



COVID-19 Resources for Hospice and Palliative Care

The following document compiles resources on the COVID-19 pandemic specific to hospice and palliative care.

Emergency Declaration

- On January 31, 2020, U.S. Department of Health and Human Services (HHS) Secretary Alex Azar [determined](#) that a public health emergency existed because of confirmed cases of the coronavirus disease (COVID-19) under the authority granted by section 319 of the Public Health Service Act (PHSA). The nationwide determination took effect January 27, 2020.
- On March 13, 2020, President Donald Trump [declared](#) the ongoing COVID-19 pandemic a national emergency under the Stafford Act.
- On March 13, 2020, Secretary Azar made the [decision](#) to retroactively waive numerous requirements for Medicare, Medicaid, CHIP, and the HIPAA privacy rule, under authority provided section 1135 of the Social Security Act, retroactive to March 1, 2020, including certain conditions of participation, requirements that physicians and other health care professionals hold licenses in the state in which they provide services if they have a license from another state, and more.
- For more information on public health emergencies and major disaster declarations, including what authorities may be exercised under each, as well as assistance available through the Federal Emergency Management Agency (FEMA) and the Small Business Association (SBA), Hart Health Strategies' primer can be found [here](#).

Guidance Addressing Hospice and Physician Services on COVID-19 by HHS

- On March 9, 2020, CMS issued guidance of hospice providers addressing [Infection Control and Prevention by Hospice Agencies](#).
- On March 13, 2020, Secretary Azar made the decision to retroactively [waive](#) certain section 1135 requirements and regulations effective March 1, 2020.
- On March 13, 2020, CMS issued blanket waivers under section 1135 that are detailed in this [Health Care Providers Fact Sheet](#) and [MLN Matters article](#). Among the topics addressed are:
 - Provider enrollment waivers
 - Waivers regarding Medicare appeals in fee-for-service, MA, and Part D
 - Durable medical equipment replacement
 - Replacement prescription fills of covered Part B drugs
- On March 15, 2020, CMS posted updated [FAQs](#) detailing emergency-related policies and procedures that may be implemented without section 1135 waivers. Included in the FAQs is a section specific to [physician services](#) and [hospice services](#).
- On March 17, 2020, CMS released a press release, fact sheet, and FAQ related to waiver of certain telehealth requirements (as further detailed below).
- On March 23, 2020, CMS issued [FAQs](#) detailing provider enrollment relief related to COVID-19, including a Medicare provider enrollment hotline for physician and non-physician practitioners. Additional information on telehealth, revalidation, and enrollment for other types of providers and suppliers is also included.

- On March 23, 2020, CMS released a [press release](#), [fact sheet](#), and [guidance to state survey agencies](#), detailing its new targeted plan for healthcare facility inspections in light of COVID-19 and findings from the Kirkland Nursing Home. CMS notes that it is temporarily postponing routine inspections to focus solely on infection control and immediate jeopardy. Standard inspections for most facilities, including hospices, will not be conducted. Additional detail is provided in the linked materials.
- On March 28, CMS announced an expansion of its accelerated and advanced payment program for Medicare participating health care providers and suppliers. See a [press release](#) and [fact sheet](#) for more information.
- On March 30, 2020, CMS issued an [interim final rule with comment period \(IFC\)](#) with policy and regulatory revisions in response to the COVID-19 public health emergency (PHE). In this rule, CMS included changes affecting the ability of hospice providers to use telecommunications technology, as further detailed below in the Telehealth Payments section.
- On March 30, 2020, CMS issued a provider-specific document identifying flexibilities that apply to [hospice](#), including related to telehealth, workforce-related waivers, burden reduction, accelerated payments, appeals processes, and cost reporting. CMS also issued a provider-specific document identifying flexibilities that apply to [physicians and other practitioners](#), including related to telehealth, communication technology-based services, workforce issues, physician self-referral law waivers, and appeals. (Note that this was updated on 4/30/2020.)
- On March 30, 2020, CMS issued an [FAQ](#) addressing provider burden relief, noting that CMS has suspended most Medicare fee-for-service medical review during the emergency period, and that no additional documentation requests will be issued for the duration of the emergency period. (See below for a July 2020 update.)
- On April 6, 2020, CMS issued a [“Dear Clinician” letter](#) summarizing certain flexibilities afforded to clinicians and other provider and supplier types, including information on accelerated and advanced payments; testing and claims reporting for COVID-19; Medicare telehealth visits and other virtual services; workforce flexibilities; changes to the Quality Payment Program; and other blanket waivers.
- On April 9, 2020, CMS updated a previously released [summary of COVID-19 emergency declaration waivers & flexibilities](#) for health care providers (initially issued 3/23/2020; updated 4/3/2020; updated 4/9/2020; updated 4/30/2020), extending additional flexibilities to hospice providers. The full list of hospice-specific flexibilities as of April 9, 2020, is included below:
 - **Waive Requirement for Hospices to Use Volunteers.** CMS is waiving the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and potential quarantine.
 - **Comprehensive Assessments.** CMS is waiving certain requirements at 42 CFR §418.54 related to updating comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment found at §418.54(d). Hospices must continue to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.
 - **Waive Non-Core Services.** CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.
 - **Waived Onsite Visits for Hospice Aide Supervision.** CMS is waiving the requirements at 42 CFR §418.76(h), which require a nurse to conduct an onsite supervisory visit every two weeks. This would include waiving the requirements 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, as this may not be physically possible for a period of time.

