Missouri Alliance for **HOME CARE**

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Please find information related to the following:

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  (Missouri Alliance for Home Care signs onto NAHC comments)
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HCBS Spending Plan – MAHC Submits Comments

The Missouri Alliance for Home Care submitted formal comments in regard to the Department of Social Services/MO HealthNet Division (DSS/MHD) along with the Department of Health and Senior Services (DHSS) and the Department of Mental Health (DMH) spending plan and project narrative regarding the activities the state intends to implement to enhance, expand and strengthen home and community-based services related to the increased federal medical assistance percentage (FMAP).

Click here for MAHC's formal comments.
Click here for MAHC's supplement comments within the proposed spending plan.

NAHC Comments to CMS Call for Important Changes to Proposed Rule *(from NAHC Report)*

(Missouri Alliance for Home Care signs onto NAHC comments)

"It is highly unlikely that home healthcare delivery in 2022 will be anything comparable to care delivery in 2020." – NAHC

The National Association for Home Care & Hospice (NAHC) has filed comments to the Centers for Medicare & Medicaid Services (CMS) on the CY2022 proposed rule, calling for no substantial changes to the PDGM payment system, but pointing out that while hospitals and skilled nursing facilities received payment boosts during the COVID-19 pandemic, home health agencies (HHA) did not.

The Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services have proposed several reforms affecting the Medicare home health benefit, survey and enforcement requirements for the hospices, and the CY 2022 payment rates.

CMS has proposed significant alterations to the PDGM case mix and reimbursement based on 2020 care data, but as NAHC Has pointed out, the delivery of care in the home in 2022 is unlikely to be anything like the delivery of care in the home in 2020.

"To comply with Medicare law, CMS must apply a PDGM-related budget neutrality adjustment methodology that exclusively is focused on PDGM-triggered behavioral changes. The change assessment methodology proposed by CMS encompasses changes unrelated to HHA behavioral changes under PDGM," NAHC wrote in its comments.

NAHC has recommended:

- CMS should maintain the structure and design of PDGM for 2022.
- CMS should withdraw its proposal to recalibrate PDGM case mix weights based on 2020 care utilization data because it is unreasonable to assume the chaotic year of health care utilization in 2020 is an appropriate foundation for 2022. Home health care delivery in 2022 is likely to be very different than it was in 2020.
- CMS should replace its suggested methodology for assessing whether behavioral changes of HHAs resulted in PDGM achieved budget neutrality in comparison to the HHPPS HHRG payment model with a methodology that focuses on behavioral changes, not change in average case mix weight.
- To comply with Medicare law, CMS must apply a PDGM-related budget neutrality adjustment methodology that exclusively is focused on PDGM-triggered behavioral changes. The change assessment methodology proposed by CMS encompasses changes unrelated to HHA behavioral changes under PDGM.
- CMS should reconsider its decision to apply the new OMB geographic designations for core-based statistical areas (CBSAs) in the annual wage index. Alternatively, CMS should treat all provider types equally in the transition to an updated wage index by extending the 5% ceiling on negative changes in wage index values as it has done for inpatient hospitals. Otherwise, massive payment rate reductions in certain areas of the country will occur, jeopardizing access to home health care services as hospitals protected by the 5% cap will be able to have a more stable financial base, allowing them to recruit staff more successfully from the same pool of professionals that work in HHAs.

- CMS should establish a process and methodology to modify HHA payment systems and rates during a Public Health Emergency to address new costs triggered by the public health emergency or unpredicted limitations in payment models.

The comments also included recommendations on the notice of admission (NOA) for home health agencies

NAHC's NOA recommendations are, as follows:

1. CMS should not assess the late submission penalty for the NOA until the issues that negatively impact HHAs are resolved.
2. CMS should provide clear and timely instructions to HHAs related to the identified system issues
3. CMS should include payer changes to the list of exceptions to the NOA timely submission penalty. CMS should require the MACs to request an ADR if addition information is required to decide on a payer change exception.
4. CMS should include other providers overlapping in the CWF as a listed exception to the NOA timely submission penalty. CMS should require the MACs to request an ADR if addition information is required to decide on whether the HHAs was prevented from submitting a timely NOA due other another provider's actions.
5. Instruct the MACs to not apply the timely submission penalty if the original NOA is submitted timely but must be canceled and resubmitted.

NAHC comments also cover the home health value-based payment program, the home health conditions of participation and other issues. Read the full comments HERE.

