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Please find information related to the following:

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- **CMS Issues Final FY2021 Payment Rule for Hospice Providers**
- **Advance Beneficiary Notice of Noncoverage (ABN) Use Delayed**
- **Senators Introduce Hospice Respite Relief Legislation to Ease Access during Pandemic** ***(from NAHC Report)***
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Valuable Resource - Littler Updates Protocols to Assist Providers in COVID-19 Response

As we continue to provide members with valuable COVID-19 resources, this document is a result of collaborative efforts from several of the leading providers in the home health and home care industries in an effort to help guide providers in their response to the COVID-19 crisis in a way that protects the vulnerable patients and clients, as well as the fearless direct care workers. Here is a summary of the changes:

- In the "Agency Screening of Clients" section, a new question was added about travel to reflect recent state orders that require individuals who travel to certain "hot spots" to quarantine following their return.
- In the "Direct Care Worker Action Steps" section, the item addressing when a direct care worker should stay home if sick (no COVID-19 diagnosis) now reflects the CDC's updated guidance that Healthcare Personnel may return to work after they have been fever-free (without fever reducing medication) for 24 hours (previously the wait was 72 hours).
- In several areas, the new CDC advice that those who are severely immunocompromised and/or had severe or critical illness from COVID-19 may remain contagious for up to 20 days.
- The section titled "Steps To Take If A Direct Care Worker Is Diagnosed With COVID-19" has been substantially updated to reflect the CDC's updated guidance on the return to work decision-making process.

Click here to access the updated protocols.

CMS Issues Final FY2021 Payment Rule for Hospice Providers

The National Association for Home Care and Hospice (NAHC) released a summary of the final hospice rule. Click on the link below to access.

https://discussion.nahc.org/wp-content/uploads/wpforo/default_attachments/1596234704-CMS-Finalizes-FY2021-Hospice-Wage-Index.pdf

Advance Beneficiary Notice of Noncoverage (ABN) Use Delayed

Due to COVID-19 concerns, CMS is going to expand the deadline for use of the renewed ABN, Form CMS-R-131 (exp. 6/30/2023). At this time, the renewed ABN will be mandatory for use on 1/1/2021. The renewed form may be implemented prior to the mandatory deadline. The ABN form and instructions may be found at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.

Senators Introduce Hospice Respite Relief Legislation to Ease Access during Pandemic *(from NAHC Report)*

On August 4, 2020, Senators Sherrod Brown (D-OH) and Shelley Moore Capito (R-W) introduced the ***COVID-19 Hospice Respite Care Relief Act of 2020*** (S. 4423), designed to establish additional flexibilities related to delivery of respite care services during public health emergencies (PHEs) such as the current COVID-19 pandemic. Specifically, the legislation provides the Secretary of Health and Human Services (HHS) authority, during any public health emergency (including the COVID-19 PHE), to:

- Waive the 5-day maximum for respite care when the caregiver is unable to provide care due to illness or isolation, for up to 15 days;
- Waive the requirement that respite care only be provided in the inpatient setting, making the hospice respite benefit available to hospice patients in their place of residence, thereby keeping the patient safe and reducing exposure to COVID-19.

The impetus for the legislation relates to challenges experienced by hospices nationwide during the COVID-19 pandemic arising from the need for extended respite in situations where family caregivers are not available to care for hospice patients for a time frame exceeding the current five-day limit (for example, when family caregivers have been diagnosed with COVID-19 and must isolate from vulnerable hospice patients). Additionally, there have been numerous instances where patients may be unwilling to enter a facility for respite care due to the potential risk of contracting COVID-19 or in cases where contracted facilities will not admit hospice patients to respite care beds due to COVID-19 concerns. The legislation is supported by the National Association for Home Care & Hospice (NAHC) and other hospice stakeholder groups.

"The *COVID-19 Hospice Respite Care Relief Act of 2020* would help to ease the challenges that have emerged around the delivery of institution-based respite care under the benefit by permitting patients to stay home while providing a break for their family caregivers, as well as to allow for longer time on respite care, if needed," said NAHC President Bill Dombi in reaction to the bill's introduction. "In addition to supporting the flexibilities in S. 4423, NAHC has urged the Centers for Medicare & Medicaid Services (CMS) to instruct surveyors to consider the special circumstances that have arisen during the

PHE that have limited the ability of hospice providers nationwide to offer respite care, such as closure of contracted respite beds in facilities."

