Flexibilities for Long-Term Care Providers During the COVID-19 Crisis

Last Updated:

May 4, 2020

Agenda

- **Context & Scope**
- **Operational Implications of New Federal & State Flexibilities**
  - Practitioner Workforce
  - Telehealth & Sites of Care
  - Administrative Activities
- **Revenue Cycle Implications & Billing Guidance**

Context & Scope

To support providers during the COVID-19 crisis, federal and state governments have authorized regulatory relief and emergency funding.

Goal for this presentation:	**Highlight new flexibilities that have significant implications for LTC providers' clinical operations and revenue cycle.**

Sources for Flexibilities Addressed

- Section 1135 waivers *(including nationwide "blanket" waivers and NY waivers)*
- CMS's interim final rules with comment period (IFCs)
- The CARES Act
- HHS and CMS Guidance *(e.g., HIPAA flexibility, Medicare coverage)*
- New York State Executive Orders (EOs) and Department of Health (DOH) guidance
- Appendix K for New York's 1915(c) HCBS waiver

See the Appendix for links to these authorities, as well as Manatt summaries and analysis

Note: The flexibilities discussed in this presentation are ***limited to patients/providers*** who are ***affected by the COVID-19 emergency***. These flexibilities are also ***temporary*** and will expire when the emergency period ends (absent legislative/regulatory action).

Flexibilities Addressed in this Presentation

This presentation highlights the operational flexibilities most relevant for New York City LTC providers.

	Focus Area(s)	Not Addressed in this Presentation
Provider Type	Nursing homes, home health, HCBS waiver providers, and hospice	▪ Other LTC providers (e.g., inpatient rehab facilities, long-term care hospitals) ▪ Non-LTC providers (e.g., hospitals, FQHCs, ESRD facilities)
Source of Emergency Flexibilities	▪ Federal legislative and executive action ▪ State action that supports implementation	Comprehensive review of additional state flexibilities (e.g., licensure laws, Medicaid policy)
Payers of Interest	Medicare and Medicaid	Commercial plans
Type of Emergency Relief	Regulatory relief	Supplemental funding that is not connected to reimbursement for particular services (e.g., CARES Act pools, Medicare advance payments)

Operational Implications of New Federal & State Flexibilities

Overview of Flexibilities

Federal and state flexibilities allow LTC providers to rapidly increase access to care.

Workforce Flexibilities

Maximize practitioner capacity by relaxing restrictions on:

- Licensure
- Scope of practice
- Supervision

Telehealth & Sites of Care

Leverage telehealth and flexibility on sites of care to:

- Increase capacity
- Enhance access
- Reduce contagion by minimizing contact among patients and practitioners

Administrative Flexibilities

Minimize administrative burdens by:

- Delaying patient assessments
- Suspending reporting and oversight activities
- Streamlining clinical operations

Workforce Flexibilities: Overview

LTC providers can maximize capacity and flexibility due to relaxed restrictions on:

- ✓ Licensure
- ✓ Scope of practice
- ✓ Supervision

Note: Licensed practitioners (including volunteers) are shielded from malpractice liability for services that are (1) within their scope of practice and (2) rendered in good faith without gross negligence.

Source: *NY Executive Orders; CARES Act.*

Workforce Flexibilities: Licensure and Training

All LTC Providers

- A practitioner may ***practice in New York*** as long as they hold a license in good standing in another state or a Canadian province

  This flexibility applies to: MD, PA, nurse (NP, LPN, RN), radiologic technologist, clinical nurse specialist, special assistant, licensed social worker, respiratory therapy technician,* various types of counselors and therapists*

- ***Medicare & Medicaid offer streamlined enrollment procedures*** and will reimburse for services rendered in New York by a practitioner with out-of-state license *(if not excluded from the program or excluded from licensure in any state)*

- ***2020 medical graduates from NY medical programs*** may practice under supervision of a NY licensed and registered physician

**For these practitioners, NY waiver permits out-of-state licensure, but not Canadian licensure*

Nursing Homes

- A ***recent RPN/LPN graduate*** from an NY school may practice for 180 days after graduation under the supervision of a licensed practitioner
- An ***uncertified nurse aide may*** work for >4 months (subject to ongoing determination of competence)

