Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE)

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This **interim final rule with comment period** (IFC) gives individuals and entities that provide services to Medicare beneficiaries needed flexibilities to respond effectively to the serious public health threats posed by COVID-19. …understanding that some pre-existing Medicare payment rules may inhibit innovative uses of technology that might otherwise be effective in the efforts to mitigate the impact of the pandemic, we are changing Medicare payment rules during the Public Health Emergency (PHE) for the COVID-19 pandemic so that physicians and other practitioners, ***home health*** and ***hospice*** providers, inpatient rehabilitation facilities, rural health clinics (RHCs), and federally qualified health centers (FQHCs) are allowed broad flexibilities to furnish services using remote communications technology to avoid exposure risks to health care providers, patients, and the community.

These regulations are applicable beginning on March 1, 2020.

Comments can be submitted up to 60 days from the date these rules are published in the Federal Register

This rule also amends the Medicaid home health regulations to allow other licensed practitioners to order home health services, for the period of this PHE for the COVID-19 pandemic in accordance with state scope of practice laws

NOTE: Physician assistants, advanced practice registered nurses, certified nurse practitioners, clinical nurse specialists and certified nurse midwives may order HHA – See §2H Gov. Edwards Proclamation No. 38 JBE 2020 – 03/31/2020

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She is the division head for Medicare home health and hospice benefits.

The first part of the IFC is dedicated to adding many services under the Physician Fee Schedule to the list of reimbursable telehealth services. *Feel free to share the list with your medical directors, and other physician "partners" that maintain their own practices. In that vein, the Louisiana State Board of Medical Examiners removed all licensing requirements for physician telemedicine services*.

All telecommunication devices are acceptable – CMS regulations previously prohibited the use of telephones, facsimile machines, and electronic mail systems for purposes of Medicare telehealth services. In light of the PHE for the COVID-19 pandemic, CMS is revising the rule to add an exception to this language on an interim basis. It reads, as follows: "**Exception. For the duration of the public health emergency, Interactive telecommunications system means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.**"

HIPAA WAIVERS

The HHS Office for Civil Rights (OCR) is exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the PHE for the COVID-19 pandemic.

https://www.hhs.gov/hipaa/forprofessionals/special-topics/emergency-preparedness/index.html

No CMP risk to defray patient's share of expense for telehealth services

On March 17, the OIG issued a policy statement that it will not subject practitioners to OIG administrative sanctions for arrangements that satisfy both of the following conditions:

1. A practitioner reduces or waives cost-sharing obligations (i.e., coinsurance and deductibles) that a beneficiary may owe for telehealth services furnished consistent with the then-applicable coverage and payment rules.
2. The telehealth services are furnished during the time period subject to the COVID-19 Declaration.

No CMP risk to offer free telehealth services

For any free telehealth services furnished during the time period subject to the COVID19 Declaration, OIG will not view the provision of free telehealth services alone to be an inducement or as likely to influence future referrals (i.e., OIG will not view the furnishing of subsequent services occurring as a result of the free telehealth services, without more, as evidence of an inducement).

Clarification of Homebound Status under the Medicare Home Health Benefit

As an example for the PHE for COVID-19 pandemic, this would apply for those patients: (1) where a physician has determined that it is **medically contraindicated** for a beneficiary to leave the home because he or she has a **confirmed** or **suspected** diagnosis of COVID-19; or (2) where a physician has determined that 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 COVID-19.

A patient who is exercising "self-quarantine" for one's own safety would not be considered "confined to the home" unless a physician certifies that it's medically contraindicated for a patient to leave home.

In cases where it is medically contraindicated for the patient to leave the home, the medical record documentation for the patient must include information as to why the individual condition of the patient is such that leaving the home is medically contraindicated. With regards to a pandemic outbreak of an infectious disease, this can include reviewing and applying any guidance on risk assessment and public health management issued by the CDC

For example, if a patient is having an exacerbation of chronic obstructive pulmonary disease (COPD) and the physician certifies that it is medically contraindicated to leave the home because the patient's compromised respiratory system makes him or her more likely to contract an infectious disease, such as COVID-19, the patient would be considered "confined to the home".

Patient Must Still Meet All Other Criteria For Home Health Eligibility

In addition to being considered “confined to the home” or “homebound”, the patient must still meet the other Medicare home health eligibility requirements to receive Medicare home health services. That is, the beneficiary must be under the care of a physician; receiving services under a plan of care established and periodically reviewed by a physician; be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy.

The Use of Technology Under CMS' Home Health Benefit

In the IFC, CMS states that it is statutorily-prohibited from paying for home health services furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care and for paying directly for such services under the home health benefit. However, for the duration of the PHE for the COVID-19 pandemic, CMS is amending the regulations to provide HHAs with the flexibility, in addition to unreimbursed remote patient monitoring, to use various types of telecommunications systems (that is, technology) in conjunction with the provision of in-person visits

Specifically, CMS is amending the regulations at 42 CFR § 409.43(a) (POC requirements) on an interim basis to state that 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

CMS is also amending the regulations at § 409.43(a) on an interim basis to state that 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.

As a reminder, the plan of care must be signed prior to submitting a final claim to Medicare for payment (§ 409.43(c)(2)); therefore, 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

§ 409.43 Plan of care requirements.

(a) * * *

(3) The plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits, as well as those items listed in § 484.60(a) of this chapter that establish the need for such services. All care provided must be in accordance with the plan of care. During a PHE, as defined in §400.200 of this chapter, the plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system and such services must be tied to the patient-specific needs as identified in the comprehensive assessment, cannot substitute for a home visit ordered as part of the plan of care, and cannot be considered a home visit for the purposes of patient eligibility or payment. The plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care

We reiterate that by law the use of technology may not substitute for an in-person home visit ordered as part of the plan of care and services furnished via a telecommunications system cannot be considered a home health visit for purposes of eligibility or payment. However, we acknowledge that the use of such technology may result in changes to the frequency or types of visits outlined on the plan of care, especially to combat the PHE for the COVID-19 pandemic. **For example**, a patient recently discharged from the hospital after coronary bypass surgery was receiving home health skilled nursing visits three times a week for medication management, teaching and assessment. The patient developed a fever, cough, sore throat and moderate shortness of breath and now has a confirmed COVID-19 diagnosis, which the doctor has determined can be safely managed at home with home health services. The patient has been prescribed new medications for symptom management and oxygen therapy to support the patient's respiratory status. The patient's home health plan of care was updated to include an in person skilled nursing visit once a week to assess the patient and to monitor for worsening symptoms. The plan of care was updated also to include a video consultation twice a week between the skilled nurse and the patient for medication management, teaching and assessment, as well as to obtain oxygen saturation readings that the patient relays to the nurse during the consultation.

With regards to payment under the HH PPS, if the primary reason for home health care is to provide care to manage the symptoms resulting from COVID-19, this 30-day period of care would be grouped into the Medication, Management, Teaching and Assessment (MMTA) – Respiratory clinical group, and it would be an early 30-day period of care with an institutional admission source. Assuming a medium functional impairment level with "low" comorbidities, the low-utilization payment adjustment (LUPA) threshold would be 4 visits. Regardless if the patient continued to receive the original 3 in-person skilled nursing visits per week (12 visits total in the 30-day period) rather than the once per-week in-person skilled nursing visits (4 visits total in the 30-day period) the HHA would still receive the full 30-day payment amount (rather than paying per visit if the total number of visits was below the LUPA threshold). In this example, the use of technology is not a substitute for the provision of in-person visits as ordered on the plan of care, as the plan of care was updated to reflect a change in the frequency of the in person visits and to include "virtual visits" as part of the management of the home health patient.

The IFC contains a lot of encouraging words favoring telehealth for home health, but, at the end of the day, until the law changes, CMS will only pay for a visit as defined at § 409.48(c) as an **episode of personal contact with the beneficiary by staff of the HHA or others under arrangements with the HHA, for the purpose of providing a covered service**. Generally, one visit may be covered each time an HHA employee or someone providing home health services under arrangement with the HHA enters the beneficiary's home and provides a covered service to a beneficiary.

