Home Health Blanket Waiver Chart

Updated 8/23/2022

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements. When there's an emergency, sections 1135 or 1812(f) of the Social Security Act (SSA) allow CMS to issue blanket waivers to help beneficiaries access care.

On January 31, 2020, HHS Secretary Alex Azar declared a public health emergency due to COVID-19. This declaration covered a 90-day period and has been extended continuously since April 2020. Each extension covers 90 days.

We have created this chart to help providers understand what requirements have been waived for home health agencies, and what the waiver means for operations. All waivers below are "blanket waivers" and providers do not need to apply for an individual or state-level waiver in order to take advantage of these flexibilities. These waivers are in effect for the duration of the federal public health emergency (PHE), unless otherwise noted.

As indicated in the chart, waivers which are still in place will end with the Public Health Emergency unless CMS terminates them early which is within their authority.

For more information, please visit the CMS Coronavirus Waivers & Flexibilities page: https://www.cms.gov/coronavirus-waivers

Waiver	**What Does it Mean?**	**What do we need to know about the end-date of this waiver?**
Initial and Comprehensive Assessment	Allow occupational therapists (OTs) to perform initial and comprehensive assessment for all patients. This temporary blanket modification allows OTs to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law.	Waiver was made permanent by the Consolidated Appropriations Act of 2021 and in CY2022 Home Health final rule 11/8/21.
Relaxing physician requirements related to ordering and certifying home health services	Nurse practitioners, clinical nurse specialists, and physician assistants can order home health, establish and review plans of care, and	Waiver was made permanent 3/27/20 when Congress passed the CARES Act permanently authorizing physician assistants, clinical nurse specialists and nurse

	certify/re-certify the need for home health.	practitioners to order home healthcare services.
Onsite Visits for HHA Aide Supervision	Waives the requirement for nurse visits every two weeks as well as registered nurse supervision to home health aides but virtual supervision is encouraged.	Waiver was made permanent, with modifications, in CY2022 Home Health final rule 11/8/21. CMS will permit the one virtual supervisory visit per patient per 60-day episode. This visit must only be done in rare instances for circumstances outside the HHA's control and must have documentation in the medical record detailing such circumstances. At § 484.80(h)(2) CMS finalized the supervisory visit requirements for nonskilled patients with modification. CMS are modified the semi-annual onsite visit to require that this visit be conducted on "each" patient the aide is providing services to rather than "a" patient.
Medicare Telehealth	Home Health Agencies 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. This cannot be considered a home visit for the purposes of eligibility for payment.	Waiver was made permanent in CY2021 Home Health final rule 11/4/20.

Telehealth Face-to-Face Encounter	The required face-to-face encounter for home health can be conducted via telehealth (i.e., 2-way audio-video telecommunications technology that allows for real-time interaction between the physician/allowed practitioner and the patient) when the patient is at home.	The face-to-face encounter can be conducted via telehealth irrespective of the COVID-19 PHE; however, the waiver only extends the "originating site" to the patient's home during the duration of the COVID-19 PHE unless changed by Congress. Currently, Congress has extended the originating site waiver for 151 days after the end of the PHE. Updated guidance 8/18/22.
Non-Physician Practitioners Ordering Therapy and Supplies	Allows non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, and physical therapy, occupational therapy or speech pathology and audiology services.	Waiver was made permanent 3/27/20 when Congress passed the CARES Act permanently authorizing physician assistants, clinical nurse specialists and nurse practitioners to order home healthcare services.
Medicaid Non-Physician Practitioner Ordering Therapy and Supplies	For Medicaid home health regulations now allow non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, and physical therapy, occupational therapy or speech pathology and audiology services, in accordance with state scope of practice laws.	Updated guidance 8/18/22.
Requests for Anticipated Payments (RAPs)	MACs can extend the auto-cancellation date of RAPs during emergencies.	Effective 1/1/22 CMS announced replacing home health RAPs with a Notice of Admission as of May 11, 2021.
Suspending audits during the emergency period	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	Resumed 9/1/21. CMS announced restarting the Targeted Probe and Educate (TPE) program on August 12, 2021.

	Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate (TPE) program, and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC). • No additional documentation requests will be issued for the duration of the PHE for the COVID-19 pandemic. • TPE reviews that are in process will be suspended and claims will be released and paid. Current post-payment 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. • However, CMS may conduct medical reviews during or after the PHE if there is an indication of potential fraud.	
Review Choice Demonstration for Home Health Services	CMS is allowing home health agencies in the Review Choice Demonstration to pause their participation for the duration of the Public Health Emergency.	Resumed 9/1/21 for NC & FL CMS announced resumption of Review Choice Demonstration for Home Health Services with a new phased in approach on August, 21 2020. Participation will begin with providers in North Carolina and Florida.
Cost Reporting	CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak.	Extension Ended 12/31/20

Accelerated/Advanced Payments	CMS will **not** be accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments. Details are available from CMS. CMS is authorized to provide accelerated or advance payments 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.	No new applications were accepted after May 2020. For a reminder on the Congressionally amended payment terms, see this article.
In-service Training Requirement	The requirement at §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period is waived through the end of the first full quarter after the declaration of the public health emergency concludes.	Effective April 30, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS. Home health agencies will have until the end of the first full quarter after the end of the PHE to resume annual trainings. Updated guidance 8/18/22.
Information Sharing for Discharge Planning	The requirement at §484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing	Effective April 30, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS.

