Medicare

COVID-19 Waivers

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President and CEO

Owns and operates
Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S.
There are no nonfinancial disclosures to share.

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Speaker and Planning Committee Disclosure

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose. Please visit https://www.harmony-healthcare.com/hhi-team for all speaker's financial and nonfinancial disclosures
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Learning Outcomes

1. Identify **documentation requirements** necessary to support utilizing the **COVID-19 Waivers.**
2. Identify **a scenario in which a provider cannot implement** medical necessity to support the utilizing the **COVID-19 Waiver.**
3. Verbalize an understanding of the **rationale for why the COVID-19 Waivers** are in place.
4. Understand **when** the **waivers** and flexibilities **will end.**

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COVID-19
Medicare Waivers

New Hospital Admission
Skilling Existing Residents
New Admission Non-Qualifying Stay

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New Hospital Admission

Any Spell-of-Illness Break COVID-19 Waivers

- Under normal coverage guidelines, a beneficiary requires a **60-day break** in a spell of illness to obtain eligibility for a new 100-day SNF benefit period.
- See **chapter 3, section 10.4 – Benefit Period (Spell of Illness)** of Chapter 3 of the Medicare General Information, Eligibility, and Entitlement manual. In some, but not all cases, the COVID-19 waivers **could permit a new benefit period without a 60-day break in a spell of illness** if the COVID-19 emergency prevented the start of a new benefit period.
- Per the 4.10.20 CMS FAQ guidance Skilled Nursing Facility Services Section, it appears that the Section 1135 waivers do **not apply** for any beneficiary who **has exhausted their 100-day benefit**, has ongoing skilled needs unrelated to COVID-19, and **has not begun** a break in their spell of illness.

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New Hospital Admission

SNF Level of Care

- The COVID-19 national emergency waivers do not impact normal SNF coverage guidelines as defined in **Chapter 8, Section 30 of the Medicare Benefit Policy Manual**
- Care in a SNF is covered if **all 4 factors** are met.

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New Hospital Admission

Need SNF Level of Care

Care in a SNF is covered if all of the following **4 factors are met**

1. The patient requires **skilled nursing services or skilled rehabilitation services**, i.e., services that must be performed by or under the supervision of professional or technical personnel (§30.2 – 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services
2. The patient requires these skilled services on a **daily basis** (§30.6); and

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New Hospital Admission

Need SNF Level of Care

Care in a SNF is covered if all of the following **4 factors are met** (continued)

3. As a **practical matter**, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF (§30.7)
4. The services delivered are **reasonable and necessary** for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

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New Hospital Admission

3-Day Qualifying Stay

- Under normal coverage guidelines, in order to qualify for post-hospital extended care services, the beneficiary must have been an **inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days** and must have been **transferred to a participating SNF within 30 days** after discharge from the hospital, unless there is a medical appropriateness exception extending this period.

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New Hospital Admission

3-Day Qualifying Stay COVID-19 Waivers

- **Chapter 8, Section 20 – Prior Hospitalization and Transfer Requirements of the Medicare Benefit Policy manual.** In some, but not all cases, per the 4.10.20 CMS FAQ guidance Skilled Nursing Facility Services Section, the **COVID-19 qualifying stay waiver could permit SNF Part A coverage to free up hospital beds regardless of whether the beneficiary's condition is directly related to COVID-19 or not**

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

3-Day Prior Hospitalization

- Using the authority under Section 1812(f) of the Act, CMS is **waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay,** which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who **experience dislocations, or are otherwise affected by COVID-19.**
- In addition, for certain beneficiaries who recently **exhausted their SNF benefits,** it authorizes **renewed SNF coverage without first having to start a new benefit period** (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

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New Hospital Admission
>60 Day Spell-of-Illness Break

- Under normal coverage guidelines, a beneficiary requires 60-day break in a spell of illness to obtain eligibility for a new 100-day SNF period. See Chapter 3, Section 10.4 – Benefit Period (Spell of Illness) of the Medicare General Information, Eligibility, and Entitlement manual.
- In some, but not all cases, the **COVID-19 waivers could permit a new benefit period without a 60-day break in a spell of illness if the COVID-19 emergency prevented the start of a new benefit period.**
- The 3.13.20 CMS COVID-19 waiver guidance, indicates scenarios where a beneficiary who has begun a break in their spell of illness but has not completed the 60 days may qualify for the spell of illness waiver.

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New Hospital Admission

Eligible for SNF Part A Benefits No Waiver Needed

- Beneficiary is eligible for Part A benefits under normal coverage, documentation and coding requirements.

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New Hospital Admission
Waiver to Avoid Hospital Admission

- CMS has indicated a primary intent for the Section 1135 waivers was to **free up hospital beds** so that they would be available to treat medical emergencies.
- COVID-19 qualifying stay waiver language would permit SNF **Part A coverage to a patient without a 3-Day Qualifying Hospital Stay to free up hospital beds regardless of whether the beneficiary's condition is directly related to COVID-19 or not.**

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Eligible for SNF Part A Benefits Spell-of-Illness Waiver Applies

- Beneficiary is eligible for Part A benefits under the Section 1135 spell-of-illness waiver.
- **Providers should document rationale for applying the waiver**, provide normal required documentation needed to support a skilled level of care. In addition, per the 4.10.20 CMS FAQ guidance Skilled Nursing Facility Services Section, SNF providers must **append the "DR" condition code** to these Part A Claims.