PART 418—HOSPICE CARE

§ 418.22 Certification of terminal illness.

(a) (4) * * *

(ii) During a Public Health Emergency, as defined in § 400.200 of this chapter, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via a telecommunications technology and is considered an administrative expense. Telecommunications technology means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

§ 418.204 Special coverage requirements. * * * * *

(d) *Use of technology in furnishing services during a PHE*

When a patient is receiving routine home care, during a Public Health Emergency as defined in § 400.200 of this chapter, hospices may provide services via a telecommunications system if it is

feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions. The use of such technology in furnishing services must be included on the plan of care, meet the requirements at § 418.56, and must be tied to the patient specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care

A terminally ill 85-year-old male with heart failure has been receiving hospice services and recently developed a fever, sore throat and cough. The patient has been diagnosed with suspected COVID-19 and his hospice plan of care now includes medications for symptom management. He is mildly short of breath but does not require supportive oxygen therapy. The patient's wife is concerned about potential for worsening cardiac and respiratory symptoms as a result of the patient's risk for increased complications due to COVID-19. The hospice plan of care has been updated to include remote patient monitoring with a telecommunications system to assess the patient's daily weight and oxygen saturation levels. The plan of care identifies the measurable goal that the patient will maintain an oxygen level above 92 percent and the patient will not gain more than 2 pounds in a 24-hour period. The plan of care identifies interventions if either of these goals are not met. The remote patient monitoring allows for more expedited modifications to the plan of care in response to the patient's changing needs.

Hospices are paid a per diem payment amount based on the level of care for each day that a patient is under a hospice election. There is no payment beyond the per diem amount for the use of technology under the hospice benefit. For the purposes of the hospice claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim. However, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE as “other patient care services”.

Face-to-face and In-person Requirements

For the duration of this PHE for the COVID-19 pandemic, it is in the best interest of patients, health care professionals and suppliers to limit face-to-face encounters and avoid exposure of vulnerable Medicare beneficiaries to COVID-19. Therefore, on an interim basis, we are finalizing that to the extent an **NCD** or **LCD** (**including articles**) would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied F2F services, those requirements would not apply.

Home Health Agencies: CMS Flexibilities to Fight COVID-1

In addition to the IFC, on March 30, 2020, CMS summarized all of the regulatory changes affecting home health agencies, most of which are in the IFC. This summary, however, gives us a quick guidance to the most significant rule changes, that include:

- Use of telehealth for home health
- Expanded definition of home bound status
- Certain mid-levels can now order home health, sign POC, certify and re-certify patient eligibility
- Extending OASIS completion deadlines from 5 to 30 days and delayed submissions will not be penalized
- Initial assessments under 484.55 can be performed remotely or by record review
- MACs are encouraged to extend the auto-cancellation date for RAPS
- Deadlines are extended for redetermination and reconsideration appeals

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- Providers are to be given more time to respond to ADR requests
- Appeals that don’t meet all of the procedural requirements will not be categorically dismissed, instead, they will be adjudicated based upon what information is available and to be flexible by assuming that appellant has good cause for delay or mistakes in filing
- CMS will facilitate access to Accelerated/Advance payments; if submitted request meets criteria, provider can expect advance payment in 7 days; repayment is extended from 90 to 120 days
- All revalidation actions are suspended
- Any new enrollment 855s will be expedited
- Cost report deadlines are extended; 10/31/19 FYE and 11/30/19 CR due respectively 03/31/20 and 4/30/20 are now due on 6/30/20. December CR are due in July 2020
- HHA nurse may obtain sample for testing but beware, this does not constitute a “skilled” visit

Additional Guidance

- The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergencypreparedness-response-operations/current-emergencies/coronavirus-waivers.
- CMS has released guidance to describe standards of practice for infection control and prevention of COVID-19 in home health agencies at https://www.cms.gov/files/document/qso-20-18-hha.pdf.
- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at https://www.cms.gov/newsroom/press-releases/cms-announces-reliefclinicians-providers-hospitals-and-facilities-participating-quality-reporting.

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