HCBS Waiver

- Direct support professionals (DSPs)* and administrative staff may deliver services ***before completing state-mandated training*** *(training must be completed by 60 days following end of emergency)*
- Employees may deliver services under supervision ***while background checks are pending*** *(criminal background, mental hygiene law, Staff Exclusion List, State Central Register)*

**DSPs work under nurse supervision to provide habilitation services to people with disabilities*

Source: *NY Executive Orders; NY 1915(c) Waiver Appendix K.*

Workforce Flexibilities: Scope of Practice & Supervision

All LTC Providers

Advanced Practice Clinicians

- NY has lifted requirements for physician supervision and written agreements for NPs, PAs, and medical assistants
- NPs, PAs, and clinical nurse specialists may order home health supplies/services, perform the face-to-face encounter, and certify eligibility *(Note: This flexibility is now permanent)*
- Any requirement for physician supervision may be performed remotely via telehealth

COVID-19 Testing

- Collection of throat/nasopharyngeal swab specimens may be:
  - Ordered by an RN (or other qualified practitioner, pursuant to standing order)
  - Performed by an RN, or an unlicensed individual who completes DOH training *(Note: Not a billable skill for Medicare home health)*

Nursing Homes

A ***physician may delegate***:

- Any task to an NP, PA, or clinical nurse specialist within their scope of practice, subject to physician supervision
- Any "physician visit" to an NP, PA, or clinical nurse specialist *who is not employed by the nursing home*

Source: *NY Executive Orders; CMS blanket waivers; CARES Act; CMS IFC 1 & 2.*

Workforce Flexibilities: Scope of Practice & Supervision

Home Health Agencies

- ***Occupational therapists**** may perform initial and comprehensive assessment (except for "nursing only" patients), with consult by RN or other practitioner as necessary
- ***Supervision of home health aides***
  - CMS waived the federal requirement for biweekly onsite nurse supervision *(but virtual supervision is recommended)*
  - NY will permit in-home supervision via telephone/ telehealth "as soon as practicable after the initial service visit"

**PTs and STs already have this ability*

HCBS Waiver

In an emergency, ***medication may be administered*** by a direct support professional* who is not current with medication administration training, if no other staff is available

**DSPs work under nurse supervision to provide habilitation services to people with disabilities*

Hospice

- Aides need not receive ***12 hours of training*** each year
- ***Aide competency*** may be evaluated using role play or computerized mannequin rather than real patients
- CMS waived requirement for biweekly ***onsite nurse supervision visit*** *(virtual supervision recommended)*
- No requirement to use ***volunteers*** *(normally required for 5%+ of patient hours)*

Source: *NY Executive Orders; CMS blanket waivers; NY 1915(c) Waiver Appendix K.*

Telehealth & Sites of Care: Overview

By leveraging telehealth and flexibility on sites of care, LTC providers can:

- ✓ Increase capacity
- ✓ Enhance access
- ✓ Minimize contagion by avoiding unnecessary physical contact among patients and practitioners

Telehealth Flexibilities

Medicare and NY Medicaid have substantially expanded the range of covered telehealth services.

Hospitals and other providers may be interested in furnishing telehealth services to patients who are homebound or residing in LTC facilities.

Program	Covered Services	Eligible Practitioners	Permissible Locations	Tech Platforms
Medicare	▪ LTC services *(discussed on following slides)* ▪ Practitioner services ▪ ED visits and critical care ▪ Hospital observation ▪ Mental health counseling *See Appendix for CPT codes*	Any practitioner qualified to bill for in-person Medicare services, including doctors, NPs, clinical psychologists, licensed clinical social workers, PT, OT, speech-language pathologists	▪ Both patient and practitioner may be anywhere, *including at home or in an LTC facility* ▪ No restrictions on urban vs. rural	▪ Common video technologies like FaceTime, Skype, or Zoom ▪ Telephone without video for certain evaluation/ management and behavioral health services
New York State Medicaid	Coverage for all Medicaid providers in all situations, if "appropriate for the care of the member"		Same as above *(home or clinical setting, urban or rural)*	▪ Common video technologies *(as above)* ▪ Telephone without video, as appropriate, for assessment, monitoring, and evaluation/ management

Reimbursement Implications

- Medicare and Medicaid telehealth services are billed at regular rate for the applicable service
- Different rates apply to certain telephonic assessments

Source: *CMS blanket waivers & IFC 1; CARES Act; HHS OCR guidance; NY Medicaid guidance.*

Telehealth Flexibilities

Telehealth may now be used for many LTC services normally required to be "in person," if appropriate for the patient.

