Missouri Alliance for **HOME CARE**

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

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Please find information related to the following:

- **Policymakers Debate $400 Billion Boost to HCBS** *(from NAHC Report)*
- **CMS Extends Medical Review Dates** *(from NAHC Report)*
- **COVID-19 Plain Language Guide for the Disability Community**
- **Crucial CDC COVID-19 Guidance for Direct Support Providers** *(from NAHC Report)*
- **Recent HCBS Memos**
- **Department of Labor Withdraws Independent Contractor Rule**
- **DHSS to Cease BinaxNOW Recoupments**
- **CMS COVID-19 Vaccine Resources**
- **FDA Warns Public Against Two Unsafe COVID-19 Antigen, Antibody Tests**
- **EEOC Issues COVID-19 Vaccine Guidance for Employers**
- **CMS Releases Guidance on COVID-19 Relief Funds for State Medicaid Programs**
- **Electronic Visit Verification Aggregator Solution Contract Awarded**
- **HRSA Announces Additional Grant Funding to Increase Vaccine Access**
- **MMAC Announces Revalidation Schedule Change**
- **MMAC Provider Enrollment Forms Now Available Through DocuSign**
- **Missouri Updates Its Visitation Guidance for Long-Term Care Facilities**
- **CMS Updates Hospice Medicare Cost Report Form 1984-14 Instructions** *(from NAHC Report)*
- **CMS Updates the Medicare Home Health Cost Report Form 1728-20** *(from NAHC Report)*
- **CMS Issues Manual Instructions for the Home Health NOA** *(from NAHC Report)*
- **CMS Corrects Conflicting Policies on Who May Sign Home Health POC, Recertification** *(from NAHC Report)*
- **Poll: Americans Want Help to Age in Place**

Policymakers Debate $400 Billion Boost to HCBS *(from NAHC Report)*

While it is impossible to determine with certainty whether President Biden's proposal to increase funding for Medicaid home and community-based services (HCBS) by $400 billion will ultimately be included in one of a number of expected large legislative packages, NAHC is encouraged by recent signaling that the HCBS boost continues to be a priority for the Administration.

The latest indication of support for the increased HCBS funding was its inclusion in the President's FY2022 budget, released on Friday, May 28th. The budget asks Congress to appropriate the $400 billion investment in HCBS over 10 years, the same proposal Biden has been pushing for as part of his infrastructure-focused *American Jobs Plan*.

The HCBS proposals currently lack detail, but much of the public positioning on the plan emphasizes supporting the direct care workforce by increasing wages, benefits, and career ladder opportunities. The President's budget states "*The President's plan makes substantial investments in the infrastructure of America's care economy, starting by creating new and better jobs for caregiving workers. It would provide home and community-based care for individuals who otherwise would need to wait as many as five years to get the services they badly need*."

While the President's budget is not a binding document, and Congress is under no obligation to craft legislation that tracks the budget's requests, it does typically have more influence when there is unified control of Congress and the Presidency, as there is now with the Democratic party. Many observers expect that the President's budget will serve as the blueprint for congressional leaders' efforts to craft their own budget resolution, which would be the first step in the process towards passing a massive infrastructure package along party lines using the complex process called "budget reconciliation".

However, President Biden has not yet definitely signaled that he supports the "reconciliation" route at this time. He continues to engage with a group of Republican lawmakers in an effort to determine if there is a bipartisan deal to be had on an infrastructure bill.

Notably, the latest Republican counterproposal to Biden's plan, released on May 27th, does not include any HCBS provisions. In an earlier memo from the Administration to the group of GOP negotiators, Biden again called out HCBS as a critical component of an infrastructure vehicle.

While timelines remain fluid, it is expected that if significant progress is not made within the next week or two on a bipartisan compromise, Democratic lawmakers will begin the reconciliation process in earnest, working under the assumption that a large infrastructure package will need to pass with Democratic votes only.

CMS Extends Medical Review Dates *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has announced that Medicare Administrative Contractors (MACs) may now begin conducting post-payment medical review for later dates of services.

On March 30, 2020 the Centers for Medicare & Medicaid Services (CMS) suspended most Medicare Fee-For-Service (FFS) medical review because of the COVID-19 pandemic. On August 17, 2020 CMS resumed medical review but limited the time frame to claims with dates of service prior to March 1, 2020 (the beginning of the COVID-19 Public Health Emergency (PHE)).

The Targeted Probe and Educate program (intensive education to assess provider compliance through up to 3 rounds of review) will restart later. The MACs will continue to offer detailed review decisions and education as appropriate.

For any medical reviews for dates of service during the current PHE, providers will want to carefully examine the review decision to ensure that any PHE waivers and flexibilities were considered. The most current waivers and flexibilities can be found here.

As a reminder the current post-payment review topics for each of the home health and hospice MACs are listed below. CMS just announced the expansion of the dates eligible for review so these topics may be updated to reflect this and/or a change in topics.

COVID-19 Plain Language Guide for the Disability Community

The Missouri Department of Health and Senior Services (DHSS) along with the Missouri Developmental Disabilities Council released a new resource, the "Missouri Plain Language Guide for People with Disabilities, their Families and Caregivers," on COVID-19 and the vaccine.

Through this partnership, the new guide will ensure that important information related to COVID-19 and vaccine access is more accessible to people with intellectual and developmental disabilities, and others with disabilities affecting reading, comprehension and other cognitive functions.

People with disabilities, their family members and caregivers have been eligible to receive the COVID-19 vaccine in the earliest phases of Missouri's vaccine rollout. Currently, any Missourian age 12 and older is eligible to receive the COVID-19 vaccine. Since the beginning of 2021, DHSS and the Missouri Advisory Committee on Equitable COVID-19 Vaccine Distribution have been focused on deploying new strategies and resources to meet the disability community where they are -- this new guide is a resource to support Missouri's disability community and those individuals, family members and caregivers who support them.

If you or someone you know is unable to visit a COVID-19 vaccination clinic without assistance, please call the COVID-19 Hotline at 877-435-8411 and press option 4 to be routed directly to your local Area Agency on Aging to make a vaccine appointment. You can also register individuals for the vaccine by visiting Missouri's COVID-19 website, MOStopsCovid.com. COVID-19 Hotline hours of operation are Monday-Friday 7:30 a.m.-5:30 p.m. and Saturday 8 a.m.-2 p.m. (Hotline is open on Saturdays through until June 11.) Individuals are encouraged to call soon to ensure their names are added to the list.

Crucial CDC COVID-19 Guidance for Direct Support Providers *(from NAHC Report)*

The Centers for Disease Control & Prevention (CDC) has created an extremely useful one-pager for Direct Support Providers, called "*Direct Support Providers: Get Vaccinated to Protect Yourself and Those You Care For from COVID-19*." We have the one-pager HERE for you in English and HERE for you in Spanish.

This one-pager and a lot more can be found on the CDC website in the Toolkit for People with Disabilities under "Vaccination Resources." The page is guidance and tools to help people with disabilities and those who serve or care for them make decisions, protect their health, and communicate with their communities.

Recent HCBS Memos

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

> **Updates to Social Services Block Grant General Revenue Protective Services Participants**
> The Home and Community Based Services (HCBS) Manual has been revised to reflect updates to Policy 3.70 Social Services Grant General Revenue Protective Services Participants.

Please refer to HCBS 06-21-01 Updates to Social Services Block Grant General Revenue Protective Services Participants and the revised policy at the links below.

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

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

COVID-19 Relief Funds Audit and Required Documentation

An audit of the HCBS COVID-19 Relief Funds reimbursements is being performed by the Division of Senior and Disability Services. The reimbursements were for costs associated with 'Increased Expenses' and 'Business Interruptions' that occurred between March 1, 2020 and December 5, 2020 due to COVID-19.

Please refer to memorandum INFO 06-21-01 for further information at https://health.mo.gov/seniors/hcbs/memos.php

Any questions regarding this memorandum should be directed to DHSS.CRF@health.mo.gov.

HCBS Web Tool Guidance – Directions to Residence Box

Memorandum regarding HCBS Web Tool Guidance for the Directions to Residence Box.

Please refer to INFO 05-21-03 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.

Communicating with HCBS Intake & PCCP Management Team Quick Guide

The Division of Senior and Disability Services (DSDS), Bureau of HCBS Intake & PCCP has centralized email accounts dedicated to ensure questions and requests are sent to the appropriate statewide teams. To assist in reaching the appropriate team, the Bureau of HCBS Intake & PCCP has developed a quick guide, *Communicating with HCBS Intake & PCCP Management.* The quick guide provides detailed contact information on the statewide teams for support.

