Home Health Regulatory Update

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COVID PHE Declaration

- First COVID PHE declared for January 21, 2020
- Last PHE declaration- January 7, 2021 effective January 21, 2021
- Renewed April 21, 2021 for 90 days

COVID-19 PHE

- March 13, 2020 President Trump declared a national emergency

- Enabled Secretary of Health and Human Services (HHS) to authorize 1135 waivers

COVID-19 PHE Waivers

- **Regulatory**
  - 1135 Waivers ---blanket or individual
    - Conditions of participation (CoPs)
    - Health Insurance Portability and Accountability Act (HIPAA)
    - Provider enrollment
  - New regulations
    - Interim Final Rules with Comments (IFC)
      - Three rules issued
      - Two (3/30 and 4/30) impact HHAs
- **Sub-regulatory**
    - Guidance documents
    - FAQs

1135 Waivers: Home Health

Comprehensive Assessment

- §484.45(a) Flexibility with the 30-day submission time frame for the OASIS data set
  - Does not specify a time frame
- §484.55(a) Initial evaluation visits conducted remotely or through medical review
  - help with 48-hour rule
- §484.55 (b)(1) Extends the 5-day window for completing the comprehensive assessment to 30 days
- 484.55(a)(2)and(b)(3) Permits OT, PT, and SLP to conduct the initial and comprehensive assessment when therapy ordered

1135 Waivers: Home Health

HCA

- §484.80(d) 12-hour annual in-service training
  - Postponed until 1st quarter after PHE ends
- §484.80(h) 14-day HHA aide supervision visit
  - Encourages HHA to conduct virtually if unable to conduct an onsite visit
- §484.80(h)(1) Annual on-site supervisory visits with the aide
  - Postponed until 60 days after PHE ends

1135 Waivers: Home Health

Other CoPs

- §484.58(a) Discharge planning – HHAs not required to use quality and resource use measures to assist patients when transferring to post acute care

- §484.65 Quality Assurance and Performance Improvement program (QAPI) (HH&H)
  - concentrate on infection control issues,
  - continued focus on adverse events (aspects of care most closely associated with COVID-19)
  - must retain an effective, ongoing, agency-wide, data-driven QAPI program

- §484.110(d) Clinical records
  - May be provided within 10 days of request rather than 4 days or next visit

1135 Waivers: All Providers

HIPAA

- Waives enforcement of noncompliant technologies used for patient encounters
  - Covered providers may use any non-public facing remote communications product-e.g. Skype, Face time, Zoom

Provider enrollment

- Waives screening requirements: fees, site visits, criminal background checks
- Postpone revalidations
- Expedite application process

Medicare Interim Final Rule : 3/30

- **Homebound**
  - If it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19

- **Telehealth**
  - Implements lifting the geographic location and originating site restriction (legislative)
    - Enables the physician F2F encounter for HH certification to be conducted in the home, HIPAA allows the F2F to be conducted using non-public facing products
  - Telehealth visit must be included in the HH POC
  - Not replace on site visit
  - Non-billable
  - Codified into regulation with 2021 HH PPS rate update rule

Medicare Interim Final Rule : 4/30

- **NPPs (NP, PA, CNS) may certify and order home health services**
  - Permanent; retroactive to March 1, 2020
  - Updated relevant regulations (CoPs, provider enrollment, payment)
  - State laws apply
    - NPPs scope of practice
    - HHAs licensing rules
  - Medicaid aligns with Medicare

- **OASIS E**
  - Delayed until January 1 following one full year after the PHE ends
    - Ex. PHE ends April. 2021 OASIS E implemented 1/1/2023

Medicare Policy and Other Regulatory Flexibilities

- RAP auto cancel extension time frame by 90 days from the paid date of the RAP
  - no longer relevant as of 1/1/2021

- Cost reporting filing delayed - For any cost reporting period ending on a date falling in the period of March 1, 2020 through December 31, 2020, providers are granted an additional 60 days from the initial due date to file their cost reports.