Nursing Homes

Nursing home physician & practitioner visits

Home Health Agencies

Medicare

- Initial assessments, including homebound status *(may be conducted by record review and/or telehealth)*
- Monitoring and other services within the 30-day episode of care, except for necessary in-person visits under the care plan; this may prompt changes in the frequency/type of in-person visits. Notes:
  - Only in-person visits should not be included in Medicare claims
  - Virtual visits do not count toward LUPA thresholds

NY Medicaid

- Physician order for LHCSA services
- Aide orientation and supervision
- Most required or necessary patient contacts (except home health aide or personal care worker services)

Source: *CMS blanket waivers & IFC 1; NY Medicaid guidance.*

Telehealth Flexibilities

Telehealth may now be used for many LTC services normally required to be "in person," if appropriate for the patient.

HCBS Waiver

- Annual Life Plan Meeting
- Day Habilitation
- Community Habilitation
- Prevocational Services
- Supported Employment
- Pathway to Employment
- Support Broker
- Community Health Assessment (CHA) for initial authorization or change *(may be conducted by telehealth or telephone)*

Hospice

- Routine hospice services *(but only in-person visits should not be included in Medicare claims)*
- Encounter to recertify hospice benefit

Other Telehealth Flexibilities

- Medicare/Medicaid will reimburse services by a practitioner with out-of-state license
- Practitioners may render telehealth services from their home without reporting home address on Medicare enrollment
- Providers may waive or reduce cost-sharing for Medicare/Medicaid telehealth visits

Source: *CMS blanket waivers & IFC 1; NY Medicaid guidance; NY 1915(c) Waiver Appendix K.*

Flexibility on Care Sites & Eligibility

Nursing Homes

- ***Surge sites*** may be set up in non-traditional locations (e.g., hotel, college dorm)
  - An alternative site of care must be:
    - Under the facility's control & oversight, and
    - State-approved to ensure "safety and comfort for patients and staff"
  - CMS has waived non-critical facility requirements (e.g., resident sleeping room need not have an outside-facing window)
  - Services provided at an alternate site are reimbursed at the usual rate
- Facility ***rooms not normally used for residents*** may be re-designated for resident use
- For ***Medicare SNF coverage***, CMS has waived:
  - The "3-day hospitalization" requirement
  - The "benefit period" limitation (subject to certain limitations)

Home Health Agencies

- Medicare patients may be certified as "***homebound***" if they have COVID-19, are suspected to have it, or are particularly vulnerable to it

Hospice

- Hospice residences may designate any number of ***dually certified inpatient beds***

Source: *CMS blanket waivers & IFC 1; NY Medicaid guidance.*

Flexibility on Care Sites & Eligibility

HCBS Waiver

- Medicaid HCBS services may continue being provided to a patient who has been relocated to an ***inpatient setting***
- ***Respite and community habilitation*** services may be provided in OPWDD-certified residence if:
  - The recipient's day service has been suspended or the recipient is otherwise unable to participate;
  - No day services can be delivered in the residence; and
  - Daily respite or community habilitation billing does not exceed 6 service hours/day, 5 days/week
- ***Day habilitation and prevocational*** services may be provided in a residential setting, including emergency residential settings (e.g., a hotel)
- ***Residential habilitation*** services may be provided in alternative certified and non-certified residential settings, including day service locations modified for emergency housing purposes
- A person may receive ***any 1915(c) waiver service in an adjacent state*** (e.g., CT or NJ) from an OPWDD-authorized waiver service provider if the recipient must temporarily reside out-of-state

Source: *CMS blanket waivers & IFC 1; NY Medicaid guidance; NY 1915(c) Waiver Appendix K.*

Administrative Flexibilities: Overview

Providers may prioritize clinical care by suspending or relaxing non-critical administrative functions.

New flexibilities allow LTC providers to:

- ✓ Delay patient assessments
- ✓ Suspend/delay reporting and oversight activities
- ✓ Streamline clinical operations

All LTC Providers

- ***Cost reports*** for October and November FYEs will be due June 30, 2020. For December FYE reports, the filing deadline is May 31 and the due date is July 31, 2020.
- Providers may narrow their ***quality assurance & performance improvement*** programs to focus on infection control & and adverse events

All providers should be mindful of CMS/CDC infection control guidelines, as well as COVID-19 notification requirements under federal and state law. CMS has suspended many types of provider surveys and citations, but *not* for infection control violations.

Administrative Flexibilities: Nursing Homes

Assessments & Oversight

- Certain federal deadlines have been extended:
  - ***PASRR*** Level 1 *(may be completed up to 30 days after admission)*
  - ***Minimum Data Set*** assessments/transmission *(no deadline specified)*
  - ***Payroll-Based Journal*** staffing data submissions *(no deadline specified)*
- CMS has suspended the requirement for 12 hours of ***annual training for nurse assistants*** *(training must be completed by the end of the quarter after the emergency period ends)*

Clinical Operations

- CMS waived ***patient rights*** to participate in in-person resident groups and to choose their room/roommate
- CMS reduced the amount of information that must be shared as part of ***discharge planning***, and waived several additional notification and care planning requirements when a facility transfers a patient for cohorting purposes *(see blanket waivers)*
- For individuals ***evacuated to a nursing home***, NY will allow providers to skip comprehensive assessments, physician approvals, and admission procedures if the resident is returned to the evacuated facility; these procedures should otherwise be completed "as soon as practicable"
- When a resident requests a ***copy of the medical record***, facilities have 10 days to respond (increased from 2 days)

Source: *CMS blanket waivers; NY Executive Orders.*

Administrative Flexibilities: Home Health

Assessments & Oversight

- CMS has extended the timeframe for ***OASIS Transmission***
  - Comprehensive assessment extended from 5 days to 30 days
  - OASIS submission may be delayed past 30 days
- MACs may extend auto-cancellation date of ***Requests for Anticipated Payment (RAPs)***
- New York has extended the timeframe for submissions to the ***Home Care Worker Registry***
- For home health aides, CMS has suspended the following annual requirements:
  - ***12 hours of training*** *(training must be completed by the end of the quarter after the emergency period ends)*
  - Onsite supervisory visit by RN or other qualified professional *(must be completed within 60 days following end of emergency period)*

Clinical Operations

- CMS reduced the amount of information that must be shared as part of ***discharge planning***
- During a covered Medicare visit, the home health nurse may obtain a ***sample to send for COVID-19 testing***
- NY is permitting ***initial patient visits*** to occur within 48 hours rather than 24 hours (applies to CHHA, LTHHCP, AIDS home care)
- When a resident requests a ***copy of the medical record***, agencies have 10 days to respond (increased from 4 days)

Source: *CMS blanket waivers; NY Executive Orders.*

Administrative Flexibilities: HCBS

Oversight

- Annual ***"level of care" recertifications*** may be delayed up to 6 months
- Locations providing residential habilitation services ***need not permit visitors***, to minimize the spread of infection
- Individualized Residential Alternatives, Community Residences, and Family Care Homes may ***exceed capacity limitations***
- ***Certified Residential or Respite facilities*** may be approved for operation if the provider has applied for and is awaiting certification of the site
- ***Consolidated Fiscal Report (CFR)*** submission deadlines for OPWDD HCBS Waiver providers will be extended until 60 days after the emergency period

Community Health Assessments

- As noted previously, CHAs must still be conducted for initial authorizations and change requests, but may be ***conducted by telephone or telehealth***
- To schedule a CHA, staff from LDSS and Conflict-Free Evaluation & Enrollment Center must ***rely on facility medical director's guidance*** as to whether the CHA is necessary
- NY has ***suspended***:
  - All periodic re-assessments of CHAs (Medicaid managed care and FFS)
  - The 6-month in-person care management home visits