For a one-page fact sheet on the legislation, please go **HERE**. A link to the legislative text is available **HERE**.

CMS Issues Home Health Quality Reporting Program Tip Sheet *(from NAHC Report)*

The Centers for Medicare and Medicaid Services has issued a Home Health Quality Reporting Program(QRP) tip sheet that outlines the quality reporting requirements for home health agencies (HHA) related to the current public health emergency.

On March 27, 2020, CMS announced temporary relief for HHAs and other providers in QRPs in response to COVID-19 PHE. These temporary exceptions due to this PHE lifted the requirements to report data to assist HHAs while they directed their resources toward caring for patients and ensuring the health and safety of patients and staff. Specific quarters for which HHAs are exempted from reporting of CAHPS® Home Health Survey and OASIS data for calendar years (CYs) 2019 and 2020 are listed below and end on June 30, 2020:

- October 1, 2019–December 31, 2019 (Q4 2019)
- January 1, 2020–March 31, 2020 (Q1 2020)
- April 1, 2020–June 30, 2020 (Q2 2020)

HHAs are reminded that the temporary exception for HH quality reporting requirements end on June 30, 2020. Starting on July 1, 2020, HHAs are expected to resume timely quality data collection and submission of OASIS and CAHPS® Home Health Survey data.

The CAHPS® Home Health Survey will be required for the third quarter of 2020 and onward. The Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) requirements for the Annual Payment Update (APU) run from April through the following March. For the CY 2022 APU, HHAs are required to submit monthly lists to their HHCAHPS approved survey vendors for the months of April 2020 through March 2021. Due to the COVID exceptions, agencies are not required to submit data for the second quarter of 2020, which is April 2020 through June 2020. The HHCAHPS-approved survey vendors are required to submit survey data on the third Thursday in the months of January, April, July, and December. The HHCAHPS approved survey vendors are required to submit HHCAHPS survey data on July 16, 2020, and onward.

Starting with Q3 that begins July 1, 2020, CMS expects providers to report their quality data, which means that for all Outcome and Assessment Information Set (OASIS) assessment time points with a M0090 date of July 1, 2020, or later, CMS expects the assessments to be submitted following the QRP requirements.

The CY 2020 data used for meeting the HH QRP requirements include July 1 to December 31, 2020, since we exempted Q1 and Q2 of 2020 (January 1 to June 30, 2020) due to the COVID-19 PHE. This means even if you submit data for Q1 and Q2 2020 to include the data for public reporting starting with Q3 2020 data, we will not include any of those data for purposes of calculating whether you meet HH QRP Requirements impacting CY 2022 payments.

CMS is continuing waivers related to the OASIS collection and submission time frames as follows: (1) extending the 5-day completion requirement for the comprehensive assessment to 30 days; and (2) waiving the 30-day OASIS submission requirement. In addition, CMS is delaying the release of the OASIS E data set until January 1 of the year that is at least 1 full calendar year after the end of the COVID-19 PHE.

OIG COVID-19 Resources and FAQs

The Department of Health & Human Services (HHS) Office of the Inspector General (OIG) has a COVID-19 Portal covering various COVID-19 topics. Among them is a set of FAQs that is updated periodically.

There are no home health or hospice specific FAQs currently posted; however, there are FAQs on topics that may be of interest to home health and hospice providers, such as those pertaining to the provision of free or discounted services.

Moreover, the OIG encourages providers to submit questions specific to a provider's situation regarding the application of OIG's administrative enforcement authorities, including the Federal anti-kickback statute and civil monetary penalty (CMP) provision prohibiting inducements to beneficiaries (Beneficiary Inducements CMP).

The OIG will review it and respond directly to the provider. If you have a question regarding how OIG would view an arrangement that is directly connected to the public health emergency and implicates these authorities, please submit your question to OIGComplianceSuggestions@oig.hhs.gov. In your submission, please provide sufficient facts to allow for an understanding of the key parties and terms of the arrangement at issue. The OIG will update the FAQ site as we respond to additional frequently asked questions.

