The Commonwealth of Massachusetts
Executive Office of Elder Affairs
One Ashburton Place, 5th Floor
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary, Executive Office of Health and Human Services

ELIZABETH C. CHEN, PhD, MBA, MPH
Secretary

Tel: (617) 727-7750
Fax: (617) 727-9368
TTY/TTD: 1-800-872-0166
www.mass.gov/elders

MEMORANDUM

To: Providers of Homemaker, Personal Care, and Home Health Aide services through EOEA Home Care, Mass Health State Plan Home Health, and MassHealth ABI/MFP Waiver programs

From: Erin Schulz, Acting Chief Financial Officer, EOEA
Lynn Vidler, Director of Home and Community Based Services, EOEA
Susan Ciccariello, Acting Chief of Long Term Services and Supports, MassHealth

Date: March 8, 2022

RE: Revised FY21 General Appropriations Act Home Care and Home Health Aide Rate Increase Policies

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A. Summary of Changes

This document has been amended since its original distribution on January 22, 2021 to include the following updates:

- Clarifies that the supplemental rate will apply to units billed for the relevant services for all Senior Care Organizations (SCOs);
- Clarifies the definition of "Other categories of worker compensation;"
- Extends the due date for the provider attestation from February 12, 2021 to March 12, 2021 and clarifies state level monitoring plans;
- Establishes a deadline for providers to distribute supplemental rate funding; and
- Clarifies billing and payment information for the supplemental rate.
- Addition of the link for the Provider Spending report.

- Extension of Provider Spending Report deadline from March 4, 2022 to March 21, 2022.

B. Purpose

The Executive Office of Elder Affairs (EOEA) received an appropriation in the Commonwealth of Massachusetts Fiscal Year 2021 (FY21) General Appropriations Act (Chapter 227 of the Acts of 2020) for $17.5M to increase rates for Homemaker, Personal Care, and Home Health Aide services from January 1, 2021 – June 30, 2021 ("Implementation Period"). The legislation defines the supplemental rates as $2.60 per service hour for Homemaker and Personal Care (or $0.65 per 15 minute unit) and $2.68 per service hour for Home Health Aide (or $0.67 per 15 minute unit).

The legislation requires that each home care and home health agency eligible to receive funds through the appropriation must submit an attestation form stating the funds shall be used for hourly wage increases, other categories of worker compensation such as bonuses, overtime and related personnel expenses and other related eligible costs, including but not limited to, personal protective equipment. The attestation form must be submitted before funds are distributed.

The legislation also requires each home care and home health agency that received funds from the appropriation to submit a spending report to EOEA accounting for the use of said funds. The report will be required to be submitted after the funds have been received by the provider.

Lastly, the legislation requires EOEA to provide a report to the house and senate committees on ways and means detailing the impact of the funds distributed through this appropriation.

In accordance with this appropriation, this memorandum outlines the implementation steps for provider compliance.

C. Supplemental Rate

The legislation will be enacted through a supplemental rate in addition to current contracted rates. The supplemental rates will be applied to units delivered during the Implementation Period of January 1, 2021 – June 30, 2021, and will no longer remain in effect after the Implementation Period has ended. The supplemental rate for each service during this Implementation Period is as follows:

- $0.67 per 15 minute unit for Home Health Aide services provided through EOEA Home Care program, MassHealth State Plan Home Health program (PT60), MassHealth ABI/MFP Waiver program (PT98), and all SCO plans

- $0.65 per 15 minute unit for Homemaker and Personal Care services provided through EOEA Home Care program, MassHealth ABI/MFP Waiver program (including both Agency rates and Individual Provider/Self Directed Worker rates for PT98), and all SCO plans

For providers that deliver services in the EOEA Home Care program, the supplemental rate will be applied to the COVID Care equivalents of the Homemaker, Personal Care, and Home Health Aide services.

ASAP Contracts

For services delivered in the EOEA Home Care program and to SCO enrollees through an Aging Service Access Point (ASAP) contract, the supplemental rate will be implemented by amending the Provider Agreement. ASAPs have already completed this process for the EOEA Home Care program. Upon distribution of this updated policy document, ASAPs will issue an additional contract amendment to apply the FY21 GAA Supplemental Rates to services provided to SCO enrollees.

Non-ASAP Contracts

For providers that contract directly with a SCO to deliver services to SCO enrollees, SCOs will be responsible for updating their currently contracted rates to include the supplemental rate for authorized services provided.

For MassHealth Sate Plan Home Health and ABI/MFP Waiver programs, the supplemental rate will be implemented through an amendment to the rates established in regulation for applicable services.