NAHC's comments are co-signed by the following state associations:

- Arizona Association for Home Care
- Association for Home & Hospice Care of North Carolina
- California Association for Health Services at Home
- HomeCare Association of Arkansas
- Home Care Alliance of Massachusetts
- Home Care Association of Colorado
- Home Care Association of Florida
- Home Care Association of Louisiana
- Home Care & Hospice Association of New Jersey
- Home Care Association of New York State
- Home Care and Hospice Association of Utah
- Home Care Association of Washington
- Home Care, Hospice, & Palliative Care Alliance of New Hampshire
- Idaho Health Continuum of Care Alliance
- Illinois HomeCare and Hospice Council
- Indiana Association for Home and Hospice Care
- Kentucky Home Care Association

- Maryland National Capital Home Care Association
- Michigan HomeCare & Hospice Association
- Minnesota HomeCare Association
- **Missouri Alliance for Home Care**
- Ohio Council for Home Care & Hospice
- Ohio Health Care Association
- Oregon Association for Home Care
- Nebraska Association for Home Healthcare and Hospice
- South Carolina Home Care & Hospice Association
- Virginia Association for Home Care and Hospice
- West Virginia Council of Home Care Agencies

Veto Session Recap

Missouri House of Representatives Considers Motions to Overturn Vetoes, Senate Fails to Adopt
The Missouri General Assembly met on Wednesday, September 15th for the Constitutionally required Veto Session. The Missouri House of Representatives considered several motions to override line-item vetoes proposed by Governor Mike Parson in the FY 2022 state operating budget.

Two of the motions to override (three made by a Republican and one by a Democrat) were adopted but were ultimately defeated on a party line vote by the Missouri Senate. While no formal motions to override any of Governor Parson's vetoes originated in the Senate (a motion to override a line item in a budget bill originates in the House), they did consider the 4 line-items adopted by the House.

OIG Study *(from NAHC Report)*

The Office of Evaluations and Inspections in the Office of inspector General (OIG) is conducting a study on HHAs' experiences during the COVID-19 pandemic. The OIG has started mailing survey invitations to study participants. The OIG also contacted NAHC in the beginning of the study to provide input on HHAs' experience during the pandemic. NAHC encourages HHAs to participate in the survey if selected. The information you provide will assist the OIG in understanding the challenges HHAs have faced during this PHE.

CMS to Proceed with Targeted Probe and Educate *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has decided to continue to proceed with the Targeted Probe and Educate (TPE) medical review, which they resumed on September 1, 2021.

Although, the Medicare Administrative Contractors (MACs) have been conducting limited medical review since August 2020, a probe audit, such as TPE, requires significantly more claims to will be reviewed. For the TPE reviews, providers are selected based on the analysis of billing data indicating aberrations that may suggest questionable billing practices.

TPE consists of up to three rounds of review, with up to 20-40 claims selected in each round. Subsequent rounds will begin 45-56 days after individual provider education is completed. Discontinuation of review may occur if appropriate improvement occurs, and error rate below the target threshold is achieved during the review process.

Because of the continued stressors providers are feeling from the ongoing COVID -19 pandemic and natural disasters, the National Association for Home Care & Hospice (NAHC) requested the Center for Program Integrity (CPI) at CMS to delay the resumption of TPE until the end of the public health emergency.

Unfortunately, the CPI responded to our request as follows:

"CMS believes that restarting the Targeted Probe and Educate (TPE) program is in the best interest of providers and CMS. TPE helps educate providers with the goal of reducing future claim denials, and if compliant, future claim audits. TPE reviews are generally limited to a subset of providers who have billing practices that vary significantly from their peers and are identified as appropriate for reviews through data analysis. The TPE program generally involves a small number of claims (generally 20-40) for each round of review. This process is typically repeated for up to three rounds, but MACs discontinue the process if/when providers/suppliers become compliant. If the MAC audits a provider, it is the responsibility of that provider to take advantage of the TPE education, and get up to 3 rounds of educational claim review to help bill accurately.

CMS has required the contractors to grant prepayment extensions to providers who need more time to comply with the medical record request. If a provider is unable to reply within the required timeframe, they are encouraged to submit an extension request to their MAC. I firmly believe the most important element is communication between the provider and the MAC."

NAHC encourages providers to work with their MACs and we have heard some MACs are providing flexibility in the number of ADRs being requested.

Recent HCBS Memos

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

Home and Community Based Services Spending Plan
A memorandum has been issued regarding the approval to utilize the funds related to the increased Federal Medical Assistance Percentage (FMAP) for HCBS rate increases.

Please refer INFO 09-21-01 at: https://health.mo.gov/seniors/hcbs/infomemos.php

Any questions regarding this memorandum should be directed to Long Term Services and Supports via email at LTSS@health.mo.gov.

