Partnership for Quality Home Healthcare
THERE'S NO PLACE LIKE HOME

Combatting Coronavirus with Home Health: Existing Waivers and Needed Additional Support

Current Waivers and Relief:[1]

Issue	Guidance Received
Homebound status	• 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. As a result, 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. 3/30/20 IFR.
Use of technology as part of a plan of care	• On an interim basis, CMS is providing HHAs with the flexibility to use various types of telecommunications systems (in addition to remote patient monitoring) in conjunction with the provision of in-person visits. The use of technology must be related to the skilled services being furnished by the nurse/therapist/therapy assistant to optimize the services furnished during the home visit or when there is a home visit. • The use of technology must be included on the home health plan of care along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in-person visit as ordered on the plan of care. HHAs have flexibility on the timing in which they obtain physician signatures for changes to the plan of care when incorporating the use of technology into the patient's plan of care. 3/30/20 IFR.
Certification and Recertification by NPs and PAs	• HHS is utilizing enforcement discretion to allow a patient to be under the care of a nurse practitioner or clinical nurse specialist, or a physician assistant to: (1) order home health services; (2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care), (3) certify and re-certify that the patient is eligible for Medicare home health services. 3/30/20 IFR; 3/30/20 HH Fact Sheet. • Congress provided permanent authority for NPs and PAs to certify eligibility for home health where permitted by the state, which CMS has 6 months to implement through rulemaking. CARES Act, Sec. 3708.
OASIS Assessment Timeframe	• Through a blanket 1135 waiver, CMS waived requirements under 42 CFR 484.20(c)(1) to provide relief to Home Health Agencies on the timeframes related to OASIS Transmission. MLN article. CMS is extending the 5-day completion requirement for the comprehensive assessment to 30 days; and waiving the 30-day OASIS submission requirement and permitting delayed submission. 3/31/20 1135 Waiver. The OASIS information must still be completed before the final claim is submitted.
Initial Assessment	• 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. 3/31/20 1135 Waiver. CMS clarified verbally that this cannot be counted as a visit.
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 wouldinclude waiving the requirements for a nurse or other professional to conduct an onsitevisit every two weeks to evaluate if aides are

[1] CMS has summarized Home Health waivers in a fact sheet released on 3/30/2020.

	providing care consistent with the care plan,as this may not be physically possible for a period of time This waiver is also temporarilysuspending the 2-week aide supervision by a registered nurse for home health agenciesrequirement at §484.80(h)(1), but virtual supervision is encouraged during the period of thewaiver. 3/31/20 1135 Waiver.
Quality Data Reporting and CAHPS	• CMS announced it is granting exceptions from reporting requirements for home health agencies related to Medicare quality data reporting programs and Home Health and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data submission. Press Release, 3/22/20.
RAPs	• To ensure the correct processing of home health emergency related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto cancellation date of Requests for Anticipated Payment (RAPs). MLN article; 3/31/20 1135 Waiver
Payment Relief	• Congress eliminated the 2 percent reduction in Medicare home health payments related to sequestration effective May 1, 2020 through December 31, 2020. CARES Act, Sec. 3709.
Reporting Technology Costs	• On an interim basis, CMS will allow HHAs to report the costs of telecommunications technology as allowable administrative and general (A&G) costs by identifying the costs in cost reports. 3/30/20 IFR.
ICD 10 Coding for COVID-19	• A new ICD-10 code has been released for 4/1/20. 3/18/20 Announcement. • We have asked CMS for the grouper under PDGM.
Face to face (F2F) via telehealth	• CMS has said that the F2F encounter can be performed via telehealth. Under the expansion of telehealth under the 1135 waiver, beneficiaries are able to use telehealth with their doctors and practitioners from home for the face-to-face encounter to qualify for Medicare home health care. COVID-19 FAQs updated 3/23/20. • CMS should further clarify that audio telephonic communication from physicians also suffices for the F2F encounter requirement.
Review Choices Demonstration	• Certain claims processing for the Review Choice Demonstration (RCD) for Home Health Services will be paused in Illinois, Ohio, and Texas. The demonstration will not begin in North Carolina and Florida on May 4, 2020, as previously scheduled. 3/30/20 FAQs. • PQHH is seeking further CMS action and clarification to assure that RCD will be stopped and that there will not be a 100% post pay review by the MACs.
Use of technology to provide home health visits	• CMS maintains that care provided using technology cannot substitute for an in person visit, but has indicated that there are many situations where home health care can be provided using communications technology. 3/30/20 IFR. • 3.0 Legislative Package would direct CMS to "consider ways to encourage the use of telecommunications systems" and "other communications or monitoring services" with respect to home health services. Sec. 3707. • CMS has been clear that billing for "Medicare telehealth services" pursuant to 1834(m) is limited to professionals and cannot be billed by Home Health Agencies or facilities like hospitals. March 17, 2020 FAQs.
Access to Personal Protective Equipment (PPE)	• CMS, CDC and FEMA have provided general guidance, but not specific to HHAs.