The OIG's advisory opinion process remains available to interested parties. An OIG advisory opinion is a legal opinion issued by OIG to one or more requesting parties about the application of the OIG's fraud and abuse authorities to the party's existing or proposed business arrangement.

An OIG advisory opinion is legally binding on HHS and the requesting party or parties.

For more information about the advisory opinion process, including information regarding how to submit an advisory opinion and how long it takes for OIG to process an advisory opinion request, please see https://oig.hhs.gov/faqs/advisory-opinions-faq.asp.

There are also toolkits for emergency response available from the OIG's portal – community-level response and facility-level response. There are toolkits for emerging infectious disease preparedness and response as well as natural disaster preparedness and response. These include the most recent lessons learned related to funding, training, testing, vaccination programs and emergency planning.

Health Update Discontinuation of Isolation for Persons with COVID-19

A new Health Update from Dr. Randall Williams entitled: Discontinuation of Isolation for Persons with COVID-19 was released on July 27. Click here to read the Alert.

Corrected Home Health Provider Preview Reports and Star Rating Preview Reports

Home Health Agency Provider Preview Reports and the Quality of Patient Care Star Rating Preview Reports that were posted previously on June 25, 2020 contained an error. The previous reports contained the HHA observed values instead of the risk adjusted values. The reports have been corrected and are now available. You can find both reports by selecting "My Reports" in iQIES. These reports preview data that will be displayed in the Home Health Compare website beginning around October 30, 2020. Providers are encouraged to save a copy of their preview reports for later reference.

Providers have until **August 20, 2020** to review their performance data. Corrections to the underlying data will not be permitted during this time; however, providers can request CMS review of their data during the preview period if they believe the quality measure scores that are displayed within their Preview Reports are inaccurate.

DHSS HCBS Provider Relief Funds – Q&A

As previously reported, the state has allocated twenty million dollars ($20,000,000) from the Coronavirus Relief Funds for relief to DHSS HCBS Providers. Providers may seek reimbursement for costs associated with necessary COVID-19 expenditures (e.g. PPE, extra staffing costs, etc.) or for loss of revenue associated with business interruption. Claims must occur between March 1, 2020 and December 30, 2020 and may not have been recovered from any other local, state, federal or private source.

A list of Frequently Asked Questions (FAQs) has been added to the DHSS HCBS Provider COVID-19 Relief Funds Page. Please review all FAQs to ensure a clear understanding of the relief fund application and reimbursement process.

Medicaid Update: Additional FAQs on CARES Provider Relief Fund

The Department of Health & Human Services has released additional information regarding the Provider Relief Fund available to Medicaid providers. Specifically, some additional FAQs have been posted that pertain to LTSS.

Specifically, the following relevant FAQs were issued since we last e-mailed you on these topics:

- Is a healthcare provider eligible to receive a payment from the Provider Relief Fund Medicaid, CHIP, and Dental Providers Distribution even if the provider received funding from the Small Business Administration's (SBA) Payroll Protection Program or the Federal Emergency Management Agency (FEMA) or has received Medicaid HCBS retainer payments?
    - Yes. Receipt of funds from SBA and FEMA for coronavirus recovery or of Medicaid HCBS retainer payments does not preclude a healthcare provider from being eligible for the Medicaid, CHIP, and Dental Providers Distribution if the healthcare provider otherwise meets the criteria for eligibility and can substantiate that the Provider Relief Fund payments were used for increased healthcare related expenses or lost revenue attributable to COVID-19, so long as they are not reimbursed from other sources and other sources were not obligated to reimburse them.

