Wound Ostomy and Continence Nurses Society®

Legislative & Administrative Actions in Response to COVID-19 Pandemic

Legislative Actions

PHASE 1

On March 6, 2020, as an immediate response to the impact of COVID-19 Congress passed and the President signed H.R. 6074- Coronavirus Preparedness and Response Supplemental Appropriations Acts, 2020 ("Phase 1"), which provides $8.3 billion in emergency funding designed to treat and prevent the widespread transmission and effects of COVID-19. Phase 1, targeted at slowing the spread of the virus, allocates a significant portion of the funds to the Department of Health and Human Services ("HHS") for vaccination research, CDC emergency funding, medical equipment, and grants for state, local, and tribal public health agencies and organizations. The bill also allows the HHS to temporarily waive certain Medicare restrictions and requirements regarding telehealth services during the coronavirus public health emergency.

PHASE 2

Having provided immediate emergency relief, attention quickly turned to providing relief to individuals finding themselves out of work as a result of the unprecedented public health crisis. On March 14, the President signed H.R. 6201- Families First Coronavirus Response Act ("Phase 2"), which provides paid sick leave, free coronavirus testing, expanded unemployment benefits, and food insecurity measures.

PHASE 3

President Trump has signed the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act" or "Phase 3") to provide emergency assistance and health care response for individuals, families, and businesses. Major provisions of the CARES Act are as follows with those most relevant to nursing highlighted:

- **The Home Health Care Planning Improvement Act (S. 296/H.R. 2150), was included in the "CARES Act" (H.R. 748). The CARES Act permanently authorizes NPs, PAs, and CNSs to certify home health care for Medicare beneficiaries, and requires regulations to be implemented no later than 6 months of the bill being signed into law. These changes are applied to Medicaid as well**.
- **Reauthorizes the Title VIII Nursing Workforce Development Programs through 2025.**
- $1 billion for Defense Production Act
- $117 billion for hospitals and veterans' health care
- $11 billion to support research and development of vaccines, therapeutics, diagnostics

- $4.3 billion for the Centers for Disease Control
- **$16 billion for the Strategic National Stockpile to procure PPE, ventilators, and other medical supplies for federal and state response efforts**
- $45 billion for FEMA disaster relief fund.
- For individuals and families, Phase 3 includes cash payments of up to $1,200 per person and $2,400 per married couple. Individuals with an adjusted gross income of less than $75,000—$150,000 for joint filers—would receive the full payment, but those earning more will see their payments phased out, and the payments would stop entirely for those earning more than $99,000 per year. Families would also receive an additional $500 per child.
- The CARES Act also includes $349 billion for lending programs for small business that maintain their payroll levels. Small businesses will be eligible for additional federally guaranteed loans if they promise to maintain their workforce, and those loans will be forgiven for businesses that continue to pay their workers.
- In addition, the bill allocates $46 billion for industry-specific loans—$25 billion for airlines, $4 billion for cargo carriers, and $17 billion for "businesses critical to maintaining national security"—and $454 billion for the Federal Reserve to leverage for additional loans to help businesses.

PHASE 3.5

On April 23rd Congress passed H.R. 266, the Paycheck Protection Program and Health Care Enhancement Act (“Phase 3.5”), a new $484 billion coronavirus relief package. The bill renews funding for the Small Business Administration's (SBA) Paycheck Protection Program (PPP), with an additional $310 billion, and restores the SBA's emergency loan program. The bill also includes new funding for hospitals, providers, and COVID-19 testing programs all detailed below.

- Provides an additional $310 billion in PPP loans
- Provides an additional $10 billion for Emergency Economic Injury Disaster (EIDL) grants.
- Provides an additional $75 billion for reimbursement to hospitals and healthcare providers to support the need for COVID-19 related expenses and lost revenue.
- Provides $25 billion for necessary expenses to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests, specifically:
- $11 billion for states, localities, territories, and tribes to develop, purchase, administer, process, and analyze COVID-19 tests, scale-up laboratory capacity, trace contacts, and support employer testing. Funds are also made available to employers for testing.

- $1 billion provided to the Centers for Disease Control and Prevention for surveillance, epidemiology, laboratory capacity expansion, contact tracing, public health data surveillance, and analytics infrastructure modernization.

