

August 24, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1730-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via <http://www.regulations.gov>

Re: Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements

Dear Administrator Verma:

I write on behalf of the National Association of Social Workers (NASW) to provide comments on *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency* (CMS-1730-P). NASW represents more than 110,000 social workers nationwide. Many NASW members serve Medicare beneficiaries, including in home health settings.

These comments primarily address Section III.D.4 of the proposed rule, “The Use of Technology Under the Medicare Home Health Benefit,” with brief comments regarding the Patient-Driven Groupings Model (PDGM).

Telehealth Use by HHAs

CMS has proposed to finalize, permanently, changes to section 409.43(a) as finalized in the first interim final rule with comment period (IFC) addressing the COVID-19 public health emergency (PHE), “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency” (2020).¹ The IFC included the following requirements:

- The home health plan of care (POC) must include any provision of remote beneficiary monitoring or other services furnished via a telecommunications system.
- The POC must describe how the use of such technology is linked to each beneficiary’s needs as identified in the comprehensive assessment.
- The POC must describe how the use of such technology will help to achieve the goals outlined on the plan of care.
- Although the use of telecommunications may result in changes to the frequencies and types of in-person visits as ordered on the POC, services provided via a telecommunications system cannot

¹ Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 42 C.F.R. §§ 409.43 (2020). https://www.ecfr.gov/cgi-bin/text-idx?SID=c430dc0f1b5a2d665ac4f8ef49ba16f5&mc=true&node=se42.2.409_143&rgn=div8

substitute for a home visit ordered as part of the POC. Similarly, in keeping with section 1895(e)(1) of the Social Security Act,² a service provided via telehealth cannot be considered a home visit for the purposes of beneficiary eligibility or payment to the HHA.

Moreover, as noted in CMS-1730-P, section 3707 of the Coronavirus Aid, Relief, and Economic Security Act (2020)³ encouraged use of telecommunications systems for home health services furnished during the PHE.

NASW has supported the use of telecommunications systems by home health agencies (HHAs) during the PHE. In its June 2020 comments to CMS regarding the first PHE IFC, the association expressed appreciation for CMS's flexibility regarding Medicare-certified HHAs' use of technology during the PHE and explained that some HHAs were not allowing home health social workers to provide services via telehealth during the PHE.

Accordingly, NASW urged CMS to

allow home health social workers and social work assistants to provide services via telehealth (both audio-only and two-way audio–video) during the PHE . . . [to] ensure ongoing access to home health services while protecting the health and safety of Medicare beneficiaries, family caregivers, and home health staff.⁴

The following factors informed NASW's recommendation:

- Medicare beneficiaries were declining in-person visits from home health personnel because they feared exposure to COVID-19.
- Multiple home health social workers reported to NASW that they lacked sufficient personal protective equipment to conduct home visits safely, were not being permitted by their HHAs to use telehealth, or both. Instead, these social workers were encouraged or required to continue in-person visits, risking not only their own health and safety but also that of the beneficiaries and families served.
- The change NASW recommended would match the flexibility outlined in the first PHE IFC for nurses⁵ and, possibly, the telehealth flexibility granted to occupational therapists (OTs), physical therapists (PTs), and speech–language pathologists (SLPs) in the Administration's *Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic*, announced on April 30.^{6,7}

The telehealth flexibilities provided to HHAs during the PHE have helped facilitate access to home health services while reducing risk of COVID-19 infection for Medicare beneficiaries, family caregivers (as defined by each beneficiary), and home health staff. NASW believes strongly that access to home health services is critical not only during the COVID-19 PHE, but at all times. Home health services help prevent hospitalization

² Consolidated Appropriations Act of 2001, 42 U.S.C. Chapter 7 § 1395fff(e)(1)(A) (2000).

<https://www.govinfo.gov/content/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXVIII.htm>

³ Coronavirus Aid, Relief, and Economic Security Act, Pub. L. 116-136 (2020). <https://www.congress.gov/bill/116th-congress/house-bill/748/text/enr?q=%7B%22search%22%3A%5B%22PL+116-136%22%5D%7D&r=1>

⁴ Mangum, A. (2020). *NASW comments re: Medicare and Medicaid programs; policy and regulatory revisions in response to the COVID-19 public health emergency* [Letter]. National Association of Social Workers. <https://bit.ly/nasw-cms-hh-tele20> [Quotation from p. 2]

⁵ Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 42 C.F.R. §§ 409.43 (2020). https://www.ecfr.gov/cgi-bin/text-idx?SID=c430dc0f1b5a2d665ac4f8ef49ba16f5&mc=true&node=se42.2.409_143&rgn=div8 [Quotation from p. 19248]

⁶ Centers for Medicare & Medicaid Services. (2020, April 30). *Second round of sweeping changes to support U.S. healthcare system during COVID-19 pandemic* [Press release]. <https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid>

⁷ CMS staff (E. Yoder) told NASW during the May 13 National Medicare Education Program call that these changes *might* apply to OT, PT, and SLP services provided in home health settings. As of this writing, NASW is unaware of clarification from CMS regarding this matter.

and stays in skilled nursing facilities, inpatient rehabilitation facilities, and other inpatient settings. Similarly, home health services are essential when beneficiaries transition to home from the hospital and postacute settings.