Provider Reassessment Process – New HCBS Policy

The Home and Community Based Services (HCBS) Manual has been updated to reflect a new policy, 4.25.1 Provider Reassessment Process. The new policy outlines expectations and processes for provider reassessors.

Please refer to HCBS 09-21-01 and the new policy at:
Memorandum - https://health.mo.gov/seniors/hcbs/hcbsmanual/hcbsmemos.php
Policy – https://health.mo.gov/seniors/hcbs/hcbsmanual/

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

COVID-19 Updates to Programmatic Flexibilities

The State of Emergency has been extended until December 31, 2021. Please refer to the memorandum, INFO 08-21-09 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.

Provider Reassessor Training Update

A memorandum has been issued regarding an update to the online Provider Reassessor Training modules.

Please refer INFO 08-21-08 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 ReassessorTraining@health.mo.gov.

Home and Community Based Services Policy Clarification Questions (PCQ's) Updates

A memorandum has been issued regarding updates to the Policy Clarification Questions (PCQ's).

Please refer to INFO 08-21-07 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.

Provider Reassessor Participation Terms and Conditions – Reminder

A memorandum has been issued regarding the approaching deadline for the new Provider Reassessor Participation Terms and Conditions.

Please refer to INFO 08-21-05 at: https://health.mo.gov/seniors/hcbs/infomemos.php

Any questions regarding this memorandum should be directed to Long Term Services and Supports via email at LTSS@health.mo.gov.

Notice of Closure vs 21 Day Notice
A memorandum has been issued regarding Notice of Closure vs 21 Day Notice.

Please refer to INFO 08-21-04 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.

HCBS Web Tool Guidance - Directions to Residence Box
Update to previous guidance released regarding the use of the Web Tool Directions Box. The previous memorandum (INFO 05-21-03) has been archived and staff and stakeholders should refer to this revised version (INFO 08-21-03) for the latest information.

Changes include:

- A Modification: Notification of the name and DCN of participants living with other HCBS participants.
- Newly Added: Notification of Aged and Disabled Waiver participants approved to exceed the cost maximum.

Please refer INFO 08-21-03 at: https://health.mo.gov/seniors/hcbs/infomemos.php

Questions regarding this memorandum should be directed to Long Term Services and Supports via email at LTSS@health.mo.gov.

Update to 4.00 Appendix 3 (HCBS-3a) In-Home Services Worksheet
The Home and Community Based Services (HCBS) Manual has been revised to reflect updates to Policy 4.00 Appendix 3 In-Home Services Worksheet (HCBS-3a).

Please refer to HCBS 08-21-01 and the revised policies at:
Policies – https://health.mo.gov/seniors/hcbs/hcbsmanual/
Memorandum - https://health.mo.gov/seniors/hcbs/hcbsmanual/hcbsmemos.php

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

Family Care Safety Registry Checks Required During Declared COVID Health Emergency
A memorandum has been issued regarding Family Care Safety Registry (FSCR) checks during the declared COVID-19 health emergency.

Please refer to INFO 08-21-02 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.

Revalidation Schedule Change

Missouri Medicaid Audit and Compliance reminds providers:

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 modified some providers' revalidation due dates.

The Revalidation portal at www.emomed.com 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.**

Providers and/or their authorized representatives 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.

Non-Emergency Medical Transportation (NEMT) for Vaccines

Effective September 1, 2021, MO HealthNet Division will allow eligible Fee-For-Service participants, that have a scheduled appointment at a pharmacy, to receive transportation to their local pharmacies to receive vaccinations. Click here to access the MO HealthNet memo.

Changes to Missouri's Adult Abuse and Neglect Hotline Hours of Operation

The Department of Health and Senior Services (DHSS) is revising the hours of operation for the **Missouri Adult Abuse and Neglect Hotline** to **7:00 a.m. to 8:00 p.m.,** 365 days a year, **effective September 1, 2021.** The Hotline's former hours of operation were 7:00 a.m. to midnight, 365 days a year. This change will allow the Department to better serve those who need to report concerns of abuse, neglect, and exploitation of vulnerable individuals 60 and older and people with disabilities between 18 and 59.

During fiscal year 2020, DHSS received and investigated 40,714 community and facility reports of abuse, neglect, bullying, and exploitation, involving seniors and adults with disabilities. That amounts to an average of over 111 reports every day. The number of cases continues to rise, but still vastly understates the extent of the problem as experts believe that for every case of adult abuse or neglect reported, as many as 23 cases go unreported.

