National Alliance for Care at Home

May 12, 2025

The Honorable Russell Vought
Director
Office of Management and Budget
725 17th St NW
Washington, DC 20503

RE: Request for Information: Deregulation

Dear Director Vought:

The National Alliance for Care at Home (Alliance) appreciates the opportunity to submit comments on the Trump Administration's Request for Information on identifying unduly burdensome, duplicative, or outdated regulations. The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations.

Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), the Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, persons with both chronic and serious illnesses as well as dying Americans who depend on those supports.

We appreciate the Administration's efforts to reduce burdensome requirements and better streamline regulations to promote a more effective and efficient healthcare system. Indeed, we are aligned in this goal, and while we support fair and appropriate regulation, it should not interfere with providers' efforts to support their communities and deliver care in the home.

Accordingly, the Alliance's recommendations reflect extensive input solicited from our diverse membership from providers throughout the country—large and small, non-profit and for profit, urban and rural, as well as state associations representing providers delivering care in the home. Feedback from our members underscores the necessity of eliminating or revising regulations as "unnecessary, unlawful, unduly burdensome, or unsound."[1]

Specifically, our members have highlighted rules that are inconsistent with the law, where regulatory costs and burdens significantly outweigh any benefits, and where provisions have become outdated or otherwise unnecessary in today's healthcare landscape. Our comments also address regulations that inadvertently burden American businesses, specifically providers delivering care in the home, impeding their ability to effectively and efficiently deliver high-quality care. By reducing barriers, we can better foster an environment where providers can support their communities and deliver care in the place where Americans overwhelmingly prefer to receive it—the home.

Our detailed comments are provided below.

[1] *See* Request for Information: Deregulation, 90 Fed. Reg. 15481, 15482

Table of Contents

Home Health

A. Home Health Face-to-Face Encounter

§424.22(a)(v)(C) - Required CMS to Issue Conforming Regulations for Who May Conduct The Face-To-Face Encounter And Certify Patients For Home Health Services - §424.22(a)(v)(C)

The CARES Act was signed into law on March 27, 2020, providing critical relief in response to the COVID-19 pandemic. Among its provisions, the Act included the *Improving Care Planning for Medicare Home Health Services Act*, which expanded the authority of non-physician practitioners (NPPs) (collectively, nurse practitioners (NP), physician assistants (PA), and clinical nurse specialists) to certify eligibility and issue orders for Medicare home health services. Additionally, the Act introduced flexibility regarding who may conduct the face-to-face (F2F) encounter, removing the requirement that only the certifying practitioner may perform this function.

On March 30, 2020, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment (IFC), entitled *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency*. This IFC included regulatory revisions under §424.22, granting NPPs the authority to certify and order home health services. However, CMS has not yet issued conforming regulations to reflect statutory flexibility on who may conduct the F2F encounter.

Despite the statutory provisions, the regulations at § 424.22(a)(v)(C) limit the F2F encounter to the certifying physician or practitioner for patients admitted from the community. Additionally, regulations at § 424.22 and § 484.4 retain a requirement for NPPs to collaborate with physicians when certifying and ordering home health services, even in states that permit independent practice for advanced practice registered nurses (APRNs). This contradicts the CARES Act, which explicitly allows NPPs to practice in accordance with state laws without requiring physician collaboration. The existing regulation is unduly burdensome to home health providers and undermines the flexibility intended by Congress. Moreover, the burden in meeting these additional administrative demands clearly exceed any benefit.

The flexibility introduced by the CARES Act was implemented in response to growing burdens associated with home health certification requirements. In light of the Supreme Court's decision in *Loper Bright Enterprises v. Raimondo*,[2] CMS's decision to limit who may perform this encounter must be considered. The CARES Act clearly reflects congressional

[2] 144 S. Ct. 2244 (2024).

intent to authorize NPPs to certify and order home health services for Medicare beneficiaries in accordance with state laws. Furthermore, Congress explicitly granted flexibility regarding who may conduct the F2F encounter, to remove unnecessary barriers that impede care access. CMS should update its regulations to align with this intent and eliminate unnecessary barriers to Medicare home health certification. *Loper Bright* makes clear that federal agencies may no longer be afforded judicial discretion in their interpretation of an ambiguous law. Here, and importantly, Congress's intent is clear—the statute unambiguously permits non-physician practitioners to act to the extent of their scope of practice permitted by state law. By not revising the regulation to include these practitioners, CMS has disregarded its statutory obligation to implement the law as enacted by Congress.

By implementing the following recommendations, CMS would align the regulations with federal law, reduce the administrative burden, and improve timely access to home health services for Medicare beneficiaries.

Recommendations:

- Revise § 424.22 and § 484.4 to reflect the expanded authority of non-physician practitioners (NPPs), allowing them to certify eligibility for Medicare home health services in accordance with applicable state laws. These revisions should remove the requirement for physician collaboration in states that permit independent practice by advanced practice registered nurses (APRNs) and other NPPs.
- Amend § 424.22 to eliminate the restriction that the certifying practitioner must personally conduct the face-to-face (F2F) encounter. Instead, CMS should revise the regulation to permit the certifying practitioner to document that the F2F encounter was conducted by a physician or an authorized NPP, consistent with the statutory flexibility provided under the CARES Act.

§ 424.22(c) - Provide Flexibility for Home Health Face to Face Encounter Requirements

The Patient Protection and Affordable Care Act (ACA) of 2010 requires that Medicare payment for home health services be conditioned on a face-to-face (F2F) encounter between the patient and a physician or certain non-physician practitioners (NPPs) prior to the certification of the need for care. If a patient is admitted directly to home health care following discharge from an inpatient facility, the certifying practitioner may rely on documentation from the facility-based practitioner who treated the patient during their stay. Current documentation requirements at § 424.22(c) are unduly burdensome because

they are unnecessarily punitive, result in costly, duplicative efforts, and place disproportionate costs on providers compared to any marginal benefits gained.

The regulation includes detailed documentation requirements that must be met by the certifying practitioner. Failure to comply may result in the home health agency being unable to bill Medicare for the services. This requirement became effective on April 1, 2011.

