June 1, 2020

The Honorable Seema Verma
Administrator
U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code (CMS-1744-IFC) Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

To Administrator Verma:

The Home Care Association of New York State Inc. (HCA) is a statewide not-for-profit organization representing nearly 400 home health and hospice providers, allied organizations, managed care providers and individuals committed to the advancement of quality home health and hospice services in New York State.

On behalf of our home health and hospice provider members that serve many of the approximately 800,000 Medicare and Medicaid home health and hospice beneficiaries annually in New York, we appreciate the opportunity to provide comments on the U.S. Centers for Medicare and Medicaid Services (CMS) Interim Final Rule (IFR) on "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency."

General Overview

HCA welcomes the efforts by CMS to assist home health agencies and hospice providers during this unparalleled public health emergency (PHE). Specifically, we note CMS's recognition of COVID-19 health risks as meeting the criteria for homebound status, various waivers of procedures and Conditions of Participation, the allowance of non-physician practitioners to order home health services, and the modest expansion of telehealth services for home health patients. HCA offers the following comments and recommendations to further facilitate the provision of home health and hospice services during the PHE.

The Use of Technology Under the Medicare Home Health Benefit During the PHE for the COVID-19 Pandemic

Issue No. 1: CMS provides home health agencies (HHAs) with the flexibility to deliver care using various types of telecommunications systems to expedite continuity of care during the PHE, yet payment restrictions still prevail. CMS also states that virtual encounters by HHAs are "in conjunction" with the provision of in-person visits, and "not substitutions" for in-person visits. As CMS states in its IFR:

> While we remain statutorily-prohibited from paying for home health services furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of the plan of care (POC) and for paying directly for such services under the home health benefit, for the duration of the PHE for the COVID pandemic, we are amending the regulations at §409.43(a) on an interim basis to provide HHAs with the flexibility, in addition to remote patient monitoring, to use various types of telecommunications systems (that is, technology) in conjunction with the provision of in-person visits.

HCA believes that CMS has the flexibility in providing reimbursement to HHAs for telecommunication encounters when included within the POC. CMS has provided significant flexibilities for physicians and non-physician practitioners related to the use of telecommunication technologies for patient encounters. CMS should do so similarly for HHAs.

Recommendation: CMS should reimburse HHAs for telecommunication encounters that are included in the home health POC. The rate scheduled should be commensurate with either the various physician evaluation and management visits paid on the physician fee schedule (PFS) or at the current low utilization payment adjustment (LUPA) rates per discipline of service.

Issue No. 2: CMS is permitting physicians to enter into contractual arrangements with a HHA to leverage auxiliary personnel, including nurses or other clinical staff, to provide virtual visits for patients in their homes. These virtual visits are considered appropriate as long as the billing practitioner is providing appropriate supervision through audio/video real-time communications technology, when needed. Payment for such services would be made to the billing practitioner who would then make the appropriate payment to the contracted entity (i.e., the HHA). This payment would be made in accordance with the PFS and would not be considered a home health service under the Medicare home health benefit. Because these patients would ostensibly be newly receiving services at home, CMS indicates that it does not expect this flexibility would overlap with a home health episode of care rendered by a home health agency, and CMS states it will be monitoring claims to make sure this does not occur.

This arrangement specifically limits the use of virtual visits to those patients not under a home health plan of care (POC). However, HCA has heard that some HHAs have been receiving requests from physicians to facilitate virtual visits for their patients that *are* under a home health POC. For example, there are instances where a physician needs to assess the condition of a wound and evaluate the wound while the HHA is visiting to perform wound care. HHAs in this scenario are concerned that that they are not permitted to bill for the home health visit since the care could be considered duplicative of the physician's service.

Recommendation: CMS should allow the HHA and the physician to each conduct and bill for concurrent visits with a shared patient of the HHA and the physician when the service is on the home health POC. During the Public Health Emergency, many physicians are conducting telehealth visits which may limit their ability to provide comprehensive evaluations for certain conditions. Furthermore, the services provided by the HHA and the physician are separate and distinct services specific to each provider type and, therefore, appropriate for separate Medicare payment.

Medicare Home health Face to Face (F2F) Encounter

Issue: CMS has issued waivers that permit practitioners to conduct and bill Medicare for virtual visits via audio-only technology. This flexibility permits practitioners to conduct audio-only visits when two-way audio/visual technology is not available or not practicable for patients. However, CMS will not permit audio-only visits to be conducted for the F2F encounter for Medicare home health certification; only in-person visits and two-way audio/visual technology are permitted for these encounters. Therefore, scheduling an acceptable F2F is frequently challenging, if even possible, for some patients, creating additional burdens for providers and delays in care for patients. Additionally, this policy restricts access to home health services for many patients residing in rural areas, especially where broadband capabilities or access are limited.

