June 1, 2020

Seema Verma

Administrator

Center for Medicare and Medicaid Services

Department of Health and Human Services

200 Independence Ave, SW

Washington, DC 20201

Subject: CMS–1744–IFC: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency

Dear Administrator Verma,

On behalf of our over 6,000 members and partners including nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations, and research centers, LeadingAge, ElevatingHOME, and the Visiting Nurse Associations of America (VNAA) are pleased to offer the following comments in response to the CMS-1744 IFC, the Interim Final Rule, published on April 6th, 2020.

Telehealth Expansion

We support and appreciate the expansion of Medicare Telehealth Services under 1834(m) during the emergency. In particular, the expansion of originating sites to include the home is critical for older adults during this pandemic. Many older adults do not want to go into a doctor’s office or other site of service and the flexibility to receive telehealth services at home is critical to promote the ability to continue to receive needed care. We recommend that CMS work to ensure that this expansion of originating sites remain permanent beyond the pandemic.

Advance Care Planning

CMS categorized the advance care planning CPT codes (99487 and 99498) as services that can be delivered via audio-only communication between the qualified professional and the patient. Our members are reporting that advance care planning conversations are being effectively conducted via audio-only technology. We recommend CMS make audio-only communication for these codes a permanent alternative.

Hospice

*Hospice and Telecommunications Flexibility*

We support that CMS recognized the flexibility for hospices to deliver routine home care services via a telecommunications system during the COVID-19 public health emergency (PHE) if it is feasible and appropriate to do so via amendment at 42 CFR 418.204. We agree with the provisions of the rule that require that the use of technology be documented in the plan of care and be used to address patient and family specific goals of care. We recommend that CMS, permanently allow for this flexibility during any future emergency rather than limiting it to the current PHE. We also recommend that CMS look at developing guidance on the appropriate use of telecommunications in hospice outside of the emergency.

The expansion of Medicare Telehealth Services during the pandemic is critically important for continuing to deliver care to older adults. However, challenges with broadband access remain, particularly in rural areas, but also in other underserved communities that people call home. For example, our members in HUD-assisted affordable housing do not have consistent Wi-Fi access. Given that, flexibility to offer audio-only services as an alternative is necessary when the option for an audio-visual encounter is not technologically feasible. We recommend that CMS revise the proposed guidance to clarify that “telecommunications systems” include the range of necessary modalities (including audio-only) to serve patients and families during the emergency (and future emergencies). CMS has made this clarification on stakeholder calls and in fact sheets, but not in guidance.

*Claims*

During stakeholder calls, CMS has clarified that claims with no visits recorded (because all visits were conducted via telecommunications) will be processed for payment. We recommend that this clarification be put in written guidance. Furthermore, we believe there is immense value in collecting data on which professionals provide visits and the number of visits being provided to patients and families via telecommunications. We encourage CMS to develop telecommunications codes and modifiers for use by hospices on the claim form in the future.

*Hospice Item Set*

Data collection for the Hospice Item Set (HIS) includes visit reporting under Section O of the HIS discharge record. There is currently no guidance on whether visits conducted through telecommunications can be counted on the HIS discharge record from the measure “Hospice Visits When Death is Imminent.” We believe that collecting data on which disciplines provided telehealth visits at the end of life and the level of service utilization would be valuable and encourage CMS to issue guidance on how to capture visits to the patient and family through telecommunications in Section O of the HIS discharge record.

*Face to Face Encounter*

We support the amendment at 418.22(a)(4) that allows for physicians or nurse practitioners to use telecommunications technology (meaning equipment that allows for two-way, real-time, interactive audio-visual communication) to perform the hospice face-to-face recertification. We also support the ability for hospice designated attending physicians to furnish services via telehealth in accordance with section 1834(m). We request that CMS consider how telecommunications technology can be utilized for the face to face requirement in the future, both during and outside of emergency periods.

*Hospice and Nursing Home Specific Guidance*

In spite of guidance on visitation issued to long-term care facilities in March and in May, there is still a lack of uniformity in how nursing homes and hospices are approaching collaborating to be sure that hospice patients who reside in facilities can access services. LeadingAge is uniquely positioned to hear about the concerns from both sides of the issue – both from nursing homes who rightfully desire to limit the number of people entering and exiting their facilities and from hospices who are struggling to connect with their patients. We request that CMS issue joint guidance from both areas at the agency that underscores the expectations regarding hospice professionals making necessary visits. For example, guidance on how to facilitate telecommunications visits from a staffing, technology, and time perspective and options on how to allocate the responsibilities is needed.