- **Hospice aide competency testing allow use of pseudo patients.** 42 C.F.R. 418.76(c)(1). CMS is temporarily modifying the requirement in § 418.76(c)(1) that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient. This modification 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. This increases the speed of performing competency testing and allows new aides to begin serving patients more quickly without affecting patient health and safety during the public health emergency (PHE).
- **12-hour annual in-service training requirement for hospice aides.** 42 C.F.R. 418.76(d). CMS is waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in-service training in a 12-month period. This allows aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care.
- On April 10, 2020, CMS updated [FAQs](#) (previously updated 3/23/20). In addition to information regarding lack of additional Medicare payment to facilities, including hospices, for personal protective equipment (PPE) or other infection control supplies, CMS added information on cost reporting period extensions for all provider types including hospice. These FAQs were also updated to include information related to changes included in the March 30 interim final rule with comment (IFC). New information on the use of telehealth and communication technology-based services was also included in the FAQ. (Note that this was updated on 5/1.)
- On April 14, 2020, CMS hosted a call with Hospice and Home Health providers to discuss COVID-19. CMS posted the recording and transcript from that call on this [CMS Podcast and Transcripts](#) page. On this call, CMS noted that hospices should following the March 27 guidance regarding flexibilities related to the Hospice Quality Reporting Program, rather than guidance issued on March 22, as previously reported below:
 - On March 22, 2020, CMS issued a [press release](#) announcing relief for clinicians, providers, hospitals, and facilities participating in quality reporting programs – including the Merit-Based Incentive Payment System (MIPS) and the Hospice Quality Reporting Program – through deadline extensions and elimination of data reporting for certain periods. On March 27, 2020, CMS issued a [memo](#) with additional detail on the reporting flexibilities it had previously announced, including for hospices.
- On April 14 and April 15, 2020, HHS updated information it previously issued on April 10, 2020, regarding \$30 billion out of \$100 billion appropriated by the CARES Act to the Public Health and Social Services Fund for health care providers. This included a [press release](#), a [fact sheet](#), and [terms and conditions](#). Providers were distributed a portion of the initial \$30 billion based on their share of total Medicare FFS reimbursements in 2019. While many health care providers received the funds on April 10, ***under revisions posted on April 15, within 30 days of receipt of those funds, a provider must return the payments or otherwise it will be viewed as accepting the Terms and Conditions.*** For a provider who does not wish to comply with the Terms and Conditions, the provider needs to contact HHS and then remit the full payment as instructed. ***On April 14, HHS updated the Terms and Conditions to state that providers must be providing or have provided after January 31, 2020 diagnosis, testing, or care for individuals with possible or actual cases of COVID-19.*** HHS also clarified that it broadly views every patient as a possible case of COVID-19. The House Ways and Means Committee Republicans also issued information on April 10, 2020, including a [fact sheet](#), [FAQ](#), and information on the amount of [funds](#) to each State.

