Let's Clarify – the Latest COVID-19 Home Health Updates and Regulations!

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YEAH... IF YOU COULD JUST
MAKE HOME CARE EASY FOR ME
THAT'D BE GREAT

Disclosure: As we are building the bridge we are walking on, the information presented in this webinar is what we know as of April 9th, 2020 and is subject to change as may be directed by CMS and/or local authorities.

Amity Healthcare Group will continue to provide updates via email notifications, LinkedIn posts and COVID-19 Resource Page at www.amityhealthcaregroup.com

CMS Updates

Homebound Status

Homebound Definition: COVID-19 infected person is classified as homebound if:

- Suspected or confirmed COVID-19 person is quarantined
- Individual deemed by physician as at risk of infection, if this individual leaves home
  - Generally applicable to individuals with some level of compromised condition
  - "Medically-contraindicated" to leave the home

So, if a beneficiary is homebound due to COVID-19 and needs skilled services, a home health agency can provide skilled home health services to this patient under the Medicare Home Health benefit.

Plans of Care and Certifying/Recertifying Patient Eligibility

According to CFR § 409.43 (plan of care requirements: an individualized plan of care must be established and periodically reviewed by the certifying **physician**) and CFR § 424.22 (Medicare Part A or Part B pays for home health services only if **a physician** certifies and recertifies the content …)

Under home health temporary waiver, CMS is adjusting the above requirements to expand the authority of non-physician providers as follows:

- Allows patient to be under the care of an NPP (NP, PA, and CNS) to the extent permitted under the **state law**
- Authorizes NPPs to:
  - Order home health services
  - Establish and review POC
  - Certify and recertify eligibility

Plans of Care and Certifying/Recertifying Patient Eligibility (cont'd)

CMS "allows patient to be under the care of an NPP to **the extent permitted under the state law**."

According to STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 26 -HOME CARE AGENCIES 6 CCR 1011-1

7.10 Plan of care

(A)Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. **Care plans established by a nurse practitioner, physician assistant or other therapists within their scope of practice may be accepted by an HCA that is not federally certified as a home care agency**.

As of April 6th, 2020, CDPHE/state of Colorado, waived the portion of this rule that prevents federally certified agencies from having nurse practitioners or physician assistants establish or periodically review care plans. Agencies must continue to meet the requirements for the establishment and periodic review of a written plan of care.

The waiver will remain in place as long as CMS is exercising enforcement discretion.

Please note that CMS waiver went into effect on 3/30/20, while state did match CMS waiver until 4/6/20.

Always be aware of any state HHA licensing and scope of practice barriers and requirements and always check to make sure that state and federal waivers match. Federal waivers do not override state requirements.

CoPs-OASIS

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 to 30 days;
- Waiving the 30-day OASIS submission requirement. A new time frame is not specified.

CoPs-Initial Assessments

CMS is waiving CoP 42 CFR § 484.55(a):

§ 484.55 Condition of participation: Comprehensive assessment of patients.

Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, **both at the time of the initial assessment visit and at the time of the comprehensive assessment.**

(a) Standard: Initial assessment visit.

(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

By waiving 42 CFR § 484.55(a), CMS allows home health agencies to perform initial assessments and determine patients' homebound status remotely or by record review. This waiver does not remove a requirement to complete a Start of Care/Comprehensive Assessment visit.

Start of Care comprehensive assessment is still required to be performed in person.

CoPs- Supervision

484.80 (h) Standard: Supervision of home health aides.

(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in § 484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.

CMS is temporarily waiving the requirements at 484.80(h), which require 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.

However, supervision requirements under state licensure requirements/Medicaid are not subject to this waiver.

According to the information initially issued by CDPHE on March 31, 2020 and then updated on April 6th, 2020, related to 6 CCR 1011-1, Chapter 26, Home Care Agencies, Part 7.15, Nurse Aide Services and Part 7.16, Nurse Aide Training and Orientation.

- The agency **must continue to provide supervision** to ensure consumer care and treatment are delivered in accordance with a plan of care that addresses the consumer's status and needs.
- The supervising nurse may evaluate the delivery of care and services **by telephone and/or video conference with the CNA and consumer**. The results of the supervisory visit must be documented by the supervising nurse.
- The supervising nurse MUST conduct an in-person supervisory visit to evaluate consumer complaints related to the delivery of care by CNA staff when such concerns cannot be successfully addressed remotely by telephone and/or video.