Since the initial implementation of the F2F encounter, CMS has revised the documentation requirements. In 2015, CMS eliminated the narrative requirement, which obligated the certifying practitioner to provide a written explanation of the patient's homebound status and need for skilled services. However, CMS continues to require that the certifying practitioner's medical record contains evidence supporting the beneficiary's eligibility for home health services. Information from the home health agency (HHA) may be included in the certifying practitioner's medical record, provided that it is corroborated by other entries made by the practitioner.

Despite the elimination of the narrative requirement in 2015, the remaining documentation expectations continue to demand that the certifying practitioner's medical record independently support the patient's homebound status and need for skilled care. This documentation must meet strict criteria, even though much of the relevant clinical information may be contained in the home health agency's record. The requirement that HHA documentation be separately corroborated in the practitioner's record creates unnecessary duplication and increases the risk of technical denials for otherwise medically necessary services.

The F2F encounter requirements, though well-intentioned, impose excessive administrative complexity, create barriers to care coordination, and risk unfair denial of payment for medically necessary services.

***Recommendations**:*

- CMS should permit full consideration of the home health medical record documentation when evaluating eligibility for Medicare home health benefits.
- Establish exemptions to face-to-face encounter requirements including, but not limited to, patients receiving home health services after an inpatient stay.

B. Outcome and Assessment Information Set

CMS policy for § 484.55 - Rescind Collection and Reporting of the OASIS on All Patients Regardless of Payers

The Outcome and Assessment Information Set (OASIS) is a standardized data set integral to the Home Health Quality Reporting Program (HHQRP). It also serves as a foundational component of the Patient-Driven Groupings Model (PDGM**)**, which governs Medicare payment determinations for HHAs. Since its implementation in 2000, CMS suspended the requirement to collect OASIS data for non-Medicare and non-Medicaid patients due to prior congressional intervention.

Section 704 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) explicitly suspended the requirement to collect OASIS data on non-Medicare and non-Medicaid patients. This suspension remained in effect until the Secretary of the U.S. Department of Health and Human Services (HHS) submitted a report to Congress evaluating the burden and utility of such data collection on small and large HHAs, and issued final regulations on the future collection of OASIS data for these patient populations. CMS subsequently conducted a study[3] and later issued a final rule in 2023 reinstating the requirement, effective July 1, 2025, that mandates HHAs to collect and report OASIS data for all patients, regardless of payer source. However, the law does not actually mandate this requirement, and the rule fails to consider the undue burden that such a requirement would impose. In fact, legislative history of the MMA underscores Congress's intent to consider the burdensome impact of this data collection on HHAs relative to any benefit to the Medicare program.[4]

This expansion has prompted significant concern across the home health industry. Providers have voiced strong opposition due to the substantial administrative and financial burdens associated with collecting OASIS data on privately insured or self-pay patients. Specifically, the expansion of OASIS reporting to all patients, regardless of payer source, represents an undue burden where costs significantly exceed any benefits, particularly given the financial strain already experienced by HHAs due to workforce shortages and resource constraints.

The burden imposed by this expanded requirement is twofold:

- **Financial and Operational Impact**: Agencies will incur increased administrative costs without any corresponding reimbursement from non-Medicare/Medicaid

[3] https://www.cms.gov/files/document/cms-oasis-study-all-payer-data-submission-2006.pdf
[4] *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, H.R. Rep. No. 108-391, at 282 (2003)

payers. These costs include both direct expenses and indirect opportunity costs associated with diverted clinical resources.

- **Workforce and Economic Strain**: The home health sector is currently facing significant challenges, including critical workforce shortages, ongoing Medicare payment reductions, and persistent inflationary pressures.

Rural providers, in particular, are expected to face disproportionate hardship due to:

- Greater travel distances required to serve geographically isolated patients.
- Heightened difficulty in recruiting and retaining qualified clinical staff.

CMS itself projects that this policy change will result in a 30% increase in the number of OASIS assessments required at each assessment timepoint, significantly increasing hourly burden and clinical costs. The projected total cost to HHAs for implementation of this requirement is estimated at $267.2 million annually, beginning in the calendar year 2025.

Recommendation:

- CMS should rescind the mandate requiring HHAs to collect and report OASIS data on all patients, regardless of payer. Data collection and reporting obligations should remain limited to Medicare and Medicaid beneficiaries, for whom the OASIS instrument is designed and directly applicable. Maintaining the current scope of reporting will preserve essential quality oversight while avoiding unnecessary administrative and financial strain on providers—particularly those already navigating workforce shortages and fiscal instability.

Modify CMS' Policy for New Certifications with a Start of Care OASIS

CMS currently mandates a new certification whenever a Start of Care (SOC) OASIS is completed to initiate home health services. In these cases, a physician or other allowed practitioner must certify the patient's eligibility for home health care. This requirement has proven particularly burdensome for HHAs when administrative discharges occur — for example, when a beneficiary changes payers, such as switching from a Medicare Advantage plan to Traditional Medicare.

In these scenarios, the patient remains under the same plan of care (POC), which has already been established and reviewed by the same practitioner who will continue managing the patient under the new payer. Yet, due solely to the required new certification, the HHA must complete a whole new admission, including extensive documentation and information gathering, despite no change in the patient's condition or plan of care. In other words, the only change is the source of payment.

Recommendation:

- CMS should revise this policy to make the new certification optional for HHAs in cases where a new SOC OASIS is required for administrative reasons.

C. Patient Assessments

§ 484.55(a)and (b) - Allow Therapist To Perform Initial and Comprehensive Assessment in All Therapy Cases

During the COVID-19 Public Health Emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) temporarily waived the requirements under 42 CFR §484.55(a)(2) and §484.55(b)(3), which limit rehabilitation professionals to performing the initial and comprehensive assessments only when therapy services were ordered and no nursing services were required. Under this waiver, any therapy discipline—physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP)—could conduct these assessments as part of a patient's plan of care.

The regulation, absent flexibility provided under the waiver, is outdated, fails to reflect the demonstrated clinical capabilities of rehabilitation professionals, and results in unnecessary RN visits—thus imposing undue operational burdens without actually improving patient care. HHAs have long advocated for a permanent regulatory change that would allow therapists to perform initial and comprehensive assessments whenever therapy services are ordered at the start of care. The existing regulation, which requires that a registered nurse (RN) conduct these assessments when both nursing and therapy services are ordered, creates operational inefficiencies. Specifically, it often necessitates non-reimbursable RN visits, even when the patient's care plan does not require nursing services prior to therapy.

