    - Covered in the commercial insurance market, except where evidence supports that there are clinically relevant differences between Medicare beneficiaries and commercially insured individuals.

An item or service deemed appropriate for Medicare coverage based on commercial coverage would be covered on that basis without also having to satisfy the bullets listed above. CMS will look to commercial insurance coverage policies in cases where there is insufficient evidence regarding appropriateness for National or Local Coverage Determination (NCDs or LCDs). CMS will consider coverage to the extent the items or services are covered by most commercial insurers. As part of CMS' consideration, CMS will include in the national or local coverage determination its reasoning for its decision if coverage is different than most commercial insurers. Not later than March 15, 2022 CMS will issue draft subregulatory guidance on the methodology of which commercial insurers are relevant based on the measurement of the majority of covered lives.

The above definition is nearly identical to the definition of reasonable and necessary in chapter 13, section 13.5.4, of the Medicare Program Integrity Manual and had been generally used to make determinations of "reasonable and necessary" but had not been codified. This final rule codifies the definition and is effective March 15, 2021. NAHC had submitted comments on the proposed rule and recommended that the definition be expanded to include palliative care in addition to "treatment" and that CMS not utilize coverage policies of commercial insurers to restrict or deny coverage. CMS did not add palliative care to the definition but did indicate in the final rule comments that it will not use commercial coverage policies to restrict or deny coverage.

MedPAC Recommends Hospice Payment Freeze, Cap Cut for FY2022 *(from NAHC Report)*

The Medicare Payment Advisory Commission (MedPAC), an advisory body to Congress, recently met to finalize payment and policy recommendations that will be incorporated in its annual March Report to Congress. Among the items MedPAC acted on were payment recommendations for the hospice sector in fiscal year (FY) 2022 and findings from a legislatively-mandated analysis of the impact of applying the hospital post-acute transfer policy to cases discharged to hospice.

MedPAC approved the following recommendations for FY2022:

- Congress should eliminate the update to the 2021 Medicare base payment rates for hospice, and
- Congress should wage-adjust and reduce the hospice aggregate cap by 20 percent.

These recommendations are estimated to decrease spending relative to current law by between $750 million and $2 billion over one year and $5 billion to $10 billion over five years. It should be noted that MedPAC's recommendations are advisory in nature and these changes would require legislative action by the Congress in order to be enacted. The National Association for Home Care & Hospice (NAHC) opposed these recommendations.

As part of its hospice discussion, MedPAC conducted a brief review of the items considered when developing payment recommendations, including an overview of Medicare hospice services data for 2019 and an assessment of payment adequacy indicators (beneficiaries access to care, quality of care, hospices' access to capital, and Medicare payments and hospices' costs) all of which were found to be, for the most part, positive.

The panel also briefly reviewed data related to the hospice aggregate cap and characteristics of hospice providers that tend to exceed the cap. Last year (for FY2021), MedPAC recommended that the aggregate cap be wage adjusted and reduced by 20 percent; this recommendation was in lieu of the commission recommending an across-the-board cut in payments for hospice providers, as it would make the cap more equitable across providers and focus payment reductions on providers with high margins and longest stays.

Section 53109 of the *Bipartisan Budget Act of 2018* required that, effective October 1, 2018, the Secretary of Health & Human Services (HHS) begin considering certain short-stay hospital patients that, following discharge, are admitted to hospice, as a "transfer" for purposes of hospital payment, and reduce hospital payments accordingly. The legislation also required that MedPAC evaluate the impact of the hospital to hospice transfer policy and provide a preliminary report to Congress no later than March 15, 2020, and a final report by March 15, 2021.

As part of its discussion on hospital-related issues, MedPAC reviewed general findings from its study and indicated that, while staff found the policy to save approximately $300 million in hospital spending during FY2019 that there is no evidence of discernible changes in timely access to hospice care.

Public COVID-19 Vaccination Dashboard Available

The Missouri Show Me Strong Dashboard added additional information showing COVID-19 vaccination rates in Missouri. The dashboard provides the public a window into overall vaccinations in Missouri, including both first and second doses of the COVID-19 vaccine. Further breakdown of the data includes administered amounts of vaccine by county, age, gender, race and ethnicity. Discrepancies in numbers between the Show Me Strong Dashboard and the Centers for Disease Control and Prevention website primarily are due to timing in data reporting.

HHS Permits Retired and Inactive Clinicians To Administer COVID-19 Vaccine

The U.S. Department of Health and Human Services will amend the Public Readiness and Emergency Preparedness Act to permit doctors and nurses who have recently retired or become inactive to administer COVID-19 vaccines, and anyone currently licensed to vaccinate in their state to administer shots across state lines. White House COVID-19 Response Coordinator Jeff Zients stated, "As the president said, we need to increase the number of places people can get vaccinated, and at the same time increase the number of vaccinators. This action by HHS will help get more vaccinators in the field."

FDA Import Alert for Alcohol-Based Hand Sanitizer From Mexico

The U.S. Food and Drug Administration placed all alcohol-based hand sanitizers from Mexico on an import alert to help stop products that may be in violation from entering the U.S. until the agency is able to review the products' safety. The agency has seen a significant number of hand sanitizer products from Mexico that were labeled to contain ethanol (also known as ethyl alcohol) but tested positive for methanol contamination or 1-propanol.

Methanol exposure can result in nausea, vomiting, headache, blurred vision, permanent blindness, seizures, coma, permanent damage to the nervous system or death. Individuals who use these products are at risk for methanol poisoning; however, young children who ingest these products and persons who drink these products as an alcohol substitute are most at risk. Health professionals and consumers are encouraged to report adverse events or side effects related to the use of these products to the FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Money Follows the Person - Stay Requirement Change Starting January 26, 2021

The MFP Program requirement of 90 days stay in a nursing facility prior to transition has been reduced to 60 days. Additionally, days at a nursing facility which were considered short-term rehabilitation days can now count toward fulfillment of the 60 day stay requirement.

- MFP has reduced the period of time for which an eligible individual must have been institutionalized from 90 days to 60 days.
- MFP has eliminated the prohibition on counting short-term rehabilitative days toward the institutional residency requirement.

Logisticare Solutions, LLC Changes Name to ModivCare Solutions, LLC

Effective January 6, 2021, MO HealthNet's Non-Emergency Medical Transportation (NEMT) vendor for fee-for-service participants changed its name from LogistiCare Solutions, LLC to ModivCare Solutions, LLC as part of a company rebranding initiative. *Modiv* is Latin for "way" and reflects the company's desire to lead innovation and change in terms of how people connect to care. **The new name will not change any of the services provided.**

Other changes as part of the rebrand include:

- Company logo and colors
- The way staff answers the phone - for members' consideration, staff will answer the phone as ***ModivCare, formerly LogistiCare***, for 12 months following the transition.
- Company website - for members' consideration, the website will reference ***ModivCare, formerly LogistiCare***, for 12 months following the transition.

What is *not* changing as part of the rebrand:

- Phone numbers and the way clients, members, facilities and transportation providers contact them.
- Their staff will remain the same.
- The way members book their rides online – members will continue to use the same links to schedule their rides as they have been.

ModivCare's purpose of this rebrand is to shift toward becoming a tech-enabled, value-based healthcare company that will translate into better member experience that delivers consistent, positive healthcare outcomes and leads the industry into a new era.

HCBS COVID-19 Flexibilities in Relation to PHE Extensions/Expirations

The Division of Senior & Disability Services (DSDS) has provided guidance to Medicaid HCBS providers delivering services authorized by DSDS. The guidance has been in effect from the date Governor Mike Parson declared a state of emergency (March 13, 2020) and throughout the period of COVID-19 Response.

State flexibilities are extended though the State of Emergency Declaration, currently set to expire on March 31, 2021. This date is subject to change upon extension of the State of Emergency. Federal flexibilities are currently extended to April 21, 2021. However, the Department of Health and Human Services (HHS) has determined that the Public Health Emergency (PHE) will likely remain in place through the end of 2021. When a decision is made to end the PHE, HHS will notify states 60 days prior to termination.

To see a chart outlining the authorities of each of the COVID flexibilities, click here.

PPE Items Added to State Supply

Gloves are available through the Missouri PPE Reserve if facilities cannot secure through other means.

- Medium and large gloves have now been placed on the on-line order form with a two case limit.
- Small and extra-large gloves can be ordered by special request. There is a limited supply of these but we can send to facilities in need.

For facilities needing to make a special request for gloves, they can email John.whitaker@health.mo.gov and provide the following information:

- Size and amount requested (1000 per case)
- Facility name and physical mailing address (no PO boxes)
- Contact name, email and phone number

Also, several Missouri manufacturers have retooled to make PPE, including N-95 masks. A list of those manufacturers can be found on the Show Me Strong Recovery website. These manufacturers will sell smaller quantities to small facilities.