CoPs- Medicare Written Notices

If you are treating a patient with suspected or confirmed COVID-19, CMS encourages the provider community to be diligent and safe while issuing the following beneficiary notices to beneficiaries receiving care:

- Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
- Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
- Home Health Change of Care Notice (HHCCN)_CMS-10280

In the light of concerns related to COVID-19, current notice delivery instructions provide flexibilities for delivering notices to beneficiaries.

Notice delivery may be made via telephone or secure email to beneficiary or beneficiary's representatives. A contact phone number should be provided for a beneficiary or a representative to ask questions about the notice. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent, as well as patient's/representative's choices, as appropriate.

Don't forget, the patient/representative still need to have a copy of the notice for their record and you need to keep a copy for your records. These copies must be identical.

Medicare Telehealth

According to CMS, during emergency period Home Health Agencies 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.

CMS did not approve a separate reimbursement for telehealth visits. CMS does not consider telehealth visits to be an equivalent of in-person visits for billing purposes.

CMS permits HHAs to provide telehealth during emergency period as follows:

- Telehealth must be physician-ordered on the POC (be specific about frequency and duration for telehealth visits, as well as description of telehealth visits-e.g. PT 3w2, 1 in-person visit per week and 2 telehealth visits per week for …..)
- LUPA thresholds are based on in-person visits (as telehealth visits do not constitute equivalent for in-person visits for billing purposes and billing is based on in-person visits only, you need to complete your LUPA threshold visits via in-person visits)
- Use of telehealth once LUPA threshold is met will not affect the amount of your 30-day episode of payment

Benefits of telehealth:

- Permits HHAs to reduce in-person visits and as such, minimize staff and patient exposure to COVID-19 and preserve PPE
- Reduces episode costs
- Preserves episode payment amount
- CMS policy does allow home health agencies to record the cost of all telehealth services in the cost report.

Medicare Telehealth (cont'd)

Case Scenario from Federal Register :

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, 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.

Federal Register April 6, 2020

Face to Face Encounter

- Physician Face to Face encounter may be conducted via telehealth in accordance with requirements to qualify patient for home health.
- Encounter has to occur via audio and video- **two-way method.**
- Skype, Facetime, Zoom etc., are appropriate at this time as this communication will not be subject to HIPAA Enforcement

Financial Relief

Accelerated/Advance Payments:

In order to increase cash flow to providers impacted by COVID-19, CMS has expanded current Accelerated and Advance Payment Program, intended to provide necessary funds when there is a disruption in claims submission.

- Providers may request up to 3 months of anticipated revenue
- After 120 days, CMS will offset claims payments against amounts owing for accelerated and advance payments (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.)
- Full repayment required within 210 days
- Unpaid amount remaining after 30 days from the date of demand letter issued by MAC will be subject to interest.

Eligibility Requirements:

Any Medicare provider/supplier who submits a request to the appropriate MAC and meets the required qualifications as follows:

- Provider must have billed Medicare in the last 180 days
- Provider may not be under medical review or program Integrity Review (RCD does not count)
- Provider must not have any outstanding/delinquent Medicare overpayments

Tips: Be careful that level of request within expected revenues. Payment should be issued within 7 days of approval of your request.

Facts: In the last 5 years, MACs had a total of 100 accelerated/advanced payment requests, since 3/31/20, there were 25, 000 requests and over $34 million dollars in payment.

Financial Relief

Medical Review

CMS is halting:

- TPE and ADR requests for all providers. For ADRs that have been already requested –claims will process and paid. No new ADR requests will be issued at the time of emergency.
- Prepayment and post payment reviews. CMS/MACs will still conduct reviews for fraud
- Review Choice Demonstration (RCD)
  - Paused in IL, Ohio and Texas 3/29
  - Will not precede in NC or Florida as scheduled. New dates to be announced after the public health emergency status is lifted.
  - Claims submitted prior to 3/29 will process as usual
  - Claims submitted after 3/29 to the end of the PHE will not be subject to review choice
  - Home Health agencies do not have to do anything for the pause to go into effect.
- **No direction on claims in appeals**

Financial Relief

- ***Requests for Anticipated Payments (RAPs):*** MACs can extend the auto-cancellation date of RAPs during emergencies.

- ***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.