In November of 2019, DHSS implemented the Adult Abuse and Neglect Hotline online reporting system allowing concerned citizens and mandated reporters to electronically submit reports of abuse, neglect, and exploitation in an efficient, secure, and confidential manner on a web-based platform. The online reporting portal is available 24 hours a day, 7 days per week and provides an alternative to calling the Adult Abuse and Neglect Hotline both during and outside of normal business hours. Since the implementation of online reporting, approximately one-third of all reports are submitted this way. While online reporting has helped to ease the Adult Abuse and Neglect Hotline's call volume demands, additional efforts are still needed to ensure that no call goes unanswered. The new

operational hours for the Hotline will allow for increased staffing during times of highest call volume. This will help reduce wait times for those reporting and make it easier to reach a trained intake professional between 7:00 a.m. and 8:00 p.m. Please note that 9-1-1 should be accessed for emergencies as the Adult Abuse and Neglect Hotline online reporting system is not intended for emergency response.

If you suspect abuse, neglect or financial exploitation of the elderly or an adult with a disability, you may call the Adult Abuse and Neglect Hotline toll-free at (800) 392-0210 or visit www.health.mo.gov/abuse/ to make a report online.

If you have any questions regarding the change in the hours of operation for the Adult Abuse and Neglect Hotline, please reach out to the Department at 573/526-3625 or DSDSOfficeofConstituentServices@health.mo.gov.

Report: Big Investment in HCBS Needed to Support Long-Term Care Needs *(from NAHC Report)*

A new report from the Bipartisan Policy Center, *Bipartisan Solutions to Improve the Availability of Long-term Care*, calls for significant investment in expansion of home and community-based services (HCBS) in order to expand access to long-term care, which will become increasingly necessary in a rapidly aging society.

"For decades, policymakers have sought to improve access to long-term services and supports (LTSS) and to strengthen these services' financing," reads the report. "Today, about half of 65-year-olds will need LTSS at some point in their life. This need will grow as baby boomers age and require more care."

About 14 million U.S. adults reported a need for LTSS in 2018, according to the American Association of Retired Persons.

More than 800,000 senior and disabled Americans are on waiting lists for HCBS, though most observers believe the true number is far higher than that. The average wait time for HCBS is about three years. "The cost for facility and in-home care services has on average increased faster than the rate of inflation since 2004," the report reads. "Long-term care providers saw significant cost increases from 2019 to 2020 as demand rose and caregiver shortages in facilities and in the community worsened. The median for the national annual cost of LTSS in 2020 ranged from $19,240 for adult day health care to $105,850 for a private room in a nursing home."

The report contains five important recommendations for how to achieve a system of LTSS.

I. Expand Access to Home and Community-Based Services

"Congress should make HCBS available for individuals with long-term care needs who are ineligible for Medicaid," reads the report. Services should be available through fully integrated care models, including improved fully integrated dual eligible special needs plans (FIDE-SNPs), Programs of All-Inclusive Care for the Elderly (PACE), or other models approved by the secretary of HHS, and would include sliding-scale subsidies.

In addition, the report recommends that Congress develop a transitional program to support the expansion and development of integrated delivery models where they are unavailable and should build caregiver capacity until the new HCBS program is fully implemented.

II. Address Disparities in the Delivery of HCBS

Congress should direct the secretary of HHS to collect data and issue an annual report on disparities in access to HCBS and make recommendations to Congress to address inequities.

III. Create a Caregiver Tax Credit

The report suggests Congress establish a refundable tax credit for caregivers to help with out-of-pocket costs for paid LTSS-related care.

IV. Improve the Viability of Private Long-Term Care Insurance

The authors recommend Congress standardize and simplify private long-term care insurance to achieve an appropriate balance between coverage and affordability, through "retirement long-term care insurance (LTCI)."

Furthermore, the report urges Congress to incentivize employers to offer retirement LTCI and to auto-enroll certain employees (age 45 and older with minimum retirement savings), with an opt-out like many employer-sponsored retirement savings accounts.

Congress should also permit early penalty-free withdrawal from retirement savings accounts to pay retirement LTCI premiums and ask NAIC to modify model laws and regulations to accommodate products that convert from life insurance to long-term care, write the authors of the report.

V. Establish a Public Education Campaign for Long-Term Care

The Bipartisan Policy Center report calls for the Financial Literacy and Education Commission and partnering federal agencies to coordinate to strengthen educational resources on LTC and incorporate LTC planning into retirement
education topics.

"No single solution will address the needs of those who require LTSS," write the report's authors. "Improving access to these services will require a combination of public- and private-sector options, and an investment of federal resources."

HHS Announces New Provider Fund Distribution & Grace Period for Reporting Obligations *(from NAHC Report)*

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services (HHS) announced it will accept applications from providers for new relief funds this week, as well education for providers to help navigate the application portal.

