

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

Last Updated: September 29, 2020

Red text indicates updates to the prior version of this deck (published on August 24, 2020). Given the fluid nature of the COVID-19 response, please consult the latest Federal, State and City guidance as needed for the most up-to-date information.

- **Context & Scope**
- **Operational Implications of Federal & State Flexibilities**
 - COVID-19 Testing & Reporting
 - Practitioner Workforce
 - Telehealth & Sites of Care
 - Administrative Activities
- **Revenue Cycle Implications & Billing Guidance**

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

Goal for this presentation:

Highlight COVID-related 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 (effective March 31, May 8, and September 2, 2020)
- 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**; most will expire at the end of the HHS Public Health Emergency (PHE) period (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	<ul style="list-style-type: none">Other LTC providers (e.g., inpatient rehab facilities, long-term care hospitals, intermediate care facilities)Non-LTC providers (e.g., hospitals, FQHCs)
Source of Emergency Flexibilities	<ul style="list-style-type: none">Federal legislative and executive actionState 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 Federal & State Flexibilities

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



COVID-19 Testing & Reporting

Expand testing capacity through flexibilities on scope of practice and coverage

Comply with NYS mandates on testing and reporting



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 in-person contact



Administrative Flexibilities

Minimize admin burdens by:

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

- ✓ **New flexibilities** expand the circumstances under which providers may administer and bill for COVID tests, including through expansions to practitioner scope of practice.



- ✓ **New DOH mandates** require providers to collect and report data to the state



COVID Testing: Flexibilities for Providers

Ordering & Administering COVID-19 Tests

Collection of swab specimens may be:

- Ordered via standing order from a physician or NP for anyone “suspected of suffering from” COVID-19
- Ordered and administered by an RN or a pharmacist
- Performed by an unlicensed individual (subject to completing DOH training)

Blood draws for antibody testing

- Non-nursing staff members who complete DOH-approved training may perform nursing tasks (such as blood draws) under the supervision of a nurse
- Pharmacists may order and administer COVID antibody tests

Nursing Homes

Point-of-care tests may be prescribed and administered in congregate facilities by any licensed healthcare personnel, including anterior nares specimen collection or tests for self-collection.





COVID Testing: Medicare & Medicaid Coverage

Coverage of Diagnostic Testing in General

Medicare will cover diagnostic tests

performed or supervised by any PA, NP, CNS, or certified nurse midwife acting within scope of practice

Medicaid will cover laboratory tests that are:

- Administered in non-office settings (e.g., parking lots)
- FDA-authorized COVID-19 tests for self-collection.

Coverage of COVID-19 Testing

Medicare

- Tests for COVID-19, influenza, and respiratory syncytial virus may be ordered by any practitioner acting within scope of practice. Medicare documentation requirements are waived if no written order.
- **Each Medicare beneficiary is entitled to one COVID-19 test without an order from a treating practitioner.**

NY Medicaid has issued [guidance](#) on billing for COVID-19 specimen collection, diagnostic testing, and antibody testing.

Medicare and Medicaid will reimburse health care providers to “counsel patients to isolate/quarantine at the time of COVID-19 testing,” using existing codes for E/M or other services, as applicable. (See [MLN SE20011](#) for details.)



COVID Testing in Nursing Homes: **State Requirements**

DOH Regulations Impose the Following Requirements on Nursing Homes:

- Any nursing home resident known to be exposed to either COVID-19 or influenza, or who exhibits symptoms of either COVID-19 or influenza, must be tested for both.
- If (1) a resident dies while in nursing home, (2) there is a clinical suspicion that COVID-19 or influenza was a cause of death, and (3) no such tests were performed in the 14 days before death, then the nursing home shall administer both a COVID-19 and influenza test within 48 hours after death.
- Any positive occurrence of COVID-19 or influenza found in a resident, or after a resident's death, shall be reported to DOH immediately upon receipt of both test results.