****** Final claims- remember that requirements for orders to be signed prior to final claim submission has not been dropped. This continues to be a condition of payment.***

Colorado Updates

Medicaid Telemedicine

On March 20th, 2020 HCPF released **COVID-19 State of Emergency Changes to Telemedicine Services** directives in order to "facilitate the safe delivery of health care services to members throughout the COVID-19 state of emergency. The Department authorized three temporary changes to the existing telemedicine policy. Including the following:

"Physical Therapy, Occupational Therapy, Home Health, Hospice and Pediatric Behavioral Health Providers - Health First Colorado has expanded the list of providers eligible to deliver telemedicine services to include physical therapists, occupational therapists, hospice, home health providers and pediatric behavioral health providers. Services allowed under telemedicine may be provided via telephone or interactive audiovisual modality for these provider types."

Requirements for Telemedicine Services:

- It is acceptable to use telemedicine to facilitate live contact directly between a member and a provider. Services can be provided between a member and a distant provider when a member is in their home or other location of their choice. Additionally, the distant provider may participate in the telemedicine interaction from any appropriate location.
- The reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as the medical assistance program rate for a comparable in-person service. [C. R. S. 2017, 25.5-5-320(2)].
- Providers may only bill procedure codes which they are already eligible to bill.
- Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.
- Providers must document the member's consent, either verbal or written, to receive telemedicine services.
- The availability of services through telemedicine in no way alters the scope of practice of any health care provider; nor does it authorize the delivery of health care services in a setting or manner not otherwise authorized by law.
- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine.
- The use of telemedicine does not change prior authorization requirements that have been established for the services being provided.
- Record-keeping and patient privacy standards should comply with normal Medicaid requirements and HIPAA.

Medicaid Telemedicine

What do we know now?

On March 31st, 2020, CDPHE Health Facilities Division issued a telemedicine waiver applications for agencies to meet specified observation, supervision, and evaluation requirements through telehealth methods rather than in-person or on-site. Additionally, the waiver allowed certain therapy services to be provided via interactive audiovisual connections.

Initially, the waiver applied to Class A and Class B licensed only agencies and excluded Medicare Certified Class A providers. However, on April 6, 2020, an update to the waiver was posted to include Class A certified providers as well.

A CDPHE provider portal message was sent out with the link to submit the waiver.

Requirement for Telehealth Policies and Procedures

The Home Care Agency must document and implement policies and procedures detailing how the requirements of this waiver, as well as the applicable rules, will be met. These policies and procedures, as well as any related staff training, must be available for review at the Department's request.

Telemedicine Waiver

For Home Care Agencies providing skilled care (Class A licensees), the following waivers are requested:

*6 CCR 1011-1, Chapter 26, Home Care Agencies, Part 7.9, Initial and Comprehensive Assessments. **A waiver is requested to allow home care nursing services to conduct comprehensive patient assessment and provide ongoing patient assessment by telephone, via live chat, or through video conferencing**. All other general requirements, such as documentation and meeting the standard of care must be met.

*6 CCR 1011-1, Chapter 26, Home Care Agencies, Part 7.15, Nurse Aide Services and Part 7.16, Nurse Aide Training and Orientation. **A waiver is requested to allow the agency to meet the requirement for direct observation of a CNA through telehealth as follows** (NOTE: All other rules in these Parts remain applicable as written, and are not modified by this waiver):

For Certified Nurse Aide (CNA) Care and Services--The agency must continue to ensure that skills learned or tested elsewhere can be transferred successfully. This review of skills must be done before the nurse installs an aide into a new consumer care situation. The supervising nurse must evaluate, and maintain documentation of the evaluation, of any skills that the CNA will utilize.

- The review of skills may be performed by the supervising nurse verbally, via video demonstration by the CNA, or by written form.
- The review must include an evaluation of the step by step process for how the CNA is to safely carry out the task(s).
- A review of skills is not necessary for currently employed CNA staff who are being newly assigned to clients who will be receiving care and services for which the CNA was previously evaluated by the supervising nurse.

Telemedicine Waiver (cont'd)

For Certified Nurse Aide (CNA) Supervision--The agency must continue to provide supervision to ensure consumer care and treatment are delivered in accordance with a plan of care that addresses the consumer's status and needs.

- The supervising nurse may evaluate the delivery of care and services by telephone and/or video conference with the CNA and consumer. The results of the supervisory visit must be documented by the supervising nurse.
- The supervising nurse MUST conduct an in-person supervisory visit to evaluate consumer complaints related to the delivery of care by CNA staff when such concerns cannot be successfully addressed remotely by telephone and/or video.