D. Allowable Uses

Providers may utilize this funding for the specific purposes described in the legislation, including:

- *"Hourly wage increase"* is an increase to the wage the provider agrees to pay an employee per hour worked. An employee's hourly wage would not include any additional amount provided under special circumstances (i.e. overtime).

- *"Other categories of worker compensation"* may include:

    - *"Bonuses"* are added compensation that is over and above an hourly rate of pay, and are not part of an employee's standard wages. An employee may receive a bonus based on tenure, merit, etc. Bonuses are at the discretion of the employer.

    - *"Overtime"* is compensation for additional hours worked beyond the employer's standard work week. Most employees must be paid one and one-half times their regular hourly rate for all hours worked in excess of 40 hours in a given work week.

    - *"Shift differential"* is additional pay beyond the employee's standard hourly wage for working a specific shift (e.g. nights, weekends, holidays, etc.). The employer has discretion to set the shift differential pay rate.

    - *"Related personnel expenses and other related eligible costs"* include other expenses associated with distributing additional compensation to workers. This may include employee or employer tax liabilities, processing costs, or other related expenses.

- *"Personal protective equipment"* refers to equipment defined in the Massachusetts Department of Public Health's "Comprehensive Personal Protective Equipment (PPE) Guidance" memorandum issued on January 6, 2021, and any subsequent revisions. A copy of this memorandum is included in this document as *Attachment 1*, and is accessible on the Commonwealth's website. This guidance is intended to identify examples of PPE that would be appropriate to purchase using this funding, and is not intended to supplant or contradict any existing standards regarding appropriate PPE in the programs within the scope of this implementation.

Providers are encouraged to choose the most optimal distribution method to benefit their employees, given the temporary nature of this supplemental rate, and to note that this supplemental rate is temporary in nature in their employee-facing communications.

Providers must expend all funds received as a result of this supplemental rate by November 15, 2021.

E. Provider Communication

EOEA and MassHealth will post documents and information related to this implementation on the EOEA website, which can be accessed here: https://www.mass.gov/lists/home-care-and-home-health-supplemental-rates. Providers are required to check this site regularly for updated information.

Providers are welcome to submit questions regarding the state level policy requirements for all impacted programs, and implementation details for MassHealth, to **homecareaiderates@mass.gov**.

Providers that contract with an ASAP should direct questions regarding implementation activities (e.g. contract amendments, billing, payments, etc.) to their ASAP Contract Manager.

Providers that contract directly with a SCO to deliver services to SCO enrollees should direct questions regarding implementation activities to each SCO with whom they contract.

F. Provider Attestation

Providers are required to submit an attestation to EOEA agreeing to the terms and conditions of the funding. All providers must comply with this requirement, except Individual Provider/Self Directed Workers (PT98) delivering Homemaker and Personal Care services through MassHealth ABI/MFP Waiver program.

EOEA and MassHealth created an online attestation form for providers to complete by **Friday March 12, 2021**. The form can be accessed from any internet browser here:

https://app.keysurvey.com/f/41544105/2fa1/

Providers are required to save or print a copy of their attestation submission for their records. EOEA and MassHealth will monitor compliance with this requirement, and will work with ASAPs and SCOs to achieve compliance as needed.

G. Provider Spending Report

After the distribution of funding from this appropriation, providers are required to submit a spending report to EOEA accounting for the use of the funds. EOEA and MassHealth have created a survey that is now available at the link below. Providers will also be notified by EOEA and MassHealth that the survey is available. The survey must be completed by **5:00 pm on Monday, March 21, 2022.**

Survey link:

https:/s/app.keysurvey.com/f/41605820/fdf8/

The spending categories will align with the types of allowable uses defined in the legislation.

H. Subcontracting

Some providers subcontract with other organization(s) to deliver certain services included in this implementation. When this occurs, the organization that contracts directly with MassHealth, an ASAP, or a SCO is referred to as the "prime contractor" and the organization that delivers the service is referred to as the "subcontractor." Providers are only required to submit an attestation and spending report if they are a prime contractor.

I. Multiple Businesses

EOEA and MassHealth recognize that some providers deliver some of the specified services through separate businesses. Providers in this situation must submit one (1) attestation and one (1) spending report per Employer Identification Number (EIN) or Tax Identification Number (TIN).

For example, a provider operates one business for its Homemaker and Personal Care services, and another business for its Home Health Aide services. The two businesses have two separate EINs. In this case, the provider must submit two (2) attestations and two (2) spending reports – one attestation and spending report for its Homemaker and Personal Care business, and a second attestation and spending report for its Home Health Aide business.