COVID Testing in Nursing Homes: **Federal Requirements**

Under CMS Regulations, Nursing Homes Must:

- Conduct COVID ***symptom screenings*** among all staff (each shift), each resident (daily), and all other persons entering the facility.
- Implement ***routine testing of staff*** (but not residents) at a frequency that scales up or down depending on the county-level rate of positive test results over the prior week. (See CMS [guidance](#).)
- If a resident shows symptoms of COVID, the resident must be ***tested and isolated*** while test results are pending.
- Staff with symptoms or signs must be ***tested and should be restricted from the facility*** pending the results of COVID-19 testing and in accordance with CDC “return to work” guidelines. Nursing homes must maintain appropriate staffing levels at all times, and should assess their ability to replace workers who can no longer work.
- ***In response to any new infection:***
 - All staff and residents should be tested every 3 days to 7 days until the facility achieves a 14-day period in which no new cases are identified.
 - For individuals who test positive, CMS recommends “symptom-based strategy” in lieu of repeated testing, in accordance with CDC guidelines.
 - Staff and residents who have recovered from COVID-19 and are asymptomatic do not need to be retested for COVID-19 within 3 months after symptom onset, consistent with CDC guidelines.

Medicare will cover COVID tests for nursing home residents these scenarios.
Nursing homes may administer tests pursuant to ***standing orders***, consistent with state law.



COVID Testing: **State Reporting Mandate**

All LTC Providers

- Licensed healthcare professionals administering COVID-19 tests must **report results to DOH within three hours** using the Electronic Clinical Laboratory Reporting System (ECLRS).
- Healthcare professionals who administer COVID-19 tests **must ask for, and report to the ECLRS, the following information:**
 - The patient's local address (and permanent address, if different)
 - Whether the individual attends school and, if so, what school
 - The individual's place of employment, if any, including an indication of whether the individual works or volunteers in an elementary, secondary or postsecondary school



Note: The requirements above apply to healthcare providers.
Clinical laboratories are subject to additional requirements not discussed here.

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

- ✓ Licensure
- ✓ Scope of practice
- ✓ Supervision



Note: Licensed practitioners are shielded from malpractice liability for services that are (1) directly related to diagnosing COVID-19 or treating a known/suspected case of COVID-19; (2) within their scope of practice; and (3) rendered in good faith without gross negligence.

Source: NY S7506B (Article 30-D), as amended by SB 8835 (similar flexibility previously provided through Executive Order).



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*

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

- **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

Nursing Homes

- A **recent NP, RPN, or LPN graduate** from an NY school may practice for 180 days after graduation, if supervised by a licensed practitioner
- An **uncertified nurse aide** may work for >4 months (subject to ongoing determination of competence)
- Minimum training for a **paid feeding assistant** is now 1 hour (*instead of the usual 8 hours*)

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 PHE*)
- 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; CMS blanket waivers.



Workforce Flexibilities: Scope of Practice & Supervision

All LTC Providers

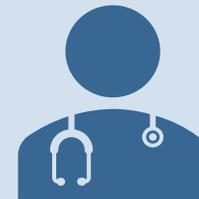
Advanced Practice Clinicians

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

Pharmacists & pharmacy interns

- Pharmacists may order & administer ACIP-recommended child vaccines, including a vaccine for COVID-19 (subject to completing an ACPE training)
- Pharmacy interns may administer ACIP-recommended child vaccines under the supervision of a pharmacist (subject to completing an ACPE training)

The requirement for **aides to receive 12 hours of annual in-service training** is suspended until end of quarter in which PHE ends (*applies to nursing, home health, and hospice aides*)





Workforce Flexibilities: Scope of Practice & Supervision

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*

Home Health Agencies

- **OTs, PTs, and speech language pathologists** 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 suspended the federal requirements for annual and 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”

