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.

• 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.

• 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), extending additional flexibilities to hospice providers. The full list of hospice-specific flexibilities is included below:
  o **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.
  o **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.
  o **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.
  o **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.

On April 14, 2020, 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 Inceptive 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.

On April 16, 2020, HHS opened the CARES Act Provider Relief Fund Payment Attestation Portal. Providers who have been allocated a payment from the initial $30 billion general distribution must sign an attestation confirming receipt of the funds and agree to the terms and conditions within 30 days of payment.
On April 20, HHS further updated the provisions of the Terms and Conditions to include information on Acceptance of Terms and to update the provision on balance billing to refer to “presumptive” cases of COVID-19 rather than “possible” cases of COVID-19.

- On April 21, CMS hosted a call for Hospice and Home Health providers. The call recording and transcript is expected to be posted on the CMS Podcasts and Transcripts page.
- On April 22, HHS provided additional information on the disbursement of the remaining provider relief funds.
- 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.

**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 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.

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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.
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. 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.
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 requirement, 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.

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.

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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 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.