Aging and Disability
BUSINESS INSTITUTE
Connecting Communities and Health Care

Hospital Without Walls: New Opportunities for CBOs
Webinar FAQ

The Aging and Disability Business Institute hosted a webinar on April 16, 2020, highlighting approaches that Area Agencies on Aging, Centers for Independent Living and community-based aging and disability organizations can use to take advantage of new Centers for Medicare & Medicaid Services issued flexibilities. Below, find responses to questions submitted from attendees.

About Hospital Without Walls Initiative/ Expanded Telehealth

What is the mechanism to get an agency to propose all or part of these services? Will there be RFPs?
Health systems that implement telehealth solutions and the Hospital without Walls intervention are not required to implement an open-bid process to identify partnering organizations to support this effort. The Centers for Medicare & Medicaid Services (CMS) is providing increased flexibility to health systems to rapidly deploy interventions to address current or emerging medical needs in their community. As a result, most facilities have the flexibility to quickly identify vendors and partners without hosting a competitive bid process.

What is the funding source for the COVID expanded services?
COVID-19 expanded medical services and associated Centers for Medicare & Medicaid Services (CMS) waivers are funded by Medicare and Medicaid.

Does care management staff have to be clinical? I.e. nurses. Or can they be other degreed individuals?
Chronic Care Management, Collaborative Care Management and support services related to transitional care management can be performed by clinical staff. CMS has clarified that clinical staff is defined based on the Current Procedural Terminology (CPT) definition of clinical staff. The CPT definition of clinical staff is determined by the American Medical Association (AMA). The AMA definition of clinical staff is the copyright material of AMA. You should consult the AMA copyrighted CPT definition of clinical staff. The CPT definition does not reference a specific license requirement. However, clinical staff includes personnel that are operating within their scope of practice and can include the following types of staff, medical assistants, health coaches and other staff.

Did they not include health coaches in the telehealth expansion?

The expanded telehealth service list does not include 0591T, 0592T or 0593T. However, the expansion of Telehealth does not impact the ability to provide the full range of care management services that include Chronic Care Management, Complex Chronic Care Management, Behavioral Health Integration or Collaborative Care Management. These services can be provided under general supervision. The American Medical Association (AMA) issued a physician training series titled AMA Steps Forward. The AMA Steps Forward guide for implementing Health Coaching outlines the AMA recommendations for health coaches and the potential for billing for chronic care management when health coaches are operating under general supervision of the healthcare provider.

Many of the services mentioned are those that would be provided traditionally by licensed or Medicare certified home care agencies. Won't AAAs have to become licensed home care agencies to provide some of these services?
Chronic Care Management services are not authorized for home health agencies. As a result, certified home health companies are not in the scope of providers of chronic care management services and this would not be a requirement to support the delivery of chronic care management services. The range of chronic care management services can be provided by organizations that are contracted with a Medicare provider and operate under general supervision of the provider. Chronic care management services can be rendered by clinical staff. CMS defers to the American Medical Association (AMA) Current Procedural Terminology (CPT) definition of clinical staff. Lastly, the American Medical Association defines the role that health coaches can provide in delivering health coaching services and the potential for billing chronic care management services when health coaches deliver chronic care management services, under general supervision of the provider. The AMA Steps Forward guide for Health coaching can be found using the following here.

What is the percentage of AAAs that have Medicare provider numbers to be able to bill under the new CMS guidelines?
While we do not have an exact number of AAAs with a Medicare provider number, we have a number of resources related to becoming a Medicare provider on the Aging and Disability Business Institute.

With the Office of the National Coordinator for Health Information Technology (ONC) changes, are there growing tech platforms being evaluated or pursued in this space?
There are ongoing efforts to identify potential technology systems and tools that can support the range of care management activities that includes chronic care management, behavioral health integration, collaborative care management and transitional care management. This is a market that is continuing to expand and resources to identify best practices are being developed.