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Eligible for SNF Part A Benefits Spell-of-Illness

Waiver Applies

Medicare Learning Network (MLN) Matters SE20011 (revised 6.18.20) states

- For certain beneficiaries who exhausted their benefits, it authorizes renewed SNF coverage without first having to start a new benefit period.
- This waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances.

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New Hospital Admission

Not Eligible for SNF Part A Benefits No Waivers Apply

- CMS has not provided guidance whether this hypothetical situation would ever be answered as “no” under the blanket waiver.

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New Hospital Admission

Eligible for SNF Part A Benefits 3-Day Stay Waiver and Spell-of-Illness Waivers Apply

- Beneficiary is eligible for Part A benefits under the Section 1135 3-day stay and spell-of-illness waivers. **Providers should document rationale for applying the waiver(s), provide normal required documentation needed to support a skilled level of care.** In addition, per the 4.10.20 CMS FAQ guidance Skilled Nursing Facility Services Section, SNF providers must append the "**DR" condition to these Part A Claims.**

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New Hospital Admission

Not Eligible for SNF Part A Benefits No Waivers Apply

- The COVID-19 national emergency waivers **do not impact normal SNF skilled level of care coverage guidelines** as defined in Chapter 8, Section 30 of the Medicare Benefit Policy Manual. Coverage decision process ends here.

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New Hospital Admission

Not Eligible for SNF Part A Benefits No Waivers Apply

- Per the 4.10.20 CMS FAQ guidance Skilled Nursing Facility Services Section, it appears that the Section 1135 waivers do **not apply for any beneficiary who has**
  - **Exhausted their 100-day benefit, has ongoing skilled needs unrelated to COVID-19, and**
  - **Has not begun a break in their spell of illness.**

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COVID-19
Medicare Waivers

Flexibility for Medicare Telehealth Services

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COVID-19
Medicare Telehealth Services

Virtual Care Services

- Virtual services (remote services) refer to any type of service provided to patients from a different location that where the patient is located

Virtual Services

- Telehealth visits
  - Care furnished to a patient via a live, synchronous video stream

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COVID-19
Medicare Virtual Services

Virtual Services (continued)

- **E-visits**
  - Synchronous and asynchronous assessment and case management through an online patient portal
- **Virtual Check-ins**
  - Synchronous and asynchronous assessment and management services "via a number of communication technology modalities"
- **Telephone Visits**
  - Provider communicates with a patient and conducts assessment and case management through a telephone call

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COVID-19
Medicare Telehealth Services

Telehealth Technology Requirements

- Use of a 2 way, HIPAA-compliant, audio and visual technology platform
- HHS Office for Civil Rights (OCR) will exercise enforcement discretion and **waive penalties for HIPAA violations** against health care providers that serve patients in good faith through everyday communication technologies, such as FaceTime or Skype, **during the COVID-19 PHE**
- https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html?language=es

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COVID-19
Medicare Telehealth Services

Starting March 6, 2020 and for the duration of the COVID-19 PHE

- Medicare will make payment for real-time Medicare telehealth services (using interactive audio and video) furnished to beneficiaries in any healthcare facility and in their home
  - Payment at the same rate as in-person treatments
- Subject to State laws, regulations, practice acts
  - Caution: Confer with legal expert before providing services across state lines
- Staff member needs to facilitate the telemedicine experience by managing the technology onsite at the nursing home

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COVID-19
Medicare Telehealth Services

- CMS published a Long Term Care Nursing Homes **Telehealth and Telemedicine Tool Kit** (3.27.20) available at https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf
  - Includes 4 pages of links to Resources for multiple Focus Areas

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COVID-19
Medicare Telehealth Services

Eligible Practitioners

- Under the CARES Act waiver authority, CMS **expanded the types of health care professionals** who can furnish distant telehealth services
- Can include physicians, nurse practitioners, physician assistants, clinical social workers, clinical psychologists, registered dieticians and nutrition professionals, certified nurse anesthetists, nurse midwifes,

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COVID-19
Medicare Telehealth Services

- On April 8th, CMS stated on their weekly Town Hall call that therapists could provide **evaluation and treatment services to patients in SNFs** via audiovisual devices (smartphones or tablets if clinically appropriate) when they were **in the same building in different locations**
  - These services would be considered **in-person services**
    - Not telehealth services
  - Included in their FAQ document on 4.9.20

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Medicare Telehealth Services

- Physical therapists, occupational therapists, speech language pathologists recently added (5.27.20) for **therapy telehealth services furnished to a SNF resident** billed on an institutional claim during the PHE
  - Retroactive to March 1, 2020.
  - For Part B, must be billed by the SNF itself (bill type 22x or 23x)
  - -95 modifier applied to the service line
  - Does not change the rules regarding consolidated billing or bundling
    - SNF PPS during a Part A stay
  - **State regulations and Practice Acts** must be followed

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Medicare Telehealth Services

- **Home Health Agency** (HHA) – On a 34X bill type, home health agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes **only** if such patients are not under a home health plan of care).

