C-TAC
COALITION TO TRANSFORM ADVANCED CARE

March 20, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar and Administrator Verma:

On behalf of the Coalition to Transform Advanced Care (C-TAC), thank you for your leadership during the unprecedented challenge our country is facing. As a not-for-profit, non-partisan coalition of diverse organizations dedicated to improving the quality of life for people living with serious illness and their families, C-TAC and our members work every day on behalf of those who are most vulnerable to the severe health-related impacts of the COVID-19 virus. We collectively stand ready to support your efforts to mitigate the outbreak and to assist in any way needed.

C-TAC requests that any rules, regulations, or other policy interventions CMS or HHS takes in response to this emergency acknowledge, and, to the extent possible, directly address the unique burdens patients and families with serious illness and the healthcare providers that care for them will face due to COVID-19. We are grateful that Administration leadership has routinely stressed the heightened risk to seniors with underlying chronic conditions,[1] and urge you to continue to advance a coordinated, cross-agency strategy that removes barriers to the most timely and efficient delivery of appropriate care for COVID-19 patients, especially the ones who are seriously ill.

Specific priority areas that need both immediate and sustained attention are:

Access to personal protective equipment (PPE) for healthcare workers- As additional expected funding becomes available to increase the supply of critical PPE such as isolation gowns, masks, and gloves, CMS and HHS should disseminate guidance to support healthcare providers' ability to swiftly access these materials, including and especially those who are delivering care to the most vulnerable seriously ill patients, such as hospice teams. At present, their care is being limited due to shortages of these critical items.

Promoting access to palliative care and hospice services- While the workforce for palliative care and hospice is limited, they are mobilizing to meet the needs of those with serious illness, which will

[1] *Remarks by President Trump, Vice President Pence, and Members of the Coronavirus Task Force in Press Conference*, March 13, 2020

dramatically increase during this crisis. We anticipate there may be limited beds, ventilators, and other treatments should a surge in hospital patients occur, but there need be no limit to providing compassionate care for those who are seriously ill. This means promoting and making access to palliative care and hospice available to those needing expert symptom management to reduce physical suffering and, where visiting policies allow it, social and spiritual support to patients and families at a critical time in their lives. Specifically:

- Promote access to patients in facilities- CMS should immediately issue specific guidance to allow non-infected hospice and palliative care providers that follow appropriate infection control protocols to treat patients in facilities like nursing homes and other institutional settings, since our members tell us there is some confusion about this in the field.
- Reduce Hospice Administrative Burden
    - Waive the 5% level of volunteer activity requirement and allow volunteers to contact patients and family caregivers remotely.
    - CMS should pause all hospice audit activity for the duration of the emergency
    - Allow verbal consent for hospice admission - In this crisis, it will be impractical and time consuming to require people to sign paperwork for hospice admission in advance of receiving such care. Allowing verbal consent, with documents completed once a hospice team member physically visits, makes more sense under these circumstances.

Access to needed medications- We will also need to ensure that there is sustained access to medications such as opioids, benzodiazepines, and other drugs that promote physical comfort for dying patients. We recommend loosening some of the opioid prescriber regulations to allow more providers to order adequate doses of these medications for patients near the end of life or who are actively dying.

Increase workforce- The health care workforce will be strained by illness and the prospect of having to care for significantly more patients. Therefore, we recommend the following:

- COVID-19 serological testing- Promote and cover such testing to identify those health care workers who have developed immunity so that they are then able to care for patients again without the risk of re-infection. Possibly extend this to volunteers in the community who could help support patients in facilities or at home if their families are unable to.
- Expand provider licensure-We appreciate the numerous provider-related blanket waivers CMS has issued.[2] We encourage you to continue to examine licensure issues under your authority that may serve as barriers to quickly mobilizing a healthcare workforce of sufficient size and readiness capable of responding to the challenges of the spreading pandemic, particularly as these barriers may impact those who deliver care to the seriously ill patients and families most at risk of poor outcomes. To the extent that a key barrier is the inability of a practitioner licensed in one state to provide services to patients in another state, and to the extent these restrictions are the result of state-level licensure laws and regulations not waived by CMS' recent blanket provider waivers, CMS should issue guidance that urges states to honor cross-state medical licensing for all health care providers until the pandemic is over.

[2] *COVID-19 Emergency Declaration Health Care Providers Fact Sheet*

- Increased scope of practice - We also recommend immediately allowing nurse practitioners and physician assistants to order home health and to certify terminal illness for hospice, if possible. As physicians become overwhelmed treating COVID cases, other providers will be needed to manage the non-COVID patients. Beyond these changes, we also encourage you to encourage states which currently limit nurse practitioner, clinical nurse specialist, and physician assistant practice to immediately waive those scope of practice barriers as they are keeping those qualified providers from operating to the fullest extent of their training and certification.

