

Home Health Federal Blanket Waivers Updates as of July 23, 2020 Highlighted in Red

The following information is based on CMS “Blanket” Waivers effective retrospectively to March 1, 2020 and that end no later than when the COVID 19 PHE (Public Health Emergency) ends. Federal “Blanket” Waivers apply to all home health agencies, as well as any waivers granted to individual companies, or State waivers that apply to Medicaid patients.

As applicable, CMS regulatory language follows each waiver statement for clarity as to the scope of the waiver.

CMS Clarifies Telehealth and Telecommunication in Delivering Home Care Services:

- *Telecommunications technology* includes 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. 3 visit types for intervention with the patient.
 - a. *Only* in-person visits can 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. Payment FAQs follow:
<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>
- Home Health Agencies (HHAs) can provide services to beneficiaries using *telecommunications*. Services by phone or 2 way-audio or video technology:
 - All types of services must be a part of the patient’s plan of care (this may result in changes to the frequency or types of visits noted on the plan of care), and
 - does not replace needed in-person visits as also ordered on the plan of care.

Homebound Definition Changes with COVID 19 Patients:

- A patient is considered homebound:
 - when their physician advises that they cannot 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 they leave the home. AND
 - needs skilled services, an HHA can provide those services under the Medicare Home Health benefit. No change.

More Practitioners Can Certify and Re-certify Home Health Eligibility and Order Home Health Care:

- A Medicare beneficiary under the care of a nurse practitioner (NP), or clinical nurse specialist (CNS), or a physician assistant (PA) may 1) order home health services; 2) establish and review a plan of care (sign the plan of care); 3) certify and re-certify the patient’s eligibility for Medicare home health.

- The above practitioners are alternatives to a physician being the only practitioner recognized to do the 3 functions above -order, establish a plan of care and certify and re-certify.
- Acceptance of signatures by a NP, CNS, or PA effective for claims with a “claim through date” of March 1, 2020 or after.
- The required F2F encounter for home health can be conducted via telehealth (i.e., 2-way audio-video) telecommunications technology that allows for real-time interaction between the physician/allowed practitioner (NP, CNS, or PA) and the patient.
- NOTE: Be aware if under your state licensure law, you can accept orders from these practitioners.

For information about the scope of practice for NPs, use this website:

<https://www.aanp.org/advocacy/state/state-practice-environment> (NPs)

<http://scopeofpracticepolicy.org/practitioners/physician-assistants/> (PAs)

Initial Assessments: May 4, 2020 – CMS removed word ‘telehealth’ from previous waiver, broadening the scope of options to do the assessment)

- CMS is waiving 42 CFR § 484.55(a), home health agencies can perform initial assessments and determine patients’ homebound status remotely or by record review.

484.55(a) Standard: Initial assessment visit. Verify home bound status.

(1) An RN must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

3 Therapies (OTs, PTs, SLPs) May Perform Initial and Comprehensive Assessments

Expanding the category of therapists who may perform initial and comprehensive assessments to include OTs, PTs, SLPs. CMS now 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 regardless of whether the service establishes eligibility for the patient to be receiving home care.

<https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf> (page 19)

- Know if the therapy performing assessments can do so under the state scope of practice law for that therapy.
- Therapies are not permitted under the waiver to perform assessments in nursing only cases.

42 C.F.R. 484.55(a)(2): Standard: Initial Assessment. (2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

484.55(b)(3) Standard: Completion of the Comprehensive Assessment: (3) When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.

COVID-19 Diagnostic Testing

- A home health nurse may obtain the sample for COVID-19 diagnostic testing during an otherwise covered visit of a Medicare home health patient already receiving Medicare home health services. The sample is then sent or made available for the laboratory COVID-19 testing.

Home Health Discharge Planning -Partial Content Waiver:

- CMS is waiving the requirements to provide detailed information to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes quality measures and other resource use measures for (another) home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH).
- All other discharge planning requirements remain.

42 CFR §484.58 (a) *Standard: Discharge planning.* An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

HH Aide Waivers and Requirements:

Annual HH Aide Training and Assessment *Postponed*:

- The annual onsite supervisory visit (direct observation) of each aide by a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) is *postponed*.
- NOTE: All *postponed* onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE.

42 CFR §484.80(h)(1)(iii): Standard: Supervision of home health aides. iii) A registered nurse or other appropriate skilled professional must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.

HHA Aide on Site Every Two Weeks On-Site Supervisory Visit Waived for Medicare and Medicaid:

- CMS waives the requirements that a nurse or other professional conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan; and,
- Temporarily suspends 2-week aide supervision by a registered RN for home health agencies, but virtual supervision is encouraged during the period of the waiver. No change

484.80(h)(1) *Standard: Supervision of home health aides.* (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.

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

CMS is postponing the requirement that home health agencies assure that each home health aide receives 12 hours of in-service training in a 12-month period until the end of the first full quarter after the declaration of the PHE concludes.

42 C.F.R. §484.80(d) *Standard: In-service training.* A home health aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient.