The Quick Guide is available on the DSDS Home and Community Based Services Provider Information page at https://health.mo.gov/seniors/hcbs/pdf/communicating-with-hcbs-intake-pccp-quick-guide.pdf.

Change to Provider Reassessment Due Date

HCBS providers who complete provider reassessments, a memorandum has been issued regarding an update pertaining to the date a provider reassessment is due.

Please refer INFO 05-21-01 at https://health.mo.gov/seniors/hcbs/infomemos.php

Any questions regarding this memorandum should be directed to the DSDS Provider Reassessor Review Team at ProviderReassessmentReview@health.mo.gov.

Department of Labor Withdraws Independent Contractor Rule

The U.S. Department of Labor announced the withdrawal – effective May 6 – of the "Independent Contractor Rule," to protect workers' rights to the minimum wage and overtime compensation protections of the Fair Labor Standards Act (FLSA).

The Department is withdrawing the rule for several reasons, including:

- The independent contractor rule was in tension with the FLSA's text and purpose, as well as relevant judicial precedent.
- The rule's prioritization of two "core factors" for determining employee status under the FLSA would have undermined the longstanding balancing approach of the economic realities test and court decisions requiring a review of the totality of the circumstances related to the employment relationship.
- The rule would have narrowed the facts and considerations comprising the analysis whether a worker is an employee or an independent contractor, resulting in workers losing FLSA protections.

Withdrawing the independent contractor rule will help preserve essential workers' rights. The FLSA includes provisions that require covered employers to pay employees at least the federal minimum wage for every hour they work and overtime compensation at not less than one-and-one-half times their regular rate of pay for every hour over 40 in a workweek. FLSA protections do not apply to independent contractors.

In addition to preserving access to the FLSA's wage and hour protections, the department anticipates that withdrawing the independent contractor rule will also avoid other disruptive economic effects that would have been harmful to workers had the rule gone into effect.

DHSS to Cease BinaxNOW Recoupments

DHSS will cease recoupments effective Friday, June 11 of any excess unused BinaxNOW test kits – meaning any recoupment requests must be received by 5:00 p.m. on Friday, June 11 in order to be sent a mailing label. As before, they will only accept unopened boxes and box lots that have at least 30 days or more to expiration. After that date, the recoupment form will be removed from the DHSS website.

CMS COVID-19 Vaccine Resources

As COVID-19 vaccines continue rolling out across the country, CMS is taking action to protect the health and safety of our nation's patients and providers and keeping you updated on the latest COVID-19 resources from the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS).

With information coming from many different sources, CMS has summarized resources and materials to help you communicate with the people that you serve. You can find these and more resources on the COVID-19 Partner Resources Page and the HHS COVID Education Campaign page. For more information, visit the CMS COVID-19 Policies and Guidance page.

FDA Warns Public Against Two Unsafe COVID-19 Antigen, Antibody Tests

The Food and Drug Administration is warning health care providers and the public not to use two COVID-19 antigen and antibody tests, due to high risk of false results. The FDA has not authorized or approved the two tests — Lepu Medical Technology's SARS-CoV-2 Antigen Rapid Test Kit and the Leccurate SARS-CoV-2 Antibody Rapid Test Kit (Colloidal Gold Immunochromatography) — in the U.S., but the agency is aware that these tests were distributed to some pharmacies to be sold for at-home testing and sold directly to consumers. Health care providers should consider re-testing with a different SARS-CoV-2 antibody test any patients who were suspected to have had recent or prior COVID-19 infection and were tested with either of the two tests in question.

EEOC Issues COVID-19 Vaccine Guidance for Employers

The following is provided by SESCO Management Consultants.

The U.S. Equal Employment Opportunity Commission (EEOC) has issued new COVID-19 vaccine guidance for employers. The new guidance addresses topics the EEOC either left unclear or did not expressly resolve in earlier publications.

Confidentiality

- Information about an employee's vaccination status is considered "confidential medical information" under the Americans with Disabilities Act (ADA).
- Like all medical information, information about an employee's vaccination status must be kept confidential and stored separately from the employee's personnel file. Unfortunately, with this general rule in mind, the EEOC has not yet offered guidance for employers on how to easily identify the vaccination status of employees at the workplace to enforce ongoing mask mandates for non-vaccinated workers (e.g., via a badge or other outward identifier).