- Accelerated and advanced payments
  - Ended April 26, 2020

Medicare Policy and Other Regulatory Flexibilities

- HHQRP and HHCAHPS optional for reporting data last quarter of 2019 and excepted for 1st and 2nd quarter of 2020
  - **Quality reporting resumed July 1, 2020 (3RD Quarter)**
  - **HHC Freeze until January 1, 2022**
  - https://www.cms.gov/files/document/hhqrp-pr-tip-sheet081320final-cx-508.pdf

- TPE and ARD requests for all providers were halted (MACs , RACs, CERT and SMRCs) OIG and UPIC audits continue
  - **MACs resumed post payment medical reviews August 17**
    - **Not TPE**
    - **Service specific medical reviews**
    - **A service specific review is one where the MAC is focused on the claim and not the provider.**
    - **Random sample**
    - **Claims prior to March1, 2020**

Medicare Policy and Other Regulatory Flexibilities

Medicare State Surveys initially suspended but resume

- Four memos issued:
  - 3/4/2020 suspended all survey activity except those that are **statutorily required (HH&H)**
  - 3/23/2020 prioritization of state surveys, no authorization of standard surveys –focused **infection control surveys**
  - 6/1/2020 Targets nursing homes but included instructions for **limited resumption** of routine survey activity for all providers.
  - 8/17/ 2020 In addition to ongoing focused infection control surveys, States are encouraged to **resume normal survey activities**, while also addressing the backlog of surveys that were postponed.
    - Based on White House guidance for states phase 3 reopening or earlier at the states survey office discretion
    - https://www.cms.gov/files/document/qso-20-35-all.pdf

Review Choice Demonstration

Paused in IL, Ohio and Texas March 29, 2020 Resumed August 31. 2020

Claims submitted under Choice 1 without going through the pre-claim review process will not be subject to a 25% payment reduction until further notice but will be subject to prepayment review.

Florida and North Carolina

Announced on 3/26/2021 Phase–in approach extended for another 90 days

HHAs have the option to participate in RCD

Claims submitted without going through the pre-claim review process will process as normal and will not be subject to a 25% payment reduction.

Claims may be subject to post payment review in the future through the normal medical review process

COVID-19 Advanced and Accelerated Payment (CAAP)

Repayment of advanced and accelerated payments began 3/31/2021

- Beginning 1 year from the date we issued the CAAP and continuing for 11 months, we'll recover the CAAP from Medicare payments due to providers and suppliers at a rate of 25%
- After the end of this 11-month period, CMS will continue to recover remaining CAAP from Medicare payments due to providers and suppliers at a rate of 50% for 6 months.
- After the end of the 6- month period the Medicare Administrative Contractor (MAC) will issue a demand letter for full repayment of any remaining balance of the CAAP.
- If CMS doesn't receive payment within 30 days, interest will accrue at the rate of 4% from the date your MAC issues you the demand letter. After that, we'll assess interest for each full 30-day period that you fail to repay the balance. SE21004 (cms.gov)

Home Health Value Based Purchasing

- 2020 -Last reporting year for the demonstration
- Payment adjustment apply to 2022
- First two quarters of 2020 measure reporting was excepted
- No word on revised calculations
- CMMI plans to expand HHVBP demo nation wide
- Will announce details through rule making process

Sequestration

- Legislation to hold sequestration extended to the end of 2021

- MACs to begin releasing claims of service April 16, 2021

No-Pay RAP

- Only applies to 2021 as HHAs transition to the NOA
- Must be submitted within 5 days after the "From" date of a HH period claim or a penalty is applied .
- Submission of the RAP can be done when the following criteria have been met: (1) the appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented, as required in regulation at 42 CFR 484.60(b) and 42 CFR 409.43(d); (2) the initial visit within the 60-day certification period must have been made and the individual admitted to home health care.
- This reduction in payment will be equal to a 1⁄30th reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date/admission date, or "from date" for subsequent 30-day periods, until the date the HHA submits the RAP.
- HHAs will be allowed to submit both the RAP for the first 30-day period of care and the RAP for the second 30-day period of care (for a 60-day certification) at the same time

No-Pay RAP

Change Request 11855 revised 3/31

r10696cp.pdf (cms.gov)

- Any valid diagnosis permitted on the RAP
- Clarifies that line 0023 date must match the claims

Multiple claims processing issues

Notice of Admission (NOA)

- Same submission criteria as the No-Pay RAP
- Same submission time frame and penalty as the No–Pay RAP
- 837I companion guide issued 4/7 on Coding and Billing Information | CMS
- Change Request issued 5/2021

Home Infusion Therapy

- New Part B benefit –permanent program 2021
- Covers the professional services related to HIT for Part B drugs- infused via a pump
- HIT suppliers must be accredited by a Medicare approved AO
- HHAs may become HIT supplier
- HHAs may subcontract with a HIT supplier
- Skilled services related to Part B infusion drugs carved out of the home health benefit beginning 1/1/2021

F2F Encounter and the CARES Act

- Legislation that allows an NP, PA, or CNS to certify and order home health services also provides flexibility for who may conducted the home health face to face encounter.