Yet, NASW is concerned about CMS's proposal to make permanent the telehealth flexibilities for HHAs. Although the ongoing use of telehealth by HHAs holds potential for enhancing service access for Medicare beneficiaries, it could also exacerbate existing disparities in health care quality, access, and outcomes. Therefore, NASW offers the following recommendations to CMS:

- Forgo permanent authorization of telehealth provisions for HHAs at this time.
- When the PHE ends, provide an extended transition period for temporary COVID-19 rules and waivers to minimize disruptions in service delivery and access.
- Use nonregulatory forums to consider carefully, in collaboration with a variety of stakeholders (such as beneficiaries, family caregivers, health care practitioners within and beyond HHAs, and HHAs themselves), the implications of extending telehealth in the future and the guardrails needed to minimize negative consequences of such an extension.
- Systematically collect and analyze data regarding telehealth provision and access to inform future decision making regarding HHAs' use of such technology.

The following comments address these recommendations in greater detail via the themes of accessibility, individualized service delivery, and evidence-based decision making.

Accessibility

NASW appreciates CMS's consideration of telehealth accessibility for people with disabilities and concurs with CMS on three points related to this topic:⁸

- inclusive access to telecommunications technology
- use of the U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR) to review beneficiaries' telehealth access-related concerns vis-à-vis the Americans with Disabilities Act (ADA)⁹ and Section 504 of the Rehabilitation Act (1973)¹⁰
- provision of information to individuals with disabilities "in plain language and in a manner that is accessible and timely, including accessible websites and the provision of auxiliary aids and services at no cost to the individual."

NASW simultaneously recognizes that disability is but one factor that must be considered to ensure accessibility to home health services provided via telehealth. Other factors influencing accessibility include economic security, geography, informed consent, literacy (digital, health, and reading), Medicare enrollment choices, preferred language, privacy protections, and the cultural responsiveness of telehealth policies and programs. Thus, planning for telehealth accessibility in the home health setting involves numerous considerations:

- provision of written materials in languages other than English and in alternative formats
- use of professional interpreters
- compatibility of telehealth platforms with assistive technology software and devices

⁸ Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements, 85 F.R. 39408 (proposed June 30, 2020) (to be codified at 42 C.F.R. §§ 409, 414, 424, 484). <https://www.federalregister.gov/documents/2020/06/30/2020-13792/medicare-and-medicaid-programs-cy-2021-home-health-prospective-payment-system-rate-update-home> [Quotation from p. 39428]

⁹ Americans With Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.* (1990). <https://www.ada.gov/pubs/adastatute08.htm>

¹⁰ Rehabilitation Act of 1973, 29 U.S.C. § 12101 *et seq.* (1973). <https://www.dol.gov/agencies/oasam/centers-offices/civil-rights-center/statutes/section-504-rehabilitation-act-of-1973>

- HHA compliance with and OCR enforcement of the Health Insurance Portability and Accountability Act (1996) (HIPAA)¹¹ and associated rules, including those governing beneficiary privacy¹² and the security of personal health information (PHI)¹³
- enforcement by OCR and other appropriate entities of all other pertinent federal civil rights laws and regulations (including the aforementioned ADA and Rehabilitation Act)
- widespread training of HHAs and home health staff to enhance cultural competence in service provision via telehealth
- implementation of culturally responsive policy strategies—such as access to technological devices, broadband, and digital literacy training—and funding authorization for the Federal Communications Commission (FCC) to decrease the digital divide, which affects beneficiaries, families, home health staff members, and HHAs
- audio-only telehealth and other modalities that do not require broadband access
- clear communication among CMS, fiscal intermediaries, licensing boards, HHAs, home health staff, non-HHA health care professionals, beneficiaries, and family caregivers regarding (a) the availability of telehealth services, (b) applicable beneficiary cost sharing, and (c) financial resources to help beneficiaries cover out-of-pocket costs
- equity between original Medicare and Medicare Advantage in regard to telehealth service and equipment availability.

