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# MEDICARE'S INTERIM FINAL RULE ADDRESSING COVID-19 PROVIDES SOME HOME HEALTH AND HOSPICE RELIEF

On March 30, 2020, CMS issued a pre-publication copy of its "Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency ("PHE")" Interim Final Rule ("Rule"). This Rule addresses regulatory changes to Medicare and Medicaid intended to help Medicare providers during the COVID-19 Pandemic. The Rule includes several changes to Medicare's Home Health and Hospice Regulations that providers have been requesting in their 1135 Waiver requests. The Rule also addresses changes resulting from passage of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"). For home health and hospice, the provisions of interest are those that clarify homebound status and address the use of technology in home health and hospice.

### 1. HOMEBOUND STATUS

CMS acknowledges that the home health industry has sought clarification from CMS regarding whether patients "who are instructed to remain in their homes or are under 'self-quarantine' are considered 'confined to the home' or 'homebound' for purposes of the Medicare home health benefit in the context of the [Public Health Emergency] for the COVID-19 pandemic." CMS states that a patient may be "confined to the home" if it is medically contraindicated for the patient to leave the home.

Although this does not mean that every person who chooses to self-quarantine is "confined to the home," for some patients, the pandemic and the risks COVID-19 poses to them may mean it is contraindicated for them to leave the home. CMS provides two examples of where a patient may be considered confined to the home due to COVID-19:

1. An individual for whom leaving the home is contraindicated due to confirmed or suspected diagnosis of COVID-19; or
2. An individual for whom leaving the home is medically contraindicated because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

Although (2) would appear to include anyone who is self-quarantining, a patient who is self-quarantining for their own safety is not "confined to the home" "unless a physician certifies that it is medically contraindicated for the patient to leave the home." The Rule acknowledges that the Centers for Disease Control and Prevention ("CDC") is instructing older adults and those with serious underlying health conditions to stay home. This means that many Medicare beneficiaries likely qualify as "confined to the home," but each patient must be assessed separately and their homebound status must be certified.

#### Takeaways

CMS is clarifying how the PHE impacts homebound status and noting that, in certain cases, a patient who is quarantining at home due to COVID-19 is homebound.

This is not a blanket announcement that quarantining at home qualifies as "confined to the home."

However, CMS appears to acknowledge that, during the PHE, many Medicare beneficiaries will potentially qualify under CDC guidelines, but each case will need to be assessed.

Home health providers ought to carefully document how a patient who is quarantining at home qualifies.

### 2. USE OF TECHNOLOGY IN HOME HEALTH

The industry, as a whole, requested CMS extend telehealth to allow home health providers to perform visits using telehealth. The Rule notes that the Social Security Act prohibits Medicare from paying for home health services furnished via telecommunications. This does not mean that home health agencies cannot use telehealth and telemonitoring. The Rule clarifies that these technologies can be used to supplement, but not replace, in-person visits.

The Rule gives an example of a patient who is recovering from coronary bypass surgery who contracts COVID-19. The physician has

determined that the patient's care can be managed safely at home. The home health agency develops a plan of care includes one in-person visit a week and two video-teleconferences per week for medication management, teaching and to obtain O2 Saturation readings. This allows the agency to monitor the patient closely but avoids exposing staff unnecessarily. CMS notes that, in this model, the patient would score into a group that has a four visit Low Utilization Payment Adjustment ("LUPA") threshold. The Home Health Aide would meet this threshold with the once a week visit. The virtual visits would not be recorded for billing and, frankly, would not matter for billing, because the LUPA threshold is met by the in-person visits.

This is an important consideration. CMS is acknowledging something we have been doing for years, using telehealth to reduce the need for in-person visits. This has always been about efficiency and quality. With the PHE, it is also about staff safety. The Rule recognizes that this is an appropriate use of technology.