In addition, there will be a grace period for the reporting deadline of September 30, 2021 for Period 1 recipients of Provider Relief Funds (PRF).

New Distributions

On September 29, 2021, health care providers will be able to apply for $25.5 billion in relief funds, including $8.5 billion in American Rescue Plan (ARP) resources for providers who serve rural patients covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) and $17 billion for Provider Relief Fund (PRF) Phase 4 for a broad range of providers with changes in operating revenues and expenses. The application will be open for a period of four weeks. Providers must submit their completed application by the **final deadline of October 26 at 11:59 p.m. ET**.

Providers who have previously created an account in the Provider Relief Fund Application and Attestation Portal and have not logged in for more than 90 days will need to first reset their password before starting a new application.

In order to streamline the application process and minimize administrative burdens, providers will apply for both programs in a single application and HRSA will use existing Medicaid, CHIP, and Medicare claims data in calculating portions of these payments.

- **Phase 4 General Distribution** — $17 billion based on providers' changes in operating revenues and expenses from July 1, 2020 to March 31, 2021.
    - To promote equity and to support providers with the most need, HRSA will:
        - Reimburse smaller providers for changes in operating revenues and expenditures at a higher percentage compared to larger providers.
        - Provide "bonus" payments based on the amount of services they provide to Medicaid, CHIP, and Medicare patients, priced at the generally higher Medicare rates.
- **American Rescue Plan (ARP) Rural** — $8.5 billion based on the amount of services providers furnish to Medicaid/CHIP and Medicare beneficiaries living in Federal Office of Rural Health Policy (FORHP)-defined rural areas.
    - To promote equity, HRSA will price payments at the generally higher Medicare rates for Medicaid/CHIP patients.

PRF Period 1 Reporting Grace Period

HRSA also recently announced a 60-day grace period for PRF recipients that are unable to meet the September 30, 2021, reporting deadline, allowing providers to remain in compliance by fulfilling the obligations of the reporting deadline prior to November 30, 2021. These providers will not face collection activities or similar enforcement actions during the grace period. The deadline to use Period 1 PRF funds remains June 30, 2021. HRSA also notes that providers must return unused funds as soon as possible after submitting their report, and no later than December 30, 2021.

Phase 4 and ARP Rural Technical Assistance Webcasts

HRSA will be hosting webinar sessions for Phase 4 and ARP Rural applicants, featuring guidance on how to navigate the application portal.

- Thursday, September 30, 3:00 – 4:00 p.m. ET – register to attend
- Tuesday, October 5, 3:00 – 4:00 p.m. ET – register to attend
- Two additional webinars during the weeks of October 11th and 18th (dates, times, and registration details forthcoming)

HHS recently hosted a briefing session to provide information about these upcoming funding opportunities – view the video.

What is ARP Rural?

ARP Rural funding is intended to help address the disproportionate impact that COVID-19 has had on rural communities and rural health care providers, and funding will be available to providers who serve patients in these communities. ARP Rural payments are administered jointly with the Provider Relief Fund, and eligible applicants can apply through the same Application and Attestation Portal that will be available to apply for the Phase 4 General Distribution to be considered for both opportunities simultaneously.

ARP Rural payments will be determined based on the location of the patients, not the provider. Applicants do not need to verify whether their patients live in an area that meets the definition of rural, and can select whether their organization (including any included subsidiaries) would like to be considered for ARP rural payments during the application process. HRSA will base payments on data already available to it on the amount and type of Medicare, Medicaid, and CHIP services provided to rural patients. HRSA will use the Federal Office of Rural Health Policy definition of rural.

CMS Launches New Tool to Compare Nursing Home Vaccination Rates *(from NAHC Report)*

Hospice organizations provide a significant level of services to nursing facility patients and have experienced numerous challenges throughout the COVID-19 Public Health Emergency delivering care to nursing home patients. Therefore, NAHC believes hospice providers might be interested in recent action taken by the Centers for Medicare & Medicaid Services (CMS) to provide public access to nursing home vaccination rates for nursing home residents and staff.

The new feature on Medicare.gov makes vaccination data available in a user-friendly format to help people make informed decisions when choosing a nursing home for themselves or a loved one. CMS and the Centers for Disease Control and Prevention (CDC) are also continuing to use this data to monitor vaccine uptake among residents and staff and to identify facilities that may need additional resources or assistance to respond to the pandemic.

"CMS wants to empower nursing home residents, their families and caregivers with the information they need when choosing care providers for their loved ones. As we continue to work with our partners to monitor the spread of COVID-19 and keep nursing home residents safe, we want to give people a new tool to visualize this data to help them make informed decisions," said CMS Administrator Chiquita Brooks-LaSure. "CMS knows that nursing home staff want to protect their residents and is calling on them to get vaccinated now. The COVID-19 vaccine is safe, effective and accessible to all at no out-of-pocket cost."