  - https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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COVID-19
Medicare Telehealth Services

Audio-Only Telehealth for Certain Services

- Waiver allows the use of certain audio-only telephone evaluation and case management services, and behavioral health counseling and educational services (designated codes at https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes)

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Therapy Codes
Waiver for Telehealth

Covered Codes

- Initial evaluations and re-evaluations (97161–97168)
- Therapeutic exercise (97110)
- Neuromuscular re-education (97112)
- Gait training (97116)
- Self-care/home management training (97535)
- Physical performance test or measurement (97750)
- Assistive technology assessment (97755)
- Orthotics management and training (97760)
- Prosthetic training, upper and/or lower extremities, initial prosthetic encounter (97761)
- Speech/language evaluations (92521–92524)
- Speech/language treatment (92507)

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COVID-19
Medicare Waivers & Flexibilities

Long Term Care Facilities: Skilled Nursing Facilities and/or Nursing Facilities:

CMS Flexibilities to Fight COVID-19

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Reporting Minimum Data Set

- CMS **waived** 42 CFR 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.
- MDS assessments must still be opened timely

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Waive Pre-Admission Screening and Annual Resident Review (PASARR)

- CMS is **waiving** 42 CFR 483.20(k), allowing nursing homes to **admit new residents who have not received Level 1 or Level 2 Preadmission Screening**
- Level 1 assessments may be performed post-admission
- On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review

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Resident Groups

- CMS is **waiving** the requirements at §483.10(f)(5) to allow for residents to have the **right to participate in-person in resident groups**
- This waiver would only permit the facility to restrict having in-person meetings **during the national emergency** given the recommendations of social distancing and limiting gatherings of more than ten people

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Staffing Data Submission

- CMS **waived** 42 CFR 483.70(q) to provide relief to long-term care facilities on the requirements for submitting staffing data through the Payroll-Based Journal (PBJ) system.
- The May 15th PBJ deadline for the January – March 2020 reporting period has been extended for data submission
  - This data can still be submitted
- The **August 14th PBJ deadline for the April – June** reporting period has not currently been extended (and may include 6 months)

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Payroll Based Journal (PBJ) Questions

- Nursing hours (job titles 5-12) must be worked on site
- The telehealth waivers for non-nursing staff hours worked remotely can be included in PBJ as long as their hours are paid by the facility (dietician, pharmacist, Medical Director etc.)
- There is one exception and that is therapy – SLP, OT and PT hours are to be included in PBJ when they are remote (telehealth) even when not paid by the facility

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Best practice regarding coding the **job titles 39 and 40** that are **optional**?

- The public use file of average daily staffing is available at includes these job titles in total staff. Find it at https://www.cms.gov/files/document/qso-20-28-nh.pdf.
- "CMS is publishing a list of the average number of nursing and total staff that work onsite in each nursing home, each day
- This information can be used to help direct adequate personal protective equipment (PPE) and testing to nursing homes."
- Consider whether you want to include the staff for these job titles (Housekeeping Service Worker and Other Service Worker) as it may be an advantage

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients

- Medicare Administrative Contactors and Medicare Advantage plans **will cover** coronavirus disease 2019 **(COVID-19) laboratory tests** in nursing home residents and patients **starting on July 6, 2020**, and for the duration of the public health emergency
- Original Medicare and Medicare Advantage plans will cover diagnostic COVID-19 lab tests and non-cover tests not considered diagnostic

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Provider Enrollment

- CMS established toll-free hotlines for all providers and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges
- Following flexibilities are provided for provider enrollment:
  - Waive certain screening requirements
  - Postpone all revalidation actions
  - Expedite any pending or new applications from providers

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities

- Waiving the discharge planning requirement in §483.21(c)(1)(viii), which requires LTC facilities to assist residents and their representatives in selecting a post-acute care provider using data
  - Such as standardized patient assessment data, quality measures and resource use

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Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities

- Temporary waiver is to provide facilities the ability to expedite discharge and movement of residents among care settings.
- CMS is maintaining all other discharge planning requirements
  - Such as ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident; and
  - Involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan address the resident's goals of care and treatment preferences.

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Clinical Records

- Pursuant to section 1135(b)(5) of the Act, CMS modified the requirement at 42 CFR §483.10(g)(2)(ii) which requires long-term care (LTC) facilities to provide a resident a copy of their records within two working days (when requested by the resident).
- CMS is modifying the timeframe requirements to allow LTC facilities **ten working days** to provide a resident's record rather than two working days.

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Physical Environment

- CMS is **waiving** requirements related at 42 CFR 483.90, specifically:
  - Provided that the state has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS is waiving requirements under § 483.90 **to allow for a non- SNF building to be temporarily certified and available for use by a SNF in the event there are needs for isolation processes for COVID-19 positive residents**, to ensure care and services during treatment for COVID-19 are available while protecting other vulnerable adults

  - CMS believes this will free up inpatient care beds at hospitals for the most acute patients while providing beds for those still in need of care. CMS will **waive certain conditions of participation and certification requirements for opening a NF if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location**

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Physical Environment (continued)

- CMS is **waiving requirements** related at 42 CFR 483.90, specifically the following:
    - CMS is also waiving requirements under 42 CFR 483.90 to temporarily allow for **rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity**
    - Rooms that may be used for this purpose include **activity rooms, meeting/conference rooms, dining rooms, or other rooms,** as long as residents can be kept safe, comfortable, and other applicable requirements for participation are met. This can be done so long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Training and Certification of Nurse Aides