The Rule makes it clear that if technology is part of the patient's care, it must be outlined in the plan of care. The plan of care must explain the technology, how it is being used, goals, etc. When utilizing technology in the home health plan of care, "the use of technology must be related to the skilled services being furnished by the nurse or therapist or therapy assistant to optimize the services furnished during the home visit or when there is a home visit."

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**Takeaways**

CMS acknowledges that telehealth may be used in home health but that telehealth visits are not billable.

CMS indicates that as long as the LUPA thresholds are met, telehealth visits may be used as appropriate supplements to home health visits.

The use of technology must be outlined in the patient's plan of care.

### 3. TECHNOLOGY AND HOSPICE

The Rule will amend 42 C.F.R. § 418.204 to allow hospices to "provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions" when the patient is receiving routine home care level of care. This change only applies to "routine home care" level of care.

As with home health, the use of technology in a hospice plan of care: (i) must be noted on the plan of care; (ii) must meet the requirements of 42 C.F.R. § 418.56; (iii) must be tied to the patient-specific needs identified in the comprehensive assessment; and (iv) must be linked to the measurable outcomes.

The Rule provides an example of using telehealth in hospice: A hospice is providing care to an 85-year-old male with heart failure. The patient contracts COVID-19 and his plan of care now contains medications for symptom management. The patient's COVID-19 symptoms include that the patient is mildly short of breath, but he does not require supporting oxygen. The patient's wife is concerned about potential for worsening cardiac and respiratory symptoms. The hospice adds telemonitoring to the patient's plan of care for remote monitoring of weight and oxygen saturation levels. The plan of care goals are maintaining a 92% O2 Saturation and not gaining more than 2 pounds. The remote patient monitoring using telehealth allows agency to identify changes and modify the plan of care more quickly.

CMS has concluded that use of technology in this fashion will provide the necessary flexibility for patients to receive services, without jeopardizing the health of patients or hospice personnel. Although CMS is clarifying the use of technology in hospice, only in-person visits should be reported on the claim.

### 4. TELEHEALTH AND HOSPICE FACE-TO-FACE

The Rule amends the hospice face-to-face regulations to allow the hospice physician or nurse practitioner to perform the hospice face-to-face encounter via telehealth. The CARES Act amended the statute to allow this, "as determined appropriate by the Secretary." The Rule allows the hospice face-to-face to occur through the use of "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient (from home, or any other site permissible for receiving services under the hospice benefit) and distant site hospice physician or hospice NP." The hospice face-to-face encounter is not a

separately billed service but an administrative expense.

The Rule also gives an example of a pandemic related situation in which the hospice physician or NP may provide billable patient care during a face-to-face encounter. Although the face-to-face encounter is not billable, the patient care provided beyond the encounter may be billable. For example, a hospice patient, who is being seen by the hospice physician for a face-to-face encounter for his end-stage heart disease with diabetes, exhibits a cough, fever, and mild shortness of breath. The physician is informed by the family that the patient has had a visit from his niece who has been diagnosed with COVID-19. The physician then addresses the patient's new illness, including taking swabs for a COVID-19 test. This attention to COVID-19 is direct patient care and would be billable.

After discussing how a patient encounter for face-to-face purposes might become a billable encounter, CMS states that "nothing in statute or regulation precludes a hospice designated attending physician from furnishing services via telehealth in accordance with section 1834(m) of the Act." However CMS cautions that it does "not believe that direct patient care for Medicare hospice patients will typically be furnished via telehealth." Nevertheless, this is important, because hospice physicians and NPs, who may also be the hospice attending physician, can perform face-to-face encounters via telehealth during the PHE. If, during such an encounter physician services are provided, they would be appropriately billable to Medicare, if the requirements of the 1135 telehealth waiver are met.

**Takeaways**

CMS is promulgating regulations to implement § 3706 of the CARES Act to allow hospice face-to-face encounters to occur by telehealth.

CMS recognizes that hospice attending physicians who provide physician services during a telehealth face-to-face encounter may bill for those services under the 1135 Telehealth waivers.

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