Missouri Alliance for **HOME CARE**

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Please find information related to the following:

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- **HCBS Web Tool System Enhancements**
- **Change to Resource Limits for Medicaid Benefits**
- **HCBS Case Record Review Policy Updated**
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Provider Rates Spared as Governor Announces Withholds

On June 30, Governor Parson announced withholds for the state's fiscal year 2021 budget. The new fiscal year began yesterday, July 1 and runs through June 30, 2021.

We were relieved that home care provider rates were spared. MAHC has been in continuous communication with budget leaders and the Governor's office over the last couple of months related to the need to protect and sustain the home care industry in Missouri, especially during this pandemic period when home care plays an even more vital role.

We are also continuing our discussions with the Governor and the Federal COVID-19 Related Funds Working Grouping, led by Treasurer Scott Fitzpatrick related to the impact the COVID-19 pandemic has had on the home care industry. As a result, the home care infrastructure is in great jeopardy at a time when it is needed the most to deal with seniors and persons with disabilities who should be isolating at home while still needing care for a wide range of conditions.

Related to the Governor's withholds, you can read the press release at FY2021 Budget Press Release and see the withholds by state department and program at FY2021 Expenditure Restrictions.

The Governor still has two weeks to take action on other bills passed by the General Assembly.

HCBS Web Tool System Enhancements

The following enhancements to the HCBS Web Tool are scheduled for implementation on July 1, 2020:

PACE Eligibility Message

- Addition of new eligibility message for individuals enrolled in the Program for All-Inclusive Care for the Elderly (PACE). Participants enrolled in PACE should be directed to their PACE provider to address any unmet needs.

Structured Family Caregiving Waiver

- Pursuant to Missouri House Bill 466, addition of a new service type: Structured Family Caregiving Waiver (SFCW).

  At this time, the Structured Family Caregiving Waiver is an unfunded mandate, therefore participants **cannot** be enrolled. **Provider assessors should disregard this service type until further notice**. Additional guidance will be issued when the SFCW becomes available for enrollment.

Questions pertaining to the SFCW should be directed to the Bureau of Long Term Services and Supports via e-mail at LTSS@health.mo.gov.

Questions pertaining to the functionality of the Web Tool should be directed to the Bureau of HCBS Systems and Data Reporting via e-mail at DSDSWebTool@health.mo.gov.

Change to Resource Limits for Medicaid Benefits

The Home and Community Based Services (HCBS) Manual has been revised to reflect updates to Policy 2.00 Appendix 1.

> As a result of the implementation of HB 1565 (2016), effective July 1, 2020 asset limits for Medicaid benefits have increased accordingly: • $5,000 for an individual; and • $10,000 for a couple.

Please refer to HCBS 06-20-02 Changes in Available Resource Limits for Medicaid Benefits 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 at LTSS@health.mo.gov.

HCBS Case Record Review Policy Updated

HCBS Policy has been revised to reflect the new Case Record Review tool and process. Please refer to HCBS 07-20-01 and the revised policy at the links below.

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.

Backdating Provider Enrollment Applications

The Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit (PEU) frequently receives requests to backdate provider enrollment applications. MMAC will not backdate the effective date of a provider's Missouri Medicaid enrollment prior to the date MMAC received the provider's application, except in very specific situations, such as out of state emergency services. This is outlined in state regulation.

13 CSR 65-2.020 Provider Enrollment and Application

> (1) Enrollment
>
> For any person to receive payment from the MO HealthNet Program for items or services other than out-of-state emergency services, the billing providers and the performing providers of such items or services must be enrolled providers in the MO HealthNet Program on the date the items or services are provided unless applicable rules or manuals permit enrollment as of an earlier date, up to a maximum of three hundred sixty-five (365) days prior to the actual enrollment date.