- For additional updates regarding the Provider Relief Funds, please see the Hart Health Strategies fact sheet on [COVID-19 Physician Provisions](#).
- On April 21, CMS hosted a call for Hospice and Home Health providers. The call recording and transcript is posted on the [CMS Podcasts and Transcripts](#) page.
- On April 22, HRSA [released information](#) related to COVID-19 claims reimbursement for uninsured patients. As part of this initial guidance, HRSA specifically noted that claims for hospice services would be excluded.
 - On April 27, HRSA launched the [Uninsured Program Portal](#). This allows providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 to request claims for reimbursement. HRSA also issued a set of [FAQs](#).
- On April 28, CMS hosted a call for Hospice and Home Health providers. The call recording and transcript is posted on the [CMS Podcasts and Transcripts](#) page.
- On April 30, 2020, CMS issued a second set of sweeping policy changes intended to increase flexibilities to respond to COVID-19. Information on CMS' changes is included in the [press release](#) and on the [CMS Coronavirus Waivers and Flexibilities page](#). Of particular note are the following:
 - A second [Interim Final Rule with comment period](#) addressing COVID-19.
 - An updated [Medicare Telehealth Services list](#), which identifies that advance care planning services may be furnished via audio-only capabilities, retroactively effective to March 1, 2020.
 - Additional waivers related to hospice care, as outlined in the this [waiver summary](#) document (previous updates noted above). New hospice waivers as of 4/30/2020 include:
 - **Training and Assessment of Aides:** (New since 4/21 Release) CMS is waiving the requirement at 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHAs, which require 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. In accordance with section 1135(b)(5) of the Act, we are postponing completion of these visits. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE.
 - **Quality Assurance and Performance Improvement (QAPI).** (New since 4/21 Release) CMS is modifying the requirement at 42 CFR §418.58 for Hospice and §484.65 for HHAs, which requires these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program. Specifically, CMS is modifying the requirements at §418.58(a)–(d) and §484.65(a)–(d) to narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. This modification decreases burden associated with the development and maintenance of a broad-based QAPI program, allowing the providers to focus efforts on aspects of care delivery most closely associated with COVID-19 and tracking adverse events during the PHE. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain.
 - **Annual Training.** (New since 4/21 Release) CMS is modifying the requirement at 42 CFR §418.100(g)(3), which requires hospices to annually assess the skills and competence of all individuals furnishing care and provide in-service training and education programs where required. Pursuant to section 1135(b)(5) of the Act, we are postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of

the first full quarter after the declaration of the PHE concludes. This does not alter the minimum personnel requirements at 42 CFR §418.114. Selected hospice staff must complete training and have their competency evaluated in accordance with unwaived provisions of 42 CFR Part 418.

- **Physical Environment for Multiple Providers/Suppliers** (New since 4/21 Release) Inspection, Testing & Maintenance (ITM) under the Physical Environment Conditions of Participation: CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality.

CMS will permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.

Specific Physical Environment Waiver Information:

- 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs all require these facilities and their equipment to be maintained to ensure an acceptable level of safety and quality. CMS is temporarily modifying these requirements to the extent necessary to permit these facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.
- 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs require these facilities to be in compliance with the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). CMS is temporarily modifying these provisions to the extent necessary to permit these facilities to adjust scheduled ITM frequencies and activities required by the LSC and HCFC. The following LSC and HCFC ITM are considered critical are not included in this waiver:
 - Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing.
 - Portable fire extinguisher monthly inspection.
 - Elevators with firefighters' emergency operations monthly testing.
 - Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing.
 - Means of egress daily inspection in areas that have undergone construction, repair, alterations or additions to ensure its ability to be used instantly in case of emergency.
- 42 CFR §482.41(b)(9) for hospitals, §485.623(c)(7) for CAHs, §418.110(d)(6) for inpatient hospices, §483.470(e)(1)(i) for ICF/IIDs, and §483.90(a)(7) for SNFs/NFs require these facilities to have an outside window or outside door in every sleeping room. CMS will permit a waiver of these outside window and outside door requirements to permit these providers to utilize facility and non-facility space that

is not normally used for patient care to be utilized for temporary patient care or quarantine.