J. Failure to Comply with Requirements

If a provider delivers services in the EOEA Home Care program or to SCO enrollees through a contract with an ASAP and does not submit an attestation, the provider will not receive the supplemental rate for billable units until the attestation has been submitted.

For providers that deliver services through the MassHealth State Plan Home Health or ABI/MFP Waiver (agency only) programs, Home Health Agency Bulletin 62 and HCBS Waiver Provider Bulletin 7 provide more information about failure to submit an attestation and spending report.

For providers that contract directly with a SCO to deliver services to SCO enrollees, MassHealth will be issuing a Managed Care Bulletin that will provide more information regarding attestation and spending report requirements and policies.

K. Billing

Service Provision

All Homemaker, Personal Care, and Home Health Aide services funded through a contract with an ASAP must be delivered in accordance with existing ASAP requirements (e.g. authorizations, deliveries, timesheets, etc.). All services provided through MassHealth or outside of an ASAP contract must be delivered in accordance with applicable MassHealth regulations.

Billing

All existing provider billing processes will remain in effect during this Implementation Period for all programs. Providers should submit billing according to normal procedures. The cost of the supplemental rates will be calculated by the payer and paid for each service month based on the number of units billed.

For providers delivering services through a contract with an ASAP, EOEA may establish unique billing timelines at the end of the fiscal year to ensure that all units are submitted timely and can be paid out during the state's accounts payable process.

In addition to standard billing processes, EOEA requires all providers delivering services through a contract with an ASAP to adhere to the following billing requirements:

- Providers must submit their billing for each service month by the 15th calendar day of the month following the service month, and to successfully remediate submitted units by the last business day of the month following the service month.

- Any units that are submitted and remediated after the last business day of the month following the service month are considered "late," and ASAPs are not required to pay the supplemental rates for these units.

Attachment 1: Massachusetts Department of Public Health's "Comprehensive Personal Protective Equipment (PPE) Guidance"

See the next page.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
67 Forest Street, Marlborough, MA 01752

CHARLES D. BAKER
Governor
KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary
MONICA BHAREL, MD, MPH
Commissioner
Tel: 617-624-6000
www.mass.gov/dph

Memorandum

TO: Health Care Facility Chief Executive Officers and Administrators
Occupational Health Program Leaders
Emergency Medical Service Directors

FROM: Elizabeth Drake Kelley, MPH, MBA, Director
Bureau of Health Care Safety and Quality

SUBJECT: Comprehensive Personal Protective Equipment (PPE) Guidance

DATE: January 6, 2021

The Massachusetts Department of Public Health (DPH) continues to work with state, federal and local partners on the outbreak of Coronavirus Disease 2019 (COVID-19), caused by the virus SARS-CoV-2, and we continue to appreciate the essential role you have in responding to this evolving situation.

DPH has developed this comprehensive guidance, based upon the Centers for Disease Control and Prevention (CDC) recommendations, to clarify the PPE that health care personnel (HCP) use in the clinical care areas, particularly during this time when we are optimizing our supplies. HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.[1] DPH is updating this guidance to clarify best practices regarding the use of N95 respirators and alternatives for HCP caring for an individual who is presumed or confirmed to be infected with COVID-19.

Facemasks:
DPH has adopted a universal facemask use policy for all HCP. All HCP should wear a facemask

[1] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

when they are in a clinical care area at all times. Facemasks are defined as surgical or procedure masks worn to protect the mouth/nose against infectious materials. This policy will have two presumed benefits. The first benefit is to prevent pre-symptomatic spread of COVID-19 from HCP to uninfected patients and colleagues by reducing the transmission of droplets. The second benefit is to protect HCP who are uninfected by reducing transmission from their surroundings, including from other staff, and patients who are not yet diagnosed with COVID-19 that may be in a pre-symptomatic stage.

Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters. Due to the improvement in the health care supply chain of facemasks, DPH is modifying earlier guidance and supports the extended use of facemasks for no more than one shift or one day under the following conditions:

- The facemask should be removed and discarded if soiled or damaged.
- HCP must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene.
- HCP should leave the clinical care area if they need to remove the facemask.

Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded facemask can be stored between uses in a clean sealable paper bag or breathable container. Homemade and cloth facemasks are not considered PPE. Their capability to protect HCP has not been demonstrated and they have not been shown to be effective in preventing transmission of illness.

DPH is supportive of the Joint Commission's public statement; it emphasizes that its standards do not prohibit staff from bringing in their own PPE or wearing PPE throughout the day.[2]

As part of universal source control, if tolerated, all patients/residents should wear a face mask when they leave their room or when staff are within six feet.

PPE for COVID-19 Patient Care

In addition to the universal facemask use policy, DPH has the following recommendations about PPE use.

Respirators:

DPH recommends that a N95 filtering facepiece respirator or higher, eye protection, isolation gown and gloves be used when caring for an individual who is presumed or confirmed to be infected with COVID-19. For performing aerosol generating procedures, such as nebulizer

[2] https://www.jointcommission.org/en/resources/news-and-multimedia/news/2020/03/statement-supporting-use-of-personal-face-masks-provided-from-home-amid-covid-19-pandemic/

treatments or intubations, HCP should don an N95 filtering facepiece respirator or acceptable alternate product.

The Food and Drug Administration (FDA) issued an update to the Non-NIOSH Approved Respirator Emergency Use Authorization (EUA) concerning non-NIOSH-approved respirators that have been approved in other countries. Consistent with the FDA's updated EUA, KN95 respirators may be considered for use as a substitute for N95 respirators only if:

- N95 respirators are not available, and
- The KN95 respirators have been tested for filtration effectiveness, and
- The use of KN95 respirators has been approved by your organization.

If a N95 respirator or equivalent is not available, a facemask should be used.

Limited re-use of a N95 respirator when caring for patients with COVID-19 may be necessary but should be limited to one shift or one day. Respirators grossly contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients must be discarded. Respirators that have been reprocessed and decontaminated (e.g., using the Battelle facility) may be reused as long as their structural integrity is maintained.

Eye Protection:

HCP should wear eye protection in the clinical care areas and for the care of all patients except those who are COVID-19 recovered[3]. Even if COVID-19 is not suspected in a patient presenting for care, HCP may encounter asymptomatic patients with COVID-19.

HCP may implement extended use of eye protection.

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
- If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on.
- Eye protection should be discarded if it becomes damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- If goggles or reusable face shields are used each facility must ensure appropriate cleaning and disinfection between uses according to manufacturer's instructions.

[3] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html#asymptomatic

- After reprocessing, eye protection should be stored in a transparent plastic container and labelled with the HCP's name.

HCP should not touch their eye protection. If they touch or adjust their eye protection hand hygiene must be performed immediately.

HCP should leave the clinical care area if they need to remove their eye protection using recommended protocols for removing and reprocessing.

Prioritize eye protection for selected activities such as:

- During care activities where splashes and sprays are anticipated, including aerosol generating procedures.
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.
- Consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of the eyes.

Isolation Gowns:

Due to shortages of disposable isolation gowns, DPH recommends shifting gown use towards cloth isolation gowns.

- Reusable (i.e., washable) gowns made of polyester or polyester-cotton fabrics can be safely laundered according to routine procedures and reused. Reusable gowns should be replaced when thin or ripped.
- Reusable patient gowns and lab coats can be safely laundered according to routine procedures.

If needed, extend the use of isolation gowns (disposable or cloth) to allow the same gown to be worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridioides difficile*) among patients. If the gown becomes visibly soiled, it must be removed and discarded.

Cloth isolation gowns can be untied and retied and be re-used without laundering in between. Any gown that becomes visibly soiled during patient care should be disposed of and cleaned.

Gowns should be prioritized for the following activities:

- During care activities where splashes and sprays are anticipated, including aerosol generating procedures
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:

- Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

Gloves:
HCP should perform hand hygiene prior to donning and after doffing gloves.

Resources:

Health care organizations and providers that require additional PPE in order to meet the use standards described in this guidance and are not able to obtain through their usual supply chain resources may request one-time support from DPH as a bridge until health care organizations increase their ordering and receipt of gowns and N95 respirators. DPH will provide additional N95 respirators, up to eight N95 respirators, and gowns, up to 15 gowns, per licensed bed per month for the months of January and February as a bridge supply for health care organizations and providers that have an immediate and insufficient supply for HCP caring for individuals with suspected or confirmed COVID-19. Every health care organization must immediately adjust their supply order to ensure that going forward they have sufficient supplies to meet this guidance. A health care organization or provider who has insufficient supply should fill out and download the PPE request form and submit it via email to Covid19.resource.request@mass.gov. The form may be found on DPH's website: https://www.mass.gov/info-details/personal-protective-equipment-ppe-during-covid-19

Please visit DPH's website that provides up-to-date information on COVID-19 in Massachusetts: https://www.mass.gov/2019coronavirus.