Home Health

*Homebound Status*

We appreciate CMS’ clarification of the expanded definition for “homebound” status for the PHE. Given the ever-evolving nature of the understanding of COVID-19, we ask that you remain flexible regarding when it is medically contraindicated for a beneficiary to leave her or his home. Noting the outsize impact, the virus has on older adults, we believe that if a beneficiary can have their health needs met at home that is advantageous for them, their families, and hospital and nursing home capacity. Additionally, we suggest that given the demands placed on physicians during this pandemic and the challenges home health agencies (HHAs) are currently experiencing obtaining signed orders, that documentation of medical contraindication be allowed by nonphysician practitioners including advanced practice nurses and physician assistants.

*Ordering Medicaid Home Health*

We appreciate CMS recognizing the need to allow nurse practitioners and physician assistants to order Medicaid home health services. Particularly, as the Home Health Care Planning Improvement Act was included in the CARES Act, allowing that authority for the Medicare home health benefit. The justification that “increased demand on the direct care services provided by

physicians during the PHE for the COVID–19 pandemic could cause a delay in the availability of physicians to order home health services in the normal timeframe” lends further credence to our comment related to allowing nonphysician practitioners to note medical contraindications for the purpose of homebound status.

*Home Health and Technology*

We support the changes in the rule that extend what HHAs are able to do with technology during the emergency. We support the changes at §409.43 that allows HHAs to utilize telecommunications in conjunction with in-person visits and appreciate that CMS specifically outlined where on the cost reports HHAs can report the cost of the technology as an allowable administrative and general cost.

We appreciate and support the ability to augment the plan of care with telecommunications visits and to contract with physicians and other auxiliary personnel to deliver telehealth services under the Physician Fee Schedule. However, the inability to count telecommunications visits toward payment means that we are still seeing members and the home health industry at large having a large increase in Low Utilization Payment Adjustments (LUPAs). The prohibition on a telecommunications visit (1) substituting for in-person home health services ordered as part of a plan of care certified by a physician; and (2) not being considered a home health visit for purposes of eligibility or payment remains a huge barrier to our members being able to continue to serve clients in a financially sustainable manner over the course of this pandemic. It is critical that HHAs be able to count telehealth visits as part of a unit of service especially since we anticipate serving patients released from the hospital or sheltering at home with COVID-19. While we appreciate the flexibility provided by this rule and the encouragement CMS to maximize telehealth during this crisis, it is not allowing HHAs to count telehealth encounters as in-person visits for payment purposes, and at the same time has compounded strains on HHAs by adding new documentation requirements.

Most of the member of the home health team – physicians, advance practice nurses, physician assistants, and therapists – can now bill Part B for telehealth services at the equivalent rate as an in-person visit but the agencies cannot. This puts HHAs in the untenable position of forfeiting adequate reimbursement to better protect their staff and patients (an ethical choice many HHAs are already making), all while suffering from the heightened regulatory burden of new documentation requirements. Telehealth services can serve as a critical supplement to in-person home health visits and should be counted as eligible for payment at this time. Without this adjustment, we believe that the combination of lower referrals and higher LUPAs due to lack of reimbursement for telecommunications visits will result in major financial consequences for HHAs around the country. We strongly encourage CMS to work with Congress to fix this issue.

*Verbal Orders*

Additionally, while there is some flexibility for verbal orders as noted in the rule, home health agencies must still obtain a written order for services in order to submit an episode for billing. Given the current environment, many physicians or other qualified professionals have been hard to track down due to office closures or, in COVID hot spots, how busy qualified professionals have been with other patients. We ask that CMS allow for the documentation of a verbal order to count for the purposes of eligibility and billing for the duration of the PHE.

Thank you for the opportunity to provide comments on this rule and we look forward to continuing to work with you on these issues. Please reach out to Ruth Katz, SVP for Policy and Advocacy, at rkatz@leadingage.org with any questions.

Sincerely



President and CEO, LeadingAge

Acting President and CEO, Visiting Nurse Associations of America and ElevatingHOME