Questions regarding enrolling with the MO HealthNet program can be emailed to MMAC.ProviderEnrollment@dss.mo.gov

CMS Creates new Office to Reduce Regulatory Burden

The Centers for Medicare & Medicaid Services (CMS) recently announced the creation of a new Office of Burden Reduction and Health Informatics "to unify the agency's efforts to reduce regulatory and administrative burden and to further the goal of putting patients first." CMS portrayed the new office as "an outgrowth of the agency's Patients over Paperwork (PoP) Initiative."

"The Office of Burden Reduction and Health Informatics will ensure the agency's commitment to reduce administrative costs and enact meaningful and lasting change in our nation's health care system," said CMS Administrator Seema Verma. "Specifically, the work of this new office will be targeted to help reduce unnecessary burden, increase efficiencies, continue administrative simplification, increase the use of health informatics, and improve the beneficiary experience."

In addition to addressing regulatory burden, the new office will focus on health informatics, which uses and applies health data and clinical information to improve patient outcomes. “Fostering innovation through interoperability will be an important priority, and the office will leverage technology and automation to create new tools that allow patients to own and carry their personal health data with them seamlessly, privately, and securely throughout the health care system,” CMS announced in a press release. “By providing clinicians with a complete medical history, they can deliver better coordinated, higher quality care. Coupled with implementation and enforcement of adopted national standards, this office will also work with the broader healthcare community to continue to make key administrative processes increasingly more efficient.”

The new new Office of Burden Reduction and Health Informatics will work across Medicare, Medicaid, the Children’s Health Insurance Program and the Health Insurance Marketplace.

A additional goal of the new office will be to increase the number of clinicians, providers, and health plans the Agency engages, to ensure that CMS has a better understanding of how various regulatory burdens impact healthcare delivery. “Stakeholder feedback is critical to addressing provider and clinician burden, as it helps CMS to remove or modify outdated regulations that impede innovation, ultimately resulting in improvements in healthcare delivery,” read the CMS press release.

EEOC Issues Important Guidance on COVID-19 and Key Employment Laws

The Equal Employment Opportunity Commission (EEOC) has provided guidance to employers on their rights and obligations and how they might have changed during the COVID-19 Public Health Emergency. This information will be extremely useful for home care and hospice organizations and we urge you to access that information **HERE**.

The EEOC guidance includes information on the following subjects and questions and a lot more.

Disability-Related Inquiries and Medical Exams

- How much information may an employer request from an employee who calls in sick, in order to protect the rest of its workforce during the COVID-19 pandemic?
- When may an ADA-covered employer take the body temperature of employees during the COVID-19 pandemic?
- May an employer administer a COVID-19 test (a test to detect the presence of the COVID-19 virus) before permitting employees to enter the workplace?

Confidentiality of Medical Information

- May a temporary staffing agency or a contractor that places an employee in an employer’s workplace notify the employer if it learns the employee has COVID-19?
- If an employer requires all employees to have a daily temperature check before entering the workplace, may the employer maintain a log of the results?

Hiring and Onboarding

- If an employer is hiring, may it screen applicants for symptoms of COVID-19?
- May an employer take an applicant's temperature as part of a post-offer, pre-employment medical exam?

Reasonable Accommodation

- If a job may only be performed at the workplace, are there reasonable accommodations for individuals with disabilities, absent undue hardship, that could offer protection to an employee who, due to a preexisting disability, is at higher risk from COVID-19?
- If an employee has a preexisting mental illness or disorder that has been exacerbated by the COVID-19 pandemic, may he now be entitled to a reasonable accommodation (absent undue hardship)?

Pandemic-Related Harassment Due to National Origin, Race, or Other Protected Characteristics

- What practical tools are available to employers to reduce and address workplace harassment that may arise as a result of the COVID-19 pandemic?
- An employer learns that an employee who is teleworking due to the pandemic is sending harassing emails to another worker. What actions should the employer take?

The guidance also includes detailed and valuable information on topics like:

- Furloughs and Layoffs
- Return to Work
- Age
- Caregivers/Family Responsibilities
- a lot more.