The temporary waiver demonstrated significant benefits during the PHE, increasing HHA capacity and enabling more efficient patient intake amid heightened demand. Moreover, therapists have long been permitted to perform these assessments when therapy is the sole service ordered, establishing a clear and effective precedent.

Recommendation:

- The Alliance strongly recommends that CMS permanently amend 42 CFR §484.55(a)(2) and §484.55(b)(2) to allow physical therapists, speech-language pathologists, and occupational therapists (to the extent permitted by statute) to perform initial and comprehensive assessments whenever therapy services are ordered, irrespective of whether nursing services are also included in the plan of care.

D. Acceptance to Service

§ 484.105 (i) - Rescind the Acceptance to Service Policy Requirements

In the Calendar Year 2025 Home Health Payment Rate Update final rule,[5] CMS finalized a requirement that home health agencies (HHAs) establish and maintain acceptance-to-service policies and procedures. These policies must include key elements such as the HHA's current caseload and case mix (i.e., the volume and complexity of patients receiving care), the anticipated needs of referred prospective patients, current staffing levels, and the skills and competencies of HHA staff. These elements are intended to inform a HHA's assessment of its capacity and determine its ability to meet the needs of referred patients.

CMS also finalized a requirement under § 484.105(i)(2) for HHAs to publicly disclose accurate information on the services they offer, including any limitations on specialty services, service duration, and service frequency. HHAs must review this information annually or as necessary to ensure accuracy.

This regulation is unsound and unduly burdens HHAs in punitive ways, adding administrative complexity without addressing the root causes of care access challenges. While the Alliance acknowledges CMS' intent to improve transparency and patient home health access, we have serious concerns about the operational and policy implications of these new requirements. The core issue affecting beneficiary access to home health services is not an agency's admission process but rather the broader challenge of resource availability. HHAs continue to face severe workforce shortages, particularly among nurses and home health aides. These staffing challenges are exacerbated by financial constraints that prevent HHAs from offering competitive compensation compared to hospitals and other care settings.

HHAs are primarily funded through government-based programs such as Medicare, Medicaid, and Medicare Advantage, which have not adjusted reimbursements to reflect rising labor costs and other operational expenses. Without adequate reimbursement rates that account for these financial pressures, HHAs will continue to struggle with workforce recruitment and retention, ultimately impacting patient access to care.

Recommendation:

- The Alliance urges CMS to consider policies that address the root causes of access challenges, including workforce shortages and financial sustainability, rather than imposing additional administrative burdens that do not resolve the underlying issues.

[5] 89 Fed. Reg. 88354

E. Home Health Aide Supervision

§484.80(h)(2)(i) - Modify Burdensome Home Health Aide Supervision Requirements

In the 2022 Home Health Prospective Payment System (HH PPS) final rule,[6] CMS revised the supervision requirements under §484.80(h)(2)(i) for home health aides providing only non-skilled care. Under this finalized rule, a registered nurse must conduct an on-site visit at least every six months to **each** patient's location to observe and assess **each** home health aide while he or she is performing care.

The finalized regulatory language at §484.80(h)(2)(i) represents a substantive modification from CMS's original proposal and introduced unnecessary administrative burdens without a clear rationale or corresponding benefit, imposing costs that clearly outweigh any meaningful improvements in patient safety or care quality. The proposed rule would have only required a registered nurse to conduct on-site observations for each home health performing patient care, but it did not specify that the observation must occur individually for each individual patient under the aide's care.

By contrast, the finalized rule introduced this more specific requirement, thereby significantly expanding the scope of the obligation. Because CMS introduced this change in the final rule without including it in its proposal, stakeholders were deprived of the opportunity to comment on this more prescriptive requirement.

The finalized requirement to observe each aide with every patient is unnecessary and imposes unnecessary administrative burdens on HHAs and disruptions for patients without any demonstrable improvement in quality of care. Home health aides who serve multiple patients would be subjected to redundant supervisory visits, increasing administrative workload and patient disruption without demonstrable benefit.

CMS's original proposal—requiring supervision of aides while performing care—adequately met the intent of the regulation to ensure appropriate oversight of aide services without imposing unnecessary operational burdens. Revising the regulation to match the originally proposed text would ensure clarity, consistency, and regulatory alignment with the intended oversight.

***Recommendation*:**

[6] 86 Fed. Reg. 62240

- CMS should revise the regulation at §484.80(h)(2)(i) to reflect the originally proposed language, as stated below:

> (ii) Semi-annually the registered nurse must make an on-site visit to the location where a patient is receiving care in order to observe and assess each home health aide while he or she is performing non-skilled care.

F. Medical Review

Modify Burdensome Medical Review Audits

Medicare review contractors, such as Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Unified Program Integrity Contractors (UPICs), and Supplemental Medical Review Contractors (SMRCs), play a central role in ensuring the integrity of Medicare payments. While we share the Administration's commitment to safeguarding the Medicare trust fund and guard against bad actors who would defraud the system and the American people, serious concerns have emerged regarding the fairness, transparency, and consistency of their review processes, especially in the home health and hospice space.

Providers have reported that these contractors often operate with opaque standards, applying subjective medical necessity criteria that vary significantly across cases and contractors. Providers frequently report retroactive denials of claims for services already delivered, even when documentation clearly meets established Medicare coverage requirements. The appeals process is lengthy and costly, often forcing providers to wait years for resolution, and lacks meaningful checks on contractor decisions during initial stages of review. Overzealous auditing practices, inconsistent guidance, and the high volume of claim reviews collectively impose undue administrative burdens, reduce patient access to necessary care, and threaten provider financial stability.

Recommendations

- CMS should develop and enforce uniform clinical and documentation standards across all contractors to reduce subjectivity and variability in claim reviews.
- CMS should create a robust oversight system with penalties for contractors that exhibit high rates of improper denials or patterns of inconsistent application of CMS policy.
- CMS should adopt a transparent, data-driven algorithm to guide the selection of providers for audit and review, focusing resources on those with demonstrably higher risk profiles for fraud, waste, or abuse.