Recommendation: CMS should permit practitioners to conduct the F2F encounter for Medicare home health certification via audio-only technology in addition to two-way audio/visual technology and in-person visits.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS's Revision of Home Health Agency Shortage Area Requirements for Furnishing Visiting Nursing Services

Issue: In its IFR, CMS is allowing RHCs and FQHCs to provide visiting nurse services to their patients regardless of whether there is a shortage of HHAs in the rural area where the clinic or center is located. CMS is providing this flexibility because it believes HHAs will become besieged in response to the PHE, effectively resulting in a shortage. However, many of HCA's HHA members in upstate and rural New York have reported to us in a survey that they have been experiencing reductions in referrals due to the suspension of elective surgeries. Additionally, many patients are refusing on-site visits from agency staff, leading to additional losses in revenue as well as caseload volume reductions. Because of these referral and case volume trends, HCA believes there is no need for RHCs and FQHCs to fill any gap in HHA availability, especially here in New York.

Recommendation: CMS should withdraw or revise the PHE waiver and instruct RHCs and FQHCs to work with HHAs before initiating visiting nurse services to its patients. The Medicare home health benefit offers more services to beneficiaries receiving care in the home than the RHCs or FQHCs can provide. Additionally, many HHAs are able to accept these patients during the PHE. CMS should restore the longstanding requirement that RHCs and FQHCs are permitted to provide visiting nurse services in the home **only** after it is determined that no HHA is available to provide the care.

Use of Technology Under the Medicare Hospice Benefit

From the start of the PHE, hospices have had significant challenges providing in-person visits due to patient and family fears of exposure to infection, residential and nursing facility limits on admitting non-facility health care providers, and personal protective equipment (PPE) shortages.

While many hospice providers had previously begun to utilize telecommunications technology as part of their care strategies, others did not, due to cost issues or concerns that Medicare would not consider these visits appropriate or sufficient to meet patient and family member needs. Early in the PHE, in response to concerns that hospices were unable to access many patients for in-person service visits, CMS noted in informal discussions that the hospice Conditions of Participation (CoPs) contain very limited references to in-person visits, and that telecommunications technologies are permitted for use in hospice care. As part of the Interim Final Rule, CMS states that "technology has become an integral part of medicine across the entire spectrum of healthcare" and that "recently, we have been asked by stakeholders to provide more clarity on how hospices can leverage technology to keep clinicians and patients safe during the PHE for the COVID-19 pandemic." In response, CMS amended hospice regulations at 42 CFR 418.204 as follows:

> 418.204 – Special Coverage Requirements
> (d) Use of technology in furnishing services during a PHE. When a patient is receiving routine home care (RHC), during a PHE as defined in §400.200 of this chapter, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions. The use of such technology in furnishing services must be included on the plan of care, meet the requirements at §418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.

CMS also stated in the Interim Final Rule that these visits performed using telecommunications technology are included as part of the per diem, and that for purposes of hospice claim submission only **in-person visits** (with the exception of social work telephone calls) should be reported on the claim. CMS indicated that the cost of telecommunications technology used to deliver routine home care during the COVID-19 emergency may be included on the hospice cost report but should be reported separately.

CMS's informal guidance advanced before the IFR (referenced above) as well as CMS's amended regulations have raised numerous questions around the use of telecommunications technology for service visits under the hospice benefit that we believe merit clarification by CMS.

HCA seeks clarification as well as the opportunity to comment and make recommendations to CMS on the following issues:

- **Technology-Based Visits Only for Patients Served at the RHC level of Care?** In its IFR, CMS indicates that a key reason for use of technology-based visits during the PHE is to

continue to provide hospice services but to limit exposure to infection for patients, family members and hospice caregiving staff. However, CMS specifies that technology-based visits are to be used only for patients being served at the RHC level of care.

The exposure risks are by no means limited to the home setting, as if such risks didn't also exist for Inpatient Respite Care (IRC) or General Inpatient (GIP) Care in contracted facilities. HCA would like know why CMS has made a distinction between RHC and inpatient levels of care relative to delivery of technology-based visits during the course of the PHE?

