



December 24, 2020

Allison Beattie  
Department of Health and Human Services  
200 Independence Avenue, SW  
Room 713F  
Washington, D.C. 20201

RE: Executive Order 13924, Regulatory Relief to Support Economic Recovery; Request for Information; ID# HHS-OS-2020-0016-0001

Dear Ms. Beattie:

The Home Care Association of New York State (HCA), Inc., on behalf of its 200 plus member home health agencies (HHAs) and fourteen hospices serving approximately 175,000 Medicare home health and hospice beneficiaries annually, appreciates the opportunity to provide comments on the November 25, 2020 Request for Information: Regulatory Relief to Support Economic Recovery (ID# HHS-OS-2020-0016-0001).

Home health and hospice agencies have faced unprecedented challenges during the COVID-19 pandemic, including staff shortages due to staff who have gotten sick or died, fears by existing and potential new staff of going into the home, and inability to train new staff; decreased revenues due to less cases as a result of family and patient concerns about people going into their homes and decreased referrals from hospitals and physician practices; lack of access to and funding for personal protective equipment (PPE) and disinfection supplies; lack of funding for telecommunications technology; utilizing precious resources and time to reengineer their employment practices to accommodate remote work by staff and local or state safe distancing rules; developing new infection control practices and training staff; lack of funding for “hazard” pay; and more.

## **Medicare Home Health**

### **111. Communication Technology-Based Services**

While not specifically mentioned under this category, CMS has allowed HHAs to provide telecommunications technology as long as it is part of the plan of care and does not replace necessary in-person visits as ordered; it can be used for completion of the comprehensive assessment and update of the comprehensive assessment; this includes remote patient monitoring; telephone calls, 2-way audio-video technology that allows for real-time interaction between the clinician and patient

**HCA Recommendation:** HCA supports and appreciates CMS’s efforts to promote the use of telecommunication technologies and the acknowledgment that technology has the potential to play a large role in enhancing the delivery of healthcare in the home. During the COVID-19 pandemic, telehealth has been used to support Medicare beneficiaries when in-home services

were not advisable or available and this should be continued after the public health emergency (PHE) ends.

However, we strongly advocate that agencies receive separate reimbursement for visits conducted via telecommunication during and after the pandemic. CMS has expanded the types of providers who can bill for such visits and not allowing this for HHAs has created financial challenges and is likely to serve as a deterrent to provide telecommunication technologies to Medicare home health beneficiaries.

Also, it is unclear whether audio only visits are included as telecommunications technologies for home health visits. Audio only visits have been permitted during the PHE, however, the recent change that allows a broader use of telecommunications technology to be reported as an allowable administrative cost on the home health agency cost report does not appear to include audio only technology. CMS should permit telecommunication technologies to include audio only (e.g. telephonic) technology.

#### **215. Eligibility for Telehealth**

Expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

**HCA Recommendation:** Allowing various types of therapists to provide telehealth services during the pandemic has permitted them to provide services to patients who fear outside individuals coming into their home and kept such patients in their preferred setting. After the PHE ends, this should be continued when accompanied by in-person visits.

#### **114. Clarification of Homebound Status under the Medicare Home Health Benefit**

Considers a beneficiary to be homebound if a physician advises the individual not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes him or her more susceptible to contract COVID-19

**HCA Recommendation:** HCA supports continuation of broadening the homebound definition to include beneficiaries whose 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. This has been very helpful for meeting the current restrictive home health eligibility criteria and thus initiating much needed services.

In addition, outside of the pandemic, HCA supports revising the homebound definition so that more individuals who need home health services but don't meet the overly restrictive homebound criteria can obtain services. If CMS won't consider major revisions to the homebound criteria, CMS should continue to reinforce the application of the Medicare homebound definition for beneficiaries with conditions where leaving the home is contraindicated, particularly when there is a high risk for the beneficiary to contract an infectious and/or communicable disease.

#### **161. HHA Reporting**

Extends the 5-day completion requirement for the comprehensive assessment from 5 to 30 days and waives the 30-day OASIS submission requirement.

**HCA Recommendation:** HCA supports the continuation of this provision during and after the pandemic.

**171. RAPs**

Allows Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.

**HCA Recommendation:** HCA supports the continuation of this provision during and after the pandemic.

**199. Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients, regardless of whether the service establishes eligibility for the patient to be receiving home care.**

HHAs have long advocated for regulatory changes to permit therapists to conduct the initial and comprehensive assessments for all patients when therapy is ordered at the start of care. The requirement for the RN to conduct the initial and comprehensive assessments when nursing and therapy are ordered results in the use of valuable resources (extra RN visits that are not reimbursable) in cases where the plan of care does not require the RN to visit prior to the therapist.

Currently, a therapist may conduct the initial and comprehensive assessment if therapy is the only discipline ordered. Therefore, there has always been precedent for a therapist to conduct the initial and comprehensive assessments.

**HCA Recommendation:** HCA supports the continuation of this provision during and after the pandemic.

**202. Waive Onsite Visits for HHA Supervision**

Waives the requirements that a nurse conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time, but virtual supervision is encouraged during the period of the waiver.

**HCA Recommendation:** This has provided tremendous relief to agencies as they address fears by patients and families of having anyone come into their homes. Allowing for virtual supervision with in-person supervision even after the pandemic ends would ensure appropriate care and minimize the cost of nursing in-person visits.

**245. Detailed Information Sharing for Discharge Planning for Home Health Agencies**

Waives the requirements 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 data that includes, but is not limited to, (another) HHA, skilled nursing facility, inpatient rehabilitation facility, and long-term care hospital quality measures and resource use measures.

**HCA Recommendation:** This has been helpful and should be continued during the pandemic to reduce time and resources needed to meet this requirement.

**266. Clinical Records for HHAs**

Extends the deadline for providing patients a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient) to ten business days.

The current four-day requirement does not provide sufficient time for agencies to produce a medical record in many cases even when there is not a PHE, and this relief has been very beneficial for HHAs.

**HCA Recommendation:** HCA urges CMS to maintain this regulatory change beyond the PHE. Ideally, CMS should align the clinical records requirement with those of the Health Insurance Portability and Accountability Act which provides 30 days for a health care entity to act upon on a request for a copy of the medical record.

**294. 12-hour Annual In-service Training Requirement for Home Health Aides**

Postpones the requirement that each home health aide receives 12 hours of in-service training in a 12-month period until the end of the first full quarter after the declaration of the PHE concludes.

**HCA Recommendation:** HCA supports this continuing throughout the pandemic as: many aides don't want to come to a central location for trainings due to concerns about being in contact with others; aides try to minimize their travel which often involves public transit; and state law social distancing rules limit the number of staff who can congregate.

After the PHE ends, the requirement can be reinstated, but agencies should be given up to six months to train their aides.

**296. Training and Assessment of HHA and Hospice Aides**

Waives the requirement for Hospices and HHAs for a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency.

**HCA Recommendation:** HCA supports this provision during the pandemic as it reduces the number of in-person visits by staff and allows them to focus on the direct provision of services. Also, this requirement could be satisfied via telecommunications technology.

**The following are not listed separately in the RFI, but are regulatory relief measures that CMS has allowed during the COVID-19 pandemic.**

**Face to Face Encounter**

Allows the Medicare home health face to face (F2F) encounter to 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).

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 or two-way audio/visual technology are permitted for these visits.

**HCA Recommendation:** 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. This should be allowed during and after the pandemic. This saves much time and resources by HHAs in ensuring compliance and by physicians so they can spend more time in providing services.

### **OASIS**

Comprehensive assessment and updates to the comprehensive assessment can be conducted using telecommunications technology (which can include audio-only or TTY telephone calls, or two-way audio-video telecommunications technology, like FaceTime or Skype) so long as it's part of the patient's plan of care and does not substitute for in-person visits as ordered on the plan of care.

**HCA Recommendation:** This has been very helpful to the operations of agencies during the pandemic and should be made permanent after it ends.

### **Allow HHAs to be Reimbursed for Services Based on Verbal Orders**

Providers are increasingly having difficulty obtaining practitioner signatures on verbal orders since many practitioners are limiting office hours during the PHE and maximizing remote patient encounters.

HHAs may provide Medicare covered services based on a verbal order, however, they may not bill Medicare for services without practitioner signed verbal orders. HHAs are providing needed home health care to beneficiaries during the PHE in good faith that they will be reimbursed by Medicare, and they are experiencing serious cash flow issues related to their inability to bill for services without signed orders.

**HCA Recommendation:** Permit home health providers to receive reimbursement for Medicare home health services based on verbal orders during the PHE.

### **Initial Assessments**

Allows initial assessments and determining patient's homebound status to be performed remotely, by phone or by record review.

**HCA Recommendation:** This has successfully addressed desires by patients and their families to minimize outside "visitors" with no adverse effect on patient care and has provided tremendous relief to agencies. It should be continued throughout the PHE and made a permanent change once the PHE ends.

### **Reassessments**

Telehealth is an option for the update of the comprehensive assessment if the patient agrees to other in-person visits. HHAs can provide more services to beneficiaries using telehealth as

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.

**HCA Recommendation:** Again, this has addressed patient concerns about staff coming into their homes and provided tremendous relief to agencies with no adverse effect on patient care. It should be continued throughout the PHE and made a permanent part of the program once the PHE ends.

## **Medicare Hospice**

### **116. Use of Telecommunications Technology**

Allows hospices to provide services via a telecommunications system, when a patient is receiving routine home care, 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 without jeopardizing the patients' health or the health of those who are providing such services.

Early in the COVID-19 PHE, CMS officials noted that there are no requirements under the hospice Conditions of Participation (CoPs) that visits outlined on the plan of care must be delivered in person and that services can be delivered using technology as long as they meet the goals of care established by the interdisciplinary team. On March 30, 2020, CMS issued an Interim Final Rule (Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency – CMS1744-IFC), which amended the hospice Special Coverage Requirements at 418.204 to allow hospice providers to “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 patient's terminal illness and related conditions.”

CMS has further clarified on provider information calls that a variety of telecommunications options (including audio only) are permitted for use, provided the technology is included on the plan of care and that the goals of care are met. This includes potential use of telecommunications technology to complete patient assessments as long as the hospice is able to conduct a thorough assessment using the selected technology. Otherwise, an in-person visit may be needed. These visits are part of the per-diem payment for hospice care and do not impact reimbursement.

Having this as an option has been extremely helpful. Due to staffing capacity issues, this has allowed hospices to bring patients on within hours, start the care plan, obtain medications and have the RN visit within 24 to 48 hours. This can be very beneficial in rural areas, where in-person recertifications by the hospice MD involves a lot of time and resources.

**HCA Recommendation:** CMS should clarify that technology-based visits are permissible outside of a PHE under the same circumstances and conditions as under a PHE, provided applicable HIPAA requirements are met.

**126. Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement**

Allows the use of telecommunications technology by the hospice physician or Nurse Practitioner (NP) for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services.

**HCA Recommendation:** HCA supports the permanent allowance of telecommunications technology by the hospice physician or NP for the F2F visit when such visit is solely for the purpose of recertifying a patient for hospice services. This has allowed hospices to maximize their resources during the pandemic and ensure that care is maintained, and should be continued after the PHE.

Some patients, however, lack access to broadband or two-way audio-visual equipment and thus cannot use this allowable telecommunications technology. 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 urge CMS to allow for use of audio-only telecommunications equipment to perform the F2F encounter under such circumstances.

**180. Hospice Aide Competency Testing**

Modifies the requirement that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient, and allows hospices to utilize pseudo patients such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient.

Limiting observation of the tasks to a patient only has severely limited hospices since implementation. Specifically, a patient must have the need for or be willing to have the task that must be evaluated by direct observation performed. It is rare to find the number of patients necessary for all the required tasks, including tub baths and shampoos, to be performed on a patient even when some patients have the need for multiple tasks. Burdening patients at the end of life by asking for an aide to be competency evaluated for a task performed on them/asking for additional non-needed tasks to be performed for the sole purpose of competency evaluation is not consistent with hospice care.

The interpretive guidelines for HHA aide competency evaluation were revised to include the use of pseudo patients, and there is no reason that this should not also be done for hospices.

**HCA Recommendation:** This has been extremely helpful during the PHE, especially for tasks that are performed infrequently and should be made permanent after the pandemic ends.

**181. Onsite Visits for Hospice Aide Supervision**

Waives the requirement for nurses to conduct an onsite supervisory visit every two weeks, including the requirement for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan.

**HCA Recommendation:** This relief has been extremely helpful during the pandemic when patients and their families want to minimize the number and frequency of staff coming into their homes. After the PHE, HHS should allow it to be done via telecommunications technology with in-person supervision as needed.

**207. 12 Hour Annual In-Service Training**

Waives the requirement that hospice aides must receive 12 hours of in-service training in a 12 month period.

**HCA Recommendation:** This should be continued during the PHE as many aides don't want to come to a central location for in-service training and meeting this requirement is difficult due to social distancing requirements. Once the PHE ends, this can be reinstated, but agencies should be given six months to meet this requirement.

**259. Non-Core Services**

Waives the requirement for hospices to provide certain non-core hospice services during the emergency for physical therapy, occupational therapy and speech-language pathology.

**HCA Recommendation:** This should be continued during the pandemic but can be reinstated once the PHE ends.

**264. Timeframes for Hospice Comprehensive Assessments**

Waives certain requirements and extends the time frames for updating comprehensive assessments from 15 to 21 days.

**HCA Recommendation:** While helpful during the PHE, this requirement should be reinstated once the PHE ends.

**270. Requirement for Hospices to Use Volunteers**

Waives the requirement that hospices use volunteers (including at least 5% of patient care hours).

Almost all hospices have reported significant reduction in available volunteers and many have reported not being able to utilize any volunteers for activities that would involve direct in person contact with patients. Some of the hospices have decided to prohibit such interaction for the sake of reducing risk to the patient and to the volunteer.

**HCA Recommendation:** HCA recommends that this be continued during the pandemic as it gives needed flexibility to hospices, and that CMS extend the waiver through at least a full 12 months after the end of the PHE. This would allow hospices the necessary time to restart volunteer training and recruit and train new volunteers to replace those lost and those deciding not to return.



**295. Annual Assessment of Hospice Aides**

Modifies the requirement that hospices annually assess the skills and competence of all individuals furnishing care and provide in-service training and education programs where required.

**HCA Recommendation:** While this relief has been helpful during the pandemic and should be continued for the rest of the PHE, it should not be made permanent.

**296. Training and Assessment of Hospice Aides**

Waives the requirement that a registered nurse make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency.

**HCA Recommendation:** While this relief has been helpful during the pandemic and should be continued for the rest of the PHE, it should not be made permanent.

Thank you for the opportunity to provide comments and you can contact me at 518-810-0662 if you have any questions or need more information.

Sincerely,

Andrew Koski  
Vice President  
Program Policy and Services