National Hospice and Palliative Care Organization

Regulatory Alerts

NHPCO
Leading Person-Centered Care

Emergency Declaration 1135 Blanket Waiver for Hospice Providers

Interim Final Rule with Comment: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

To: *NHPCO Provider Members*
From: *NHPCO Policy Team*
Date: *March 31, 2020*

Summary at a Glance

1. **On March 30, CMS issued a set of blanket 1135 waivers that apply to various Medicare provider types, including hospice. Long requested by NHPCO and state hospice and palliative care organizations, these temporary regulatory waivers and new rules will provide some relief and maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic.**
   Hospice-specific waivers include:

   - Waive the requirement for hospices to use volunteers: including the 5% patient care hours.
   - Comprehensive Assessments: extended the timeframes for updating the assessment from 15 to 21 days.
   - Waive Non-Core Services: includes waiver of hospice requirement to provide physical therapy, occupational therapy, and speech-language pathology.
   - Waived Onsite Visits for Hospice Aide Supervision: removes the requirement for a nurse to conduct an onsite supervisory visit every two weeks.
   - Other waivers that apply to a broader group of Medicare provider types, listed in alert below.

2. **On March 30, CMS also issued an Interim Final Rule with Comment (IRC) with policy and regulatory revisions in response to COVID-19.** The revisions that apply to hospice include:

   - Guidance to conduct face-to-face encounters through telehealth.
   - Guidance for using telehealth to provide routine home care visits.
   - Information on accelerated/advance payments.
   - Information on flexibilities for appeals.

3. **On March 30, CMS released 2019-Novel Coronavirus (COVID-19) Provider Burden Relief Frequently Asked Questions (FAQs)**

   - Announcement that CMS has suspended most medical review for Medicare FFS providers.
   - Includes TPE, ADRs, SMRC and RAC audits and more

Since the HHS Secretary Azar's declaration of the public health emergency on January 31, 2020, NHPCO has been working to ensure that the needs of hospice providers are taken into consideration as regulatory flexibilities are considered. When CMS issued the first set of 1135 blanket waivers on March 13, 2020, hospice providers were not listed. NHPCO met with CMS staff to review the concerns of hospice providers throughout the country and requested clarity in some of the most difficult regulatory requirements. At the same time, NHPCO worked with state leaders and providers to inform them about the 1135 waiver process and the Hospice Action Network's Virtual Advocacy network to successfully executed a multi-faceted advocacy plan that resulted in CMS granting several blanket Medicare waivers on behalf of hospice providers and the patients and families they serve.

1. 1135 Blanket Waivers

On March 30, the Centers for Medicare & Medicaid Services (CMS) issued 1135 blanket waivers with the goal of giving the healthcare system maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Four waivers specific to hospice were included. According to CMS Administrator Seema Verma, "front line healthcare providers need to be able to focus on patient care in the most flexible and innovative ways possible. This unprecedented temporary relaxation in regulation will help the healthcare system deal with patient surges by giving it tools and support to create non-traditional care sites and staff them quickly."

Effective date: The blanket waivers are in effect today, with a retroactive applicability date of March 1, 2020 through the end of the emergency declaration. States and providers **no longer** need to apply for these waivers individually by sending a request to the CMS 1135 waiver mailbox or to the CMS regional office.

CMS Waivers Specific to Hospices:

1. ***Waive Requirement for Hospices to Use Volunteers*** (**42 CFR §418.78(e**)): This requirement is waived, including the requirement for volunteers to provide time that equals at least 5% of patient care hours.

2. ***Comprehensive Assessments (42 CFR* §418.54(d))**: Applies to the timeframes for updates to the comprehensive assessment. While hospices must continue to complete the required assessments and updates, the **timeframes for updating the assessment may be extended from 15 to 21 days.**

3. ***Waive Non-Core Services (42 CFR §418.72)***: This waives the requirement for hospices to provide certain non-core hospice services, which includes physical therapy, occupational therapy, and speech-language pathology.

4. ***Waived Onsite Visits for Hospice Aide Supervision (42 CFR §418.76(h))***: This waiver removes the requirement for a nurse to conduct an onsite supervisory visit every 14 days to evaluate if aides are providing care consistent with the care plan.

2. Interim Final Rule with Comment

On March 30, 2020, CMS also issued an Interim Final Rule with Comment with in response to the COVID-19 Public Health Emergency. There are two provisions that impact hospice providers: additional guidance for the telehealth hospice face-to-face encounter and the telehealth routine home care visit during this national emergency.