HHS Issues Blanket Waivers

Many individuals that we provide services to are Medicaid recipients, could this apply?
The COVID-19 blanket waivers implemented by the Centers for Medicare & Medicaid services apply to both Medicare and Medicaid beneficiaries. In addition, dually enrolled beneficiaries (Medicare + Medicaid) have Medicare as the primary payer for medical services with Medicaid operating as the secondary payer for medical services. However, long-term services and supports are primarily paid for by Medicaid for a dual-eligible beneficiary. The blanket waivers apply to Medicare, Medicaid and to beneficiaries that are dually enrolled in Medicare and Medicaid.

Will there be cost sharing for these services? Are they still under the "testing" category?
Most Medicare Part-B services require cost-sharing (co-insurance) and deductibles to be met by the beneficiary. The cost-sharing requirements have not been waived for all Part B services. However, the Part-B co-insurance has been waived specifically for COVID-19 testing. Medicare Part B services that are not specifically related to COVID-19 testing, are not included in the blanket wavier. However, CMS is allowing providers to deliver telehealth services and the provider has the option of rendering telehealth services and not collecting the co-insurance for the telehealth services provided. However, the co-insurance is not removed. The clinician has been granted waiver authority to not collect the co-insurance for medical services delivered via telehealth.

Is there a new minimum stay for SNF admission, or can any individual go from hospital to SNF with regular Medicare payment?
One of the COVID-19 Blanket waivers is the waiving of the 3-day eligible stay rule. For the duration of the COVID-19 Public Health Emergency, the 3-day eligible stay rule is waived. Therefore, a hospital can admit a beneficiary to a skilled nursing facility and Medicare will reimburse for a SNF stay— even if the beneficiary did not have a 3-day eligible stay prior to admission to the SNF. There is no special requirement that must be in place to utilize the 3-day eligible stay waiver and the 3-day eligible stay waiver is applicable nationwide.

What is the likelihood of the waivers are made permanent post COVID-19 crisis?
The Centers for Medicare & Medicaid Services (CMS) has made it clear that the authorization for the blanket waivers will remain in place for the duration of the Public Health emergency. There has been no indication that the blanket waivers, issued by CMS, will extend beyond the Public Health Emergency.

How does Medicare work with COVID-19?
Medicare reimburses providers for any medical care and testing required for persons that have COVID-19 or are suspected of having COVID-19. The blanket waivers issued by CMS apply to all Medicare beneficiaries, even when there is no concern of COVID-19 infection.

Impact of the Crisis on High Risk Populations and Services

Here's the response we've heard from the health system: "Because elective procedures are not happening, we have an abundance of staff that we're going to furlough. Rather than do that, why wouldn't we just repurpose our own staff and then collect the whole amount— rather than subcontract the work to you where we would receive only a portion of the possible payment?"
Telehealth services and Hospital Without Walls specifically require the implementation of healthcare services in alternative care settings. These alternative care settings are outside of the hospital facility. Therefore, repurposed hospital staff would be required to enter community settings to implement these programs. The deployment of hospital clinical staff, into community settings, to serve vulnerable populations is a complicated decision. Deploying repurposed hospital staff into community settings must be balanced with the risk of exposing these populations to increased COVID-19 exposure risk originating from contact with clinical staff operate from the hospital. In addition, some vulnerable populations have expressed concerns with having any contact with personnel from hospital settings, so the acceptance of hospital personnel, into community settings, may be impaired. Therefore, collaboration with organizations that are embedded in community settings, that agree to work with clinical hospital staff, may increase the acceptance by the target population and reduce the potential COVID-19 exposure risk originating from hospital staff leaving traveling to serve populations in community settings. Any organization that works to support care delivery should be compensated according to the fair market value for the service rendered.

Can you touch on getting prescription medications to seniors who don't have access to the internet, a credit card or a caregiver?
Medication adherence is an important part of managing chronic conditions. People who are sheltering in place or have limited mobility may have limited ability to obtain medication or fill prescriptions. This is a critical part of the disease management process and should be highlighted as a function that community-based organizations can address for vulnerable populations. The ability to obtain prescription medication to assist with improving medication adherence is a vital component of the care delivery process.