- An updated [Hospice-specific fact sheet](#) on new waivers and flexibilities (previous updates noted above).
- Updated [FAQs](#) on Medicare FFS policies, including new FAQs related to hospice care and use of telecommunications technologies. (update posted 5/1; previous updates noted above)
- On May 5, 2020, CMS hosted a call for Hospice and Home Health providers. The call recording and transcript is posted on the [CMS Podcasts and Transcripts](#) page.
- On May 11, 2020, CMS updated its [Summary of Waivers and Blanket Flexibilities](#) document, including adding the following additional waivers that apply to inpatient hospice: CMS is waiving and modifying particular waivers under 42 CFR §482.41(b) for hospitals; §485.623(c) for CAHs; **§418.110(d) for inpatient hospice**; §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS is modifying these requirements as follows:
 - **Alcohol-based Hand-Rub (ABHR) Dispensers:** We are waiving the prescriptive requirements for the placement of alcohol based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §482.41(b)(7) for hospitals; §485.623(c)(5) for CAHs; §418.110(d)(4) for inpatient hospice; §483.470(j)(5)(ii) for ICF/IIDs and §483.90(a)(4) for SNF/NFs.
 - **Fire Drills:** Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area.
 - **Temporary Construction:** CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients.

Note: These updates were also added to the [Hospice-specific fact sheet](#) on new waivers and flexibilities (previous updates noted above) on May 15, 2020.

- On May 12, 2020, CMS hosted a call for Hospice and Home Health providers. The call recording and transcript is posted on the [CMS Podcasts and Transcripts](#) page.
- On May 18, 2020, CMS released new guidance related to the reopening of nursing facilities (see the [guidance](#), a [press release](#), and [FAQs](#)). This guidance may have implications for hospice providers that provide services to patients in the facilities.
- On May 19, 2020, May 26, 2020, June 9, 2020, and July 7, CMS hosted a call for Hospice and Home Health providers. The call recordings and transcripts will be posted on the [CMS Podcasts and Transcripts](#) page.
- On July 7, 2020, CMS released a [Hospice Quality Reporting Program COVID-19 Public Health Emergency Tip Sheet](#).
- On July 7, 2020, CMS updated the [Provider Burden Relief FAQ](#) to specify that, as states reopen, CMS expects to discontinue exercising enforcement discretion beginning on August 3, 2020, regardless of the status of the public health emergency.

- On July 9, 2020, CMS updated the [Medicare FFS FAQs](#) and the [Hospice-specific COVID-19 fact sheet](#) to provide updates regarding cost-reporting deadlines.
- On August 26, CMS again updated the [Medicare FFS FAQs](#) to provide guidance regarding the HHS Provider Relief Fund and the Small Business Administration’s (SBA) Paycheck Protection Program (PPP) payments. The FAQs provide guidance to providers on how to report PRF payments, uninsured charges reimbursed through the Uninsured Program administered by the Health Resources and Services Administration (HRSA), and SBA Loan Forgiveness amounts on provider cost reports. The FAQs also address that PRF payments should not offset expenses on the Medicare cost reports.
- CMS released a [third COVID-19 IFC](#). Among numerous other provisions, CMS is requiring long-term care facilities to test all of their residents and facility staff for COVID-19. Under this requirement, “staff” are considered any individuals employed by the facility, any individuals that have arrangements to provide services for the facility, and any individuals volunteering at the facility. An example of individuals providing services under arrangement include a hospice that may have an agreement in accordance with the requirements for the use of outside resources under § 483.70(g) and (o) to provide hospice care for residents in the facility.
- On January 5, 2021, CMS updated its [Medicare FFS FAQs](#) to specify that – for any cost reporting period falling in the period of March 1, 2020 through December 31, 2020 that CMS had not previously identified – providers are granted an additional 60 days from the initial due date to file their cost reports.

Telehealth Payments in Response to the COVID-19 Pandemic

See the Hart Health Strategies Telehealth Overview resource [here](#) for more information about telehealth payments in response to the COVID-19 pandemic, including information on [key limitations and additional considerations](#).

Actions by HHS

Following the passage of legislation to expand waiver authority to increase access to telehealth services under declared emergencies (The [Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020](#), Public Law No: 116-123, and [Family First Coronavirus First Response Act](#), Public Law No: 116-127)¹, HHS undertook several actions to expand providers’ ability to use telehealth services, including:

- On March 17, 2020, CMS provided new information regarding the implementation of this new waiver authority for the Medicare program, including a [press release](#), [fact sheet](#) and updated [FAQ](#). Under the waiver, which is effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in all areas of the country and in all settings, including in beneficiaries’ homes.
- For Medicaid, states can gain new authority to use their Medicaid programs to respond to the coronavirus pandemic under the national emergency declared by President Donald Trump under waivers that fall under section 1135 of the Social Security Act. For instance, States may be able to expand the use of telehealth services in their Medicaid programs to combat the coronavirus outbreak. On March 17, 2020, CMS issued additional Medicaid telehealth [guidance](#) and while also highlighting their main [website](#) for telehealth in Medicaid. Per the [FAQs](#), “[n]o federal approval is needed for state Medicaid programs to

¹ Section 3703 of the *Coronavirus Aid, Relief, and Economic Security Act (CARES)* (H.R. 748) dramatically modified the provision to expand the flexibility provided to CMS to waive Medicare telehealth requirements that apply to physicians and certain other qualified professionals. The CARES Act was signed into law on March 27, 2020. The HHS Secretary must issue guidance detailing how waivers will be used to provide additional telehealth flexibilities.

reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.”

- In addition, the Office of Inspector General ([OIG](#)) published its opinion that during the emergency period “[a] physician or other practitioner reduces or waives cost-sharing obligations (i.e., coinsurance and deductibles) that a beneficiary may owe for telehealth services furnished consistent with the then-applicable coverage and payment rules” under Federal Health care programs. The opinion further states that this does “not require physicians or other practitioners to reduce or waive any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services.” For more information, visit the OIG fact sheet [here](#).
- On March 17, 2020, the Office of Civil Rights ([OCR](#)) announced enforcement discretion for certain widely used communications. Specifically, the OCR press release states “effective immediately, that it will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency. This exercise of discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19.” For more information, see the [statement](#), [fact sheet](#), and [Bulletin](#).
- On March 20, 2020, the Food and Drug Administration (FDA) issued a [final](#) guidance document that allows manufacturers of certain FDA-cleared non-invasive, vital sign-measuring devices to expand their use so that health care providers can use them to monitor patients remotely. The devices include those that measure body temperature, respiratory rate, heart rate and blood pressure.
- On March 20, 2020, [OCR](#) further announced enforcement discretion regarding HIPAA security, privacy, and breach requirements, while clarifying that this discretion does not apply to the confidentiality of substance use disorder records, given the Substance Abuse and Mental Health Services Administration ([SAMHSA](#)) has announced separate enforcement discretion regarding those rules. OCR continues to discourage the use of certain “public facing” platforms such as Facebook Live, Twitch, and TikTok. For additional OCR FAQs, visit [here](#). To summarize its guidance, OCR assembled a [bulletin](#) addressing civil rights, HIPAA, and COVID-19.
- On March 24, 2020, OIG issued additional [FAQs](#) regarding its enforcement discretion related to cost-sharing.
- On March 30, 2020, CMS issued an [interim final rule with comment period \(IFC\)](#) with policy and regulatory revisions in response to the COVID-19 public health emergency (PHE). This rule included a second round of sweeping changes to Medicare policies related to the delivery of telehealth services and communication technology-based services that apply effective March 1, 2020 and through the duration of the COVID-19 public health emergency (PHE). (Note that the effective date of these policies does not align with the March 6 effective date of the original telehealth waivers, which eliminated geographic restrictions on the use of Medicare telehealth services. Absent further guidance from CMS, the geographic restrictions are only waived effective March 6, 2020.) CMS also issued an accompanying [press release](#) and [fact sheet](#). Note that some of these policies supersede information included in previous CMS announcements (e.g. the [March 17 fact sheet](#) notes that virtual check-ins and e-visits are limited to established patients, which is no longer the case under the IFC).
- On April 8, 2020, CMS hosted a Special Open Door Forum (SODF) focused on telehealth, where CMS answered questions submitted by callers on various aspects of telehealth, including payment for telephone only services; addition of new types of providers who can provide telehealth (e.g. therapists); delivery of services using telecommunication technology when patients and practitioners are at the same location; and more. The recording of this SODF is posted on the CMS [Podcasts and Transcripts](#) page.

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During this call, CMS responded to a question regarding hospice assessments, noting that those visits would require both audio and video components for delivery via telehealth. Questions on assorted telehealth issues have also been raised on other CMS calls posted on the same page.

- On April 9, 2020, CMS updated an [FAQ](#) document to include new information on telehealth and communication-technology based services based on information included in the March 30 IFC.
- On an April 14, 2020 call for Home Health and Hospice Providers that is posted to the [Podcasts and Transcripts](#) page, CMS responded to a question about the use of audio only for hospice assessments differently than it had on the April 8 Telehealth SODF, indicating that it depended on whether the service could be adequately furnished using audio alone.
- On April 30, 2020, CMS issued a second [Interim Final Rule with comment period](#) addressing COVID-19, which included several additional flexibilities related to telehealth. CMS also posted an updated [Medicare Telehealth Services list](#), which identifies that advance care planning services may be furnished via audio-only capabilities, retroactively effective to March 1, 2020. Additional information on provisions in that rule may be found in the Hart Health Strategies Telehealth Overview resource [here](#).
- On May 5, CMS hosted a call for Hospice and Home Health providers. The call recording and transcript is posted on the [CMS Podcasts and Transcripts](#) page. In response to a question on the requirement to conduct a hospice recertification visit using both audio and video capabilities, CMS staff indicated that the statute requires a “face-to-face” visit, which CMS interprets as requiring the video component.

Application to hospice care

One key concern is whether certain activities (e.g., the required face-to-face encounters for 180-day hospice recertification) could be administered via telehealth under a section 1135 waiver. While a CMS [FAQ](#) from March 15, 2020 originally signaled the ongoing application of the face-to-face requirement², Section 3706 of the *Coronavirus Aid, Relief, and Economic Security Act (CARES)* (H.R. 748) updated statute to allow for the face-to-face encounter to be completed via telehealth during a public health emergency (PHE). The CARES Act was signed into law on March 27, 2020.

The March 30, 2020 CMS IFC included two provisions expanding the allowable use of telehealth services for hospice providers.

- **Use of Technology under the Medicare Hospice Benefit.** CMS updated hospice regulations to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so. The use of such technology must be included on the plan of care.
- **Face-to-Face Visit for Hospice Recertification.** CMS updated hospice regulations to allow the use of audio and video equipment permitting two-way, real-time interactive communication for completion of the face-to-face recertification visit when the visit is solely for the purpose of recertification during the PHE.

² The applicable FAQ reads as follows: **Question:** *Are the hospice requirements for a face-to-face encounter waived under Section 1135 of the Act?* **Answer:** *No. The required timeframe for the occurrence of a hospice face-to-face encounter is typically flexible enough to allow hospices to meet this requirement, even in emergency situations. A face-to-face encounter can occur up to 30 days prior to the start of the third benefit period and 30 days prior to any subsequent benefit periods thereafter (see section 20.1 in chapter 9 of the Medicare Benefit Policy Manual (Pub. 100- 02)). However, if conditions related to the emergency cause a provider to expect to be unable to meet these timeframes, that provider should contact the CMS RO to allow for tracking and completion of this encounter as soon as conditions allow. (emphasis added)*

On May 1, 2020, CMS updated its [FAQs](#) on Medicare FFS policies, including adding new FAQs related to hospice care and use of telecommunications technologies, as detailed below.

- **Question:** Can hospices furnish services using telecommunications technology during the PHE for the COVID-19 pandemic?
 - a. **Answer:** Yes. Hospices are able to furnish services using telecommunications technology during the PHE when a patient is receiving routine home care. This can include telephone calls (audio only or TTY), two-way audio-video telecommunications technology that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of hospice as to whether such technology can meet the patient’s/caregiver’s/family’s needs and the use of technology should be included on the plan of care for the patient and family. New: 5/1/20
- **Question:** Can hospice physicians/hospice nurse practitioners conduct the required face-to-face encounter for re-certifications using telecommunications technology?
 - a. **Answer:** Hospices are allowed to use 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and the clinician (e.g., FaceTime, Skype) to satisfy the face-to-face encounter requirement, which is required for the third benefit period (after the patient has typically been receiving hospice for six months) and each subsequent 60-day benefit period thereafter. An explanation of why the clinical findings from the hospice face-to-face encounter support that the patient still has a life expectancy of six months or less is required as part of the recertification narrative. We do not believe that telephone calls (audio only or TTY) would provide the necessary clinical information for a hospice physician to determine whether the patient continues to have a life expectancy of six months or less. As such, telephone calls (audio only or TTY) cannot be used to satisfy the hospice face-to-face encounter requirement. New: 5/1/20
- **Question:** Can hospices include services furnished using telecommunications technology on the hospice claim that it submits to Medicare for payment?
 - a. **Answer:** Only in-person visits (with the exception of social work telephone calls) are to be reported on the hospice claim submitted to Medicare for payment. For purpose of service intensity add-on (SIA) payments, only in-person visits performed by registered nurses and social workers provided during routine home care during the last seven days of life are eligible for these add-on payments. As a reminder, the SIA payments are made above and beyond the routine home care per diem payment amount. On the hospice cost report, hospices can report the costs of telecommunications technology used to furnish services under the routine home care 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-19”. New: 5/1/20
- **Question:** Can hospices complete the initial and comprehensive assessments virtually or over the phone during the PHE for the COVID-19 pandemic?
 - a. **Answer:** Assuming that the patient is receiving routine home care during the initial and comprehensive assessment timeframe, furnishing services using telecommunications technology (e.g., using two-way audio-video telecommunications technology that allows for real-time interaction between the clinician and the patient, like FaceTime or Skype, or using audio-only or TTY telephone calls) would be compliant if such technology can be used to the extent that it is capable of resulting in a full assessment of the patient and caregiver’s needs to

inform an individualized plan of care. The initial and comprehensive assessment are the foundation of the plan of care, laying out the patient and family needs/goals and outlining the plan for the delivery of these services. An in-person initial and comprehensive assessment is standard practice and crucial to establishing the patient-hospice relationship. During this PHE, we expect in most, but not all, situations that the initial and comprehensive assessment visits would be done in person (especially when assessing skin/wound care; uncontrolled pain/symptoms; effectively teaching patient/caregiver medication administration, etc.). The assessments must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The ultimate goal of these assessments is to fully identifying the needs of the patient and caregivers to establish an individualized patient-centered plan of care. New: 5/1/20

Prescription of Controlled Substances

On March 20, the Drug Enforcement Agency ([DEA](#)) issued a press release noting that DEA-registered practitioners may use telehealth during the public health emergency for the prescription of controlled substances, provided that:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.

On March 25, the DEA granted an [exception](#) to the requirement that a DEA registrant must be registered in each state in which the practitioner dispenses controlled substances. Under this exception, DEA-registered practitioners are not required to obtain additional registration with the DEA in the additional state(s) where the dispensing (including prescribing and administering) occurs, for the duration of the public health emergency if they are registered in at least one state and have permission under state law to practice using controlled substances in the state where the dispensing occurs, including for the practice of telemedicine. Additional detail is in the linked notice.

On March 27, the DEA announced [exceptions](#) to requirements regarding paper delivery of a prescription of an oral emergency prescription, including allowing the prescription to be sent via facsimile, or for the prescription to be photographed, scanned, and sent in place of the paper prescription.

On March 31, 2020, the DEA [announced](#) that it is providing flexibility to provide buprenorphine to new and existing patients with opioid use disorder (OUD) for maintenance and detoxification treatment via telephone by otherwise authorized practitioners without requiring such practitioners first conduct an examination of the patient in person or via telemedicine. This policy is effective from March 31, 2020 through the duration of the PHE.

American Medical Association Resources

In response to the Medicare changes, the American Medical Association (AMA) shared the [Quick Guide to Telemedicine in Practice](#), a new resource to help mobilize remote care with implementation tips, as well as a reference to Current Procedural Terminology (CPT[®]) codes for reporting telemedicine and remote care services. The AMA also offers an education module in the AMA's [STEPS Forward™](#) that can help physicians [use telemedicine](#)

[in practice](#), and the [Digital Health Implementation Playbook](#) with a 12-steps process for adopting remote monitoring of patients outside the traditional clinical environment. AMA also released [special coding advice](#) related to coding of various scenarios related to care for COVID-19 for physicians and other professionals, some of which address telehealth.

Select Stakeholder Actions

Several organizations have taken action to address care delivered by hospice and palliative care providers.

- On March 12, 2020, the National Hospice and Palliative Care Organization (NHPCO) submitted a [letter](#) to CMS addressing several aspects of hospice care, including use of telephonic and telehealth-based encounters to meet face-to-face encounter requirement for hospice recertification and other care delivery requirements; timeframes for submitting completing certain actions; staffing flexibilities; personal protective equipment (PPE) and testing; and more.
- On March 16, 2020, the National Coalition for Hospice and Palliative Care submitted a [letter](#) to support Senate passage of the [Family First Coronavirus First Response Act](#), H.R. 6201, specifically focusing on COVID-19 testing without cost-sharing, availability of personal protective equipment, and expanded coverage of telehealth.
- On March 17, 2020, the following hospice stakeholder organizations - the NHPCO, the National Association for Home Care and Hospice, the National Partnership for Hospice Innovation, and Leading Age/Visiting Nurse Associations of America/Elevating Home – submitted a combined [letter](#) to request funding and regulatory relief. The letter addresses additional funding for hospices – including funding to access PPE and additional staffing; pauses of audit activity; expanded use of telehealth; and additional regulatory flexibility.
- As the Phase III package is being developed, NHPCO requested a statutory change to allow telehealth to be used for hospice face-to-face encounters during the COVID-19 national emergency. NHPCO further launched a grassroots action encouraging individuals to ask for a blanket 1135 waiver and additional funding and availability of PPE.
- On March 20, 2020, AAHPM submitted a letter to Senate leadership requesting a temporary waiver or increased telehealth flexibilities for hospice face-to-face visit recertification requirements. The Senate republican Phase III draft released on March 22, 2020 included temporary authority to use telehealth for hospice face-to-face encounters during the current public health emergency.
- On April 3, 2020, the following hospice stakeholder organizations – the NHPCO, the National Association for Home Care and Hospice, the National Partnership for Hospice Innovation, and Leading Age/Visiting Nurse Associations of America/Elevating Home – submitted a [combined letter](#) to Congressional leadership that included additional requests related to COVID-19, including related to priority PPE distribution and testing, additional hospice funding, enhanced access to advance care planning (including through waiver of cost sharing, advance directive portability, and expansion of eligible providers), and support for legislation that enhances the hospice and palliative care workforce.
- On April 3, 2020, the Coalition to Transform Advanced Care submitted a [letter](#) to Congressional leadership addressing a wide range of issues including advance care planning services, investments for the public health and workforce infrastructure (including requesting the PHSSEF funding to be made available to home and community-based serious illness providers), public awareness of serious illness care and advance care planning, access to home-based primary care, and support to family caregivers.
- On April 13, 2020, the Hospice and Palliative Nurses Association submitted a [letter](#) to Congressional leadership addressing the urgent need for PPE and medical supplies for first responder hospice and palliative nurses.

- On April 30, the National Coalition for Hospice and Palliative Care submitted a letter to the [National Institutes of Health](#) to address the need for enhanced palliative care content in the NIH COVID-19 Treatment Guidelines.
- On May 5, the National Coalition for Hospice and Palliative Care submitted a [letter](#) to Congress to identify priorities for ongoing legislation related to COVID-19. Priorities included workforce issues, support for bereavement and trauma care, physician assistants in hospice, expanding the role of social workers in furnishing advance care planning services, and development of a CMS Innovation Center model on community-based palliative care.