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*



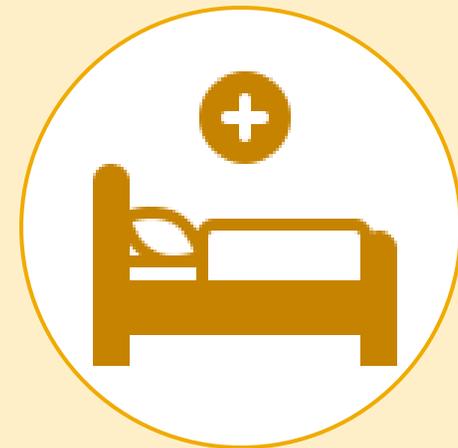
Hospice

- **Aide competency** may be evaluated using role play or computerized mannequin rather than real patients
- CMS suspended:
 - Annual and biweekly **onsite nurse supervision** (*virtual supervision recommended*)
 - **Annual skills assessment** & training for individuals who furnish care
- 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.

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	<ul style="list-style-type: none"> LTC services (<i>discussed on following slides</i>) ED visits and critical care Hospital observation Mental health counseling <p>Full list here. See Appendix for example CPT codes</p>	Any practitioner qualified to bill for in-person Medicare services, including doctors, NPs, clinical psychologists, licensed clinical social workers, PT, OT, speech-language pathologists	<ul style="list-style-type: none"> Both patient and practitioner may be anywhere, <i>including at home or in an LTC facility</i> No restrictions on urban vs. rural 	<ul style="list-style-type: none"> Common video technologies like FaceTime, Skype, or Zoom Audio-only for certain evaluation/mgmt. & behavioral health services, as listed in the Physician Fee Schedule
New York State Medicaid	Coverage for all Medicaid providers in all situations, if “appropriate for the care of the member,” as described here .		Same as above (<i>home or clinical setting, urban or rural</i>)	<ul style="list-style-type: none"> Common video technologies (<i>as above</i>) Audio-only, as appropriate, for assessment, monitoring, and evaluation/ mgmt

Reimbursement Implications

- Medicare and Medicaid telehealth services are billed at regular rate for the applicable service
- Different rates apply to certain telephonic assessments, although CMS’s May 8 interim final rule increased the RVU for certain audio-only E/M services (99441 to 99443)



Source: CMS blanket waivers & interim final rules (3/31 & 5/8); 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 & interim final rule (3/31); 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 & interim final rule (3/31); 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., *facility may establish temporary barriers, 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(See [MLN SE20011](#) for billing details regarding these waivers)

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 & interim final rule (3/31); MLN SE20011; NY Executive Orders; 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 & interim final rule (3/31); NY Medicaid guidance; NY 1915(c) Waiver Appendix K.

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

COVID-related flexibilities allow LTC providers to:

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





Administrative Flexibilities: All LTC Providers

- CMS extended the deadlines for **cost reports** and provided guidance on how to account for Provider Relief Fund payments and Small Business Administration Loan Forgiveness. See the [Medicare FFS FAQs \(Section V\)](#) for details.
- CMS relaxed Quality Reporting Program (QRP) requirements for [nursing homes](#), [home health providers](#), and [hospice](#).
- Providers may narrow their **quality assurance & performance improvement** programs to focus on infection control & and adverse events
- Providers may **use PHI to contact patients who've recovered from COVID-19** to provide information about donating blood & plasma, consistent with the HIPAA privacy rules on “healthcare operations.”

Although CMS initially [suspended](#) many types of provider surveys, CMS [directed states](#) in August to **resume certain types of provider survey, certification, and enforcement activities**, with a particular focus on long-term care facilities.

[Effective August 17](#), the Medicare Administrative Contractors (MACs) have **resumed post-payment reviews** of items/services provided under Medicare FFS before March 1, 2020. *(The Targeted Probe and Educate program will restart later.)*

All providers should be mindful of federal infection control guidance (e.g., [here](#) and [here](#)).

Source: CMS blanket waivers; CMS Medicare FFS FAQs; HHS OCR [HIPAA Guidance](#).