Take a look at the new data feature HERE.

Hospice Quality Reporting Program Update: HIS Timeliness Compliance Threshold Report *(from NAHC Report)*

Hospices can now access their confidential Quality Measure (QM) reports in CASPER for two new publicly reported measures, Hospice Care Index (HCI) and Hospice Visits in the Last Days of Life (HVLDL). These two claims-based measures will be publicly reported on Care Compare no sooner than May 2022.

Hospices have been anxiously waiting to see the reports as no national performance data on either measure was available for hospices to use for benchmarking. Hospices must rely solely on CMS' (Centers for Medicare & Medicaid Services) calculations of the HCI because hospital claims data is used for some of the indicators comprising this Index and hospices do not have access to this data.

According to the CMS notice about the QM reports being available claims from fiscal years 2018 and 2019 were used to calculate the measures. The CASPER Report User's Guide has been updated to include the new reports.

In addition to the QM reports now being available, the Timeliness Compliance Threshold for HIS Submissions: Fact Sheet has been updated. This fact sheet outlines the timeliness compliance threshold for HIS (Hospice Item Set) submissions, details the algorithm for calculation and explains the associated CASPER report. It is especially prudent at this time for hospices to view their Timeliness Compliance Threshold report because the annual payment update penalty of two percent that is applicable to hospices that have not complied with the HIS and/or CAHPS Hospice Survey submission requirements jumps to four percent effective with the FY2024 payment year.

However, the HIS and CAHPS Hospice Survey submission period impacting the FY2024 payment year begins January 1, 2022 as noted below.

Annual Payment Update	HIS	CAHPS
FY2024	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/22 – 12/31/22.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022

Hospices not currently at the 90 percent HIS submission threshold should implement improvements now to ensure achieving the 90 percent prior to January 1. To determine if the CAHPS Hospice Survey data is being submitted by your CAHPS vendor as required, go to the CAHPS Hospice Survey Data Warehouse. More information on accessing the Warehouse is available here.

Hospices that have fewer than 50 survey eligible decedents/caregivers during January 1 – December 31, 2021 can request a participation exemption for size for 2022 submissions (which impact the FY2024 payment update). More information on this exemption is available here.

CMS Issues Additional Home Health Claim Processing Instructions *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has issued Change Request 12424 that provides additional instructions related claims processing for the notice of admission (NOA) for claims that span calendar years 2021 and 2022, and special circumstances for discharges when no visits are made in a subsequent 30 day period.

In the Medicare Claims Processing Manual, chapter 10, Section 10.1.10.3 – Submission of the Notice of Admission (NOA) has been revived to read:

For all beneficiaries receiving HH services in 2021 whose services will continue in 2022, the HHA shall submit an NOA with a one-time, artificial 'admission' date corresponding to the "From" date of the first period of continuing care in 2022. For example, if a period of care begins in 2021 and ends on January 10, 2022, the HHA submits and NOA with an admission date of January 11, 2022 and then submits a claim when the 30-day period of care is over. The HHA should submit the January 11, 2022 admission date on all subsequent claims until the beneficiary is discharged and another NOA is required. This is to ensure the claim is matched to the correct NOA and the correct receipt date is used for payment.

Section 40.2 – HH PPS Claims, in the manual has been revised to read:

Patient discharge status - In cases where an HHA provides care in a 30-day period of care and then discharges the beneficiary in the next 30-day period of care, but does not provide any billable visits in the next 30-day period, special handling of the patient status code may be needed. Normally, the patient status code for 30-day period before the discharge would be 30, since the beneficiary has not yet been discharged. However, since there will not be a claim for the period in which the discharge occurred, this would result in the HH admission period remaining open in Medicare systems and prevent billing for any later HH services.

In order to close the HH admission period in these cases, the HHA should report patient status 01 on the claim for the last 30-day period in which visits occurred. This will trigger Medicare systems to close the HH admission period. If the claim has been submitted with patient status 30 before the discharge occurred, the HHA should adjust the claim to change the patient status to 01.

If the cause of the discharge in the next 30-day period is a transfer to another HHA before any visits were provided, the HHA should take care not to report patient status 06 on the claim. This would result in an incorrect partial period payment adjustment. If the cause of the discharge in the next 30-day period is the beneficiary's death, the HHA should take care not to report patient status 20 on the claim.

This would result in an incorrect date of death being recorded in Medicare systems and potentially affect claims from other providers.

