Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

June 19, 2020

Demetrios Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services
Director, Center for Medicare
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Principal Deputy Administrator Kouzoukas:

I am writing to thank you on behalf of the Partnership for Quality Home Healthcare ("PQHH"), for speaking with our leadership on June 11, 2020 regarding key issues facing the home health sector. We believe that we can work together to improve this important benefit to address the needs of both patients and the Medicare program.

PQHH is a national coalition of skilled home healthcare providers with a proud track record of offering high quality skilled homecare services to millions of Medicare beneficiaries. Every year, 3.5 million patients rely on skilled health care services delivered in their own homes to recover after an illness or injury. Our patients and their families count on us for exceptional care and unparalleled service. We take seriously the trust patients and families have placed in us and our skilled nurses, therapists and aides to care for them with dignity, expertise and compassion.

We are very gratified that the Centers for Medicare and Medicaid Services ("CMS") has consistently recognized the quality and importance of this benefit to patients, and the value it creates through savings for both the Medicare program and beneficiaries. The Medicare home health benefit is particularly important to the vulnerable population of seniors who tend to be older, sicker, and poorer than the general Medicare population.

The current public health emergency (PHE) related to COVID-19 has demonstrated the critical nature of access to care at home. The home health benefit provides beneficiaries access to skilled care in the home and both in-person and through remote monitoring and care. We appreciate the waivers and flexibilities put in place by CMS to reduce regulatory burdens and support home health providers as they address the care needs of patients during this challenging period. Our recent experience has shown that many of these policies offer improvements to the home health benefit that support good patient care, reduced burden for providers, and value for the Medicare program. PQHH is pleased to outline additional thoughts

surrounding some of the issues we discussed with you, as well as provide further recommendations on certain areas where permanent adoption of CMS' policies make sense under the home health benefit.

Homebound Requirement

In order to be eligible to receive covered services under the Medicare home health benefit, the law requires a physician's certification that a patient is homebound. While the "homebound" requirement serves to limit the home health benefit, it should not also act as a barrier to eligible patients receiving high quality post-acute care in a setting that is often preferred by beneficiaries and their physicians, is safer (particularly in the context of infectious disease), and also is the lowest cost setting for the Medicare program.

In the current PHE, CMS has taken steps to "presumptively" determine that patients with COVID-19 are "homebound." This is consistent with the existing homebound requirement set forth in law and regulation, as patients with COVID-19 and those who would be vulnerable to infection clearly meet the criteria. As explained by CMS, "the definition of "confined to the home" (that is, 'homebound') allows patients to be considered 'homebound' if it is medically contraindicated for the patient to leave the home....While an individual does not have to be bedridden to be considered 'confined to his home', the condition of the individual should be such that there exists a normal inability to leave home and, that leaving home requires a considerable and taxing effort by the individual."

Beyond the current PHE, PQHH believes that CMS's use of a presumptive homebound determination could be broadened and include other clinical conditions which meet Medicare's criteria. For example, these conditions could include those for which skilled nursing services are generally required following surgery and an acute hospital stay; or clinical conditions that require skilled treatment over a continuous period of time, making it difficult for the patient to leave the home. An analysis of the current conditions where home health is ordered could be performed to identify appropriate conditions for which to apply a presumptive determination. Such an approach has precedent in policy under the Medicare skilled nursing facility benefit, where Medicare applies an administrative presumption of coverage based on certain case-mix classification categories.

PQHH believes that adoption of this approach offers an opportunity to reduce burden on providers, streamline patient care transitions after an acute hospital stay, and provide greater flexibility for physicians in ensuring patients get the right care in the right setting. This would be a prudent policy decision that would make sense for patient care, as well as the Medicare program.

Telecommunications and Remote Monitoring

We appreciate CMS allowing physicians to complete the face-to-face visit that is required for coverage under the home health benefit via telehealth during the PHE. This was very helpful in supporting patient access to skilled services in the home during the PHE, and we encourage CMS to continue the policy under the permanent benefit and support efforts aimed at maintaining the home as an originating site for telehealth services under the Medicare program. Even if telehealth originating site requirements are again restricted following the PHE, CMS should allow the home health face-to-face visit to be done as a telehealth service whenever telehealth is an available option.

We agree that physicians, home health agencies, and other providers should be able to readily access technologies to make care delivery more efficient and flexible to meet patients' care needs. CMS has acknowledged how technology can expand the reach of healthcare into the home, through consultation with specialized clinicians and critical care teams, as well as through the integration of devices designed to increase patient involvement and compliance. The agency noted that incorporating various forms of technology, in addition to remote patient monitoring, can be appropriate in furnishing home health services when used in conjunction with the provision of in-person visits.

Although HHAs currently have the flexibility to provide telecommunications visits and perform remote monitoring, CMS noted in the rule that payment for home health services remains contingent on the furnishing of an in-person visit. While PQHH believes that CMS should revisit this restriction, particularly under a PHE, we nevertheless appreciate the Agency's strong support for the use of telecommunications technology in home health and its recognition of current policy. We encourage CMS to work with PQHH to explore expanded use of telecommunications technologies to benefit patients in the home. This is a policy change that will create efficiencies in the home health system and benefit patients.

Recommendations

As noted above, it is our strong recommendation that CMS:

1. **Allow use of presumptive homebound determinations, to support access to care.**

2. **Allow the home health face-to-face visit to be provided via telehealth.**

While we limited our discussion with you to the items above, we also note that a number of additional flexibilities related to telecommunications provided by CMS during the current PHE have been successful in meeting Medicare's requirements while reducing burden for physicians and providers and facilitating more seamless care for patients. We have identified these below and encourage CMS to adopt these policies as part of the permanent program:

3. **Allow flexibility in the timing for obtaining physician signatures for changes to the plan of care for incorporating use of technology.**

4. **Allow providers to perform the initial and comprehensive assessments remotely or by record review; In addition, allow any rehabilitation professional to perform these assessments when therapy services are included in the plan of care.**

5. **Allow the required once a year supervisory visit for home health aides to be met using telecommunications technology.**

6. **Allow the costs of telecommunications technology to be included on the cost report as an allowable cost.**

Conclusion

PQHH appreciates the many efforts that you and CMS have undertaken to support providers and patients in addressing the challenges associated with the COVID-19 PHE. This recent experience has shown us that there are efficiencies to be gained in the system through the use of technology and streamlining eligibility determinations that will improve health care services for Medicare beneficiaries in the delivery in post-acute care.

Thank you again for the time you spent with us discussing these important issues. We appreciate your consideration of our recommendations. As discussed on the call, we will follow up with your team to discuss next steps and data to inform the design of improvements to the system.

Sincerely,

Keith Myers
Chairman
Partnership for Quality Home Healthcare