Hospice Care

A. Certification of Terminal Illness

Certification of terminal illness/Refine Hospice Face-to-Face Requirements – §418.22

Federal law governing the hospice recertification face-to-face encounter specifies that the encounter is conducted prior to the start of the applicable benefit period.[7] This in and of itself imposes significant burdens on hospices, especially when patients require immediate readmission due to an advanced illness following a period without hospice care. In 2011, CMS allowed hospices to delay the face-to-face encounter up to two days after a patient's hospice election under certain documented exceptional circumstances.

A number of concerns have arisen relative to the hospice face-to-face requirement and the exceptional circumstances allowance:

- Hospices must complete the face-to-face encounter prior to the beginning of the applicable benefit period. This encounter must be arranged by the hospice. As a result, a patient's care may be delayed while the hospice identifies a physician or NP available and schedules the encounter. For many hospices, those in rural areas in particular, this delay can be much longer than two days. This is because these areas often lack immediate access to physicians or NPs who meet CMS's employment or contract requirements. However, these hospices may have access to physician's assistants and other non-physician practitioners. While the Bipartisan Budget Act of 2018 amended the Social Security Act (SSA) to allow hospice patients to select a physician assistant (PA) as their attending physician, it did not similarly authorize a PA to conduct face-to-face encounters.
- The face-to-face requirement applies continuously, regardless of the length of time since a beneficiary's previous hospice stay. A patient may have been off hospice service for a lengthy period of time, then begin rapid deterioration and need admission very quickly. In such cases, the face-to-face requirement may not only delay admission but forces the patient to unnecessarily be subjected to an assessment.
- CMS data sets are not reliably accessible 24/7, and frequently lack current patient information necessary to confirm whether a face-to-face encounter is required. CMS has clarified that if the data systems are not available, and because of this the hospice is not aware that the patient is entering his/her third or subsequent benefit period, the hospice has two days in which to obtain this information and complete the face-to-face. This two-day time period is insufficient time for the hospice to get the face-to-face scheduled as the two days, in essence, could be only one working day. For instance, patients admitted on a Friday or holiday when CMS data systems

[7] 42 U.S.C. § 1395f(a)(7)(D)(i).

are inaccessible may not have their hospice histories confirmed until the next business day—potentially Monday or even Tuesday after certain holidays. The hospice accesses the data system the morning of the next CMS business day, sees that the patient is in his/her third or subsequent benefit period, and then has to get a hospice physician or NP to conduct the face-to-face. Getting the face-to-face scheduled can, as mentioned above, take several days.

- Sometimes CMS data systems fail to display prior hospice service due to delayed submission of a Notice of Election (NOE), Notice of Termination/Revocation (NOTR), or claims by previous hospice providers. In such situations, the current hospice provider is not able to determine that a face-to-face encounter is required and often does not know this until after the two-day exceptional circumstance period has passed. These hospices are technically not permitted to bill Medicare for those days of service, which could mean a significant financial loss. Through no fault of its own and completely out of its control, the current hospice cannot get paid for the care it has provided in good faith to the patient.
- Hospices are not reimbursed for costs related to the face-to-face requirements, which may be prohibitive – particularly for small hospices in rural areas.
- If continuing hospice care is needed but the hospice cannot swiftly access a physician meeting CMS requirements or an NP to conduct the face-to-face encounter, the hospice will not be reimbursed for services provided until the encounter is completed.

For a variety of reasons, the exception is not working as intended and the required face-to-face encounter creates unnecessary burden on beneficiaries as well as hospices. Specifically, the face-to-face encounter regulation at §418.22, as currently structured, is inconsistent with the realities of practice and creates an undue burden for hospice providers, with administrative costs significantly outweighing any benefit. A timeframe of seven (7) days following hospice re-election at the third or later benefit period would accommodate the commonly experienced delays, reduce the significant burden on hospices and beneficiaries, and improve access to end-of-life care for beneficiaries.

***Recommendation*:**

- CMS should reexamine issues related to "exceptional circumstances" and make provisions for the hospice face-to-face to take place within seven (7) days following admission.

Hospice Certifying Physician Enrollment Requirement – §424.507(b)

The requirement for hospice certifying physicians to enroll in Medicare Part B when they exclusively bill through Part A is unduly burdensome and creates considerable confusion among providers and MACs. This misalignment results in avoidable administrative

inefficiencies and can interrupt care continuity if physicians face delays or deactivation due to enrollment issues. In the FY 2024 Hospice Wage Index and Payment Rate Update final rule,[8] CMS finalized a requirement that physicians who certify Medicare hospice services must enroll or validly opt-out of Medicare. However, in practice, physicians may only opt-out of Medicare or enroll through Medicare Part B via the CMS-855I Medicare enrollment application processed by the Part B MAC, even though hospice physician services are reimbursed exclusively under Medicare Part A. This disconnect between enrollment requirements and billing practices creates significant operational confusion and compliance challenges.

Hospice physicians typically provide care exclusively to hospice patients and thus have their services billed exclusively under Medicare Part A. Despite this, these physicians must enroll through Medicare Part B, which inherently anticipates frequent claims submission. Illustratively, a provider or supplier can have their Medicare billing privileges deactivated after six consecutive months of non-billing.[9] In other words, physicians enrolled under the CMS-855I face potential deactivation due to infrequent submission of Part B claims, jeopardizing their enrollment status and ability to certify hospice patients' terminal illness, while physicians enrolled under CMS-855O are not truly opted-out as they are submitting claims through Part A.

This caused significant confusion on the part of the Part B MACs which delayed processing of the enrollment applications. Additionally, MACs have often provided conflicting or incorrect guidance regarding which application to submit—CMS-855I or CMS-855O—further exacerbating confusion and administrative burden. To complicate matters further, CMS instructions for implementation of the edit that enforces the enrollment/opt-out requirement are inconsistent with regulation and contained other processing errors such that it had to be revised several times.

The Alliance appreciates the program integrity reasons that are the impetus for the certifying physician regulation. However, enrollment of physicians under Medicare Part B for situations where the physician is only seeing hospice patients and, therefore, only submitting claims on the hospice Part A claim creates unintended consequences.