CMS to Resume Provider Enrollment Activities *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has announced the resumption of several provider enrollment activities that have been paused since the beginning of the public health emergency related to the COVID-19 pandemic.

Beginning in October 2021, the following activities will be resumed.

- Application Fees – 42 C.F.R. 424.514
- Criminal background checks associated with fingerprint-based criminal background checks– 42 C.F.R. 424.518
- Revalidation – 42 C.F.R 424.515

CMS instructs providers to review the following questions (19, 20, 26 and 27) in the COVID-19 Medicare Provider Enrollment Relief FAQs (PDF),

19. When will CMS be resuming provider and supplier revalidation activities?

CMS will be resuming provider and supplier revalidation activities in a phased approach for existing providers and suppliers that missed their revalidation due date during the PHE. Revalidation letters will be sent in October 2021 with due dates in early 2022. This revalidation effort does not apply to providers and suppliers that received temporary billing privileges through the Medicare enrollment hotlines. Once the PHE is lifted, providers with temporary billing privileges will be separately asked by their MAC to submit a complete CMS-855 enrollment application in order to establish full Medicare billing privileges. See FAQ #16.

20. How will providers and suppliers be notified of their revalidation due date?

Providers and suppliers that are required to revalidate in this initial phase of revalidation will be notified of their revalidation due date in two ways:

- The Medicare Revalidation Tool at https://data.cms.gov/revalidation will be updated to display an adjusted revalidation due date in addition to the provider or supplier's original revalidation due date (pre-PHE). The adjusted revalidation due date will be displayed at least 3 months in advance of the provider's or supplier's adjusted due date.
  • The MAC will issue a revalidation notice to the provider and supplier at least 3 months in advance of their adjusted due date. Letters will be sent to the correspondence address on file in the Provider Enrollment Chain and Ownership System (PECOS).

26. Has CMS resumed collecting provider enrollment application fees?

Beginning October 2021, CMS will resume collecting application fees, in accordance with 42 C.F.R. 424.514, for institutional providers that are:

(1) initially enrolling in Medicare,

(2) adding a practice location, or

(3) revalidating their enrollment information.

The application fee will continue to be waived for providers and suppliers who receive temporary billing privileges through the Medicare enrollment hotlines. Once the PHE is lifted, those providers and suppliers will be asked to submit a complete CMS-855 enrollment application in order to establish full Medicare billing privileges, at which time the application fee will be required, if applicable.

27. Has CMS resumed fingerprint-based criminal background checks (FCBC)?

Beginning October 2021, CMS will resume FCBC, in accordance with 42 C.F.R. 424.518, for high risk categories of providers and suppliers (e.g., newly-enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs). Fingerprint-based background checks are generally completed on people with a 5% or greater ownership interest in a provider or supplier that falls under the high risk category. A 5% or greater owner includes any person that has any partnership interest (general or limited) in a high risk provider or supplier.

High risk providers and suppliers enrolling for the first time after October 2021 will be contacted by their MAC via letter to complete a fingerprint-based background check within 30 calendar days from the date of the letter. FCBC will continue to be waived for providers and suppliers who receive temporary billing privileges through the Medicare enrollment hotlines. Once the PHE is lifted, those providers and suppliers will be required to submit a complete CMS-855 enrollment application in order to establish full Medicare billing privileges, at which time FCBC will be required, if applicable.

SBA Offers Loan Forgiveness, IRS Expands Paid Leave Tax Credit for Vaccinations

(from NAHC Report)

The U.S. Small Business Administration (SBA) has announced the opening of the Paycheck Protection Program Direct Forgiveness Portal to ease the COVID-19 burden for small businesses. The announcement reflects the reality that while the federal funds made available to millions of small business owners enabled many to stay in business during the COVID-19 public health emergency, some of those same businesses are still struggling during the early days of an uncertain economic recovery, made more uncertain by the ravages of the Delta Variant of COVID-19.

As many small business owners to took on the loans are currently unable to pay them back, the SBA's initiative will allow small businesses with loans of $150,000 or less to apply directly to the SBA for loan forgiveness. The process to receive loan forgiveness has also been streamlined.

"The SBA's new streamlined application portal will simplify forgiveness for millions of our smallest businesses – including many sole proprietors – who used funds from our Paycheck Protection Program loans to survive the pandemic," said SBA Administrator Isabel Casillas Guzman. "The vast majority of businesses waiting for forgiveness have loans under $150,000. These entrepreneurs are busy running their businesses and are challenged by an overly complicated forgiveness process. We need to

deliver forgiveness more efficiently so they can get back to enlivening our Main Streets, sustaining our neighborhoods and fueling our nation's economy."