- Are healthcare providers that only bill Medicaid or CHIP through a waiver eligible for the Medicaid, CHIP, and Dental Providers Distribution?
    - Yes. Healthcare providers that bill for services in Medicaid or CHIP that are covered under either a waiver or state plan, including disability service providers and other providers of Medicaid-funded home and community-based services (HCBS) (e.g., day habilitation, HCBS waiver program services), are eligible for the Medicaid, CHIP, and Dental Providers Distribution if they otherwise meet the other eligibility criteria.
- Should Fiscal Management Services (FMS) organizations count self-directed providers as FTEs in the relevant fields in the Enhanced Provider Relief Fund Payment Portal?
    - The FMS organization should include an individual provider in the FTE count if the individual is an employee and receives a W-2. Contracted providers that are not employees should not be included in the FTE count. If the provider works without physician supervision, they should be counted as a primary provider FTE in field 27. If the provider works under physician supervision, they should be counted as a non-primary provider FTE in field 28.
- Do FMS organizations need to calculate their equivalent FTE based upon hours billed?
    - Yes, the FMS organization should calculate FTE status based on the number of hours billed unless the FMS or state has another method for counting FTEs. A 1.0 FTE works whichever number of hours the applicant considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. To compute FTE of a part-time provider, divide the total hours worked by the provider by the total number of hours that your medical practice considers to be a normal workweek
- How can an individual Home- and Community-based Services (HCBS) self-directed provider determine whether they should be applying on their own behalf or relying on the FMS organization to apply for the Medicaid, CHIP, and Dental Providers Distribution?
    - In general, if the individual is being paid through an FMS organization, the organization is likely the filing and billing TIN and would be eligible to apply for the Medicaid, CHIP, and Dental Providers Distribution. In that situation, the self-directed provider should contact the FMS organization to confirm that the organization is submitting an application on their behalf or whether the provider should submit an application as an individual self-directed provider.
- FMS organizations typically have two Taxpayer Identification Numbers (TINs) to comply with Internal Revenue Service requirements. One TIN is used to submit claims and received payment from the state Medicaid program and the other is used to process payroll to pay participant-directed workers on behalf of Medicaid beneficiaries who receive participant-directed services. Can an FMS organization include both TINs and use the associated revenue from both TINs' tax returns in their application?
    - Yes. The FMS organization can include both TINs and associated revenues in their application for the Medicaid, CHIP, and Dental Providers Distribution, as long as the services delivered under both TINs qualify as "patient care" and the entity can meet the attestation requirements for both TINs.
- Can FMS organizations' revenue from administrative fees provided by the state Medicaid program be included as "patient care"?
    - Yes. Applicants may include administrative fees provided by the state Medicaid program in the reported revenue, as well as in the percentage of revenue from patient care reported in field 12.
- How should Medicaid HCBS provider applicants categorize personal care services in Field 5?
    - HCBS provider applicants, including FMS organizations applying on behalf of self-directed providers, should categorize personal care services as "Other," code OT.

- The application instructions indicate that “real estate revenues” should be excluded from revenues from patient care. For residents that live in skilled nursing facilities, are resident fees that cover their accommodations considered service revenue or real estate revenues?
    - Resident fees that cover their accommodations can be considered patient service revenue.

There are also other non-LTSS specific FAQs that may be relevant to some LTSS providers, such as what to do if the provider does not have an NPI; if the provider is not a directly-enrolled Medicaid provider; and many others. We encourage you to make sure your provider community is aware of the funding as well as this list of important answers and clarifications.

The full list of FAQs is available here: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/medicaid-distribution/index.html

Brain Injury Waiver Referrals Being Accepted

Effective immediately, referrals for the Brain Injury Waiver (BIW) in Missouri will be accepted. The BIW program provides service coordination and home and community-based services to MO HealthNet recipients ages 21 to 65 who are living with a traumatic brain injury (TBI). Individuals must require medical care equivalent to the level of care received in a nursing home, not be enrolled in another waiver, and have been diagnosed with a TBI.

Please contact the Bureau of Special Health Care Needs at 800-451-0669 to speak with a BIW Service Coordinator to obtain further information and to begin the referral process.

HCBS Provider Contact Information

The Bureau of Long-Term Services and Supports (BLTSS) has asked that we remind HCBS providers of the May 1, 2020 memo.

This memorandum advised HCBS providers of the importance of keeping correct contact information on file with Missouri Medicaid Audit & Compliance (MMAC). HCBS Intake, Person Centered Care Planning teams, and Assessor teams utilize the contact information submitted to MMAC when notifying providers of case management activities. To be consistent, HCBS teams will only utilize the contact information kept on file by MMAC when notifying providers of these activities. Providers who wish to update their contact information may do so by submitting an HCBS Change Request form to MMAC. Submission instructions are included in the form. For other instructions, providers may access the HCBS Change Request Instructions document. Questions regarding this memorandum should be direct