- CMS is waiving the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a SNF and NF **may not employ anyone for longer than four months unless they met the training and certification requirements** under § 483.35(d)
    - To assist in potential staffing shortages with the COVID-19 pandemic.
    - CMS is not waiving 42 CFR § 483.35(d)(1)(i), which requires facilities to not use any individual working as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services.
    - Not waiving § 483.35(c), which requires facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Physician Visits in Skilled Nursing Facilities/Nursing Facilities

- CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in- person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Resident Roommates and Grouping

- CMS is waiving the requirements in 42 CFR 483.10(e) (5), (6), and (7) solely for the purposes of **grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19** and separating them from residents who are asymptomatic or tested negative for COVID-19
- Waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to
  - share a room with his or her roommate of choice in certain circumstances,
  - provide notice and rationale for changing a resident's room, and
  - provide for a resident's refusal a transfer to another room in the facility
- This aligns with CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents

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Resident Transfer and Discharge

- CMS is waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and § 483.21(a)(1)(i), (a)(2)(i), and (b) (2)(i) (with some exceptions) to **allow a long term care (LTC) facility to transfer or discharge residents to another LTC facility solely for the following cohorting purposes**
    1. Transferring residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents;

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Resident Transfer and Discharge (continued)

2. Transferring residents without symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19; or
3. Transferring residents without symptoms of a respiratory infection to another facility that agrees to accept each specific resident to observe for any signs or symptoms of a respiratory infection over 14 days.

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Exceptions

- These requirements are only waived in cases where the transferring facility receives confirmation that the receiving facility agrees to accept the resident to be transferred or discharged

- Confirmation may be in writing or verbal. If verbal, the transferring facility needs to document the date, time, and person that the receiving facility communicated agreement

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Exceptions (continued)

- In § 483.10, CMS is only waiving the requirement, under § 483.10(c)(5), that a facility provide advance notification of options relating to the transfer or discharge to another facility
- Otherwise, all requirements related to § 483.10 are not waived
- In § 483.15, CMS is only waiving the requirement, under § 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), and (d), for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Exceptions (continued)

- In § 483.21, we are only waiving the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes explained in 1–3 above

- Receiving facilities should complete the required care plans as soon as practicable, and we expect receiving facilities to review and use the care plans for residents from the transferring facility, and adjust as necessary to protect the health and safety of the residents the apply to

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Exceptions (continued)

- These requirements are also waived when the transferring residents to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements," as long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department

- In these cases, the transferring LTC facility need not issue a formal discharge, as it is still considered the provider and should bill Medicare normally for each day of care

- The transferring LTC facility is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Exceptions (continued)

- If the LTC facility does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare billing purposes.

- The LTC facility should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility should then bill Medicare appropriately for the type of care it is providing for the beneficiary.

- If the COVID-19 isolation and treatment facility is not yet an enrolled provider, the facility should enroll through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Physician Services

- **Physician Delegation of Tasks in SNFs.** 42 CFR 483.30(e)(4). Waiving the requirement in §483.30(e)(4) that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally.
- Waiver gives physicians the **ability to delegate any tasks to a**
  - Physician assistant,
  - Nurse practitioner, or
  - Clinical nurse specialist
    - who meets the applicable definition in 42 CFR 491.2 or is licensed as such by the State and is acting within the scope of practice laws as defined by State law.
- Tasks delegated must continue to be under the supervision of the physician.
- Does not include provision of § 483.30(e)(4) prohibiting a physician from delegating a task when it is prohibited under State law or by the facility's own policy

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Physician Services

- **Physician Visits.** 42 CFR 483.30(c)(3). CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (**not already exempted in § 483.30(c)(4) and (f)**) must be **made by the physician personally**
- To permit physicians to **delegate any required physician visit** to a
  - Nurse practitioner (NPs),
  - Physician assistant, or
  - Clinical nurse specialist
  - Who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope of practice laws

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Physician Services

- CMS **not waiving** the requirements **for the frequency of required physician visits** at § 483.30(c) (1)
- **Modified** the requirement to allow for the **requirement to be met by an NP, Physician Assistant, or Clinical Nurse Specialist, and via telehealth or other remote communication options**, as appropriate
- **Not waiving** requirements for **physician supervision** in § 483.30(a)(1), and the requirement at § 483.30(d) (3) for the facility to provide or arrange for the provision of physician services **24 hours a day**, in case of an emergency

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Quality Assurance and Performance Improvement (QAPI)

- CMS is modifying certain requirements in 42 CFR §483.75, which require long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program
- CMS is modifying §483.75(b)–(d) and (e)(3) to the extent necessary to **narrow the scope of the QAPI program to focus on adverse events and infection control**
- This will help ensure facilities **focus on aspects of care delivery** most closely associated with COVID-19 during the PHE

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

In-Service Training

- CMS is **modifying the nurse aide training requirements** at §483.95(g)(1) for SNFs and NFs, which requires the nursing assistant to receive at least 12 hours of in-service training annually
- In accordance with section 1135(b)(5) of the Act, we are postponing the deadline for completing this requirement **throughout the COVID-19 PHE** until the end of the first full quarter after the declaration of the PHE concludes

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Paid Feeding Assistants

- CMS is modifying the requirements at 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) regarding required training of paid feeding assistants,
- CMS is modifying the minimum timeframe requirements in these sections, which require this training to be a minimum of 8 hours. CMS is modifying to allow that the **training can be a minimum of 1 hour in length**. CMS is **not waiving** any other requirements under 42 CFR §483.60(h) related to paid feeding assistants or the **required training content** at 42 CFR §483.160(a)(1)-(8), which contains **infection control training** and other elements
- CMS **not waiving or modifying** the requirements at 42 CFR §483.60(h)(2)(i), which requires that a **feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN)**

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Medicare Telehealth

- Physician visits in skilled nursing facilities/nursing facilities: CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Required Facility Reporting

- Under the new §483.80(g), CMS is requiring facilities to report COVID-19 cases in their facility to the CDC National Health Safety Network (NHSN) on a weekly basis.
- CDC and CMS is using information collected through the new NHSN Long-term Care COVID-19 Module to:
  - Strengthen COVID-19 surveillance locally and nationally;
  - Monitor trends in infection rates; and
  - Help local, state, and federal health authorities get assistance to nursing homes faster.
- The information is posted online for the public under the Spotlight section of Nursing Home Compare

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Required Facility Reporting (continued)

- Facilities are also required to notify residents, their representatives, and families of residents in facilities of the status of COVID-19 in the facility, which includes any new cases of COVID-19 as they are identified
- Supports CMS' commitment to transparency so that individuals know important information about their environment, or the environment of a loved one

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Notification of residents, their representatives, and families of residents in facilities of the status of COVID-19

- Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. No requirement to provide separate counts of new vs total cases.
  - This information must—
    - (i) Not include personally identifiable information;
    - (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
    - (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Notification of residents, their representatives, and families of residents in facilities of the status of COVID-19

- If a facility provides 1 or more notifications to the resident/reprehensive/family in a given week due to having a confirmed COVID case or a 72 hour cluster of 3 suspected cases **then an additional weekly notification is not needed that week**
- A weekly notification, if required, would include a general status update with existing cumulative totals and info on actions being taken

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Public Health Emergency Waivers & Flexibilities

The **Public Health Emergency** (PHE 90 day extension) is **through July 26**. In late July, HHS Secretary Azar has **two options**:

- **Allow the PHE and the Section 1135 to expire; or**
- **Allow the PHE to expire but extend the Section 1135**

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Long-Term Care Facilities, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs)

Cost Reporting

- CMS delayed the filing deadline of certain cost report due dates due to the COVID-19 outbreak; 42 CFR § 413.24(f)(2)(ii) allows this flexibility
- CMS delayed the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020
- The extended cost report due dates for these October and November FYEs will be June 30, 2020
- CMS also delayed the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020

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- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs

- https://www.cms.gov/files/document/guidance-memoexceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf

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COVID-19
Medicare Waivers & Flexibilities

Beneficiary Notice Delivery Guidelines

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Beneficiary Notice Delivery Guidelines

- CMS encourages the provider community to be diligent and **safe** while issuing beneficiary notices to beneficiaries with **suspected or confirmed COVID-19** receiving institutional care.
- **Beneficiary Notices included**:
  - Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
  - Detailed Explanation of Non-Coverage (DENC)_CMS-10124
  - Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
  - Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)_CMS-10055

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Beneficiary Notice Delivery Guidelines

- Hard copies of notices may be **dropped off** with a beneficiary **by any worker** able to enter a room safely
- A **contact phone number should be provided** for a beneficiary to ask questions about the notice, if the individual delivering the notice is unable to do so
- If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also be **delivered via email, if a beneficiary has access** in the isolation room
- The **notices should be annotated** with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent

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Beneficiary Notice Delivery Guidelines

- Notice delivery may be made via telephone or secure email to **beneficiary representatives who are offsite**. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

- Review all of the specifics of notice delivery, in Chapter 30 of the Medicare Claims Processing Manual at https://www.cms.gov/media/137111

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Medicare Appeals
Fee for Service (FFS), Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) in the FFS program pursuant to 42 CFR §405.942 and 42 CFR §405.962 (including for MA and Part D plans), as well as the MA and Part D Independent Review Entities (IREs) under 42 CFR §422.562, 42 CFR §423.562, 42 CFR §422.582 and 42 CFR §423.582, to **allow extensions to file an appeal**
- CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 and the MA and Part D IREs to **waive requests for timeliness requirements** for additional information to adjudicate appeals

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Medicare Appeals
Fee for Service (FFS), Medicare Advantage (MA) and Part D

- CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.910 and MA and Part D plans, as well as the MA and Part D IREs, to **process an appeal even with incomplete Appointment of Representation forms** as outlined under 42 CFR §422.561 and 42 CFR §423.560. However, any communications will only be sent to the beneficiary
- CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 (also including MA and Part D plans), as well as the MA and Part D IREs, to **process requests for appeals that do not meet the required elements** using information that is available as outlined within 42 CFR §422.561 and 42 CFR §423.560
- CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 (also including MA and Part D plans), as well as the MA and Part D IREs under 42 CFR §422.562 and 42 CFR §423.562 to **utilize all flexibilities available in the appeal process as if good cause requirements are satisfied**

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COVID-19
Medicare Waivers & Flexibilities

Life Safety Code Waivers

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Specific Life Safety Code (LSC) for Multiple Providers

Waiver Information

- CMS is waiving and modifying particular waivers under 42 CFR §482.41(b) for hospitals; §485.623(c) for CAHs; §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs

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Specific Life Safety Code (LSC) for Multiple Providers