If you're interested in taking advantage of this new initiative, go to the Direct Forgiveness SBA website.

The new PPP Loan Forgiveness Portal began accepting applications from borrowers on August 4, 2021.

In other COVID-related news, the Internal Revenue Service and the Treasury Department are allowing eligible employers to claim tax credits equivalent to the wages paid for providing paid time-off to employees to take a family or household member or other individuals to get vaccinated for COVID-19, or to take care of a family or household member or other individuals recovering from a vaccination.

Comparable tax credits are also available for self-employed individuals. This new policy, announced August 5, expands a tax break first announced in the spring.

CMS Increases Payments for In-Home COVID-19 Vaccinations *(from NAHC Report)*

The Centers for Medicare & Medicaid Services has announced additional in-home payment amounts for certain Medicare beneficiaries that receive COVID-19 vaccinations in their home, including communal living settings. The payment amount applies to administering vaccines to multiple residents in home setting or communal home setting on the same date of service.

The additional in-home payment amount applies if the beneficiary:

- Has a condition that makes them more susceptible to contracting a pandemic disease such as COVID-19.
- Is generally unable to leave the home, and if they do leave home, it requires a considerable and taxing effort.
- Has a disability or faces clinical, socioeconomic, or geographical barriers to getting a COVID-19 vaccine in settings other than their home.
- Faces challenges that significantly reduce their ability to get vaccinated outside the home, such as challenges with transportation, communication, or caregiving.

On June 8, 2021, CMS added a $35 increased in payment for administering the COVID-19 vaccine to beneficiaries in their home, However, the additional payment was applied once per setting per date of service regardless of how many beneficiaries were vaccinated at the site on that day.

Beginning August 24, 2021, the additional $35 will be applied to each beneficiary vaccinated at the site up 5 beneficiaries if there are fewer than 10 beneficiaries are vaccinated at the site on the same day,

Medicare only pays the additional amount for administering the COVID-19 vaccine in the home if the sole purpose of the visit is to administer a COVID-19 vaccine. Medicare doesn't pay the additional amount if you provide another Medicare service in the same home on the same date. In those situations, Medicare pays for administering the COVID-19 vaccine at the standard amount (approximately $40 per dose).

If you administer the COVID-19 vaccine to more than one Medicare patient in a single home in the same multi-unit or communal living arrangement on the same day, Medicare pays:

- Approximately $40 to administer each dose of the COVID-19 vaccine, including additional doses administered on or after August 12, 2021
- For dates of service between June 8, 2021 and August 24, 2021, Medicare pays the additional payment amount of approximately $35 only once per date of service in that home regardless of how many Medicare patients receive the vaccine.
- Effective on August 24, 2021, Medicare pays the additional payment amount (approximately $35 per dose administered), for up to a maximum of 5 vaccine administration services per home unit or communal space within a single group living location; but only when fewer than 10 Medicare patients receive a COVID-19 vaccine dose on the same day at the same group living location

For example, if you administer a COVID-19 vaccine on the same date between June 8, 2021 and August 24, 2021 to 2 Medicare patients in the same home, Medicare pays approximately $115 ($35 for the in-home vaccine administration, plus 2 x $40 for each dose of the COVID-19 vaccine).

Effective August 24, 2021, if you administer a dose of the COVID-19 vaccine on the same date to two Medicare patients in the same home, Medicare pays approximately $150 (2 x $35 for the in-home vaccine administration, plus 2 x $40 for each dose of the COVID-19 vaccine).

Effective August 24, 2021, if you administer a dose of the COVID-19 vaccine on the same date to nine Medicare patients in the same home (including a communal space in a group living setting), Medicare pays approximately $535 (5 x $35 for the in-home vaccine administration, plus 9 x $40 for each dose of the COVID-19 vaccine).

Effective August 24, 2021, if you administer a dose of the COVID-19 vaccine on the same date to 12 Medicare patients in the same home (including a communal space in a group living setting), Medicare would pay $515 (12 x $40 for each dose of COVID-19 vaccine, and 1 x $35 for one in-home vaccine administration – only one home add-on payment is billable in this circumstance because 10 or more Medicare patients were vaccinated at the same group living location on the same date).

Effective August 24, 2021, if you administer a dose of the COVID-19 vaccine on the same date to 5 Medicare patients in a communal space in a group living setting and to 3 additional Medicare patients in their individual rooms, Medicare would pay $600 (5 x $35 for the in-home vaccine administration services in the single communal space, plus 3 x $35 for each of the in-home vaccine administration services in individual homes, plus 8 x $40 for each dose of the COVID-19 vaccine).

Click here for more information Medicare payments for COVID-19 vaccinations.