

Home Health (updated 5/13/2020)

CMS announced [additional blanket waivers](#) on May 11, 2020.

New 5/11 *Initial and Comprehensive Assessment*

- Now occupational therapists (OTs), physical therapists (PTs), and speech language pathologists (SLPs) can perform initial and comprehensive assessment for all patients. This temporary blanket modification allows any rehabilitation professional (OTs, PTs, SLPs) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law. Rehabilitation professionals would not be permitted to perform assessments in nursing-only cases.

New 4/30 *In-service Training Requirement*

- The requirement at §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period is waived through the end of the first full quarter after the declaration of the public health emergency concludes.

New 4/30 *Information Sharing for Discharge Planning*

- The requirement at §484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, other provider's quality measures and resource use measures is waived. All other discharge planning requirements are unchanged.
- Hospitals are also having the requirement at §484.58(a) waived so that they will not be sharing quality data and resource use information with patients, caregivers, and their representatives at discharge for post-acute care settings.

New 4/30 *Clinical Record Sharing*

- The deadline for completion of the requirement at §484.110(e) to provide a patient a copy of their medical record at no cost during the next visit or within 4 business days is extended to 10 business days.

New 4/30 *Training and Assessment of Aides*

- Annual on-site supervisory visits at §484.80(h)(1)(iii) by nurses or other skilled professionals are postponed for the duration of the public health emergency. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the public health emergency.

New 4/30 Quality Assessment and Performance Improvement (QAPI)

- CMS is narrowing the scope of the QAPI program at §484.65 to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. The requirement that home health agencies maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain.

New 4/30 Expanding Telehealth

- CMS is waiving the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2) which expands the types of health care professionals that can furnish telehealth services to include all those that are eligible to bill Medicare for their professional services. Specifically, this allows physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

<u>What did LeadingAge, ElevatingHOME, & VNAA ask for</u>	<u>Did we get it</u>	<u>What is in the rule</u>
Relaxing requirements for the comprehensive assessment	Yes	<ul style="list-style-type: none"> • Extending of the 5-day completion requirement for the comprehensive assessment and waiving the 30-day OASIS submission requirement • Home health agencies can perform initial assessments and determine patients’ homebound status remotely or by record review
Relaxing physician requirements related to ordering and certifying home health services	Yes	<ul style="list-style-type: none"> • Nurse practitioners, clinical nurse specialists, and physician assistants can order home health, establish and review plans of care, and certify/re-certify the need for home health
Relaxing the homebound requirement	Yes	<ul style="list-style-type: none"> • If a physician advises a beneficiary 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

		<p>susceptible to contract COVID-19 they are considered homebound</p> <ul style="list-style-type: none"> • If a beneficiary is homebound due to COVID-19 and needs skilled services, a home health agency can provide those services under the Medicare Home Health benefit
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In addition to the items included in LeadingAge, ElevatingHOME, and VNAA’s waiver requests, the following provisions are included in the home health waivers:

Medicare Telehealth

- 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.

Requests for Anticipated Payments (RAPs)

- MACs can extend the auto-cancellation date of RAPs during emergencies.

Review Choice Demonstration for Home Health Services

- CMS is allowing home health agencies in the Review Choice Demonstration to pause their participation for the duration of the Public Health Emergency.

Cost Reporting

- CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak.

Non-Physician Practitioners Ordering Therapy and Supplies

- Allows 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.

Onsite Visits for HHA Aide Supervision

- Waives the requirement for nurse visits every two weeks as well as registered nurse supervision to home health aides but virtual supervision is encouraged.

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.

New 4/26 Accelerated/Advanced Payments

- CMS will **not** be accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments. [Details are available](#) from CMS.
- 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.