***Recommendation*:**

- CMS should rescind the requirement that hospice certifying physicians be enrolled under Medicare Part B or validly opted out when these physicians provide care only

[8] 88 Fed. Reg. 51164
[9] 42 CFR §424.540(a)(1)

to hospice patients, and therefore, will only bill services through Part A as part of the hospice claim.

B. Hospice Conditions of Participation

Condition of participation: Core Services/Dietary Counseling – §418.64

Under the Medicare Conditions of Participation, dietary counseling, when identified in the hospice plan of care, must be performed by a qualified individual, which includes dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met. If an RN is capable of meeting the patient's needs, then dietary counseling may be provided by the RN. If the needs of the patient exceed the expertise of the nurse, then the hospice must have available an appropriately trained and qualified individual such as a registered dietitian or nutritionist to meet the patient's dietary needs. CMS requires, despite the fact that hospices may use RNs or other trained individuals to routinely provide dietary counseling, that a hospice must still have an employment arrangement with a registered dietitian or nutritionist in order to demonstrate that it can meet potential patient needs.

This is not consistent with CMS reasoning at §418.64(b)(3). Here, CMS allows hospices to contract for "Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract." CMS' interpretive guidelines for this regulation state that "[h]ighly specialized services, such as complex wound care and infusion specialties, are determined by the nature of the service and the nursing skill level required to be proficient in the service. For example, a hospice may need to contract with a pediatric nurse because of the very infrequent pediatric patients the hospice cares for and that to employee a pediatric nurse would be impracticable and expensive." [10]

The requirement to employ dietitians or nutritionists imposes unnecessary operational and financial burdens on hospice providers, particularly small businesses and those operating in rural regions, and is inconsistent with existing regulatory flexibilities for specialized services. Dietitians and nutritionists are also a highly specialized service as evidenced by the training required and professional licensure/certification requirements. It is impractical and expensive for hospices to have to employ dietitians/nutritionists and hospices report that dietitians/nutritionists who are only going to be working infrequently will not enter into an employment relationship with the hospice making it impossible to comply with the requirement. Furthermore, CMS' interpretation of this condition of participation is not consistently upheld and enforced by survey entities.

[10] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_m_hospice.pdf

***Recommendation*:**

- CMS should rescind the requirement that a registered dietitian or nutritionist be employed by the hospice. Unless a hospice's patient mix warrants an employment arrangement with a registered dietitian or nutritionist, or the hospice does not have other staff sufficiently trained to supply dietary counseling to the hospice's patients, this requirement places an unnecessary burden on the hospice.

Condition of participation: Volunteers – §418.78

While hospices are statutorily required to utilize volunteers, regulations at §418.78(e) require that the hospice must utilize volunteers in day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. CMS further requires that hospices maintain documentation of this level of activity as well as the cost savings associated with the use of volunteers.

This volunteer requirement is outdated, reflects historical rather than current operational realities, and places an undue burden on hospices with unforeseen consequences of heightened compliance risks that significantly outweigh any benefits to the Medicare program. The use of volunteers was included in the inception of the Medicare hospice benefit as an essential component due to the volunteer grassroots nature of the hospice movement in the United States some forty plus years ago. The regulations at §418.78 go beyond the intent of the statute and are exceptionally burdensome to hospices and volunteers in today's environment. Specifically, the availability of volunteers prior to the COVID-19 pandemic made it challenging for hospices to meet the 5% level of activity, but this pandemic essentially decimated the potential pool of volunteers.

In a study conducted by Volunteer Match in 2020,[11] researchers found that a large portion of nonprofits suspended all volunteering activities until further notice during the pandemic, Corporate Social Responsibility (CSR) leaders were investing significantly less in their corporate giving and workplace volunteering programs, and that nonprofit entities adjusted their volunteer programs by offering more virtual volunteer opportunities and less in person opportunities. Even though the needs for volunteers increased, nonprofit and for-profit hospices alike had to suspend their volunteering activities during the pandemic due to the risk of infection and inability to enter facilities where some patients resided. Despite the reduced risk of infection from COVID19, the pandemic experience has made volunteers

[11] Volunteer Match, The Impact of COVID-19 on Volunteering A Two-Month Comparison

more aware of the risk of infections of any type (flu, respiratory illnesses, etc.) in the healthcare environment and has caused them to not return to their volunteer duties.

Many hospices report not being able to meet the 5% level of activity required by CMS and those that are meeting the requirement often do so only with administrative volunteers. While administrative volunteers are essential to hospices their work does not meet the intent of the volunteer component of the Medicare hospice benefit which was to have volunteers provide direct patient care. This type of volunteerism is now nearly impossible in many parts of the country. During the COVID-19 pandemic, the requirement to meet the 5% was waived and for a period after the pandemic ended the waiver remained in place to allow hospices to ramp up their volunteer recruitment and utilization.

When the waiver ended, CMS surveyors used its judgement in determining whether the hospice was meeting the intent of the requirement to utilize volunteers when they were not able to show a 5% level of activity. The surveyors typically required that the hospices showed that they were actively recruiting volunteers and were utilizing them in at least some capacity. Hospices report that this continues today.

Additionally, the requirement to maintain records of the cost savings for the utilization of volunteers is pointless. Hospices and volunteers must maintain detailed records of the time spent volunteering and associate a cost with these hours, but this information is not used for any purpose other than a CMS surveyor to glance at it during a certification or recertification survey to ensure that it was completed. Documentation of the cost savings of utilizing volunteers in administrative or direct patient care work under hospice does not impact patient care in any way.

***Recommendation*:**

- CMS should revise the CoPs to require only that hospices utilize volunteers, have a recruitment and retention plan for volunteers, and actively recruit volunteers annually.

C. Medical Review

Modify Burdensome Medical Review Audits

As discussed above, medical review audits, particularly in the hospice and home health space, have been astoundingly burdensome on legitimate, ethical providers. Many hospices have reported that despite not appearing as outliers in various metrics, such as the Program for Evaluating Payment Patterns Electronic Reports (PEPPER), they continue to be subject to repeated and pervasive audits, even in cases where these providers have been successful on appeal in overturning prior audit findings and demonstrated a pattern

of compliance. In response to rising concerns about audits in the hospice sector, the Alliance—through its legacy organizations—and in partnership with other national stakeholder organizations, published a report in 2024 outlining findings from a national hospice audit survey conducted in the fall of 2023.[12] That survey provided detailed information regarding the challenges experienced by hospice providers during the audit process.