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*)

Note: Effective June 25, CMS has rescinded the waiver that previously delayed the deadline for Payroll-Based Journal staffing data submissions

- CMS relaxed the following “**physical environment**” requirements:
 - Inspection, Testing & Maintenance (ITM) of facilities/equipment
 - Placement of alcohol-based hand-rub dispensers
 - Fire drills(See [blanket waivers](#) for details)

Source: CMS blanket waivers; NY Executive Orders.

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 details)
- When a resident requests a **copy of the medical record**, facilities have 10 days to respond (increased from 2 days)

Note: NY has repealed the waivers that previously allowed providers to skip comprehensive assessments, physician approvals, and admission procedures for individuals evacuated to a nursing home as long as the resident is returned to the evacuated facility.

Note: Nursing homes should be mindful of testing and reporting requirements under [federal law](#) and [state law](#).

In addition, Nursing homes must publish a Pandemic Emergency Plan by September 15, 2020, in accordance with recently enacted PHL 2803(12) and [DOH guidance](#).



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)**

Note: NY has repealed the waiver that previously extended the timeframe for submissions to the Home Care Worker Registry

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 PHE

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 the PHE)
 - 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
- CMS relaxed the following **“physical environment” requirements for inpatient hospice**:
 - Inspection, Testing & Maintenance (ITM) of facilities and equipment
 - Placement of alcohol-based hand-rub dispensers
 - Fire drills(See [blanket waivers](#) for details)



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	<ul style="list-style-type: none"> 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). See SE20011 for details. When waiving cost sharing for Part B claims, use the modifier “CS” to bill Medicare for the full claim amount.
Medicaid	<ul style="list-style-type: none"> 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.”

Source: MLN Matters SE20011; NY Medicaid coverage guidance.



Billing Guidance (cont.)

Program	Billing Guidance
Use the appropriate billing code for COVID 19-Testing	
CMS Billing Guidance	Current HPCPC and CPT codes for COVID diagnostic and antibody testing are listed here .
Bill appropriately for professional telehealth services	
Medicare	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 [MM11960](#) & [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 <i>(supervised residences)</i>	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

- **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 August 20, 2020)
 - ◆ CMS summaries of waivers applicable to [LTC facilities](#), [home health](#), and [hospice](#)
 - [Manatt primer](#) on the 1135 waiver authority
- **The [CARES Act](#), enacted on March 27, 2020** (Manatt summary [here](#))
- **CMS Interim Final Rules with Comment Periods**
 - Interim Final Rule effective [March 31, 2020](#) (Manatt summary [here](#))
 - Interim Final Rule effective [May 8, 2020](#)
 - [Interim Final Rule effective September 2, 2020](#) (and related [CMS guidance on nursing home testing requirements](#))
- **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](#)
- **Medicare Coverage and Billing**
 - CMS [guidance](#): Medicare Fee-for-Service (FFS) Response to COVID-19, MLN Matters SE20011 (last updated August 26, 2020)
 - CMS [FAQs](#) on Medicare FFS Billing during COVID-19 (last updated September 11, 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](#) and [here](#)**
- **CDC Nursing Home [COVID-19 Toolkit](#)**
- **HHS PREP Act [Declarations](#)** (last updated August 24, 2020)

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. **The Governor has renewed all healthcare-related waivers and directives until early October, except as expressly terminated or modified. Most healthcare measures are currently scheduled to expire on October 4, although some have already been extended until later in the month. (See the renewal language EO Nos. [202.60](#), [202.64](#), and [202.65](#)).**

- 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. [202.18](#) (April 16, 2020)

No. [202.30](#) (May 10, 2020) No. [202.40](#) (June 9, 2020) No. [202.44](#) (June 21, 2020)

No. [202.61](#) (Sept. 9, 2020)
Manatt summary [here](#)

▪ 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](#): Medicaid Update, Telehealth & Telephonic Services During COVID-19 (last updated May 29, 2020)
- NY DOH [Medicaid Billing Guidance](#) for COVID-19 Testing and Specimen Collection
- 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](#)

See [here](#) for the current list of Medicare services that may be furnished via audio-video telehealth and billed at the usual Medicare rate. See below for a sample of newly eligible CPT codes.

(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)