- $1.8 billion provided to the National Institutes of Health to develop, validate, improve, and implement testing and associated technologies; to accelerate research, development, and implementation of point-of-care and other rapid testing; and for partnerships with governmental and non-governmental entities to research, develop, and implement the activities.

- $1 billion for the Biomedical Advanced Research and Development Authority for advanced research, development, manufacturing, production, and purchase of diagnostic, serologic, or other COVID-19 tests or related supplies.

- $22 million for the Food and Drug Administration to support activities associated with diagnostic, serological, antigen, and other tests, and related administrative activities.

- $825 million for Community Health Centers and rural health clinics.

- Up to $1 billion may be used to cover the costs of testing for the uninsured.

Administrative Actions

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements, called 1135 waivers. In response to the COVID-19 pandemic HHS has authorized the following relevant waivers:

Home Health Agencies (HHAs)

- Prior Authorization for DMEPOS: CMS and the DME MACs are suspending the requirements to prior authorize certain power mobility devices (PMDs) and pressure reducing support surfaces (PRSS). This suspension of PA will last for the duration of the COVID-19 Public Health Emergency (PHE).

    - The DME MACs will continue to accept and review voluntary PA requests for the affected HCPCS codes on the Required Prior Authorization List; however, claims associated with a non-affirmation decision or claims submitted without requesting prior authorization that would normally cause a payment denial will be processed for payment for the duration of the COVID-19 PHE.

    - Suppliers must continue to use the appropriate modifiers for all HCPCS codes on the Required Prior Authorization List. For the duration of the COVID-19 PHE, suppliers are to apply the CR modifier (CATASTROPHE/DISASTER RELATED) to the claim line(s) for the HCPCS code(s) billed. Additionally, suppliers are

instructed to enter "COVID-19" in the NTE 2400 (line note) or NTE 2300 (claim note) segments of the American National Standard Institute (ANSI X12) format or field 498-PP of the National Council for Prescription Drug Program (NCPDP) format. These abbreviations may also be used in Item 19 of the CMS-1500 claim form. These instructions also apply to all subsequent rental months' claims in order to ensure continued payment throughout the rental series.

- Homebound Definition: A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19. As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit.

- Telehealth: (HHAs) can provide more services to beneficiaries using telehealth within the 30 day episode of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. The use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care.

- Plans of Care and Certifying/Recertifying Patient Eligibility: HHS is utilizing enforcement discretion with regards to the requirements at §§ 409.43 and 424.22 in order to allow a patient to be under the care of a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1861(aa) (5)) who is working in accordance with State law, or a physician assistant (as defined in section 1861(aa)(5)) who is working in accordance with State law, and for such physician/practitioner: (1) order home health services; (2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care), (3) certify and re-certify that the patient is eligible for Medicare home health services. This will provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. HHS will not conduct audits to ensure that only physicians provided orders, signed and dated the plans of care, and certified/recertified patient eligibility for claims with "claim through dates" of March 1 or later submitted during this public health emergency. Note: This provision was made permanent through the CARES Act

- Reporting: CMS is providing relief to HHAs on the timeframes related to OASIS Transmission. This waiver includes extending of the 5-day completion requirement for the comprehensive assessment and waiving the 30-day OASIS submission requirement. HHAs are expected to complete the 2 04/14/2020 comprehensive assessment within 30 days and delayed submission is permitted. CMS will continue to require that patients still have an assessment to determine and be able to appropriate meet their care needs.

- Infection Control for HHAs: CMS has provided updated guidance for HHA's to follow regarding improved infection control measures. This memorandum responds to questions CMS has received and provides important guidance for all Medicare and Medicaid participating Home Health Agencies (HHAs) and Religious Nonmedical Healthcare Institutions (RNHCIs) in addressing the COVID-19 outbreak and minimizing transmission to other individuals. The full guidance can be found here: https://www.cms.gov/files/document/qso-20-18-hha-revised.pdf

Additional Settings:

- Medicare Physician Supervision requirements: For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.

- Medicare Physician Supervision requirements: Direct physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.

- Practitioner Locations: Temporarily waive Medicare and Medicaid's requirements that physicians and non-physician practitioners be licensed in the state where they are providing services. State requirements will still apply.

Additional waivers and actions taken by CMS in response to COVID-19 can be found here:

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers