

## COVID-19 PUBLIC POLICY UPDATE

(as of March 30, 2020)

### Relief for the U.S. Healthcare System

- Provides additional funding for the prevention, diagnosis, and treatment of COVID-19
- Limits liability for volunteer health care professionals
- Prioritizes Food and Drug Administration (FDA) review of certain drugs
- Allows emergency use of certain diagnostic tests that are not approved by the FDA
- Expands health-insurance coverage for diagnostic testing and requires coverage for preventative services and vaccines (Aetna and CIGNA, more to follow)

Revises other provisions regarding the medical supply chain, the national stockpile, the health care workforce, the Healthy Start program, telehealth services, nutrition services, Medicare, and Medicaid.

### CMS Interim Final Rule for Home Health

An unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 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:

- Ensure local hospitals and health systems have the capacity to handle a potential surge through temporary expansion sites (CMS Hospital Without Walls)
- Remove barriers for physicians, nurses, and other clinicians to be readily hired from within the community or from other states to meet workforce demand
- Increase access to telehealth to ensure Medicaid patients have access to MDs and clinicians while keeping patients safe at home
- Expand in-place testing at home or in community-based settings
- Put patients over paperwork: temporary provider relief from paperwork, reporting and audit requirements to focus on providing care to COVID-19 Medicare and Medicaid beneficiaries

## CARES Act Relief for Home Health and Hospice Providers

Offers home-based providers favorable regulatory relief on both a temporary and permanent basis.

1. Allows non-physicians to certify home health services moving forward
  - a. Nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNSs) the ability to certify home health permanently.
2. Encourages the use of telehealth in home health care but does not yet provide Medicare reimbursement for this equipment.
  - a. An emergency rule making its way through the U.S. Office of Management and Budget (OMB) could enable providers the chance to be compensated for telehealth services.
  - b. Under Medicare, roadblocks to reimbursement have kept providers from investing heavily in telehealth until now.
3. Expanded Accelerated and Advance Payment Program to Medicare providers
4. Suspends 2% Medicare sequestration (ongoing reimbursement rate cut), effectively boosting home health and hospice reimbursement during an 8-month period to Dec. 31.
5. May relax the current homebound restrictions for home health.
6. Creates a \$100 billion health care fund for recovering COVID-19 costs
7. Increases Medicare reimbursement to providers for taking care of COVID-19 patients

## New Blanket Waiver Relief for Home Health

*CMS announced March 30 the following blanket waivers in effect, retroactive to March 1, 2020, extending through the end of the emergency declaration.*

### Home Health Agencies

- **Requests for Anticipated Payment (RAPs)** CMS is allowing Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.
- **Reporting** CMS is extending the 5-day completion requirement for the comprehensive assessment to 30 days.
- **Waiving the 30-day OASIS submission requirement.** Delayed submission is permitted during the public health emergency.

- **Initial Assessments.** CMS is allowing HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review.
  - To allow patients to be cared for in the best environment while supporting infection control and reducing impact on acute care and long-term care facilities.
  - To allow for maximizing coverage by already scarce MDs and APRNs
- **Waive onsite visits for HHA Aide Supervision.** CMS is waiving the requirement 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.
  - This waiver is also suspending the 2-week aide supervision by a registered nurse for home health agencies requirement, but virtual supervision is encouraged during this period.

### **New Blanket Waiver Relief for Hospice Providers**

#### **Hospice Agencies**

- **Waives Requirement for Hospices to Use Volunteers.** CMS is waiving the requirement that hospices are required to use volunteers (including at least 5% of patient care hours) due to potential quarantine.
- **Comprehensive Assessments.** CMS is waiving certain requirements related to updating comprehensive assessments of patients. Hospices must continue to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.
- **Waive Non-Core Services.** CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements for physical therapy, occupational therapy, and speech-language pathology.
- **Waived Onsite Visits for Hospice Aide Supervision.** CMS is waiving the requirements at which require a nurse to conduct an onsite supervisory visit every two weeks to evaluate if aides are providing care consistent with the care plan.

### **Immediate Financial Assistance for Home Health and Hospice Agencies**

#### **Accelerated/Advance Payments Under the COVID-19 CARES Act**

CMS has expanded the current Accelerated and Advance Payment Program to a broader group of Medicare Part A providers and Part B suppliers.

- The expansion of this program is only for the duration of the public health emergency.
- 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.

## **Eligibility, Qualification and Process**

To qualify the provider must:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form
- Not be in bankruptcy
- Not be under active medical review or program integrity investigation
- Not have any outstanding delinquent Medicare overpayments.

## **Payment Amount**

- Qualified providers are to request a specific amount using an Accelerated or Advance Payment Request form provided on each MAC's website.
- Most providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period.

## **Processing Time**

- Each MAC will review and issue payments within seven (7) calendar days of receiving the request.

## **Repayment**

- CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment.
- Home health and hospice providers will have 210 days from the date of the accelerated or advance payment was made to repay the balance.

## **Recoupment and Reconciliation**

- Providers can continue to submit claims as usual after the issuance of the accelerated or advance payment; however, recoupment will not begin for 120 days.
- Providers will receive full payments for their claims during the 120-day delay period.
- At the end of the 120-day period, the recoupment process will begin, and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advanced payment.
- Instead of receiving payment for newly submitted claims, the provider's/supplier's outstanding accelerated/advance payment balance is reduced by the claim payment amount. This process is automatic.