Additional Relief Sought:

Combatting Coronavirus	Impediments under current rules	Potential solution/mechanism to address
PRIORITY: Access to Relief Funds	HHAs have experienced increased expenses due to costs of PPE and otherwise, and loss of revenue due to cancelled elective surgeries and refused visits due to COVID-19 concerns.	• HHS should ensure that Home Health Agencies can receive a proportional allocation of funds available under the CARES Act Public Health and Social Services Emergency Fund (PHSSEF). • PQHH and NAHC have jointly asked for $3 billion for home health providers. 4/2/20 Letter.
PRIORITY: Reevaluation of Behavioral Adjustments	2020 HHAs payments include a 4.3% payment adjustment based on assumed changes in behavior related to implementation of the PDGM. These assumptions were made during 2019 when the current public health emergency could not have been imagined	• CMS should reevaluate its behavioral assumptions and make an immediately-effective change to reflect the fact that, due to COVID-19, CMS's assumptions regarding implementation of PDGM are no longer relevant. Eliminating the 4.3% reduction will better align home health payments with the reality of the current emergency situation. • CMS should also make clear that when reviewing the first year impact of PDGM to determine behavior change, CMS should exclude 2020 from the data set as being a non-representative sample due to COVID19.
PRIORITY: Physician signature requirements and use of virtual orders	Health care communications systems have been completely disrupted, making everyday challenges in obtaining physician signatures dramatically more difficult. Guidance around reliance on verbal orders is unclear.	• CMS should waive or relax physician signature requirements and allow HHAs to operate based on verbal orders. • Particularly with respect to updates to plans of care, CMS should allow HHAs to document verbal orders from physicians. • This change is imperative due to a severely compromised physician communication system resulting from COVID19.
Allow virtual/telephonic home health visits	Right now, current home health patients are turning away scheduled home health care visits due to fears of coronavirus. Without the ability to interact with their providers, these patients could end up needing acute care. Further, PPE is becoming increasingly unavailable, creating an urgent need for new care modalities.	• To ensure continuity of care for home health patients, CMS should allow telephonic visits *immediately* by waiving requirements for home health visits to occur physically in the home. • Telephonic visits could involve video, but not all patients have smartphones to support this. • CMS should allow visits over the phone to count as visits and towards LUPA thresholds. • Through virtual care, HHAs can also take on COVID-positive or presumed positive patients in need of skilled monitoring.
Access to Personal Protective Equipment (PPE)	PPE supplies are running low but are critical to prevent exposure during home health visits that could harm home health workers or spread the virus to other homebound patients.	• HHAs will look to CMS and CDC guidance on getting the most out of PPE, but interventions through the SNS and in the supply chain should prioritize access to PPE for HHAs. • Higher costs of PPE should be considered in identifying appropriate rates for home health services during the coronavirus emergency and response.

Recertification	If patients are COVID positive, it is critical that have access to treatment for as long as necessary. Currently, the standard of care for COVID-positive patients is evolving, as we learn best practices for combatting this novel disease. If new therapeutics or other novel treatments or techniques are developed, there could be a need for additional episodes of care to treat patients at home.	• Beneficiaries that may test positive for the virus should be presumed recertified or eligible for recertification for a 30 day episode of care consistent with a plan of care. • CMS should allow for recertification of patient eligibility for home health as necessary in order to support ongoing treatment for COVID-19.
Use of Part B telehealth by home health agencies	Despite the recent Congressional action to allow telehealth to originate from patient homes in both rural and urban areas, home health agencies cannot conduct patient visits services via telehealth. HHAs have infrastructure and expertise for remote monitoring and virtual care, but Medicare HH episodes require in person visits.	• Just as Medicare pays for professional services furnished remotely via telehealth, CMS should consider options to allow Home Health providers to provide telehealth services. • CMS could potentially allow qualified HA personnel to provide Part B telehealth services to support access to care during high need.
Low Utilization Payment Adjustment (LUPA)	The LUPA reduces home health payment when patients are not seen frequently during an episode of care. However, responding to coronavirus requires minimizing in-person exposure as much as possible.	• CMS could waive LUPA for COVID-19 patients to avoid requiring unnecessary visits. • Allowing televisits to count as home health visits would also help, as would a presumption that an appropriate plan of care would include initial visits and remote monitoring.
Coding	It is unclear how home health episodes for COVID-19 patients will be coded and paid for by Medicare.	• CMS could provide guidance on appropriate coding groups for COVID-19 home health patients. • Assuming COVID-19 patients fit into an established payment group would help to support waivers of portions of OASIS, speeding the process. • In selecting appropriate payment groups, CMS should consider the potential complexity of treating a novel disease, costs of PPE, and costs associated with remote monitoring and use of telemedicine (or add-on payments or percent increases to cover these costs).