- The statute states that the certifying physician or allowed practitioner must document that a physician or allowed practitioner has had a face-to-face encounter prior to certification.

- Statutory changes are a double win for HHAs

F2F Encounter and the CARES Act

- 1814(a)(2)(C)
- "~~and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that prior to making such certification the physician must document that the physician himself or herself , or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician, has had a face-to-face encounter~~
- and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after the date of the enactment of the (CARES Act), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or physician assistant has had a face-to-face encounter'' (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary;

F2F Encounter and the CARES Act

- MACs follow the Policy Manual instructions

- Medicare Benefit Policy Manual, Chapter 7, section 30.5.1.1 – Face-to-Face Encounter: 1. Allowed Provider Types As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician or allowed practitioner himself or herself, a physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

- Follow the manual instructions until CMS make conforming changes

Policy Manual Conflicts

Medicare Benefits Policy Manual , chapter 7, 30.5.3 - Who May Sign the Certification or Recertification

The physician or allowed practitioner who signs the certification or recertification must be permitted to do so by 42 CFR 424.22. A physician or allowed practitioner in the same group practice as the certifying physician or allowed practitioner who established the home health plan of care and the certification/recertification statement, may sign in place of the physician or allowed practitioner when he/she is unavailable. The HHA is responsible for ensuring that the physician or allowed practitioner who signs the plan of care and certification/recertification statement practices in the same group practice as the physician or allowed practitioner who established the plan of care and completed the certification. The physician or allowed practitioner that performed the required face-to face encounter must 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

Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 - Physician Certification and Recertification of Services.
30.1 - Content of the Physician's Certification
……..
Certifications must be obtained at the time the plan of care is established or as soon thereafter as possible. The physician must sign and date the plan of care (POC) and the certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The plan of care may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC, oral order, or certification via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

Policy Manual Conflicts

COVID-19 Frequently Asked Questions (FAQs) on (cms.gov) AA, question#13

Question: 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?

- 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. New: 6/19/2

Emergency Preparedness - Appendix Z

- Issued 3/26

- Interpretive guidelines related to:
  - Burden reduction rule changes to §484.102
  - Expanded guidance related to emerging infectious diseases (EIDs):
  - Additional guidance based on best practices, lessons learned and general recommendations for planning and preparedness for EID outbreaks.

- QSO-21-15-ALL (cms.gov)

OSHA NEP

National Emphasis Program

- Ensure that employees in high hazard industries or work tasks are protected from the hazard of contracting Coronavirus Disease 2019 (COVID-19)
- Includes an added focus to ensure that workers are protected from retaliation
- Home health care service organizations are a targeted industry for this NEP

Guidance documents

Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace | Occupational Safety and Health Administration (osha.gov)

CDC COVID-19 guidance

OSHA NEP

- OSHA COVID -19 citations
  - Inspections with COVID-related Citations | Occupational Safety and Health Administration (osha.gov)

HIPAA Privacy Proposed Rule

Issued in the FR 1/21/2021-comments due May 6, 2021

- Eliminate the requirement for written acknowledgment of receipt of the privacy notice and retention.
- Required response time to no later than 15 calendar days from the current 30 days
- Strengthening individuals' rights to inspect and receive their PHI in person
- Revises allowable fees
- Requiring covered entities to post estimated fee schedules on their websites for access and for disclosures
- Revises the privacy notice header
- Clarifies requirements around uses and disclosures of PHI and sending NPI to a third partyt

2020-27157.pdf (govinfo.gov)

HHQRP

- Hospice rate update proposed rule --4/8/2021
- Eliminate Q1 AND Q2 2020 of data for quality measure reporting – January 2022 –July 2024(accommodates some claims-based measures)
- Q3 and Q4 of 2020 and Q1 of 2021
- Testing shows this approach achieves scientifically acceptable quality measure scores for the HH QRP
- 2021-07344.pdf (federalregister.gov) , Table 33

PureWick External Urinary Collection System

- New female external urinary collection system

- HCPCS code K1006 (Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system)

- CGS DMEPOS MAC statement:
  - The Pure Wick Urine Collection System has a useful life of 1 year and therefore does not meet the durability definition at 42 CFR 414.202 to be considered as durable medical equipment (DME). Any supplies billed to the DME MAC for this item should also deny as noncovered.

Home Health Regulatory Update

QUESTIONS??