	data that includes, but is not limited to, other provider's quality measures and resource use measures is waived. All other discharge planning requirements are unchanged. Hospitals are also having the requirement at §484.58(a) waived so that they will not be sharing quality data and resource use information with patients, caregivers, and their representatives at discharge for post-acute care settings.	
Clinical Record Sharing	The deadline for completion of the requirement at §484.110(e) to provide a patient a copy of their medical record at no cost during the next visit or within 4 business days is extended to 10 business days.	Effective April 30, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS.
Training and Assessment of Aides	Annual on-site supervisory visits at §484.80(h)(1)(iii) by nurses or other skilled professionals are postponed for the duration of the public health emergency. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the public health emergency.	Effective April 30, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS. All postponed onsite assessments of aides must be completed by the appropriate skilled professionals no later than 60 days after the expiration of the PHE. Updated guidance 8/18/22.
Home Health Quality Reporting Program	HHAs are exempted from the Home Health Quality Reporting Program reporting requirements. The time period covered by this exemption was October 1, 2019 through June 30, 2020. HHAs that did not submit data for those quarters will not have their	HHAs are required to begin collecting the Transfer of Health Information quality measures and certain SPADEs on January 1, 2023. Updated guidance 8/18/22.

	annual market basket percentage increase reduced by two percentage points. CMS delayed the compliance dates for collecting and reporting the Transfer of Health Information quality measures and certain standardized patient assessment data elements (SPADEs) adopted for the HH Quality Reporting Program.	
Quality Assessment and Performance Improvement (QAPI)	CMS is narrowing the scope of the QAPI program at §484.65 to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. The requirement that home health agencies maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain.	Effective April 30, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS.
COVID-19 Diagnostic Testing	If a patient is already receiving Medicare home health services, the home health nurse, during an otherwise covered visit, could obtain the sample to send to the laboratory for COVID-19 diagnostic testing.	Effective April 20, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS. Updated guidance from 8/18/22 does not discuss the end of this waiver after the PHE. LeadingAge is following up with CMS to clarify if this is no longer considered a waiver but part of the scope of home health services.
Relaxing requirements for the comprehensive assessment	Extending of the 5-day completion requirement for the comprehensive assessment and waiving the 30-day OASIS submission requirement.	Effective April 20, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS.

	Agencies can perform initial assessments and determine patients' homebound status remotely or by record review.	
Relaxing the homebound requirement	If a physician advises a beneficiary 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 they are considered homebound If a beneficiary is homebound due to COVID-19 and needs skilled services, a home health agency can provide those services under the Medicare Home Health benefit.	~~Effective April 20, 2020 and goes through the end of PHE unless otherwise modified or terminated by CMS.~~ This is not a change in the definition of homebound and is irrespective of the COVID-19 PHE. Updated guidance 8/18/22.
COVID-19 Vaccinations	CMS released an Interim Final Rule with comment period (IFC) announcing that Medicare Part B would establish coding and payment rates for COVID-19 vaccines and their administration as preventive vaccines, without cost-sharing, as soon as the Food and Drug Administration (FDA) authorized or approved the product through an Emergency Use Authorization (EUA) or Biologics License Application (BLA). CMS also established an additional payment amount of approximately $35.50 per dose to administer COVID-19 vaccines in the home for certain Medicare patients. For vaccines requiring multiple doses, this payment applies for each dose in the series, including any additional or	Effective October 28, 2020. Updated guidance from 8/18/22 states CMS will continue to pay a total payment of approximately $75 per dose to administer COVID-19 vaccines in the home for certain Medicare patients through the end of the calendar year that the PHE ends. CMS will be setting future payments for COVID-19 vaccinations to be effective January 1 of the year following the end of the PHE. LeadingAge is following up with CMS staff to better understand if an interim price will be available if CMS has not finalized a future payment by January 1 of the year following the end of the PHE.

	booster doses, and we geographically adjust the additional amount and administration rate based on where the provider or supplier administers the vaccine.	
COVID-19 Monoclonal Antibodies	During the PHE, CMS covers and pays for these infusions or injections the same way it covers and pays for COVID-19 vaccines when furnished consistent with the EUA. There's also no beneficiary cost sharing and no deductible for COVID-19 monoclonal antibody products when providers administer them. CMS doesn't pay for the COVID-19 monoclonal antibody product when a health care setting has received it for free. If a health care setting purchased the product from the manufacturer, Medicare pays the reasonable cost or 95% of the average wholesale price.	Updated guidance from 8/18/22 states effective January 1 of the year following the year that the PHE ends, CMS will pay for monoclonal antibodies the same way they pay for other biological products
COVID-19 Remdesivir	FDA updated the approval of VEKLURYTM (remdesivir) and authorized its use in the outpatient setting. The federal government didn't purchase a supply of remdesivir. Medicare Part B provides payment for the drug and its administration under the applicable Medicare Part B payment policy when a facility or practitioner provides it in the outpatient setting, according to the FDA approval and authorization. In most cases, the Medicare patient's yearly Part B deductible and 20% co-insurance apply.	Effective January 21, 2022. Updated guidance from 8/18/2022 makes no changes to this drug's pricing or usage.

COVID-19 Tests	Medicare implemented a demonstration program to allow people with Medicare to receive up to eight tests per calendar month at no cost. This is the first time that Medicare has covered an over-the-counter, self-administered, test. This new initiative enables people with Medicare Part B, including those enrolled in a Medicare Advantage plan, to receive tests at no cost from providers and suppliers who are eligible to participate.	Effective April 2, 2022 and goes through the end of PHE unless otherwise modified or terminated by CMS. Updated guidance 8/18/22.