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MEMORANDUM

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

From: Rachel Goldstein, Chief Financial Officer, EOEA
Lynn Vidler, Director of Home and Community Based Services, EOEA
Whitney Moyer, Chief of Long Term Services and Supports, MassHealth

Date: October 12, 2021

RE: FY22 General Appropriations Act Home Care and Home Health Aide Rate Increase Policies

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A. Purpose

The Executive Office of Elder Affairs (EOEA) received an appropriation in the Commonwealth of Massachusetts Fiscal Year 2022 (FY22) General Appropriations Act (Chapter 24 of the Acts of 2021) for $27.9M to increase rates for Homemaker, Personal Care, and Home Health Aide services.

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.

B. 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 from October 1, 2021 – June 30, 2022 ("Implementation Period"), 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:

- $0.89 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

- $0.99 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 all equivalents (including 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.

Non-ASAP Contracts

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

For MassHealth State 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 (101 CMR 449.00: Rates for Certain Home- and Community-Based Services Related to Workforce Development).

C. 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 updated on August 16, 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, 2022.

D. 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 to **homecareaiderates@mass.gov** regarding the state-level policy requirements for all impacted programs and implementation details for MassHealth.

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.

E. 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 the MassHealth ABI/MFP Waiver program.

EOEA and MassHealth created an online attestation form for providers to complete by **Wednesday December 1, 2021**. The form can be accessed from any internet browser here:

https://app.keysurvey.com/f/41591527/101f/

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.

F. 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 will be creating an online spending report tool for providers to submit this information. EOEA and MassHealth will release this spending report form and instructions in subsequent provider communications. This information will also be posted on the website.

Providers can expect that the spending categories will align with the types of allowable uses defined in the legislation and in this document.

G. 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 required to submit an attestation and spending report only if they are a prime contractor.

H. 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.

I. 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, MassHealth will 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.

J. 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.

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Memorandum

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

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

SUBJECT: Comprehensive Personal Protective Equipment (PPE) Guidance

DATE: August 16, 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 clinical care areas and in other non-clinical areas in health care facilities. HCP refers to all paid and unpaid persons serving in healthcare settings and emergency medical services 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 incorporate strategies for PPE use in settings where there are high numbers of individuals being quarantined or isolated due to COVID-19 and reflect the increasing community prevalence of SARS-CoV-2.

It is expected that these changes will be implemented no later than August 18, 2021.

Universal Use of Facemasks

DPH has adopted a universal facemask use policy for all HCP. All HCP should don a facemask upon entry to the healthcare facility premises or care area. 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-

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

19 from HCP to uninfected patients and colleagues by reducing the transmission of droplets. The second benefit is to protect HCP 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 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 face mask use as follows:

- As PPE to protect their nose and mouth from exposure to splashes, sprays, splatter, and respiratory secretions (e.g., for patients on Droplet Precautions). When used for this purpose, facemasks should be removed and discarded after each patient encounter.
- As source control to cover one's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. When used for this purpose, facemasks may be used for multiple patient encounters under the following conditions:

    - The facemask should be removed and discarded if soiled, damaged or hard to breathe through.
    - 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. (i.e., outside of the patient room)
    - Facemasks should not be stored or put down on a surface; if they are then they should be discarded and HCP should don a new facemask.
    - If HCP remove their facemask to eat, drink or during a break they should perform hand hygiene with soap and water or an alcohol-based hand rub before and after touching their mask.

Homemade and cloth facemasks are not considered PPE and are not appropriate for use in the healthcare setting.

As part of universal source control, if tolerated, patients/residents should wear a facemask when they leave their room or when staff are providing care to them.

PPE for patients with suspected or confirmed COVID-19, or confirmed exposures

DPH recommends that a fit-tested N95 filtering facepiece respirator or alternative, eye protection, isolation gown and gloves be used when caring for patients with suspected or confirmed COVID-19 or confirmed exposure.

Respirators:

Proper use of respiratory protection by HCP requires a comprehensive program (including medical clearance, training, and fit testing) that complies with OSHA's Respiratory Protection Standard.

For performing aerosol generating procedures, such as nebulizer treatments or intubations, HCP should don a fit-tested N95 filtering facepiece respirator or acceptable alternate product except in the following circumstances:

- The patient is fully vaccinated, asymptomatic and the COVID-19 status is unknown or negative;
- The patient is asymptomatic, not fully vaccinated, but a COVID-19 test obtained within the past three days is negative.

Facilities should eliminate the practice of reuse and extended use of N95 respirators. N95 respirators should always be discarded after doffing, such as when leaving a patient room, during a break or when eating or drinking. Respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids must be discarded immediately.

If reusable N95 respirator alternatives such as elastomeric respirators are used each facility must ensure appropriate cleaning and disinfection between uses and filter exchange according to manufacturer's instructions.

Eye Protection:

HCP should wear eye protection when caring for all patients. Consistent with previous recommendations, eye protection is required when caring for patients with suspected or confirmed to be infected with COVID-19 or with a confirmed exposure. At this time, when the risk community transmission of COVID-19 in Massachusetts is increased, the use of eye protection for all patient encounters is also indicated.

Disposable eye protection should be removed and discarded after each use. Reusable eye protection should be cleaned and disinfected after each patient encounter. Eye protection may be used for multiple patient encounters under the following conditions:

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
- 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 reusable goggles or face shields are used each facility must ensure appropriate cleaning and disinfection between uses according to manufacturer's instructions.
- After cleaning and disinfection, 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.

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

Isolation Gowns:

Nonsterile, disposable patient isolation gowns, which are used for routine patient care in healthcare settings, are appropriate for use by HCP when caring for patients with suspected or confirmed COVID-19 or confirmed exposure. HCP may also use reusable (i.e., washable) gowns made of polyester or polyester-cotton fabrics; they can be safely laundered according to routine procedures and reused. Reusable gowns should be replaced when thin or ripped, and per the manufacturer's instructions. Gowns should be disposed of or laundered after each patient encounter.

Any gown that becomes visibly soiled during patient care should be disposed of or laundered, as appropriate.

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

Other Considerations:

Health care organizations and providers that are caring for high numbers of patients with suspected or confirmed COVID-19, or confirmed exposures during high rates of community transmission may choose to adopt either of the following principles when caring for patients in the same cohort (i.e. all confirmed COVID-19 cases):

- Utilize the same N95 respirator between multiple patient encounters provided that the N95 respirator is always discarded after doffing, during a break, when eating or drinking or when contaminated with blood, respiratory or nasal secretions, or other bodily fluids.
- Utilize reusable eye protection between multiple patient encounters provided that the eye protection is clean and disinfected after doffing, or when contaminated with blood, respiratory or nasal secretions, or other bodily fluids.

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 August, September and October t 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