Waiver Information

Alcohol-based Hand-Rub (ABHR) Dispensers

- Waiving the prescriptive requirements for the placement of alcohol based hand rub (ABHR) dispensers for use by staff and others
  - Due to the need for the increased use of ABHR in infection control.
- ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers
  - Restricting access by certain patient/resident population to prevent accidental ingestion
  - Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area

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Specific Life Safety Code (LSC) for Multiple Providers

Waiver Information

Fire Drills

- **Permit a documented orientation training program** related to the current fire plan, which considers current facility conditions
  - Due to the **inadvisability of quarterly fire drills** that move and mass staff together
- The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area

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COVID-19
Medicare Waivers & Flexibilities

Home Health Agencies

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Home Health Agencies (HHAs)

- Allow OTs, PTs, and SLPs to Perform Initial and Comprehensive Assessment for all Patients
  - CMS is waiving the requirements in 42 CFR § 484.55(a)(2) and §484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered
    - Temporary blanket modification allows any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care

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Home Health Agencies (HHAs)

- **Allow OTs, PTs, and SLPs to Perform Initial and Comprehensive Assessment for all Patients**
  - Existing regulations at §484.55(a) and (b)(2) would continue to apply; rehabilitation skilled professionals would not be permitted to perform assessments in nursing- only cases.
  - CMS expects HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible
  - Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments, and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice

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Home Health Agencies (HHAs)

Medicare Telehealth and Telecommunications Technology

- Home Health Agencies (HHAs) can provide more services to beneficiaries using telecommunications technology within the 30-day period of care, so long as it's part of the patient's plan of care and **does not replace needed in-person visits** as ordered on the plan of care
  - The use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care
    - Telecommunications technology can include, for example: remote patient monitoring; telephone calls (audio only and TTY); and 2-way audio-video technology that allows for real-time interaction between the clinician and patient
  - **Only in-person visits can be reported on the home health claim**
  - The required face-to-face encounter for home health can be conducted via telehealth

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Home Health Agencies (HHAs)

Homebound Definition

- A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19.

- If a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit.

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Home Health Agencies (HHAs)

Clinical Records

- In accordance with section 1135(b)(5) of the Act, CMS is extending the deadline for completion of the requirement at 42 CFR §484.110(e), which requires HHAs to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient)
- CMS will allow HHAs **ten business days to provide a patient's clinical record, instead of four**

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Home Health Agencies (HHAs)

Plans of Care and Certifying/Recertifying Patient Eligibility

- In addition to a physician, section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law.
- These physicians/practitioners can:
  - Order home health services;
  - Establish and periodically review a plan of care for home health services (e.g., sign the plan of care),
  - Certify and re-certify that the patient is eligible for Medicare home health services.
- These changes are effective for Medicare claims with a “claim through date” on or after March 1, 2020.

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Home Health Agencies (HHAs)

Detailed Information Sharing for Discharge Planning for Home Health Agencies

- CMS waived the requirements of 42 CFR §484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to,
  - (another) home health agency (HHA),
  - skilled nursing facility (SNF),
  - inpatient rehabilitation facility (IRF), and
  - long-term care hospital (LTCH) quality measures and resource use measures.
- This temporary waiver provides facilities the ability to expedite discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements.

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Home Health Agencies (HHAs)

Training and Assessment of Aides

- CMS waived the requirement at 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHAs, which require a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency.
- In accordance with section 1135(b)(5) of the Act, CMS postponed completion of these visits.
- All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE.

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Home Health Agencies (HHAs)

12-hour annual in-service training requirement for home health aides

- CMS modified the requirement at 42 C.F.R. §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period

- In accordance with section 1135(b)(5) of the Act, CMS postponed the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes

- This allows aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care and additional time for staff to complete this requirement

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Home Health Agencies (HHAs)

Quality Assurance and Performance Improvement (QAPI)

- CMS modified the requirement at 42 CFR §418.58 for Hospice and §484.65 for HHAs, which requires these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program.
- CMS modified the requirements at §418.58(a)–(d) and §484.65(a)–(d) to narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events.
- This modification decreases burden associated with the development and maintenance of a broad-based QAPI program, allowing the providers to focus efforts on aspects of care delivery most closely associated with COVID-19 and tracking adverse events during the PHE.
- The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data driven quality assessment and performance improvement program will remain.

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Home Health Agencies (HHAs)

Waive Onsite Visits for HHA Aide Supervision

- CMS waived the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks.
- Includes waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan,
- Temporarily suspends the 2-week aide supervision by a registered nurse for home health agencies requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver.

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Home Health Agencies (HHAs)

- Reporting: CMS is providing relief to HHAs on the timeframes related to OASIS transmission through the following:
  - 1) extending the 5-day completion requirement for the comprehensive assessment to 30 days; and
  - 2) waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.
- Allowing 30 days for the completion of the comprehensive assessment.
- HHAs must submit OASIS data prior to submitting their final claim in order to receive Medicare payment.

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Home Health Agencies (HHAs)

Home Health Quality Reporting Program

- HHAs are exempted from the Home Health Quality Reporting Program reporting requirements.

- The time period covered by this exemption is October 1, 2019 through June 30, 2020. HHAs that do not submit data for those quarters will not have their annual market basket percentage increase reduced by two percentage points.

- CMS is delaying the compliance dates for collecting and reporting the Transfer of Health Information quality measures and certain standardized patient assessment data elements (SPADEs) adopted for the HH Quality Reporting Program.