Source: *CMS blanket waivers; NY Executive Orders; NY 1915(c) Waiver Appendix K.0*

Administrative Flexibilities: Hospice

Assessments & Oversight

- CMS has waived:
  - The requirement for hospices to provide ***"non-core" services*** *(including PT, OT, speech-language pathology)*
  - The annual requirement for onsite supervisory visit by an RN *(must be completed within 60 days following end of emergency period)*
  - The general requirement for ***annual training and assessments*** *(hospices must continue to provide trainings/assessments where specifically required under the federal rules)*
- CMS has extended the timeframe for ***updating the comprehensive assessment*** from 15 days to 21 days

Source: *CMS blanket waivers.*

Revenue Cycle Implications & Billing Guidance

Billing Guidance

Avoid billing issues by using appropriate codes and modifiers, supported by proper documentation in the medical record.

Program	Billing Guidance
Use modifiers to ensure smooth billing when exercising emergency flexibilities	
Medicare	▪ When billing for services that relied on 1135 waivers, use the condition code "DR" (disaster related) for institutional billing (form CMS-1450), and the modifier "CR" (catastrophe/disaster related) for non-telehealth Part B billing, both institutional and non-institutional (form CMS-1500). ▪ When waiving cost sharing for Part B claims, use the modifier "CS" to bill Medicare for the full claim amount.
Medicaid	▪ For COVID-related testing and treatment, report Type of Admission Code "1" for institutional billing, and use Emergency Indicator "Y" for practitioner visits and testing. ▪ Undocumented immigrants are eligible for Medicaid coverage of "emergency services," including COVID-19 testing and treatment; use coverage code "07."
Bill appropriately for professional telehealth services	
Medicare	▪ Code Place of Service (POS) as if the service was furnished in-person. Use Modifier "95" to indicate the use of telehealth. ▪ The CR modifier is not necessary for telehealth services. ▪ There are no billing changes for institutional claims.
Medicaid	▪ NY DOH has provided detailed billing guidance for both telehealth and telephonic services.
Ensure appropriate documentation of emergency flexibilities, especially regarding alternative sites of care	
Medicare & Medicaid	▪ Services provided in alternative/temporary sites are billed at the provider's usual rate. ▪ A provider should bill at the appropriate rate based on services actually rendered, even if the patient was located in a bed designated for a different type of care (e.g., SNF furnishing services in an inpatient rehab bed).

Source: *MLN Matters SE20011; NY Medicaid coverage guidance.*

HCBS Reimbursement Changes

New York Medicaid will provide enhanced reimbursement and retainer payments for certain types of HCBS providers.

Affected Providers	Description
Enhanced Reimbursement	
Residential Habilitation *(supervised residences)*	Rate boost aims to compensate providers for additional staffing hours needed when day services are unavailable (e.g., because services are suspended, or because resident is unable to attend for health reasons). The enhanced rate is not available if the provider is also billing a retainer day or Respite services.
Community Habilitation	Rate boost (up to 25%) to allow additional funding for Personal Protective Equipment (PPE) for staff and increased Direct Support Professional training costs regarding COVID-19 procedures.
Retainer Payments	
Community Habilitation, Day Habilitation, Prevocational, Fiscal Intermediary	Payments are available for up to 14 days to agencies with day service utilization <80% of the average monthly utilization rate (for July to Dec 2019), and also to allow a Fiscal Intermediary to retain "self-hired" staff who are unable to work. Retainer payment amounts may be up to 80% of the regular rate.