OASIS Submission and Comprehensive Assessment Timing Extended:

- Comprehensive Assessment: 5-day completion requirement for the comprehensive assessment extended to 30 days.
- Waiving the 30-day OASIS submission requirement, delayed submission is allowed during PHE.
- The OASIS must be transmitted prior to submitting the final claim for payment.

Narrowed Scope of QAPI:

- The QAPI program's scope is narrowed to concentrate on infection control issues, while retaining the requirement to focus on adverse events during the PHE period.
- Goal is to focus efforts on aspects of care delivery most closely associated with COVID-19.
- The requirement that HHAs maintain an effective, ongoing, agency-wide, data driven quality assessment and performance improvement program remains.

§484.65(a)–(d) QAPI Program Activities: a) Program Scope; b) Program data; c) Program Activities; d) Measure program improvement.

Home Health Quality Reporting Program Exemption:

- HHAs are exempted from the Home Health Quality Reporting Program reporting requirements for the time period of 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 (2%).

Transfer of Health Information and SPADES data elements Postponed:

- The compliance dates are delayed for collecting and reporting the Transfer of Health Information quality measures and certain standardized patient assessment data elements (SPADEs).
- Data collection of the Transfer of Health Information quality measures and certain SPADEs elements is to begin on January 1st of the year that is at least one calendar year after the end of the public health emergency.

Medicaid Home Health Services and Equipment: No change

- Medicaid home health regulations 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.

Timeframe to Provide Copies of Medical Records to Patients Extended:

- CMS extends the deadline for completion of the requirement that HHAs provide a patient a copy of their medical record at no cost during the next visit or within four (4) business days (when requested by the patient) to ten (10) business days.

42 CFR §484.110(e) *Standard: Retrieval of clinical records.* A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first).

Requests for Anticipated Payments (RAPs): No change

- MACs can extend the auto-cancellation date of RAPs during the PHE. Contact your MAC.

July 23, 2020: Home Health Review Choice Demonstration Paused – Now Resumes August 3 2020

During the pause, home health claims submitted on or after March 29, 2020, were subject to the review choices made by home health agencies.

- The initial choice selection period will begin in North Carolina and Florida on August 3, 2020 and end on August 17, 2020.
- The choice selection period for Ohio's second review cycle will begin August 3, 2020 and end on August 17, 2020.
- Following these choice selection periods, home health claims in all demonstration states (Illinois, Ohio, Texas, North Carolina, and Florida) with billing periods beginning on or after August 31, 2020, will be subject to review under the terms of the choice selected by the provider.
 - This includes pre-claim review, prepayment review, postpayment review, or any applicable 25% payment reduction.
- Following the resumption of the demonstration, the MAC will conduct postpayment review on claims subject to the demonstration that were submitted and paid during the pause.
- CMS will work with affected providers to develop a schedule for postpayment reviews that not does significantly increase provider burden.

- Claims that received a provisional affirmative pre-claim review decision and were submitted with an affirmed Unique Tracking Number (UTN) will continue to be excluded from most future medical review.
- CMS will post additional information on its demonstration website

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services>

Medical Claims Review Resumes August 3 2020:

- CMS expects to MAC financial reviews beginning on August 3, 2020, regardless of the status of the public health emergency.
- If selected for review, providers should discuss with their contractor any COVID-19-related hardships they are experiencing that could affect audit response timeliness.
- This includes pre-payment medical reviews conducted by MACs under the Targeted Probe and Educate program, and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC)
- CMS notes that all waivers and flexibilities in place at the time of the dates of service of any claims potentially selected for review will also be applied.

Delaying Cost Reports: No change

- For the following fiscal year end (FYE) dates are extended:
 - FYE 10/31/2019 cost reports due by March 31, 2020, now due June 30, 2020
 - FYE 11/30/2019 cost reports due by April 30, 2020 now due June 30, 2020
 - FYE 12/31/2019 cost reports due by May 31, 2020 now due July 31, 2020.

Accelerated/Advanced Payment:

As of April 26, 2020, CMS is reevaluating all pending and new applications for the Accelerated Payment Program and has suspended the Advance Payment Program, considering direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund.

- Distributions made through the Provider Relief Fund do not need to be repaid.
- For providers and suppliers who have received accelerated or advance payments related to the COVID-19 Public Health Emergency, CMS will not pursue recovery of these payments until 120 days after the date of payment issuance.
- Providers and suppliers with questions regarding the repayment of their accelerated or advance payment(s) should contact their appropriate Medicare Administrative Contractor (MAC).

Appeals - Medicare Advantage (MA) and Medicare Fee-for-Service (FFS):

- Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (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 can allow extensions to file an appeal.

- 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 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).
- 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: 1) the enrollee requests the extension; 2) 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, 3) 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).
- 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 can 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.
- 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 can process requests for appeal that don't meet the required elements using information that is available. 42 CFR 422.562, 42 CFR 423.562.
- 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 can utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

CMS Waiver Statements can be found at

<https://www.cms.gov/files/document/covid-home-health-agencies.pdf>

and

<https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>