The extent to which adverse denials are overturned on appeal for these providers—particularly at the third level of appeal, the Administrative Law Judge (ALJ)—suggests that the audit process is inefficient and ineffective at safeguarding Medicare dollars from those actors who are truly trying to defraud the program. We have been, and continue to be, concerned about fraud in the hospice space. In fact, the Alliance, through its legacy organizations, and in tandem with other national stakeholder organizations, published a list of 34 program integrity recommendations in 2023 in the goal to preserve the Medicare hospice benefit and protect beneficiaries from unscrupulous actors.[13] However, the current audit process is simply not working, is targeting the wrong actors, and is implemented with ineffectual oversight.

As discussed above, the appeals process is incredibly burdensome to providers, with no meaningful checks on contractors at earlier stages of review. In fact, a high percentage of the denials are overturned at higher levels of appeal. Appeal decision statistics provided by the Office of Medicare Hearings & Appeals (OMHA) show a favorable rate of only 21.28 percent.[14] Overzealous auditing practices, inconsistent guidance, and the volume of claim reviews conducted by the various contractors, all contribute to administrative burden, reduced patient access to care, and financial instability for providers. We reiterate our above medical review activity recommendations here.

***Recommendations*:**

- CMS should develop and enforce uniform clinical and documentation standards across all contractors to reduce subjectivity and variability in claim reviews.
- CMS should create a robust oversight system with penalties for contractors that exhibit high rates of improper denials or patterns of inconsistent application of CMS policy.

[12] https://allianceforcareathome.org/wp-content/uploads/Hospice_Audit_Survey_Report.pdf
[13] https://allianceforcareathome.org/wp-content/uploads/Hospice_Program_Integrity_Ideas_Hospice_Industry_Consensus-4.pdf
[14] https://www.hhs.gov/about/agencies/omha/about/current-workload/decision-statistics/index.html

- CMS should adopt a transparent, data-driven algorithm to guide the selection of providers for audit and review, focusing resources on those with demonstrably higher risk profiles for fraud, waste, or abuse.

D. Telemedicine Prescribing of Controlled Substances

Special Registrations for Telemedicine and Limited State Telemedicine Registrations – Docket No. DEA-407

In January 2025, the Drug Enforcement Administration (DEA) issued a proposed rule, entitled, Special Registrations for Telemedicine and Limited State Telemedicine Registrations.[15] While the Alliance appreciates the DEA's efforts to consider the needs of hospice and palliative care practitioners in balancing patient access with preventing the diversion of controlled substances, we are deeply concerned that the proposed rule would raise considerable burdens and significantly and irreparably impede timely and appropriate medication access for individuals in the home under its proposed special registration framework, particularly for terminally ill and seriously ill patients receiving hospice and palliative care services. Therefore, we strongly urge the DEA to clarify that hospice practitioner prescribers are not subject to in-person medical evaluation requirements under the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (Ryan Haight Act) when prescribing medications to hospice patients.

The Alliance submitted detailed comments[16] on this proposed rule and we reiterate our recommendations here.

***Recommendations*:**

- Clarify that hospice physicians, hospice NPs, and hospice PAs are not subject to in-person medical evaluation requirements under the Ryan Haight Act when prescribing controlled substances to hospice patients.
- To avoid any ambiguity, the DEA should exempt hospice practitioners from in-person medical evaluation requirements under the Ryan Haight Act.
- Eliminate the monthly 50% cap on Schedule II prescriptions issued via telemedicine for hospice and palliative care practitioners.
- Eliminate in-state restrictions for Schedule II prescriptions issued via telemedicine for hospice and palliative care practitioners.
- Under the proposed Advanced Telemedicine Prescribing Registration, eliminate the requirement for an NP, PA, or other physician providing hospice care or palliative care to be board certified in a certain specialty.

[15] 90 Fed. Reg. 6541

[16] https://www.regulations.gov/comment/DEA-2023-0029-41888

- Do not finalize Prescription Drug Monitoring Program (PDMP) nationwide verification requirements.
- Allow audio-only prescribing of medications for hospice, palliative, and homebound patients with limitations that make telemedicine video encounters impractical or impossible.
- Remove photographic and identity verification requirements for homebound patients and those receiving hospice care or palliative care.
- Reduce reporting and recordkeeping requirements for special registrant prescribers.
- Revise and update definitions to promote clarity.

E. Hospice Outcome & Patient Evaluation (HOPE) Tool Implementation

CMS implemented the reporting of quality data through the Hospice Quality Reporting Program (HQRP) in 2014. The HQRP is scheduled to expand to include the submission of data from the Hospice Outcome & Patient Evaluation (HOPE) instrument beginning on October 1, 2025. The HOPE replaces the current hospice data collection instrument: the Hospice item Set (HIS). Two new HQRP measures are based on the HOPE— the Timely Follow-up for Pain Impact (#01795-02-CHQR) and Timely Follow-up for Non-Pain Symptom Impact (#01796- 01-C-HQR).

HOPE's implementation presents substantial unforeseen operational and financial burdens for hospice providers, due to punitive penalties for non-compliance and inadequate time to prepare for its transition. The transition from the HIS to HOPE is technically complex and carries significant financial risk for hospice providers. The HQRP is a "pay-for-reporting" program, which requires hospices to submit a high percentage (90%) of data records within a specified timeframe or receive an annual payment penalty of four percent. This penalty is twice that of other providers and a significant impact for hospice providers as many are small, independent businesses. The Alliance remains fully committed to the Hospice Quality Reporting Program, including the payment penalties with non-compliance, and recognizes the critical importance of accurate, timely data submission to inform the delivery of high-quality hospice care. However, we have serious concerns about the potential for successful implementation of HOPE. We are seriously concerned about the lack of information and clarity necessary for providers and vendors to have a smooth, successful transition.

Hospice providers must utilize a third-party vendor to code the HOPE instrument responses. The vendors coding the HOPE responses are usually the hospice's Electronic Medical Record (EMR) vendor. Necessary details of the data specifications were not available to vendors until April 22, 2025. Specifically, CMS held a vendor call in January 2025 about HOPE implementation and indicated on this call that specification corrections

needed to be made. On the call, the team in charge of this transition area was not available to address associated questions or the necessary corrections. Also, during this call, CMS indicated a second vendor call would be scheduled soon. To date, there has been no call, nor has there been any information provided about such a call being scheduled. The Alliance understands from the vendor community, based on what they have learned through the QIES Technical Support Office (QTSO) helpdesk, that CMS has not yet determined whether an additional vendor call will be scheduled. This is of great concern as there are outstanding questions about HOPE implementation and more information is needed.

Additionally, the Validation Utility Tool (VUT), used by vendors to ensure their software can successfully submit data, is not yet available. We have heard from a vendor that they were told the VUT and other reference materials for the QTSO website may not be available until September. That is not reasonable with a scheduled implementation date of October 1, 2025, and without sufficient time for testing to occur, we do not believe this will lead to a successful launch.

A transition in data submission platform, from QIES to iQIES, is necessary for hospices to submit their HOPE records. The Alliance supports this transition intended to strengthen the protection of data. However, we have significant concerns about the timing and how this transition would occur. CMS has indicated that additional information will be available in summer 2025 yet has not provided a specific month for publication nor communicated a firm date by which hospices must be transitioned.

Historically, CMS has experienced delays in transitioning other provider types to the iQIES platform. Most recently, on March 25, 2025, CMS announced another delay in moving skilled nursing facility (SNF) surveys to the iQIES platform, with a previously scheduled February 2025 date delayed by an additional four months. The delay seems to be due to CMS moving the SNF surveys to the cloud-based version of iQIES. It is unclear whether hospices will also transition to this cloud-based version, and how the ongoing delays experienced by SNF will affect the timeline for hospices.

There are numerous steps a hospice provider must take to enroll in iQIES. These include, among other things, having a privacy security official and other staff apply for iQIES access and undergo required criminal background checks, a process that typically takes a minimum of 3-5 business days.

A date has not yet been published for when hospices will have the ability to begin this process. This needs to be done well in advance of the HOPE implementation date. Sufficient lead time for iQIES access is necessary to transition to HOPE. As with many

software transitions, there are bound to be disruptions to the daily operations workflow. This is fully expected in the hospice transition, as this occurred with the home health transition (2021). A simultaneous transition could be disastrous for hospices as well as for CMS in terms of the amount and quality of data.

In addition to the ordinary financial burdens of a software transition and transition to a new data collection tool, hospices are especially vulnerable to an adverse financial impact of this transition, as hospices are held accountable to the data submission timeliness thresholds during the first quarter of transition to iQIES and implementation of the HOPE. Hospices are the only provider with a four percent payment penalty for not complying with the timeliness thresholds. The consequence of adverse outcomes cannot be understated. The risk of negative financial consequences for hospice providers is largely dependent this year on the success of two transitions—iQIES and HOPE—that are not within their control.

Considering the volatility inherent with these transitions and the lack of information provided to date, CMS should revise its implementation strategy for HOPE.

Recommendations:

- CMS should waive timeliness submission for at least the first quarter post implementation. The Alliance does not make this recommendation lightly, as we remain fully committed to the Hospice Quality Reporting Program and recognize the critical importance of accurate, timely data submission to inform the delivery of high-quality hospice care. Our recommendation reflects our shared goal to ensure hospices are appropriately prepared to meet this important requirement and facilitate a successful transition.
- CMS should delay implementation of the HOPE until the critical communication, education and technical specifications providers and vendors need to successfully implement this new tool have been made available and there is sufficient time (at least six months) for vendors and hospice providers to review and develop and execute internal training and implementation plans.

Home Care

A. Companionship Services Exemption

Fair Labor Standards Act Companionship Services Exemption – 29 C.F.R. §§ 552.6 and 552.109

For decades, the Fair Labor Standards Act (FLSA) included an exemption for workers providing companionship services in private homes in recognition of the unique, relationship-based nature of this work and the critical role it plays in supporting aging in place. In 1974, Congress extended FLSA coverage to domestic service workers but carved

out an exemption for "any employee employed in domestic service employment to provide companionship services" to elderly or infirm individuals.[17] Pursuant to that authority, the Department of Labor's (DOL) original 1975 regulations broadly defined those terms and included companions employed by third-party agencies within the exemption. However, in 2013, the DOL reversed course and revised its regulations (effective 2015) under the FLSA to significantly narrow the federal exemption for companionship services, which previously exempted most home care workers from federal minimum wage and overtime protections. This regulatory change has imposed undue burdens on American businesses, particularly home care agencies and caregivers, resulting in fragmented care and reduced affordability for individuals who ultimately depend on these services.

The 2015 changes eliminated this exemption for most home care workers, requiring that they receive both minimum wage and overtime pay under federal law. The change disrupted the longstanding treatment of private home care as a distinct, relationship-based support service.

The revised 2015 rule has led to several unintended consequences:

- Reduced continuity of care due to agency-imposed caps on caregiver hours to avoid overtime costs.
- Increased financial burden on families paying out-of-pocket, particularly for those needing 24-hour care who do not qualify for Medicaid.
- Decline in caregiver earnings and flexibility, contributing to workforce dissatisfaction.
- Increased administrative and financial strain on small and mid-sized agencies that dominate the industry.

The rule fails to recognize that care provided in private homes is non-clinical, client-directed, and fundamentally different from institutional healthcare delivery. The narrow exemption undermines the goals of aging in place and consumer-directed care, which rely on caregiver consistency and affordability.

Care provided in private homes differs significantly from institutional healthcare. It is:

- highly individualized and often directed by the client or their family,
- often non-clinical in nature, centered around companionship and supervision rather than skilled services, and
- fundamentally relationship-driven, where trust and familiarity are paramount.

[17] *See* 78 Fed. Reg. 60454, 60457; *see also* 29 U.S.C. § 202(a), 206(f), 207(l), and 213(a)(15).

The rigid overtime requirements applied under the current regulatory framework do not reflect these dynamics and have led to fragmented care, reduced caregiver satisfaction, and limited access to affordable services, especially for older adults and individuals with disabilities who wish to remain in their homes.