Telehealth- We are very grateful for the recently announced flexibility and recommend these additional steps:

- Include hospice and home health in the waiver- Expand telehealth waivers included under the recently passed *Coronavirus Preparedness and Response Supplemental Appropriations Act* to include hospice and home health agencies and to permit use of audio-only telephonic interactions based on technology available to patient.
- Private payers and state waivers- Encourage private payers and states to adopt similar telehealth waivers since state regulations may be more restrictive than federal ones in some states.
- Face-to-face hospice recertification- if this requirement cannot be suspended during this crises, then allow it to be delivered via telehealth until the emergency is over.
- Rural Health Clinics and Federally Qualified Health Centers- Issue guidance that clarifies that these sites are eligible for the telehealth flexibility recently announced.
- Hospital inpatient telehealth- Consider allowing clinicians to communicate with hospitalized patients and their families via telehealth. This could promote advance care planning or goals of care conversations without risking further exposure to the virus.
- Consent to telehealth- Consider waiving the current required separate consent process for telehealth services for the duration of the emergency and use the telehealth encounter as presumed consent since it may be hard to contact a patient's surrogate in this crisis. In the case of those patients who are physically or cognitively unable to provide consent, consider allowing the caregiver or clinician caring for them to do so. Also, waive the requirement to receive additional telehealth consent for established patients.
- Additional telehealth codes. We greatly appreciate the historic steps Congress and the Administration have taken thus far to broaden access to telehealth during this emergency.[3] We continue to urge you to utilize the full extent of your regulatory authority to ensure that those delivering care to seriously ill and dying patients, including hospice and palliative care providers, are able to do so via telehealth where appropriate. More specifically, while we applaud the broad range of services now eligible for Medicare Telehealth Visits during the outbreak[4], we ask that you add the following code sets[5] to the list of allowable telehealth services, as they are important for home-based care provision to seriously ill beneficiaries:

[3] *Medicare Telemedicine Health Care Provider Fact Sheet*, March 17, 2020
[4] https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
[5] https://med.noridianmedicare.com/web/jeb/specialties/em/home-and-domiciliary-visits

- *Domiciliary, Rest Home, or Custodial Care Services* - CPT codes 99324 – 99337- These codes are used are used to report E/M services to individuals residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis. This includes assisted living facilities.
- *Home Services* – CPT Codes 99341 – 99350- These codes are used to report E/M services furnished to a patient residing in his or her own private residence.
- *Skilled Nursing Facility/Nursing Facility (SNF/NF)* – CPT Codes 99304-99316 – These codes are used to report post-acute and long-term care visits (skilled and custodial) in nursing homes, and currently only a few of the codes are eligible for telehealth, and only once per month. Given that many providers may have residents in numerous facilities and given that these residents are at the highest risk for serious morbidity or death from COVID-19, only absolutely medically necessary face-to-face visits with direct contact should be performed during this time of crisis. Medical evaluation of these nursing home residents can be safely achieved via telemedicine visits in most cases.

Durable Medical Equipment (DME) and Oxygen- As a goal in this pandemic is to keep those who do not need to be hospitalized out of the hospital, we recommend removing all barriers/burdens to accessing DME and oxygen for initial requests and replacements. Oxygen, in particular, will need to be able to be ordered and delivered quickly for those with COVID-19 receiving care at home.

Advance care planning- While decisions in this crisis will need to be made in the moment, we urge you to also promote advance care planning to ensure that future care will be in line with patient's personal goals and values. If there ever was a time when Americans needed to designate a health care agent to speak for them if they became acutely ill, and to share their wishes for future treatment with that agent and their healthcare providers, it is now. Specifically:

- If possible, waive patient cost-sharing and deductibility of Medicare Advance Care Planning services (CPT codes 99497 & 99498) or designate them as a preventative activity and waive any cost-sharing and deductibility related to them.
- If possible, include clinical social workers as eligible providers that are able to bill for Medicare Advance Care Planning services.
- Require the HHS Secretary to develop standards for including completed advance care planning documents within a patient's electronic health record.
- Encourage physicians, nurse practitioners and physician assistants to create portable medical orders (e.g.,, POLST paradigm orders and pre-hospital DN(A)R orders) for the appropriate patient population to avoid subjecting them to unwanted and invasive medical interventions, and to free up what is likely to be limited access to intensive care units, ventilators, etc.

Medicare Advantage- Given that a third of Medicare beneficiaries are now enrolled in Medicare Advantage (MA)[6], it is important that changes be made there as well to address this crisis. Specifically,

[6] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/

we recommend that MA should be required to comply with the Public Health Emergency guidelines regarding waivers.

C-TAC appreciates the opportunity to provide these recommendations. We will continue to monitor and analyze the outbreak as it unfolds and identify areas where we believe CMS and HHS can best support patients, their families, and the healthcare professionals who care for them. C-TAC and its members also stand ready to help the Administration in any way during this challenging situation.

Thank you again for your commitment and work on behalf of all Americans as we face this extraordinary challenge together. If C-TAC can be of any assistance to you at all, please do not hesitate to reach out to C-TAC's Senior Regulatory Advisor Dr. Marian Grant, at mgrant@thectac.org, and Policy & Advocacy Manager Davis Baird, at dbaird@thectac.org.

Sincerely,

Jon Broyles
Executive Director