Accessibility must also reflect continuity of home visits by HHA staff. To that end, NASW recommends that CMS require Medicare Advantage plans to use in-person services, not telehealth services, as the basis for determining network adequacy.

Individualized Service Delivery

Throughout the proposed rule CMS has stressed the importance of developing and following an individualized POC for each beneficiary. NASW agrees wholeheartedly on the centrality of this concept in all health care delivery, including home health. The association appreciates CMS’s reminder that telehealth in HHAs was intended to supplement, not supplant, visits to beneficiaries’ homes. Similarly, NASW affirms CMS’s statement that, *should* telehealth be extended, an HHA

cannot discriminate against any individual who is unable or unwilling to receive home health services that could be provided via telecommunications technology. In those circumstances, the HHA must provide such services through in-person visits as the intent of the Medicare home health benefit as defined in section 1861(m) of the [Social Security] Act is to provide items and services on a visiting basis in the individual’s home.¹⁴

These important statements notwithstanding, the use of telehealth must be considered carefully in the context of each beneficiary’s circumstances. As the previous quotation makes clear, home visits constitute the heart of the Medicare home health benefit. The “homebound” requirement associated with home health eligibility underscores the complex conditions and social isolation many beneficiaries experience during the episode of care. Consequently, home visits are extremely valuable not only in facilitating trust of home health staff by beneficiaries and family caregivers, but also in informing each home health staff member’s assessment and intervention. For example, for a home health social worker, a home visit can provide in-depth information about

¹¹ Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (1996).

<https://www.govinfo.gov/content/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf>

¹² The HIPAA Privacy Rule, 45 C.F.R. §§ 160, 164 (2002). <https://www.hhs.gov/hipaa/for-professionals/privacy/index.html?language=es>

¹³ The HIPAA Security Rule, 45 C.F.R. §§ 160, 164 (2003). <https://www.hhs.gov/hipaa/for-professionals/security/index.html?language=es>

¹⁴ CY 2021 Home Health Prospective Payment System Rate Update, p. 39428

the beneficiary’s psychosocial coping and the family’s caregiving capacity, thereby enabling provision of counseling and referrals. For any home health team member, a home visit can reveal invaluable information about the beneficiary’s physical environment and the beneficiary’s (and, if applicable, family caregivers’) ability to manage the physical condition at home. This trusting relationship and depth of information often enable home health staff to tailor education and interventions to each beneficiary’s needs. Such person-centered service delivery is integral to the quality of life for beneficiaries who use home health services and for family caregivers. It also reduces risk for the beneficiary, family caregivers, and HHA alike.

To prevent a “one-size-fits-all” approach, therefore, NASW asserts that widespread, ongoing education is essential before CMS extends telehealth use for Medicare HHAs. Such education must involve prescribing practitioners (physicians, nurse practitioners, clinical nurse specialists, and physician assistants), HHAs and staff, beneficiaries, family caregivers, state-level boards that license HHAs, fiscal intermediaries, and Medicare Advantage plans and must include the following topics:

- the responsibility of the *prescribing practitioner* to establish, review, and revise the POC in collaboration with the HHA, consistent with § 409.43 of home health services under hospital insurance
- the rights of each beneficiary who receives home health services, consistent with § 484.50 of the Medicare home health conditions of participation (CoP)
- the rights of each beneficiary in relation to the home health POC, consistent with § 484.60 of the CoP
- the beneficiary’s right to receive home visits rather than telehealth services because of need or preference and without incurring additional utilization management requirements
- the responsibility of each home health staff member (including social workers and social work assistants) to collaborate with each beneficiary (and, if appropriate, with family caregivers) regarding the beneficiary’s preferences and needs
- the responsibility of each home health staff member to exercise professional judgment to ensure that services provided via telehealth are clinically appropriate.

Evidence-Based Decision Making

NASW recognizes that CMS’s action to enable telehealth during the PHE has been essential for the safety of Medicare beneficiaries who use home health services, family caregivers, and home health staff. Furthermore, as stated previously, the association is advocating for a gradual telehealth transition for home health services when the PHE ends. However, NASW believes that any decision to extend HHAs’ use of telehealth beyond this transition period must be based on evidence to ensure quality of care and to prevent exacerbation of longstanding digital, economic, and health disparities.

Accordingly, the association strongly recommends collection and robust analysis (including multifactorial analysis) of detailed demographic on telehealth availability, usage, and outcomes during and following the PHE. Such demographic data must include age, disability, economic status, ethnicity, gender, gender identity, geography, insurance coverage (including original Medicare and Medicare Advantage), race, sexual orientation, and preferred language. NASW stresses that HIPAA requirements be followed throughout the data collection and analysis process, including an opt-out process for beneficiaries who do not wish to provide demographic data and clear deidentification procedures for PHI. Routinely collected, self-reported data from beneficiaries and family caregivers regarding the effects of telehealth on home health service delivery and outcomes are also critical to informed decision making regarding potential extensions of telehealth.