EEOC Suspends EEO-1 Reporting Until March 2021

Federal regulations require that all employers in the private sector with 100 or more employees, and federal contractors and subcontractors with 50 or more employees and a federal contract or subcontract amounting to $50,000 or more, file the EEO-1 Report annually. The EEO-1 requires company employment data to be categorized by race/ethnicity, gender, and job category. Note that, as of September 2019, the EEO-1 no longer includes a pay data component, and so employers will not be required to submit pay information with their 2019 and 2020 EEO-1 data.

The Equal Employment Opportunity Commission (EEOC) has announced that the deadline for filing the 2019 and 2020 EEO-1 Report is March 31, 2021.

Please contact SESCO should you have any questions. For assistance, contact us at 423-764-4127 or by email at sesco@sescomgt.com**.**

Good Morning America Celebrates the Work of Home Care Nurses – Check out the Video!

ABC morning show Good Morning America followed the nurses of the VNA Health Group in New Jersey on their rounds recently and the resulting story demonstrates, yet again, the courage and hard work of the people who are working every day to provide the best quality health care to people in the setting they prefer, their own homes. However, the twist this time is that all this is being done during a pandemic that poses a unique threat to the mostly elderly and disabled recipients of home health and hospice care.

The nurses at VNA Health Group in New Jersey work in pairs, with one nurse dealing directly with the patient, while the other nurse remains in the car to provide remote assistance and then to de-contaminate their partner when the visit is over. The segment includes interviews with Florence Maffeu, VNA Director of Hospice Education & Improvement, as well as registered nurses Leo Cayanong and Brook Savino, who work together as a team to treat patients.

VNA Chief Nursing Officer Ellen Gusick explains the importance of telehealth in home health care, particularly during the Public Health Emergency. “It was a game-changer for all of us,” says Ms. Gusick.

As an added bonus, Verizon has made a substantial donation to VNA Health Group in New Jersey to aid in their life-saving work. Watch the video to find out more.

This story is great content and the side of home health care that all Americans need to see and understand. The more people understand the value of health care in the home, the more America can have a health system that provides the best care at the best price and the more lives that will be saved and changed for the better.

Click here to access the video from Good Morning America.

Cost Report Deadlines Extended

Following is a posting from the CGS website regarding extensions on deadlines for some cost reports. Please note that the deadline for 10/31/19 and 11/30/19 cost reports remained at 6/30/2020 while other deadlines have been further extended.

Cost Report (Part A, Home Health and Hospice)

CMS currently extended the delay for the following fiscal year end dates. The current regulation at 42 CFR § 413.24 (f) (2) (ii) allows this flexibility. In addition, this is a blanket extension and providers do not need to request for extensions. The due date of the 10/31/19 and 11/30/19 cost reports remain the same with a due date of 6/30/2020.

- The due date of the 12/31/19 cost reports are extended further from 7/31/20 to a due date of 8/31/20.
- The due date of the 1/31/20 cost reports are extended from 6/30/20 to a due date of 8/31/20
- The due date of the 2/29/20 cost reports are extended from 7/31/20 to a due date of 9/30/20

Pause for Request for Cost Reports Worksheet S-10 Audit Documentation, Medicare Desk Reviews, Audits and Reopenings Documentation. (Part A and Home Health and Hospice)

Due to the current Novel Coronavirus (COVID-19) Public Health Emergency (PHE), the Centers for Medicare & Medicaid (CMS) has provided instructions for CGS to suspend requests for documentation for the following Medicare Cost Report activities:

- Cost Reports Worksheet S-10 (W/S S-10) audits for all cost reports that begin during Federal Fiscal Year (FY) 2018 for hospitals that qualify for Disproportionate Share Hospital (DSH) payment until May 15, 2020. If you have already received a request for documentation, the due date has been extended to May 15, 2020.
- All Medicare Desk Reviews, Audits and Reopenings until May 15, 2020. CGS shall work on any in-house Desk Reviews, Audits and Reopenings based on the documentation that they have already received. If additional information is needed to complete the reviews, a request for such information will not be sent before May 16, 2020.

National Government Services

Due to updated instructions received from CMS relative to the COVID-19 public health emergency, and in accordance with 42CFR§413.24(f)(2)(ii), the due date for submission of Medicare cost reports has again been extended for the Fiscal Year Ends noted below. Please reference the table for the revised due dates.

FYE	Initial Due Date	Revised Due Date
12/31/2019	June 1, 2020 Extended to July 31, 2020	August 31, 2020
1/31/2020	June 30, 2020	August 31, 2020
2/29/2020	July 31, 2020	September 30, 2020

This extension applies to all provider types and does not require a request or notification to the MAC.

Cost report reminder letters that were sent out previously will not be re-issued. Questions can be directed to our cost report filing mailboxes at JK_Cost_Report_Filing@anthem.com or J6_Cost_Report_Filing@anthem.com.

You can find more information on filing via MCReF on the CMS Web site reference below:
CMS Web Site: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/MCReF.html.

OMB Approves Advance Beneficiary Notice of Non-Coverage Form for Renewal

The Advance Beneficiary Notice of Non–coverage (ABN), Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. The ABN form is renewed every three years in accord with *Paperwork Reduction Act*. The use of the renewed form with the expiration date of June 30, 2023 will be mandatory on August 31, 2020.

The form and instructions may be found at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.

The ABN is issued by providers, including, home health agencies, and hospices to fee for service beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued in order to transfer potential financial liability to the Medicare beneficiary in certain instances.

NAHC Analysis of the CY 2021 Home Health Proposed Rule

The preview of the CY 2021 home health proposed rule, Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements, has been posted. The proposal is light compared to recent years' proposed rules but does contain meaningful updates and changes.

"CMS has issued the proposed Medicare home health services payment rule in June for the first time in several years," noted Bill Dombi, President of the National Association for Home Care & Hospice. "It is evident from the rule that its early release was made possible by the limited changes that CMS proposes. NAHC appreciates CMS's recognition that any significant changes during the infancy of the PDGM system would be premature given the limited data available from 2020, combined with the chaos created by the Covid-19 pandemic. This proposal should help home health agencies achieve some semblance of stability during these difficult times."

Below is a summary of each of the areas addressed by the Centers for Medicare & Medicaid Services (CMS) – payment rates, telehealth, quality program and home infusion therapy.

Payment Rates
The 2021 proposed Medicare home health rates represent a simple inflation rate update, a significant change in wage index area designations, no change in the structure of the Patient Driven Groupings Model (PDGM) payment model, a scheduled phasing-out of the rural add-on, and a continuation of outlier payment standards. Overall, this proposal would bring a rare year of relative stabilization in Medicare payments for most home health agencies. However, it is noteworthy that the wage index changes will have a significant impact on HHAs that serve certain geographic areas. This reimbursement factor does not get the headlines, but it can be very meaningful for some providers.

Generally, CMS explains that it is doing very little to change the payment model and the payment rates because it has only limited data from the new PDGM model. That limitation is compounded by the chaotic impacts on patient case mix, service modalities, and patient volume triggered by the COVID-19 pandemic. Earlier this year, NAHC advocated for CMS to roll back the 2020 behavioral adjustment that was set at 4.36% due to these changes. CMS later responded that it felt that is was premature to do so given the data limitations even though there were strong signs pointing to a significant increase in LUPAs.

Here are some of the details on the 2021 reimbursement proposals

- Base payment rates are increased by a net Market Basket Index of 2.7%. An annual inflation update of 3.1% is reduced by a 0.4% Productivity Adjustment to net at 2.7%. The results is that:
    - The base 30 day payment rate is increased from $1864.03 to $1911.87 after application of wage index budget neutrality factor of 0.9987. HHAs that did not submit required quality data have that rate reduced by 2%.
- The LUPA per visit rates are set at:
    - SN $153.54
    - PT $167.83
    - SLP $182.42
    - OT $168.98
    - MSW $246.10
    - HHA $69.53
- LUPA rates are also reduced by 2% for those HHAs that did not submit required quality data.
- The LUPA add-on for LUPA only patient continues. For example, for SN as the first LUPA visit the add-on results in a first visit payment of $283.30. Each discipline would get its own add-on rate.
- The area Wage Index that applies based on the patient's residence has changed significantly to reflect updated census information. Due to the significant change, CMS proposes to cap any reduction in the wage index at 5%. There is no cap on wage index increases.
- The Outlier Fixed Dollar Loss ratio stays a 0,63. That would mean that no increase or decrease in the national volume of outlier episodes is expected.
- The rural add-on phase-out continues
    - High Utilization areas—- 0% add-on
    - Low Population Density areas—2% add-n
    - All other areas—–1% add-on
- The PDGM case mix weights and LUPA thresholds stay at the 2020 levels

The combination of these changes is projected to increase Medicare home health services spending by $540 million in CY 2021.

Telehealth

CMS is proposing to finalize the plan of care requirements at §409.43(a) related to telehealth as was issued in the COVID-19 Interim final rule published on March 30. The plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system and describe how the use of such technology is tied to the patient-specific needs as identified in the comprehensive assessment and will help to achieve the goals outlined on the plan of care. The amended plan of care requirements at §409.43(a) also state that these services cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment. CMS is also proposing to allow HHAs to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the home health agency cost

report. Additionally, CMS is proposing to include not only remote patient monitoring, but other communications or monitoring services, consistent with the plan of care for the individual.

Quality Program

In the CY 2020 HH PPS final rule, twenty measures for the CY2022 quality reporting program (QRP) were finalized. These are listed in the table below for reference. No new changes to the HH QRP were proposed in the CY2021 proposed rule.

TABLE 28 MEASURES CURRENT ADOPTED FOR THE CY 2022 HH QRP

SHORT NAME	MEASURE NAME AND DATA SOURCE
OASIS BASED	**OASIS BASED**
Ambulation	Improvement in ambulation/locomotion NQF #0167
Application of Falls	Application of percent of residents experiencing one or more falls with major injury (Long Stay((NQF #0674
Application of Functional Assessment	Application of percent of Long Term Care Hospital (LCTH) patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631)
Bathing	Improvement in bathing (NQF #0174)
Bed Transferring	Improvement in bed transferring (NQF #0175)
DRR	Drug regimen review conducted with follow-up for identified issues – post acute care (PAC) HH QRP
Drug Education	Drug education on all medications provided to patient/caregiver during all episodes of care

Dyspnea	Improvement in dyspnea
Influenza	Influenza immunization received for current flu season
Oral Medications	Improvement in management of oral medications (NQF #0176)
Pressure Ulcer/Injury	Changes in skin integrity post-acute care
Timely Care	Timely initiation of care (NQF #0526)
TOH – Provider	Transfer of Health Information to provider post-acute care
TOH – Patient	Transfer of Health Information to patient post-acute care
CLAIMS BASED	**CLAIMS BASED**
ACH	Acute-care hospitalization during the first 60 days of of HH (NQF #0171)
DTC	Discharge to community post-acute care (PAC) Home Health (HH) Quality Reporting Program (QRP) (NQF #3477)
Ed Use	Emergency department use without hospitalization during the first 60 days of HH (NQF #0173)
MSPB	Total estimated Medicare spending per beneficiary (MSPB) post-acute care (PAC) HHQRP
PBR	Potentially preventable 30-day post-discharge readmission measure for HH quality reporting program

HHCAHPS-BASED	HHCAHPS-BASED
CAHPS Home Health Survey	CAHPS Home Health Care Survey (experience with care) (NQF #0517 • How often does the HH care team give care in a professional way. • How well did the HH team communicate with patients. • Did the HH team discuss medicines, pain, and home safety with patients. • How do patients rate overall care from HHA. • Will patients recommend HHA to friends and family.

There are, however, proposed changes to the OASIS testing requirements for new home health agencies. Section 484.45(c)(2) of the home health agency conditions of participation (CoPs) requires that new home health agencies must successfully transmit test data to the Quality Improvement & Evaluation System (QIES)or CMS OASIS contractor as part of the initial process for becoming a Medicare-participating home health agency. This required a virtual private network (VPN) and use of a fake CMS Certification Number (CCN) for the test transmission since new HHAs do not yet have a CCN, and limited the number of users to two.

CMS recently enhanced the system that HHAs use to submit OASIS data to be more user friendly. The new CMS data submission system, Internet Quality Improvement & Evaluation System (iQIES), is now internet-based. Under this new system, HHAs are no longer limited to two users for submission of assessment data. In addition, the new iQIES data submission system requires users to include a valid CCN with their iQIES user role request that will allow them to submit their OASIS assessment data to CMS; the new data system no longer supports the use of test or fake CCNs, making it impossible for new HHAs that do not yet have a CCN to submit test data. Therefore, the requirement at §484.45(c)(2) is obsolete. CMS proposes to remove the requirement at §484.45(c)(2). HHAs must be able to submit OASIS assessments in order for the claims match process to occur and relay the data needed for payment under the PDGM system. This link to the payment process gives HHAs strong incentive to ensure that they can successfully submit their OASIS assessments in the absence of this regulatory requirement.

Home Infusion Therapy

This proposed rule reiterates the home infusion therapy supplier policies for coverage and payment finalized in the CY 2019 and CY 2020 HH PPS final rules. This proposed rule includes regulation text changes from Section 5012 of the *21st Century Cures Act* that amended section 1861(m) of the Act to exclude home infusion therapy from the definition of home health services, effective on January 1, 2021.

In the proposed rule CMS sets out the Medicare provider enrollment policies for qualified home infusion therapy suppliers. Providers wanting to become a home Infusion therapy supplier must be currently and validly accredited by a CMS-recognized home infusion therapy supplier accrediting organization (AO), comply with Home Infusion Therapy Supplier Standards; enroll in Medicare using Form CMS- 855B and pay the application fee; be in compliance with all Medicare provider enrollment requirements; and comply with screening requirements based on assigned provider risk .

Please NOTE:

In the proposed rule for the CY 2021 HHPPS rate update there are two CMS confirmed errors.

1) In the section for the outlier payments CMS states the following:

"CY 2020 is the first year of the PDGM and the change to a 30-day unit of payment, for CY 2021, we are proposing to maintain the fixed-dollar loss ratio of 0.63, as finalized for CY 2020 " - However, the 2020 FDL ratio is 0.56. CMS clarified that the proposed FDL ratio for CY 2021 is 0.56 as finalized I the 2020HHPPS rate update rule.

2) The wage index budget neutrality factor is different in tables 9 and 10 (.9988) than what is in the text. The text in the proposed rule states as follows: "By dividing the total payments for LUPA 30-day periods using the CY 2021 wage index by the total payments for LUPA 30-day periods using the CY 2020 wage index, we obtained a wage index budget neutrality factor of.9985" CMS has confirmed that the wage index budget neutrality factor .9988 listed in tables 9 and 10 is correct.

CMS recommends comments submitted on the proposed rule include addressing these errors and also reminds HHAs that these factors could change in the final rule because more recent data will be used to calculate the final 2021 HHPPS payments rates.

Better Late Than Never – MAHC Receives CMS Response to 1135 Waiver Requests

In the early onset of COVID-19, many provider groups were sending waiver requests to the Centers for Medicare & Medicaid Services (CMS) to address the challenges providers were now faced with. On March 27, 2020, the Missouri Alliance for Home Care (MAHC) submitted our request letter of issues at the time. While you are aware of the waivers that have already been granted by CMS, for your reference, I wanted to provide a copy of our response letter from CMS dated June 29. **Click here** to view the letter.