6 CCR 1011-1, Chapter 26, Home Care Agencies, Part 7.17, Therapy Services. A waiver is requested to allow the agency to modify how this part is met, as follows:

- For therapy services, such as physical therapy, occupational therapy, and speech therapy, services and supervision may be provided and supervised through an interactive audiovisual connection. All other general requirements, such as documentation and meeting the same standard of care must be met.

In order to take advantage of the above waivers, providers need to complete waiver application. According to CDPHE, current processing time is 4 days.

EVV & PPE

EVV:

Per HCPF directions from April 3rd, 2020 webinar, EVV cannot be delayed, and as a result, as of right now change in the implementation date of **08/03/2020** is **not** expected.

PPE:

It was recommended for providers to reach out to the local departments of health and/or emergency managers to address PPE shortages and requests.

For multiple providers the above recommendation did not prove to be effective.

Per HCPF directions from April 3rd, 2020 webinar, you may contact **Sadie Martinez**, Access and Functional Needs Coordinator with Division of Homeland Security, at **720-610-1691** or email: sadie.martinez@state.co.us with questions related to PPE or lack of response from emergency managers.

PPE (cont'd)

The Personal Protective Equipment (PPE) Burn Rate Calculator excel icon[3 sheets] is a spreadsheet-based model that will help healthcare facilities plan and optimize the use of PPE for response to COVID-19.

To use the calculator, enter the number of full boxes of each type of PPE in stock (gowns, gloves, surgical masks, respirators, and face shields, for example) and the total number of patients at your facility. The tool will calculate the average consumption rate, also referred to as a "burn rate," for each type of PPE entered in the spreadsheet. This information can then be used to estimate how long the remaining supply of PPE will last, based on the average consumption rate.

Before loading and starting the PPE Burn Rate Calculator, you may need to change Excel's security level. To do so:

- Open a blank Excel spreadsheet.
- Click Tools and then click Macro, choose Security.
- Set Security Level to Medium.
- Click OK.
- Double-click and open PPE Burn Rate Calculator file.
- When asked to Disable Macros or Enable Macros, click Enable Macros.

Good Practice…

- Implement your Emergency Preparedness procedures including COVID-19 guidelines. Determine if your Incident Command operates in efficient and effective manner. Prepare to be flexible and evolve your processes. Assure effective reporting and communication.
- Provide additional education (use of PPE, donning and doffing of PPE, home health COVID-19 guidelines, etc.), as may be necessary.
- Protect and check in with your staff (ex: implement weekly ZOOM meetings, emotional support, etc.)
- Keep communication with your community partners and vendors.
- If you update your policies or implement new policies during the emergency period, please make a reference to the document/guidelines from CMS/CDPHE/HCPF or other authority that you utilized and maintain it in your records.
- If you are not able to care for a COVID-19 positive patient who is currently in your care, carefully consider patient's needs. Consider transferring patient to another agency that is able to accommodate COVID-19 patients to assure that patient's care is not compromised instead of putting patient's care on hold.

Success Stories…

- Multiple healthcare facilities implemented daily COVID-19 screening for their staff to assure reduced exposure to COVID-19. It is a little more complicated to do so with home health field staff, however, several agencies implemented an equivalent of daily screening by having all field staff members complete an attestation via text messaging/phone prior to the first home visit of the day.

Sample:

My temperature this morning is:_____

Do you have any signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat? (yes/no)

Have you had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with respiratory? (yes/no)

- Some agencies are contracting with infection disease specialists for additional guidelines in caring for COVID-19 positive patients or patients who are under investigation.

- Many agencies work together to sew clothes facial masks. This is a great teambuilding activity that keeps everyone involved. WE ARE IN THIS TOGETHER!

Thank you!

QUESTIONS?

References

- 1. Federal Register: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency -A Rule by the Centers for Medicare & Medicaid Services on 04/06/2020. Retrieved from https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public
- 2.Department of Health Care Policy and Financing: COVID-19 Updates Volume 01, April 2020. Retrieved from: https://myemail.constantcontact.com/COVID-19-Updates-April-3--2020.html?soid=1120776134797&aid=fHQAuzQDTXI
- Department of Health Care Policy and Financing: Telemedicine - Provider Information. Retrieved from: https://www.colorado.gov/hcpf/provider-telemedicine
- Home Health Agencies: CMS Flexibilities to Fight COVID-19
- National Association of Homecare and Hospice: Home Health and Hospice Pandemic Relief: Medicare and More.