Missouri Alliance for **HOME CARE**

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Supplemental information related to April 1st MAHC update - **CMS Issues New Waivers under the Home Health Conditions of Participation and Waivers for Hospice**

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

Click here to download the entire 225-page Interim Final Rule.

Below is the section related to CMS' view on not allowing reimbursement for Home Health Telehealth Visits

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While we remain 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, for the duration of the PHE for the COVID-19 pandemic, we are amending the regulations at § 409.43(a) on an interim basis to provide HHAs with the flexibility, in addition to remote patient monitoring, to use various types of telecommunications systems (that is, technology) in conjunction with the provision of in-person visits. Specifically, we are amending the regulations at § 409.43(a) 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. We are 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. In addition, HHAs may also provide services based on verbal orders in accordance with the regulations at §§ 484.60(b) and 409.43(d). Finally, on an interim basis HHAs can report the costs of telecommunications technology as allowable administrative and general (A&G) costs by identifying the costs using a subscript between line 5.01 through line 5.19.

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.