Employer Inquiries

- Employers may ask employees whether they obtained the vaccine from a third party in the community (pharmacy, personal doctor, etc.), and this question is not a "disability-related inquiry."
- Employers may ask employees to provide documentation or other confirmation of the vaccination from such sources without the request being a "disability-related inquiry."

Vaccinating Subsets of Employees

- Employers may offer vaccinations to certain groups of employees and not to others (e.g., assembly versus office workers), so long as the employer does not discriminate in the offering based on a protected class.

Vaccine Incentives

- Employers may offer incentives to employees who voluntarily receive the vaccine from a third-party vaccine provider (health department, pharmacy, personal medical provider, etc.).

- Employers may offer incentives to employees to voluntarily provide documentation that they received the vaccine from a third-party vaccine provider.
- Employers may offer incentives to employees who voluntarily receive a vaccination administered by the employer or its agent, so long as the incentive is not "so substantial as to be coercive." One gap in the guidance provided by the EEOC is any further discussion of what constitutes a "coercive" incentive. What is so substantial as to be coercive and thus no longer voluntary under the ADA? **Hopefully, the EEOC will further clarify this question but an incentive under $500 would likely be permissible.** This was a central issue in the EEOC's prior efforts to delineate regulations covering permissible incentives related to employer-sponsored wellness plans under the ADA. Although the EEOC had released new Trump-era wellness regulations in January 2021, they had not yet been published in the Federal Register when President Biden took office, and so they were withdrawn.
- Employers may not offer an incentive to an employee in return for the employee's family member getting vaccinated by the employer or its agent.
- Employers may offer to vaccinate family members without offering the employee an incentive. However, employers must not require employees to have their family members get vaccinated and must not penalize employees if their family members decide not to do so. Employers must also ensure all medical information obtained from family members during the screening process is used only for the purpose of providing the vaccination, is kept confidential and is not provided to any managers, supervisors or others who make employment decisions for the employees.

SESCO Management Consultants will continue to monitor and report on developments with respect to the COVID-19 pandemic and will post updates in the firm's COVID-19 Resource Center as additional information becomes available.

CMS Releases Guidance on COVID-19 Relief Funds for State Medicaid Programs

The Centers for Medicare and Medicaid Services issued guidance on how states could receive enhanced funding through the American Rescue Plan to increase access to home and community-based services for Medicaid beneficiaries.

Benefits for home and community-based services are geared toward older adults and those with disabilities that allow them to receive health services in their homes rather than in assisted living facilities and other institutions.

The guidance is meant to assist states in leveraging federal resources to enhance equity in Medicaid beneficiaries' access to these services.

MAHC had previously submitted initial ideas on how Missouri could best utilize these additional funds. MAHC will continue to work with legislators and department leaders on this issue.

Electronic Visit Verification Aggregator Solution Contract Awarded

The State of Missouri (State) Office of Administration (OA) has awarded Contract #CT210348001 to Sandata Technologies, LLC. (Sandata) to implement the State's Electronic Visit Verification (EVV) Aggregator Solution effective April 1, 2021. This contract was issued in order to meet the requirements established by the federal 21st Century Cures Act (the Cures Act), the Centers for Medicare & Medicaid Services (CMS) rules and regulations, and Missouri Rule 13 CSR 70-3.320.

As part of this contract, Sandata will implement an EVV vendor-neutral aggregator system designed to interface and store the data from the EVV vendors operating in Missouri. Sandata will be responsible for interfacing with the EVV systems and ensuring the required data elements are being captured and exchanged. Sandata is experienced in developing interfaces with EVV vendors and has done so across multiple states. Sandata will provide the necessary specifications for EVV vendor integration. In addition, Sandata will offer training for both EVV vendors and personal care service providers regarding utilization of the aggregator system.

Based on the State's Provider Choice model, each personal care service provider can choose their preferred EVV vendor and is responsible for ensuring the EVV data is recorded into the EVV vendor's system accurately and in a timely manner. Communications from Sandata regarding initial steps for data and system integration will be forthcoming. EVV-related bulletins, administrative rules, and other announcements can be found at the MO HealthNet Division's website.

Project implementation for personal care services will take place over the next twelve months. The State will be working closely with personal care service providers, EVV vendors, and Sandata to achieve successful implementation.

HRSA Announces Additional Grant Funding to Increase Vaccine Access

The Health Resources and Service Administration announced a second round of grant funding to support the community-based workforce to increase vaccine access. The purpose of the program is to establish, expand and sustain a health care workforce to prevent, prepare for and respond to COVID-19. This includes community health workers, patient navigators and social support specialists to educate and assist individuals in accessing and receiving COVID-19 vaccinations. The program intends to address persistent health disparities by offering support and resources to vulnerable and medically underserved communities, including racial and ethnic minority groups and individuals living in areas of high social vulnerability.

MMAC Announces Revalidation Schedule Change

To avoid any processing delays for providers, due to the large number of enrollments ***originally due for Revalidation during 2023 and 2024****, Missouri Medicaid Audit and Compliance is scheduling some providers to revalidate sooner than the current five-year schedule.*

- ***All Provider Types that require Medicare enrollment prior to enrolling with MO HealthNet and have a next revalidation due date that falls during 2023 or 2024 will now be due in 2022.***
- ***All individual providers, Health Departments, and Schools with a next revalidation due date that falls during 2024 will now be due in 2023.***

Providers and/or their authorized representative will begin receiving system emails 90 days prior to the due date directing them to revalidate at the www.emomed.com portal.

Any questions regarding the change in revalidation due date or other revalidation related questions should be directed to: mmac.revalidation@dss.mo.gov.

The eMomed portal has been updated with the new revalidation due dates. If you have a previous notice reflecting a different due date, use the date showing in the portal.

MMAC Provider Enrollment Forms Now Available Through DocuSign

Many of MMAC's Provider Enrollment forms are now available through DocuSign, including the Provider Update Request form, EFT Change form, and others. This DocuSign process allows for authenticated signatures without the need to print and fax/scan documents.

To receive the menu of DocuSign forms:

HCBS PROVIDERS:

- Send an email to MMAC.DocuSign-NOREPLY@dss.mo.gov
  with "HCBS" in the subject line and a menu of HCBS enrollment forms will be sent to you.

NON-HCBS/MEDICAL PROVIDERS:

- Send an email to MMAC.DocuSign-NOREPLY@dss.mo.gov
  (no subject line is required) and a menu of HCBS enrollment forms will be sent to you.

You can still submit your forms the way you always have:

- The PDF versions of the **HCBS** forms are available here: https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/
- The PDF versions of our **non-HCBS** forms are available here: https://mmac.mo.gov/providers/provider-enrollment/new-providers/provider-enrollment-forms/

Missouri Updates Its Visitation Guidance for Long-Term Care Facilities

DHSS has updated its guidance to reflect recent changes to CMS' visitation guidance and to clarify and provide examples of those considered outside health care workers, which includes hospice workers (all disciplines). **MAHC continued to communicate with the Department the need for clear and somewhat stern language instructing long-term care facilities that all hospice disciplines MUST be allowed entrance. We are thankful to the Department for adding such language**.

The changes include:

Visitor Vaccination Status
When both the resident and all of their visitors are fully vaccinated and while alone in a resident's room or the designated visitation room, residents and their visitor(s) can choose to have close contact (including touch) and to not wear source control. Visitors should wear source control and physically distance from other healthcare personnel and other residents/visitors that are not part of their group at all other times while in the facility.

Visitors shall be given the opportunity to disclose their vaccination status to determine if the visitor may have close contact (including touch) and not wear source control while alone in a resident's room or the designated visitation room, however the facility may not require visitors to disclose their vaccination status or to show proof of vaccination. Visitors that decline to disclose their vaccination status should adhere to the infection control principles of COVID-19 infection prevention for unvaccinated persons.

Outside Health Care Workers
Clarified and provided examples of outside health care workers and the expectation that outside healthcare workers MUST be permitted to come into the facility. Health care workers who are not employees of the facility, such as hospice workers (all disciplines), Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technologist, radiology technologists, social workers, clergy, etc., but provide direct care to the facility's residents MSUT be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or showing signs or symptoms of COVID-19 after being screened.

Communal Dining and Group Activities
Fully vaccinated residents can participate in communal dining and group activities without use of source control or physical distancing. If unvaccinated residents are present, all residents should use source control when not eating and unvaccinated residents should continue to remain at least 6 feet from others.