- **Reporting on Hospice Claims**: CMS has specified that hospices are only to report in-person visits on hospice claims (with the exception of medical social services phone calls). Failure to collect data on use of telecommunications technology to perform hospice visits severely limits CMS's ability to monitor use of technology-based services and the potential impact of these technologies on quality of care. In addition, the lack of such visit information would result in an inaccurate picture of the total services actually being provided for patients in hospice care. **HCA recommends that CMS create codes or modifiers that can be used to report technology-based visits on hospice claims. This would allow CMS to have additional claims data that may be helpful if CMS considers possible payment reforms in the future.**

- **Clarifications Regarding the Hospice Cost Report**: In its IFR, CMS indicates that "hospices can report the costs of telecommunications technology used to furnish services under the RHC level of care during the PHE for the COVID-19 pandemic as other patient care services using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as 'PHE for COVID'."

  However, CMS has not provided clarification as to whether other COVID-19-related expenses (in addition to telecommunications technology) are expected to be reported on the hospice cost report and whether those expenses will be included or excluded from future rate-setting. If those expenses will be included in future rate setting, are hospice providers still permitted to include these otherwise un-reimbursable COVID-19-related costs as part of their accounting of COVID-19-related costs that will be reported for the Department of Health and Human Services (HHS) Provider Relief Fund or other COVID-related financial relief?

  HCA recommends that CMS and/or HHS provide additional details as it relates to the reporting of PHE-related costs on the cost report as well as for purposes of provider relief efforts to ensure appropriate reporting by hospice providers.

- **Clarification for Hospice Item Set (HIS) Reporting:** From the start of the PHE, hospice providers have sought clarification from CMS regarding reporting of technology-based visits as part of the Hospice Item Set (HIS), but CMS has yet to respond. **HCA recommends that CMS clarify whether technology-based visits may or may not be reported on the HIS Discharge record.**

Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement

Issue No. 1: In its IFR, CMS outlines existing requirements for the hospice face-to-face (F2F) encounter for the purpose of gathering clinical information to support ongoing eligibility for hospice care. The F2F encounter is required to be performed by a hospice physician or hospice nurse practitioner (NP) within the 30 days prior to the beginning or the third or subsequent benefit periods. In its IFR, CMS expresses its belief that the F2F visit could be performed via telecommunications technology if the F2F encounter is the sole purpose for the visit during the course of the PHE for the COVID-19 pandemic. In its IFR, CMS made the following regulatory revision:

> §418.22 Certification of terminal illness. During a PHE, as defined in §400.200, if the F2F encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via a telecommunications technology and is considered an administrative expense.
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> Telecommunications technology means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

Request for Clarification: New York hospice providers in rural and remote areas operate in localities with limited access to broadband. They also encounter other prohibitions (such as lack of two-way audio-visual equipment) that do not allow for performance of the F2F either in-person or using two-way audio-visual telecommunications technologies. In order to address these circumstances, and since clinical information gathered during the F2F encounter is not the only information used by the certifying physician to support continuing eligibility, **we request CMS to provide clarification as to whether hospices that are unable to use two-way audio-visual technology and are not able to enter a patient's home to conduct the F2F must discharge the patient or if CMS will allow, in these special circumstances, use of audio-only technologies to support the F2F encounter**.

Issue No. 2: In its IFR, CMS has indicated that community-based attending physicians may bill the Medicare program for services delivered using telehealth technologies, and hospice programs may bill Part A for medical services delivered via telehealth technologies that are provided by a hospice-connected attending physician.

Recommendations: CMS should clarify that, during the course of the PHE, hospices are permitted to bill Medicare Part A for medical services provided by a hospice physician using telehealth technologies regardless of whether the hospice physician is the designated attending physician or not. This clarification would provide for greater consistency with the manner in which payment policy for physician services is administered under routine circumstances.

Issue No. 3: In its IFR, CMS states that "if a hospice physician, or a hospice NP who is also the patient's designated attending physician, provides reasonable and necessary non-administrative patient care during the F2F, that portion of the visit would be billable under the Medicare rules." However, the flexibilities included in the rule only permit that, for the duration of the PHE, telehealth may be used to perform the F2F interaction provided that that is the sole purpose for the interaction.

Recommendation: In order to make the flexibilities consistent with existing policies, for the duration of the PHE, CMS should permit hospices to bill for non-administrative services provided in conjunction with the F2F (even if the encounter is performed via telecommunications technology) if the medical services are provided by a hospice physician or a hospice-employed NP who is also the patient's designated attending physician.

Conclusion

HCA thanks CMS for this opportunity to submit comments and respectfully requests CMS's consideration of our concerns and recommendations.

I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or (518) 810-0661.

Sincerely,

Patrick Conole, MHA
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Home Care Association of New York State, Inc.