Source: *NY 1915(c) Waiver Appendix K.*

Thank You

For additional questions, please contact
COVIDProviderSupport@cityhall.nyc.gov

Appendices

Appendix: Key Federal Legislation & Executive Action

- **The CARES Act, enacted on March 27, 2020** (Manatt summary here)
- **Section 1135 Waivers issued by the Department of Health & Human Services (HHS) and CMS**
  - CMS Webpage with New Waivers & Flexibilities for Health Care Providers
    - Full text of CMS blanket waivers (last updated April 29, 2020)
    - Manatt summary of CMS blanket waivers (as of April 2, 2020)
    - CMS summaries of waivers applicable to LTC facilities, home health, and hospice
  - Manatt primer on the 1135 waiver authority
- **CMS Interim Final Rules with Comment Periods (IFCs)**
  - IFC 1, issued March 31, 2020 (Manatt summary here)
  - IFC 2, issued April 30, 2020 (Manatt summary forthcoming)
- **Telehealth & HIPAA**
  - CMS fact sheet & FAQs re: telehealth & HIPAA (March 17, 2020)
  - Manatt summary of telehealth flexibilities (as of March 18, 2020)
  - OCR HIPAA guidance re: commonly used telehealth technologies (March 17, 2020)
  - OIG guidance on waiving cost sharing
  - Manatt summary of HIPAA changes during the pandemic (as of April 23, 2020)
- **Medicare Coverage and Billing**
  - CMS guidance: Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on COVID-19, MLN Matters SE20011 (April 10, 2020)
  - CMS guidance: Coverage and Payment Related to COVID-19 Medicare
  - CMS guidance: Medicare Advantage and Medicare Part D: CMS, Information Related to COVID-19 (March 10, 2020)
- **Additional CMS Guidance on suspension of non-emergency surveys and infection control practices here**

Appendix: Key State Executive Actions

New York Executive Orders and Department of Health (DOH) Guidance, catalogued by Manatt here

- **Executive Orders**
  - These flexibilities may be renewed in 30-day increments, in accordance with N.Y. Executive Law § 29-a. On April 7, 2020, all flexibilities were renewed until May 7, 2020 (EO No. 202.14).
  - Particularly relevant Executive Orders include:
    - No. 202 (March 7, 2020)
    - No. 202.1 (March 12, 2020)
    - No. 202.5 (March 18, 2020)
    - No. 202.10 (March 23, 2020)
    - No. 202.15 (April 9, 2020)
    - No. 202.16 (April 12, 2020)
    - No. 202.18 (April 16, 2020)
- **Medicaid Coverage Guidance**
  - NY DOH Medicaid Update: New York State Medicaid Coverage and Reimbursement Policy for Services Related to Coronavirus Disease 2019 (COVID-19) (last updated March 27, 2020)
  - NY DOH guidance: Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services During the COVID-19 State of Emergency, Medicaid Update, Special Edition Vol. 36, No. 5 (last updated May 1, 2020)
  - For background, see CMS guidance: Coverage and Benefits Related to COVID-19 Medicaid and CHIP
  - NY DOH Letter: COVID-19 Guidance for Authorization of Community Based Long-Term Services and Supports Covered by Medicaid
  - NY 1915(c) Waiver Appendix K

Appendix: Telehealth

Medicare will now cover the services listed below when furnished via telehealth, as described in CMS's interim final rule and guidance. These services may be billed at the usual Medicare rate.

(See here for telehealth guidance in the New York Medicaid program.)

- **Emergency Department Visits, Levels 1-5**
  (CPT codes 99281-99285)
- **Initial and Subsequent Observation and Observation Discharge Day Management**
  (CPT codes 99217-99220; CPT codes 99224-99226; CPT codes 99234-99236)
- **Initial hospital care, hospital discharge day management**
  (CPT codes 99221-99223; CPT codes 99238- 99239)
- **Initial nursing facility visits, All levels (Low, Moderate, and High Complexity), nursing facility discharge day mgmt.**
  (CPT codes 99304-99306; CPT codes 99315-99316)
- **Critical Care Services**
  (CPT codes 99291-99292)
- **Domiciliary, Rest Home, or Custodial Care services, New and Established patients**
  (CPT codes 99327- 99328; CPT codes 99334-99337)
- **Home Visits, New and Established Patient, All levels**
  (CPT codes 99341- 99345; CPT codes 99347-99350)
- **Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent**
  (CPT codes 99468- 99473; CPT codes 99475-99476)
- **Initial and Continuing Intensive Care Services**
  (CPT codes 99477-994780)
- **Care Planning for Patients with Cognitive Impairment**
  (CPT code 99483)
- **Psychological and Neuropsychological Testing**
  (CPT codes 96130-96133; CPT codes 96136- 96139)
- **Therapy Services, Physical and Occupational Therapy, All levels**
  (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- **Radiation Treatment Management Services**
  (CPT code 77427)