CMS Updates Hospice Medicare Cost Report Form 1984-14 Instructions *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) issued Transmittal 4 for the Hospice Medicare Cost Report Form 1984-14 on April 30, 2021. The effective date of the Transmittal is stated to be cost reporting periods ending on or after December 31, 2020. The Transmittal contained mostly minor changes and updates that CMS has made since release of Transmittal 3 in April 2018, including updates to the Level 1 edits that were effective in September 2018.

Following is a summary of the changes from CMS.

Please note: throughout this article new material included in the instructions will be printed in ***italics bold***.

Worksheet S – Certification Page

The electronic signature page format is changing but this is mostly the electronic format. The e-signature is still required to be the Chief Financial Officer or Administrator.

4306.2 Part II – Certification: ***This certification is read, prepared, and signed by a Chief Financial Officer or administrator of the hospital after the cost report has been completed.***

Line 1 – The signatory (administrator or Chief Financial Officer) must:

- ***sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and enter Y in column 2 to check the electronic signature checkbox to transmit the cost report electronically with an electronic signature; or***
- ***sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and enter Y in column 2 to check the electronic signature checkbox to submit the cost report with an electronic signature; or***
- ***sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(2); and make no entry in column 2 to submit the cost report with an original signature.***

Lines 2, 3, and 4 – Enter the signatory name, the signatory title, and the date signed.

Worksheet S-2 – Hospice Reimbursement Questionnaire

This worksheet contains various questions so that CMS will obtain general information about the provider and to identify certain worksheets that must be completed. These questions are separated into several categories about provider organization and operation, financial data and reports, and PS&R data. All eleven questions must be answered "Y" or "N" or it will be a Level 1 edit error.

Worksheet A – Trial Balance of Expenses (Level 1 edit error 1050A)

Certain cost centers must contain cost and be greater than zero in column 7.

- Line 1 Capital Related Costs – Building
- Line 2 Capital Related Costs – Movable Equipment
- Line 3 Employee Benefits
- Line 4 Administrative & General
- ***Line 13 Volunteer Service Coordination (New)***
- ***Line 33 Medical Social Services (New)***
- Line 37 Hospice Aide and homemaker Service
- Line 38 Durable Medical Equipment / Oxygen
- ***Line 9 and/or 28 Nursing Administration / Registered Nurse – must be present and the sum of lines 9 and 28 must be greater than zero (New)***
- ***Line 14 and/or 42.50 Pharmacy / Drugs Charged to Patients – must be present (New)***

If the balance in any of these cost centers is not greater than zero, it will be a Level 1 edit error.

Contracted Inpatient Costs (Worksheet A, line 25) — Column 1 on the Trial Balance has been shaded. Column 1 is for salary expense. Since contracted inpatient costs would be all non-salary costs, this column would not apply to Worksheet A, Worksheet A-3 – Inpatient Respite Costs and Worksheet A-4 – General Inpatient Care.

Worksheet F-2 – Income Statement

CMS has established a standard line on the Income Statement for the reporting of revenue recognized in the cost reporting period for COVID 19 stimulus funds. The amount is line 16.50. Any unrecognized funds would still be on the Balance Sheet.

Line 16.50–Enter the aggregate revenue received for COVID-19 Public Health Emergency (PHE) funding including both Provider Relief Fund and Small Business Association Loan Forgiveness amounts, in column 3 and, in column 4, enter the sum of columns 1, 2, and 3.

While the effective date of the Transmittal is stated to be for cost reporting periods ending on or after December 31, 2020, CMS is still accepting 2020 cost reports filed using Transmittal 3.

A cost report cannot be submitted with a Level 1 edit error.

Transmittal 4 can be found on the CMS website.

CMS Updates the Medicare Home Health Cost Report Form 1728-20 *(from NAHC Report)*

The Centers for Medicare and Medicaid Services (CMS) has issued two transmittals that implement a new Medicare Cost Report Form for Home Health Agencies. The new form set, known as Form 1728-20, was released on October 2, 2020, in Transmittal 1 in Chapter 47. **Click here** to access the article that highlights some of the significant changes to the new form as well as review additional changes that CMS published in Transmittal 2 released on April 30, 2021.

CMS Issues Manual Instructions for the Home Health NOA *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has issued Change Request (CR) 12256, *Replacing Home Health Requests for Anticipated Payment (RAPs) with the Notice of Admission (NOA)*.