  - HHAs will be required to begin collecting the Transfer of Health Information quality measures and certain SPADEs on January 1st of the year that is at least one calendar year after the end of the public health emergency.

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Home Health Agencies (HHAs)

Home Health Value Based Purchasing (HHVBP) Model

- CMS is implementing a policy to align HHVBP data submission requirements with any exceptions or extensions granted for purposes of the Home Health Quality Reporting Program during the PHE for the COVID-19 pandemic,
- Implementing a policy for granting exceptions to the New Measures data reporting requirements under the HHVBP Model during the PHE for the COVID-19 pandemic.

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Home Health Agencies (HHAs)

Review Choice Demonstration for Home Health Services

- CMS is offering home health agencies in the Review Choice Demonstration for Home Health Services the option of pausing their participation for the duration of the Public Health Emergency.
- Home Health agencies do not have to do anything for the pause to go into effect.

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Home Health Agencies (HHAs)

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs)
  - in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and
  - MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs),
  - 42 CFR 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 to allow extensions to file an appeal;

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Home Health Agencies (HHAs)

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals;

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Home Health Agencies (HHAs)

- MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if:
  - The enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or
  - The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1);

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Home Health Agencies (HHAs)

- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even **with incomplete Appointment of Representation forms** 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs to **process requests for appeal that don't meet the required elements** using information that is available 42 CFR § 422.562, 42 CFR § 423.562.

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562 to **utilize all flexibilities available in the appeal process as if good cause requirements are satisfied**.

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Home Health Agencies (HHAs)

- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs to **process an appeal even with incomplete Appointment of Representation forms** 42 CFR § 422.561, 42 CFR § 423.560.

- However, any communications will only be sent to the beneficiary;

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Home Health Agencies (HHAs)

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs to **process requests for appeal that don't meet the required elements** using information that is available 42 CFR § 422.562, 42 CFR § 423.562.

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Home Health Agencies (HHAs)

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562

  - To utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

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Home Health Agencies (HHAs)

Ordering Medicaid Home Health Services and Equipment

- Medicaid home health regulations now allow non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, and physical therapy, occupational therapy or speech pathology and audiology services, in accordance with state scope of practice laws.

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Home Health Agencies (HHAs)

COVID-19 Diagnostic Testing

- If a patient is already receiving Medicare home health services, the home health nurse, during an otherwise covered visit, could **obtain the sample to send to the laboratory for COVID-19 diagnostic testing.**

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Home Health Agencies (HHAs)

Initial Assessments

- CMS is waiving the requirements at 42 CFR §484.55(a) to **allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review.**
  - Allows patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long- term care facilities.
  - Allows for maximizing coverage by already scarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.

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Home Health Agencies (HHAs)

Waive Onsite Visits for HHA Aide Supervision

- CMS is waiving the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would
- Includes waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time.
- Temporarily suspending the 2-week aide supervision by a registered nurse for home health agencies requirement at §484.80(h)(1), virtual supervision is encouraged during the period of the waiver.

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Home Health Agencies (HHAs)

Requests for Anticipated Payment (RAPs)

- CMS is allowing Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.

- **Reporting**
  - CMS is providing relief to HHAs on the timeframes related to OASIS Transmission through the following actions below:
    - Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
    - Waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.

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- CMS has released guidance to describe standards of practice for infection control and prevention of COVID-19 in home health agencies

- Find it at https://www.cms.gov/files/document/qso-20-18-hha.pdf

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Home Health Agencies (HHAs)

- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs

- Find it at https://www.cms.gov/files/document/guidance-memoexceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf

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Home Health Agencies (HHAs)

1. Section 3708 of the CARES Act made changes regarding who is able to certify beneficiaries for eligibility and order services under the home health benefit. Who can now perform these services?

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Home Health Agencies (HHAs)

- Answer
  - "Allowed practitioners" in addition to physicians, can now certify beneficiaries for eligibility, order home health services, and establish and review the care plan. Allowed practitioners are defined at 42 CFR 484.2 as physician assistants, nurse practitioners, or clinical nurse specialists as defined elsewhere in 42 C.F.R. Part 484. The definitions for such practitioners are aligned with existing definitions in regulation at §§ 410.74– 410.76, for consistency across the Medicare program and to ensure that Medicare home health beneficiaries are afforded the same standard of care. In general, nurse practitioner (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) are required to practice in accordance with state law in the state in which the individual performs such services. Individual states have varying requirements for conditions of practice, which determine whether a practitioner may work independently without a written collaborative agreement or supervision from a physician, or whether general or direct supervision and collaboration is required.

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Home Health Agencies (HHAs)

2. Will the changes to allow NPs, CNSs and PAs to order and certify patients for eligibility under the Medicare home health benefit be permanent or only during the Public Health Emergency for COVID-19?

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Home Health Agencies (HHAs)

- Answer
  - This IFC **makes permanent changes** to sections 1814(a) and 1835(a) of the Act, pursuant to section 3708 of the CARES Act, **to allow NPs, CNSs, and PAs, to order and certify patients for eligibility under the Medicare home health benefit**

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Home Health Agencies (HHAs)

3. Can a nurse practitioner, physician assistant, or clinical nurse specialist sign the home health recertification statement and the plan of care in place of a physician or another allowed practitioner?

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Home Health Agencies (HHAs)

- Answer
  - The home health conditions of participation do not prohibit home health agencies (HHAs) from accepting orders from multiple physicians, and now with the recent statutory change, nurse practitioners, physician assistants, and clinical nurse specialists (i.e., allowed practitioners). The HHA is ultimately responsible for the plan of care, which includes assuring communication with all physicians and allowed practitioners involved in the plan of care and integrating orders from all physicians/allowed non-physician practitioners involved in the plan to assure the coordination of all services and interventions provided to the patient. This responsibility extends to a physician or other allowed non-physician practitioner, other than the certifying physician or allowed non-physician practitioner who established the home health plan of care, who signs the plan of care or the recertification statement in the absence of the certifying physician or allowed non-physician practitioner. This is only permitted when such physician or non-physician practitioner has been authorized to care for his/her patients in his/her absence. The HHA is responsible for ensuring that the physician or allowed non-physician practitioner who signs the plan of care and recertification statement was authorized by the physician or allowed non-physician practitioner who established the plan of care and completed the certification for his/her patient in his/her absence. Our regulations at 42 CFR 424.22(a)(1)(v)(A) require that the physician or allowed practitioner that performed the required face-to-face encounter also sign the certification of eligibility, unless the patient is directly admitted to home health care from an acute or post-acute care facility and the encounter was performed by a physician or allowed practitioner in such setting

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Home Health Agencies (HHAs)

4. Can home health agencies furnish services using telecommunications technology during the PHE for the COVID-19 pandemic?

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Home Health Agencies (HHAs)

- Answer
  - Yes. Home health agencies are able to furnish services using telecommunications technology during the PHE as long as such services do not substitute for in-person visits ordered on the plan of care. This can include telephone calls (audio only and TTY), two-way audio-video telecommunications that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of the home health agency and patient's physician/practitioner as to whether such technology can meet the patient's need. The use of telecommunications technology in furnishing services under the home health benefit must be included on the plan of care and the plan of care must outline how such technology will assist in achieving the goals outlined on the plan of care

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Home Health Agencies (HHAs)

5. Can home health agencies include services furnished using telecommunications technology on the home health claim that it submits to Medicare for payment?

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Home Health Agencies (HHAs)

- Answer
  - Only in-person visits are to be reported on the home health claim submitted to Medicare for payment. On an interim basis, HHAs can report the costs of telecommunications technology on the HHA cost report as allowable administrative and general (A&G) costs by identifying the costs using a subscript between line 5.01 through line 5.19.

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Home Health Agencies (HHAs)

6. Can ordering clinician include “as needed” or “when necessary” (commonly abbreviated as PRN) on the orders for the home health plan of care for telecommunications encounters in the event the patient chooses not to have in-person visits by home care nurse?

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Home Health Agencies (HHAs)

- Answer
  - If an HHA anticipates that there may be the need for “PRN” telecommunications encounters (including telephone calls) for the purposes of providing a skilled service, these **“PRN” orders can be included on the home health plan of care similar to how “PRN” orders for in-person visits would be included**. That is, orders for services to be provided “as needed” or “PRN” must be accompanied by a description of the beneficiary's medical signs and symptoms that would occasion the visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If a range of visits is ordered, the upper limit of the range is considered the specific frequency under 42 CFR §409.43(b).

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Home Health Agencies (HHAs)

7. Can home health agencies complete the initial assessments virtually or over the phone during the PHE for the COVID-19 pandemic?

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Home Health Agencies (HHAs)

- Answer
  - Yes. CMS has waived the requirements at 42 CFR §484.55(a) to **allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely, by phone, or by record review**. This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long- term care facilities. This will also allow for maximizing coverage by already scarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.

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Home Health Agencies (HHAs)

8. Can home health agencies complete the comprehensive assessment and updates to the comprehensive assessment virtually or over the phone during the PHE for the COVID19 pandemic?

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Home Health Agencies (HHAs)

- Answer
  - Utilizing telecommunications technology is an option for the completion of the comprehensive assessment and the update of the comprehensive assessment. HHAs can provide services to beneficiaries using telecommunications technology (which can include audio-only or TTY telephone calls, or two-way audio-video telecommunications technology, like FaceTime or Skype) so long as it's part of the patient's plan of care and does not substitute for in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care. The plan of care should be modified to reflect which visits will be made in person, and which visits will be conducted via telecommunications technology.

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Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

- When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to have the flexibility to **waive replacements requirements** such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required.
- Suppliers must **still include a narrative description** on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was **lost, destroyed, irreparably damaged,** or otherwise rendered unusable or unavailable as a result of the emergency.

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Practitioner Locations

- CMS is temporarily **waiving requirements** that **out-of-state practitioners be licensed in the state where they are providing services** when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met:
  1. Must be **enrolled** as such in the **Medicare program**;
  2. Must possess a **valid license to practice in the state**, which relates to his or her Medicare enrollment;
  3. Is furnishing services – whether in person or via telehealth – **in a state in which the emergency is occurring** in order to contribute to relief efforts in his or her professional capacity; and,
  4. Is not affirmatively excluded from practice in the state or any other state that is part of the **1135 emergency area**

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Further Information?

- Specifics questions can be emailed to:
  - Kris Mastrangelo at Harmony Healthcare International
    - kmastrangelo@harmony-healthcare.com
  - The COVID-19 mailbox at CMS
    - covid-19@cms.hhs.gov

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Questions?

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