A. Hospice Face-to-Face Encounters Using Telehealth: New language is added to § 418.22 Certification of terminal illness which allows face-to-face to be done through telehealth during a public health emergency. Subpart B of the hospice regulations is changed as follows:

> **§ 418.22 Certification of terminal illness.**
>
> **(a)** (4) (ii) During a Public Health Emergency, as defined in § 400.200 of this chapter, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter **may occur via a telecommunications** technology and is considered an administrative expense. Telecommunications technology means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

Equipment: The IRC also requires that face-to-face encounters use 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.

Billable visit providing direct patient care: If a hospice physician or hospice NP acting as the patient's designated attending physician provides direct patient care during the course of the face-to-face encounter:

- The physician or NP may bill for such direct care services for Medicare beneficiaries under the Physician Fee Schedule (PFS).

Unanswered questions:

- How can this be billed through Part A?
- Is there a requirement to use the telehealth code of 02 for this bill?

B. Using Telehealth for Routine Home Care: Additional language has been proposed to be added to § 418.204, Special coverage requirements. New paragraph added:

(d) Use of technology in furnishing services during a Public Health Emergency. When a patient is receiving routine home care, during a Public Health Emergency as defined in § 400.200 of this chapter, hospices may 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. The use of such technology in furnishing services must be included on the plan of care, meet the requirements at § 418.56, and must be tied to the patient specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.

Technology: When using technology, it must be:

- included on the plan of care
- meet the requirements at § 418.56
- Tied to the patient specific needs as identified in the comprehensive assessment
- The plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.

Access to Technologies: CMS states that clarifications at § 418.204 will help to increase access to technologies, such as **telemedicine and remote patient monitoring**, will enable the necessary flexibility for patients to be able to receive necessary services without jeopardizing their health or the health of those who are providing those services while minimizing the overall risk to public health during the PHE for the COVID-19 pandemic.

Other telehealth requirements waived:

- Telehealth originating site requirements under section 1834(m)(4)(C) of the Act (both geographic and site of service) for telehealth services furnished in an emergency area;
- Restriction on use of a telephone for furnishing telehealth services (in § 410.78(a)(3)), but only if the telephone has audio and video capabilities that are used for two-way, real-time interactive communication.

Can telehealth visits for RHC be counted as visits on the claim form? No. CMS states:

> For the purposes of the hospice claim submission, only **in-person visits (with the exception of social work telephone calls)** should be reported on the claim. NHPCO is already in conversation with CMS to discuss this issue and welcome provider input and examples for why telehealth visits for RHC should be counted.

Can costs of telecommunications technology be reported on the cost report? Yes. CMS states that the costs can be added under the routine home care level of care as "other patient care services" on Worksheet A. Identify this cost center as "PHE for COVID-19".

3. Accelerated/Advance Payments

CMS announced that accelerated/advanced payments are available and intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. They are provided 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. A fact sheet is available from CMS. NHPCO issued a Regulatory Alert (03/30/20) specifically on this issue for members.

4. Appeals:

CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) to:

- Allow extensions to file an appeal;
- Waive requirements for timeliness for requests for additional information to adjudicate appeals;
- Process an appeal even with incomplete Appointment of Representation forms. However, any communications will only be sent to the beneficiary
- Process requests for appeal that don't meet the required elements using information that is available
- Utilize all flexibilities available in the appeal process as if good cause requirements are satisfied

Summary of CMS Waivers Impacting Hospices

CMS also provided a summary of all waivers and clarifications impacting hospice in the Hospice: CMS Flexibilities to Fight COVID-19 fact sheet.

5. Provider Burden Relief Frequently Asked Questions (FAQs)

On March 30, CMS issued a set of FAQs specifically addressing provider burden relief. Among the FAQs is discussion of Medicare FFS medical review. The question and the answer follow:

Q. Is CMS suspending most Medicare Fee-For-Service (FFS) medical review during the Public Health Emergency (PHE) period for the COVID-19 pandemic?

A. **Yes,** CMS has suspended most Medicare Fee-For-Service (FFS) medical review during the emergency period due to the COVID-19 pandemic. This includes:

- pre-payment medical reviews conducted by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate program
- Post-payment reviews conducted by:
  - MACs
  - Supplemental Medical Review Contractor (SMRC) reviews
  - Recovery Audit Contractor (RAC)
- No **additional documentation requests will be issued** for the duration of the PHE for the COVID-19 pandemic.
- Targeted Probe and Educate reviews that are in process **will be suspended and claims will be released and paid.**
- Current postpayment MAC, SMRC, and RAC reviews **will be suspended and released from review.**

- This suspension of medical review activities is for the duration of the PHE.
- CMS may conduct medical reviews during or after the PHE if there is an indication of potential fraud.

NHPCO remains committed to supporting our members and the hospice community every single day as we all cope with the challenges of COVID19. Your ability to care for patients and families and your communities is our paramount concern and we will do everything we can to advocate for you and to provide timely and accurate information as it is available.

For additional questions, please contact covid19@nhpco.org for assistance.

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