Multiple entities, including FCC, HHS, and the Medicare Payment Advisory Commission, should be involved in this evaluation process. NASW recommends that the process include provider-level data—not only from HHAs but also from individual home health staff of every discipline—regarding the following topics:

- access to HHA-funded broadband, telecommunications equipment, and HIPAA-compliant telehealth software
- comfort using telecommunications in home health practice and training needs regarding the same
- perceptions of how telehealth affects service provision
- recommendations for the potential extension of telehealth in HHAs.

NASW also encourages CMS to solicit data regarding the use of telehealth in home health settings by issuing a request for information one year following the end of the PHE and by convening multiple stakeholder calls during and after the PHE. To maximize feedback, the association recommends that CMS offer multiple calls for each of the following groups:

- Medicare beneficiaries and family caregivers
- HHA administrators
- home health aides
- nurses
- OTs
- prescribing practitioners
- PTs
- SLPs
- social workers and social work assistants.

Creative, well-planned outreach will be needed to involve beneficiaries, family caregivers, prescribing practitioners, and individual home health disciplines—people who might not ordinarily participate in CMS’s helpful Open Door Forums.

PDGM

Since the implementation of PDGM in January 2020, home health social workers have notified NASW of the following disturbing trends:

- Computer models have supplanted clinical judgment in determining the number of visits of each home health discipline is allowed, resulting in an inadequate number of visits and compromised care for beneficiaries.
- They have been informed by their HHAs that the Medicare home health benefit no longer includes medical social services as a result of PDGM—in direct contrast to CMS’s Medicare Learning Network Matters article of February 2020.¹⁵
- OTs, PTs, and SLPs within their HHAs have experienced job loss or decreased hours since PDGM implementation.

NASW has received similar reports about reduced OT, PT, and SLP staffing from other beneficiary advocates, such as the Center for Medicare Advocacy (CMA). CMA has noted that this effect is consistent with a spring 2019 survey conducted by the National Association for Home Care and Hospice (Threlkeld, 2020), which found that one-third of the 685 responding HHAs planned to reduce therapy staffing under PDGM (as cited by CMA).¹⁶

¹⁵ Centers for Medicare & Medicaid Services. (2020). *The role of therapy under the home health patient-driven groupings model (PDGM)* (Medicare Learning Network Matters article number SE20005). <https://www.cms.gov/files/document/se20005.pdf>

¹⁶ Stein, J., & Holt, K. (2020). *Medicare home health updates in light of the new Medicare payment model* [Webinar]. Center for Medicare Advocacy. <https://medicareadvocacy.org/webinars/> [Study citation from slides 14–15; subsequent paraphrased content from slide 24]

NASW is also concerned about the following PDGM-related trends observed by CMA:

- PDGM provides financial incentives for HHAs to serve beneficiaries with short-term needs, thereby reducing access for people with long-term home health needs. These beneficiaries include those who are eligible, under the *Jimmo* settlement agreement, for OT, PT, SLP, or skilled nursing services to maintain or prevent decline.^{17,18,19}
- PDGM provides financial incentives for HHAs to serve beneficiaries who are referred following a stay in an inpatient hospital, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility. This prioritization decreases access for beneficiaries admitted from the community who have not had a recent inpatient stay.

Considered together, these trends indicate dramatic, troubling shifts in Medicare beneficiaries' access to home health services—shifts that threaten the integrity of the Medicare home health benefit. NASW urges CMS to remedy these problems as quickly as possible.

Thank you for the opportunity to provide input on the proposed rule. Please contact me at amangum.nasw@socialworkers.org or (202) 336-8210 if you need additional information.

Sincerely,



Anna Mangum, MSW, MPH
Deputy Director, Programs

¹⁷ *Jimmo v. Sebelius*, Civil Action No. 5:11-CV-17-CR (D. Vt. 2011). <https://law.justia.com/cases/federal/district-courts/vermont/vtdce/5:2011cv00017/19913/56/>

¹⁸ *Jimmo v. Sebelius* settlement agreement (D. Vt. 2013). <https://www.medicareadvocacy.org/wp-content/uploads/2012/12/Jimmo-Settlement-Agreement-00011764.pdf>

¹⁹ *Jimmo v. Burwell* corrective action plan (D. Vt. 2016). <https://cases.justia.com/federal/district-courts/vermont/vtdce/5:2011cv00017/19913/115/0.pdf?ts=1486138986>