The CR updates multiple sections of the Chapter 10 of the Medicare Claims Processing Manual to reflect requirements for the Patient Driven Groupings Model such as adding "Notice of Admission" when applicable and replacing the phrase "60-day episode/30-day periods" with "30day-period" throughout the Manual chapter.

In the Manual, CMS replaces the requirements for the RAP with the requirements for submitting the NOA. The NOA has the same submission criteria as the No-Pay RAP but requires different elements to be reported. Section 40.1 in chapter 10 has been revised to outline the NOA requirements, along with section 40.2 on the impact of the NOA for claims processing.

Home health agencies must submit the NOA to the Medicare Administrative Contractor by mail, electronic data interchange (EDI) or direct data entry (DDE). However, EDI submissions require more information on the NOA to satisfy transaction standards, such as line-item service information and primary diagnosis, than what is required by the Medicare program for the other submission modes.

HHAs using EDI for the NOA submission should review the 837I companion guide on the CMS web site.

CMS also provides more specific instructions in section 10.1.19– Applying OASIS assessment Items to Determine HIPPS Code on ensuring the Outcome and Assessment Information Set (OASIS) and the claim match, and when it is appropriate to resubmit a claim related to OASIS and claim matching errors.

CMS Corrects Conflicting Policies on Who May Sign Home Health POC, Recertification *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has issued Change Request (CR) 12218, which updates the Medicare Benefit Policy Manual, chapter 7 to correct information on who may sign the certification and recertification for home health patients, and includes instructions for the no -pay request for anticipated payment (RAP).

In November 2020, CMS updated chapter 7of the Medicare Benefit Policy Manual to reflect policies that allowed nurse practitioners, clinical nurse specialist, and physician assistants to certify patients and write orders for home health services. In section 30.5.3, **Who May Sign the Certification or Recertification**, CMS erroneously included language limiting who may sign the plan of care to physicians and allowed practitioners in the same group practice, when a certifying physician or allowed practitioner is unavailable.

This revision to section 30.5.3 conflicted with long standing CMS policy that allows one practitioner to authorize another practitioner to sign the orders in his/her absence. This CMS policy does not limit authorization to practitioners in a group practice.

The National Association for Home Care & Hospice requested clarification from CMS and was informed that changes to the Medicare Benefit Policy Manual, chapter 7, section 30.5.3 did include erroneous information and a correction to the manual would be issued.

Also in the CR, CMS is updating the Medicare Benefit Policy Manual, chapter 7 to reflect the no-pay RAP policies for calendar year 2021. There are no changes in these policies. CMS has made several revisions to the Medicare Claims Processing Manual, chapter 10 related to the No Pay RAP policies but had not updated the Medicare Benefit Policy Manual, chapter 7, until now.

Poll: Americans Want Help to Age in Place

Overwhelmingly, Americans want to age in place in their own homes and communities, but want help to do so, citing assistance from Medicare as a key priority, according to a big new survey from the AP-NORC Center and The SCAN Foundation. The findings are consistent with polls done by these groups since 2013.

The "vast majority of Americans (88%) want to stay in their own home or the home of a loved one in the event they need ongoing living assistance as they age," according to the survey. "Receiving care at their own home is the preferred option for 76%, and 11% would prefer a friend or family member's home. Just 10% would prefer a senior community, and 2% a nursing home… The desire to age in their own home is consistent across race and ethnicity, as well as urban, suburban, and rural environments."

The top concern for poll respondents is losing their independence.

According to the survey:

- Support is high for government action in helping Americans pay for long-term care: 60% favor a government-administered long-term care insurance program similar to Medicare and 63% favor government funding for program to allow people with low incomes to receive care at home.
- Americans think health insurance companies (52%), Medicare (51%), and Medicaid (41%) should have a large or very large responsibility to pay for ongoing living assistance. Just 35% think individuals and 15% think families should be responsible.
- 51% think shoring up the Medicare trust fund should be a top priority for the Congress and the Biden administration and another 38% think it is a lower but still important priority. Just 9% think it is not an important priority or shouldn't be done at all.
- Common concerns about aging include losing independence as they age (67%), being alone without family or friends around them (60%), and having social needs met (57%). Many also worry about having to leave their home and move into a nursing home (53%) and about experiencing health and safety issues in a retirement community or nursing home (54%).
- Most Americans do not feel prepared for their own care needs: 69% say they have done little or no planning and just 16% are confident they will have the financial resources they need to pay for long-term care.