What do you suggest for the problem with DSPs going into the home and the fear of spreading the virus? What can we do for that situation?

There is a particular concern of Direct Service Providers (DSPs) sending personnel into homes of vulnerable beneficiaries. This staff includes personal care aides and other supportive service personnel. DSP staff have the potential to expose the beneficiary to COVID-19 or vice versa. There have been reports of DSP personnel exposing multiple beneficiaries to COVID-19. It is important that DSPs implement processes and procedures to limit the risk of exposing beneficiaries to COVID-19 by implementing a process of regular symptom monitoring for DSP staff, quarantining any personnel that exhibit any related symptoms (elevated temperature, cough, tiredness, etc.) and conducting contact tracing when a beneficiary or DSP staff member is confirmed to have a COVID-19 diagnosis. Lastly, the DSP must ensure that all direct service providers have proper personal protective equipment (PPE). PPE includes items such as masks, gloves and disposable gowns and should not be reused. Disposable gowns are important when DSP personnel are assisting with activities of daily living which often requires direct contact between the beneficiary and the staff. A disposable gown will limit the direct contact that could lead to exposure. This is particularly important when DSP staff work with more than one beneficiary because there is the risk of cross contamination between beneficiaries served by the DSP staff. Policies and procedures to conduct universal symptom monitoring and the provision of PPE can limit the risk of DSP staff exposing vulnerable beneficiaries to COVID-19.

Are hospitals limiting discharge planning so that they can get patients out sooner?

Several factors go into decisions related to altering discharge planning operations. One factor is reducing the risk of exposure of discharge planning staff. Discharge planning for people who are at-risk for COVID-19 exposure or diagnosed with COVID-19 must be conducted with limited contact between the discharge planner and the patient. Therefore, the discharge planner may not be able to conduct a detailed in-person, face-to-face assessment of the beneficiary while completing the discharge plan. Some facilities have moved to a reduced discharge planning process where all discharge planning is conducted using remote services. In addition, some facilities have limited options for discharge planning as post-acute care providers report reduced capacity for new patients with COVID-19 diagnoses or with potential COVID-19 exposure. Therefore, hospitals have been granted with increased flexibility for discharge planning in order to limit the requirements on providing a number of community options that may or may not exist and limiting the discharge planning assessment requirements to limit the potential COVID-19 exposure for discharge planning staff.

When the President talks about opening up the economy, will that trigger the end of the emergency declaration?

The Public Health Emergency is not directly related to the opening the economy. The Public Health Emergency was issued by the Secretary of Health and Human Services, Alex. M. Azar on 01/31/2020. The issuing of the public health emergency provides the authorization for the CMS blanket waivers. The waivers will remain in place for the duration of the public health emergency. Efforts to close the economy did not occur at the time of the issuance of the public health emergency. Therefore, actions related to the economy are not directly a causative factor for public health emergency actions. In addition, there are concerns of a potential resurgence of COVID-19 in the fall/winter of 2020. Therefore, health precautions will remain in place as long as there is a public health threat from COVID-19, that includes planning for a resurgence in the Fall/Winter 2020.

Is there anything specially tailored for persons with dementia going on in this crisis?

Beneficiaries with dementia often suffer from multiple chronic conditions. In addition, this population is often dependent on paid and non-paid caregivers for support. The dependency on caregivers for support increases the risk of COVID-19 exposure and limits the ability of this population to self-quarantine. In addition, the population with a dementia diagnosis may have a reduced ability to monitor for COVID-19 symptoms or report when COVID-19 symptoms are occurring. Therefore, increased surveillance and monitoring is required for the population with a dementia diagnosis during this time. Lastly, there was specific inclusion of CPT 99483 in the expanded telehealth waiver. CPT 99483 provides reimbursement for the assessment and care plan development for a beneficiary with cognitive impairment. The CY2020 National Reimbursement rate is $265.26 for this service and includes the development of a comprehensive care plan to address the unique needs of the beneficiary, with a dementia diagnosis and their caregiver.