

## Combatting Coronavirus: Opportunities for Expanded use of Home Health to Support Patient Safety and Public Health

Combatting Coronavirus	Impediments under current rules	Potential solution/mechanism to address
<b>URGENT: Allow virtual/telephonic home health visits</b>	Right now, current home health patients are turning away scheduled home health care visits due to fears of coronavirus. Without the ability to interact with their providers, these patients could end up needing acute care. Further, PPE is becoming increasingly unavailable, creating an urgent need for new care modalities.	<ul style="list-style-type: none"> <li>To ensure continuity of care for home health patients, CMS should allow telephonic visits <i>immediately</i> by waiving requirements for home health visits to occur physically in the home.</li> <li>Telephonic visits could involve video, but not all patients have smartphones to support this.</li> <li>CMS should allow visits over the phone to count as visits and towards LUPA thresholds.</li> <li>Through virtual care, HHAs can also take on COVID-positive or presumed positive patients in need of skilled monitoring.</li> </ul>
<b>URGENT: Access to Personal Protective Equipment (PPE)</b>	PPE supplies are running low but are critical to prevent exposure during home health visits that could harm home health workers or spread the virus to other homebound patients.	<ul style="list-style-type: none"> <li>HHAs will look to CMS and CDC guidance on getting the most out of PPE, but interventions through the SNS and in the supply chain should prioritize access to PPE for HHAs.</li> <li>Higher costs of PPE should be considered in identifying appropriate rates for home health services during the coronavirus emergency and response.</li> </ul>
<b>Homebound status</b>	Eligibility for the home health benefit depends on homebound status of patients and their need for skilled intermittent care. It is unclear whether patients who are self-quarantining due to suspected exposure or even those who are presumed or confirmed COVID-positive would be considered homebound and meet other requirements.	<ul style="list-style-type: none"> <li>CMS should clarify that patients quarantined in their home for a minimum of 14 days due to coronavirus are presumed to be homebound and in need of skilled intermittent care.</li> <li>CMS could issue guidance related to the homebound requirement outlining its presumptive determination that coronavirus exposure is a condition such that leaving the home is medically contraindicated.</li> <li>If presumptive eligibility is not included, allow NPs and PAs to certify eligibility for home health where permitted by the state</li> </ul>
<b>Recertification</b>	If patients are COVID positive, it is critical that have access to treatment for as long as necessary. Currently, the standard of care for COVID-positive patients is evolving, as we learn best practices for combatting this novel disease. If new therapeutics or other novel treatments or techniques are developed,	<ul style="list-style-type: none"> <li>Beneficiaries that may test positive for the virus should be presumed recertified or eligible for recertification for a 30 day episode of care consistent with a plan of care.</li> <li>CMS should allow for recertification of patient eligibility for home health as necessary in order to support ongoing treatment for COVID-19.</li> </ul>

	there could be a need for additional episodes of care to treat patients at home.	
<b>Face to face (F2F)</b>	In general, patients must have a F2F visit prior to receiving home health. CMS allows physicians to see patients for their F2F visit via telehealth, and the recent statutory telehealth changes may support telehealth F2F visits originating from a patient’s home. Still, the F2F is a barrier to patients obtaining necessary home health care.	<ul style="list-style-type: none"> <li>• CMS should specify that F2F visits for home health can be provided through smart phone video chats from patients homes (via telehealth), or via telephone, recognizing that not all Medicare beneficiaries have smart phones.</li> <li>• CMS could further make a presumptive determination that presumed COVID-19 patients have been seen and referred to home for services.</li> </ul>
<b>Use of telehealth to provide home health</b>	Despite the recent Congressional action to allow telehealth to originate from patient homes in both rural and urban areas, home health agencies cannot conduct patient visits services via telehealth. HHAs have infrastructure and expertise for remote monitoring and virtual care, but Medicare HH episodes require in person visits.	<ul style="list-style-type: none"> <li>• Just as Medicare pays for professional services furnished remotely via telehealth, CMS should consider options to allow Home Health providers to provide telehealth services.</li> <li>• CMS could potentially allow qualified HA personnel to provide Part B telehealth services to support access to care during high need.</li> </ul>
<b>OASIS Assessment</b>	Home health intake typically requires an initial visit and assessment in the patient’s home that generally takes 3 hours to complete. The duration of this visit means significant exposure for home health workers.	<ul style="list-style-type: none"> <li>• CMS could waive all or some of the OASIS assessment for COVID-positive or presumptive COVID-positive patients.</li> <li>• CMS could also waive the requirement for this to occur based on in-person observations and instead allow portions to be completed via telephone or video conference.</li> </ul>
<b>Low Utilization Payment Adjustment (LUPA)</b>	The LUPA reduces home health payment when patients are not seen frequently during an episode of care. However, responding to coronavirus requires minimizing in-person exposure as much as possible.	<ul style="list-style-type: none"> <li>• CMS could waive LUPA for COVID-19 patients to avoid requiring unnecessary visits.</li> <li>• Allowing telehealth visits to count as home health visits would also help, as would a presumption that an appropriate plan of care would include initial visits and remote monitoring.</li> </ul>
<b>Remote patient monitoring</b>	There are opportunities to bill under Part B, but home health is not separately paid for these services. While CMS has previously allowed investments in remote patient monitoring to be reported as home health costs, these costs are not paid for directly.	<ul style="list-style-type: none"> <li>• In order to support use of remote patient monitoring equipment for COVID-19 patients, CMS should consider remote patient monitoring costs in determining appropriate payment for home health, and the important role of remote monitoring as part of a plan of care designed to minimize in-person contact.</li> </ul>
<b>Coding</b>	It is unclear how home health episodes for COVID-19 patients will be coded and paid for by Medicare.	<ul style="list-style-type: none"> <li>• CMS could provide guidance on appropriate coding groups for COVID-19 home health patients.</li> <li>• Assuming COVID-19 patients fit into an established payment group would help to support waivers of portions of OASIS, speeding the process.</li> <li>• In selecting appropriate payment groups, CMS should consider the potential complexity of treating a novel disease, costs of PPE, and costs associated with remote monitoring and use of telemedicine (or add-on payments or percent increases to cover these costs).</li> </ul>