# Home Health Agencies: CMS Flexibilities to Fight COVID-19

The Trump Administration is issuing an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) to ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 2) remove barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states so the healthcare system can rapidly expands its workforce; 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

***Medicare Telehealth***

- Home Health Agencies (HHAs) can provide more services to beneficiaries using telehealth within the 30 day episode 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. 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.

***Patients Over Paperwork***

- *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. 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.
- *Plans of Care and Certifying/Recertifying Patient Eligibility:* HHS is utilizing enforcement discretion with regards to the requirements at §§ 409.43 and 424.22 in order to allow a patient to be under the care of a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1861(aa)(5)) who is working in accordance with State law, or a physician assistant (as defined in section 1861(aa)(5)) who is working in accordance with State law, and for such physician/practitioner: (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. This will provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. HHS will not conduct audits to ensure that only physicians provided orders, signed and dated the plans of care, and certified/recertified patient eligibility for claims submitted during this public health emergency.
- *Reporting:* CMS is providing relief to HHAs on the timeframes related to OASIS Transmission. This waiver includes extending of the 5-day completion requirement for the comprehensive assessment and waiving the 30-day OASIS submission requirement. HHAs are expected to complete the comprehensive assessment within 30 days and delayed submission is permitted. We continue to require that patients still have an assessment to determine and be able to appropriate meet their care needs.

- *Initial Assessments:* By waiving 42 CFR § 484.55(a), home health agencies can perform initial assessments and determine patients' homebound status remotely 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 allow for maximizing coverage if there are limited physician and advanced practice clinicians, and will allow those clinicians to focus on caring for patients with the greatest acuity.
- *Requests for Anticipated Payments (RAPs):* MACs can extend the auto-cancellation date of RAPs during emergencies. RAPs are a pre-payment for home health services.
- *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.

***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;
- 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; 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);
- 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.
- *Accelerated/Advance Payments:* In order to increase cash flow to providers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/advance payment is a payment intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the public health emergency to any Medicare provider/supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/accelerated payments begins at 90 days, however for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment.

Providers can get more information on this process here: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

- *Provider Enrollment:* CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment:
  - Waive certain screening requirements.
  - Postpone all revalidation actions.
  - Expedite any pending or new applications from providers.

***Cost Reporting***

- CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. We are currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay 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 will also delay 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.

***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.

***Workforce***

- *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.
- *Waived onsite visits for both HHA Aide Supervision:* CMS is waiving the requirements at 484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include 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. This waiver is also temporarily suspending 2-week aide supervision requirement at 42 CFR §484.80(h)(1) by a registered nurse for home health agencies, but virtual supervision is encouraged during the period of the waiver.

***Additional Guidance***

- The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergency-preparedness-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-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting.