Regulatory/Statutory Considerations
HHS/CMS should institute the following policies where it is within their authority and support statutory modifications where necessary to reduce exposure risks of patients and clinicians and to increase availability of clinicians for patient care rather than paperwork.

HOME HEALTH LEGISLATIVE			
Statute or Regulation	**Outcome sought**	**Rationale**	**Status**
1814(a)(2); 42 CFR 409. 42(a)	Establish a "homebound" interpretation to consider individuals suspected of infection and those that need intermittent skilled care who are at increased risk in using outpatient services to meet the "homebound" requirement for benefit eligibility. Presumptive eligibility for all individuals over age 60 a sit is medically contra-indicated to leave the home during the pandemic.	Patients who are suspected or confirmed to have COVID-19 along with other Medicare beneficiaries of advanced age may not physically meet the homebound standard even though they are instructed to self-isolate in their home. However, CDC and other guidance firmly states that these individuals should self-isolate and not venture into the open community as they are at high risk. As such, it is "medically contra-indicated" that they leave their homes. That is an existing standard for homebound status.	COMPLETED
1814(a)(2)(C)	Medicare face-to-face physician encounter requirements for home health—permit telephonic encounters as an alternative to direct physician contact.	The face-to-face physician encounter may be conducted by telehealth but not telephonically. Many home health patients do not have access to or use sophisticated technologies, and therefore will need to leave their home to see a physician.	NEARLY COMPLETED Need to permit audio telephonic communications as an acceptable medium..
1814(a)(2)(C)	Allow NPs and PAs to	Under current statute,	Congress passed

	certify for eligibility and order home health services where permitted by the state.	only a physician may certify patients for Medicare for home health services and write orders patients served by the Medicare certified agency. NP and PAs are increasingly serving as the primary practitioner for patients, particularly in rural areas. HHAs must locate a physician that is willing to oversee the patient care when the primary practitioner for a patient is an NP or PA	legislation to permit NPs, PAs, and CNSs to certify an order home health (as permitted under state scope of practice). CMS accelerated implementation through non enforcement policy issuance. REQUESTING: Accelerate formal regulation to implement CARES provision
1814(a)(2)(C) and 1835(a)(2)(A)	Allow beneficiaries to qualify for home health services on the sole basis for needed venipunctures.	The Act specifically excludes venipuncture as a sole basis for qualifying for Medicare home health services. Physicians are requesting HHAs to perform venipunctures for beneficiaries unable to leave the home due to the pandemic. These beneficiaries required monitoring related to clinical conditions and /or to monitor drug levels, such as PT/INR, digoxin, thyroid, etc.	Requested
HOME HEALTH REGULATORY			
Payment			
§484.205(g)(1)	Restore RAP payment to 60% of payment for initial 30day periods and 50% for subsequent 30 day periods PAYMENT PRIORITY #3	Under PDGM RAP payment were decreased to 20% for all 30 day periods. Increasing RAP payments will provide agencies with the necessary cask flow needed to maintain	REQUESTED

		operations.	
§484.205(a)	Suspend the 2020 4.36% behavior adjustment and the annual Productivity adjustment in the current payment system (PDGM) PAYMENT PRIORITY #1	Suspending the adjustment would infuse some financial support to HHAs while they are experiencing vast changes in the makeup of the patients served (including Covid-19 patients), increased costs for infection controls and emergency actions, staffing costs as caregivers face infections, and many other complications not built into the PDGM system. It is appropriate because both 2020 behavior and productivity has been turned inside out. The failsafe in suspending the adjustment is that the law includes a reconciliation authority to ensure budget neutrality.	REQUESTED
§484.220(a)	Permit agencies to receive reimbursement when the primary diagnosis is a contact/exposure code (such as Z20.828 or Z03.818)	Symptom codes such as Z03.818 and Z20.828 are unacceptable primary diagnosis codes for home health claims and are not grouped in the PDGM payment model. HHAs cannot be reimbursed for care provided to PUI for COVID-19	REQUESTING
§409.43(c)	Waive or suspend the requirements that HHAs have signed and dated physician certifications and care orders prior to billing. PAYMENT PRIORITY #2	Physicians are unavailable to sign orders during the emergency. Verbal orders should be sufficient to bill Medicare.	REQUESTED

§409.46(e)	Permit physician-ordered telehealth and remote monitoring visits to count as Medicare home health visits.	In order to continue care for patients while maintaining social distancing, HHAs are planning on using telehealth services and remote monitoring in lieu of visits. In addition, patients are refusing to permit HHA staff into their home due to the COVID 19 outbreak. Telehealth and remote monitoring visits by HHAs are not reimbursable under the Medicare program and will cause significant financial hardship for both the agency and the staff.	CMS did not allow for telehealth reimbursement or credit as visit equivalency
HOME HEALTH COVERAGE			
POLICY			
Pub. 100.2, chapter 10, 40.1.3	Provide flexibility in the definition of "intermittent skilled nursing" to permit a one-time skilled nursing visit for specified interventions, such as, injections that would ordinarily be provided during a physician's office visit.	The Act at 1861(defines intermittent, for the purposes of §§1814(a)(2) and 1835(a)(2)(A), as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable.) However. CMS policy includes a requirement that the patient must have a medically predictable recurring	REQUESTED

		need for skilled nursing services, which prohibits a physician from ordering one–time home health skilled nursing visits.	
Demonstrations and Appeals			
CMS Demonstration Program	Suspend expansion of the Review Choice Demonstration (RCD) project DEMO PRIORITY #1	The RCD is a very resource intensive medical review process that requires HHAs to submit the entire medical record to the Medicare claims processing contractor before payment can made on the claim. In states where the demonstration is being conducted, a HHA's ability to respond to the COVID-19 pandemic would be significantly limited	RCD suspended However, CMS will have MACs do 100% post-pay review REQUESTING: Suspension of post-pay review as it adds burden and increases HHA risk Extension of RCD review choice selection deadline until an announcement as to the new start date.
CMS-CPI	Suspend Targeted Probe and Educate audits	TPE is not focused on parties suspected of fraud and abuse. Current "improper payment rate" is at an all-time low. TPE management requires HHA staff to focus on paperwork, not patient care.	COMPLETED
CMS/OHA	Institute National Accelerated Appeals Settlements	Providers of all types have pending Medicare appeals. Past settlement efforts proved beneficial to Medicare and appellants in terms of efficiencies. The PHE justifies broad-scale settlements to reduce	REQUESTING

		burdens on all stakeholders	
CMMI	Suspend the HHVBP demo	We are very supportive of the HHVBP demo. However, there has been a massive change in case mix and clinical practice while addressing the pandemic. As a performance year, 2020 would not be a good time to learn about how financial incentives and penalties impact patient outcomes	REQUESTING
HOME HEALTH REGULATORY			
Conditions of Participation			
§484.80(h)	Supervision of home health Aides. Agencies must make an on-site visit every 14 days to supervise the home health services	Telephonic/telehealth supervision of home health aides for home health agencies to extend the availability of clinical staff and promote social distancing while maintaining home care aide oversight should be sufficient in the emergency period. It reduces PPE need and expands clinical service time availability.	COMPLETED
§484.80(c)	Streamline home care aide competency evaluations to include only those competencies required for direct patient care.	Several of the competency requirements could be waived during the pandemic to permit additional personnel be trained as home care aides	REQUESTED
§484.80(d)	Waive the 12-hour annual in-service training requirement for home health aides	Will help address staffing shortages and address need to focus efforts on patient care	REQUESTED

§484.55(a)	Permit HHAs to conduct the initial evaluation visit using telehealth and medical record review.	The initial evaluation assesses for beneficiary eligibility and immediate care needs which could appropriately be evaluated via telehealth and medical record review fostering efficient use of resources when evaluating referrals	COMPLETED
§484. 55(c)	Permit agencies to conduct an abbreviated comprehensive assessment, which includes the OASIS items, to include only items needed for care planning and payment. Home Health COP PRIORITY #1	Many of the items in the assessment are required to be collected by the conditions of participation, but not required for payment or care planning. An abbreviated assessment will free up valuable clinician time that can be dedicated to patient care during a pandemic. CMS has approved such in the past emergencies.	REQUESTED
§484.55(b)	Allow for Flexibility Regarding Comprehensive Assessments completion time frame	The conditions of participation require that the extensive comprehensive assessment must be completed within 5 days of the admission to the HHA. Adhering to tight time frames for the assessment completion misappropriates needed resources during a pandemic. Resources should be dedicated to patient care and not administrative activities to meet regulatory requirements.	COMPLETED

§484.55(a) and (b)	Permit a therapist to conduct the initial visit and comprehensive assessment when both therapy and nursing are ordered at the start of care.	Therapists are not permitted to conduct the initial evaluation visit and comprehensive assessment when nursing services are also ordered. There is no clinical rationale for the requirement and it wastes valuable staff resources.	REQUESTED
§484.55(d)	Permit home health agencies to perform telephonic or telehealth OASIS recertification assessment visits on homebound patients that have a continued skilled need and are refusing visits due to fear of exposure.	This will allow the home health agency to continue monitoring the patient condition to assure no decline, potentially avoiding a hospitalization. Otherwise the HHA must be discharge the patient from the agency at the end of the 60 day episode.	REQUESTED
§484.60(c)	Waive the requirement for written information to be provided to the patient at admission and allow HHAs to verbally inform the patient of the required information under this standard.	Information, such as, a medication list, all services and treatments listed on the plan of care, and visit schedules must be provided to the patient in writing on admission to the agency, and updated whenever changes occur. Limiting the amount of written information that must be provided to patients on admission will allow clinicians more time for direct patient care.	REQUESTED
§484.105(f)	Waive the one service directly requirement for home health agencies to meet increased, but temporary service demand	Under the one service directly rule at least "one discipline" in its entirety must be provided by a W2	REQUESTED

		employee of the agency. Staffing shortages that might occur during the COVID-19 pandemic could require that home health agencies contract for all disciplines.	
§484.100(c)	Relief from restrictions under the Clinical Laboratories Improvement Act to permit home health and hospice personnel to collect, transport, conduct, and report COVID-19 test results	HHAs must have a designated laboratory and meet CLIA standards in order conduct laboratory tests unless the test is a CLIA waived test. As the pandemic progresses HHAs will be well positioned to collect, transport, conduct and report laboratory tests related to COVID-19.	REQUESTED
42 CFR Part 484	Delay OASIS-E	While OASIS-E is not scheduled to start until 2021, much work will need to be done by HHAs on their contractors to prepare for it in 2020.	REQUESTING
HOSPICE LEGISLATIVE			
Statute or Regulation	**Outcome sought**	**Rationale**	**Status**
1814(a)(7)(D)(i)	Permit use of telehealth technologies to fulfill the hospice face-to-face requirement, including telephonic audio communications	Allow confirmation of continuing eligibility for hospice care and address staffing shortages; limit threat of virus spread	PARTIALLY COMPLETED REQUESTING: extend to telephone audio and record review as options
1814(a)(7)(D)(i)	Allow physician assistants (PAs) to conduct the hospice face-to-face encounter Expanded 1135 Waiver Authority PRIORITY #1	PAs may serve as hospice attending physicians; allowing them to conduct the face-to-face will ease demands on physicians and allow timely	REQUESTING

		compliance with requirement	
1814(a)	Allow PAs and NPs to certify hospice eligibility EXPANDED 1135 Waiver Authority PRIORITY #2	Allows PAs and NPs to perform up to full scope of practice and will ease burdens on hospice physicians	REQUESTING
HOSPICE REGULATORY			
1135	Expand telehealth waivers to include hospice visits on the plan of care and for assessment purposes; permit use of various technologies, including audio-only telephonic interactions, as needed based on technology available to patient. Permit inclusion of telehealth visits on the claim Hospice Regulatory PRIORITY #1	Limit the spread of the virus, address growing concerns among seniors around admitting individuals into their homes, address difficulties in accessing patients in nursing homes and other facilities, maximize use of staff	CMS issued clarification; permits telecommunication-based visits as ordered on plan of care without reimbursement effect REQUESTING: Expand telehealth allowance to include GIP and respite care when needed for consultations between hospice staff and patient'facilty .
1135	Allow hospice physician services conducted via telehealth to be billed as regular physician services, comparable to community physicians	Address staffing limitations, expanded patient care needs and limits potential virus spread	PARTIALLY COMPLETED; CMS allows hospice to bill medical services by hospice physicians and NPs serving as attending physician; must meet "telehealth" standard
§418.64	Allow contracting for core services (nursing, medical social services, counseling)	Address staffing shortages and increased patient care needs	REQUESTED
§418.72	Waive non-core services requirement during national emergency	Allows hospices to not provide PT, OT, speech-language to reduce	CMS initiated; COMPLETED

		exposure	
§ 418.54(a), 418.54(d), 418.56(d)	Allow for flexibility regarding time frame for completion of initial and comprehensive assessments, and updates to the comprehensive assessment and review of the plan of care (currently every 15 days) Hospice COP PRIORITY #2	Ability to deliver patient visits is being limited as patients are fearful of potential risk; this will allow for those circumstances where a full initial or comprehensive assessment (or routine reassessment) may not be completed within time frames specified in regulation; will help align safety/care requirements with ability of hospice staff to make necessary in-person visits	Partially addressed; timeframes for updates to assessments extended to up to 21 days REQUESTING: Timeline extension on initial and comprehensive assessments
§418.204, 418.108, 418. 302	Allow for flexibilities related to use of General Inpatient Care (GIP), Continuous Home Care (CHC), and Inpatient Respite Care to address circumstances under which patients may not be admitted to nursing homes (due to lockdowns) or require more intensive care from hospice due to caregiver illness; allow respite care to be provided in the home. Ease CHC to allow hospices to determine care needs (reduce minimum hour requirements, allow for different staffing ratio, allow CHC to be calculated using any 24-hour period). Waive 5-day limit for respite care.	Helps address growing challenges regarding care transitions, need for additional care when family caregiver is ill, reduced availability of inpatient and respite beds in facilities and allows patients to meet eligibility requirements given special pandemic circumstances	REQUESTED
§418.76(h)	Permit telephonic/telehealth supervision of hospice aides and LPNs/LVNs to meet supervision requirements where appropriate	Will help address RN shortages and limit risk of patient exposure during pandemic	COMPLETED; CMS waived requirement

§418.76(c)(1)	As part of hospice aide competency evaluation, allow hospices to use pseudo patients for competency testing of aides for tasks that must be observed on patient; allow "qualified hospice aides" to include those who are competency tested only in the areas/tasks for which they will be assigned	Will help address staffing shortages and exposure of patients to risk	REQUESTED
§418.76(d)	Waive the 12-hour annual in-service training requirement for hospice aides	Will help address staffing shortages and address need to focus efforts on patient care	REQUESTED
§418.78(e)	Waive the 5% level of activity requirement for hospice volunteers	Many hospice volunteers are elderly and/or have health conditions; this will help reduce exposure of these individuals (and patients); will also address current limitations on hospice worker entry to nursing homes and assisted living facilities	COMPLETED
§418.56(d)	Align timeframe for review of the plan of care with the extended timeframe for the comprehensive assessment	Updated comprehensive assessments drive the plan of care so hospices typically review the plan of care along with completing the updates to the comprehensive assessments.	REQUESTING
§418.24(a)(2); 418.26	Provide flexibility on 5-day timely filing requirement for NOE/NOTR	Ease staffing burdens and allow staff to focus on essential needs related to patient care	REQUESTED
CMS-CPI	Suspend Targeted Probe & Educate Audits	TPE is not focused on parties suspected of fraud and abuse. Current "improper payment rate"	COMPLETED

		is at an all-time low. TPE management requires hospice staff to focus on paperwork, not patient care.	
418.24(b)(8)	Allow verbal election of the Medicare Hospice Benefit in circumstances where the patient is unable to make his/her own decisions and the legal representative cannot be available to sign the statement due to the pandemic/is not able to utilize alternative methods of delivery of a signed election statement (i.e. mail, FAX, etc.)	When the legal representative is not available and cannot leave the home for alternative delivery methods (i.e. cannot go to public FAX location, cannot go to post office, etc.), verbal election allows the patient to be admitted to hospice care and begin receiving services immediately.	REQUESTED
§418.116(b) Standard: Laboratory services	Relief from restrictions under the Clinical Laboratories Improvement Act to permit home health and hospice personnel to collect, transport, conduct, and report COVID-19 test results	HHAs must have a designated laboratory and meet CLIA standards in order conduct laboratory tests unless the test is a CLIA waived test. As the pandemic progresses HHAs will be well positioned to collect, transport, conduct and report laboratory tests related to COVID-19.	REQUESTED
MEDICAID			
484.55(h)(2)	60-day aide supervisory visit	Allows waiver of 60-day aide supervisory visit when patient is only receiving personal care services	REQUESTED