We also note the introduction of H.R. 2304, a bill that would reinstate the FLSA companionship exemption for certain home care workers. While this legislation has not yet advanced in Congress, its introduction reflects growing awareness of the negative impact the 2015 changes have had on the home care ecosystem.

We urge the Administration to consider this bill's intent and support a regulatory framework that aligns with it: one that restores flexibility, improves access to care, and sustains the caregiving workforce without compromising essential labor protections.

Recommendations:

The Alliance recommends that the DOL and the Administration:

- Restore the federal companionship exemption for workers providing non-medical supervision, assistance with activities of daily living, and companionship services in private homes.
- Develop a modernized regulatory approach that reflects the distinct nature of private duty home care and allows for client-directed flexibility.
- Engage with providers, caregivers, and families to ensure that policies intended to protect workers do not unintentionally limit access to essential care.

B. Regulation of Health Illness and Injury in Home-Based Care Settings

Heat Illness and Injury Prevention Standards in Home-Based Healthcare – OSHA Docket No. OSHA-2021-0009

On August 30, 2024, the Occupational Safety and Health Administration (OSHA) issued a Notice of Proposed Rulemaking (NPRM), Heat Injury and Illness Prevention in Outdoor and Indoor Work Settings.[18] OSHA's proposed rule, as applied to home-based care settings, is unsound, and imposes disproportionate and unforeseen burdens on healthcare providers, including home care, home health, and hospice, because it fails to consider the realities of providing care in the home. Unlike traditional workplaces, these providers deliver services in private residences that are not under the employer's control. The proposed mandates for environmental regulation, mandatory rest breaks, cooling measures, and compliance monitoring fail to account for the unique dynamics and limitations of home-based care.

[18] 89 Fed. Reg. 70698

The Alliance fully supports the goal of protecting workers from heat-related illness; however, the proposed regulatory framework does not reflect the operational realities of caregiving in private homes. In these settings, the environment is controlled by the client—not the employer—creating inherent barriers to compliance. For example, providers cannot mandate that clients install cooling equipment or adjust their thermostat. If a client declines such measures, the provider remains noncompliant under the proposed rule, despite having no authority to remedy the situation.

Moreover, the rule's requirement for mandatory rest breaks when the heat index exceeds 90°F is operationally unworkable in most home-based settings. Caregivers typically work alone in clients' homes, and it is often unsafe or logistically impossible to leave a vulnerable patient unattended to take a break. Dispatching relief staff to facilitate such breaks adds cost and complexity, disproportionately impacting small and rural agencies with limited staffing resources.

Enforcement also presents significant challenges. OSHA has not clarified how it intends to enforce heat-related compliance standards in private homes, where the employer lacks supervisory access and control. Without clear guidance, providers face significant liability exposure without any practical means to ensure compliance.

The rule also imposes additional administrative burdens related to training, documentation, and recordkeeping. Home care agencies must develop specialized training programs tailored to decentralized work environments and manage documentation for a widely dispersed and mobile workforce. These burdens, when coupled with unclear enforcement protocols and impractical requirements, create a disproportionate compliance barrier for home-based care.

Finally, the rule fails to reconcile the competing needs of clients and workers. Many homebound patients require warmer indoor temperatures due to underlying medical conditions. Imposing strict temperature limits or cooling mandates without regard for patient health needs may undermine care delivery and patient safety.

We urge the DOL and the Administration to recognize the distinct nature of home-based care and provide regulatory flexibility accordingly. Specifically, the DOL should exempt home-based healthcare settings from environmental control requirements when compliance is beyond the employer's authority—such as when a client declines to adjust indoor temperatures or refuses the use of fans or air conditioning. OSHA should also revise the mandatory rest break provisions for these settings. Agencies should not be required to send additional personnel solely to relieve a caregiver for a break, especially when it would interrupt continuity of care or place the patient at risk. Instead, OSHA should allow for

reasonable alternatives, such as enabling rest within shaded areas inside the home or in safe adjacent locations, where appropriate.

For small and rural providers, the DOL should adopt a tiered compliance framework that includes extended implementation timelines, simplified training requirements, or modified compliance thresholds to reduce operational disruption and financial burden.

Additionally, the DOL must develop clear and practical guidance on how it intends to monitor and enforce compliance in non-institutional settings. This includes defining reasonable employer obligations, offering illustrative scenarios for compliance, and clarifying the boundaries of employer liability when control over the work environment is lacking. Finally, given the costs associated with compliance, the Administration should consider offering financial support—such as grants for training and subsidies for portable cooling equipment—to help resource-limited providers meet regulatory expectations without sacrificing patient care or workforce stability. The Alliance submitted comments[19] on this proposed rule and we reiterate our recommendations here.

Recommendations:

The Alliance recommends that the DOL and the Administration:

- Provide exemptions or alternate compliance options for providers delivering care in the home in situations where environmental controls are beyond the employer's authority.
- Adapt the mandatory rest break requirement when the heat index exceeds 90°F for home care settings.
- Provide compliance accommodations for small and rural providers, including extended implementation timelines, simplified training mandates, or reduced administrative burden.
- Issue clear and practical guidance specific to home-based care, clarifying the scope of employer responsibility and liability in client-controlled settings, and offering examples of acceptable compliance practices.
- Explore funding opportunities or incentives to assist small and rural agencies in meeting requirements.

[19] https://www.regulations.gov/comment/OSHA-2021-0009-22438

Medicaid

A. Medicaid Access Rule

In 2024, the Biden Administration released a final rule, entitled Medicaid Program; Ensuring Access to Medicaid Services,[20] which contained a policy at 42 CFR §441.301(k) that requires providers of home health aide, homemaker, and personal care services to allocate 80% of Medicaid revenues on compensation to the direct care workers providing the services beginning in 2030. Although we understand the rationale behind this policy and agree that more should be done to support the workforce, this policy is unworkable within the context of the Medicaid program's payment rates and the accompanying administrative, quality, and program integrity requirements.

Furthermore, the regulation was implemented without any legal authority. In the preamble to the rule, CMS cited sections 2402(a)(1) and 2402(a)(3)(A)(iii) of the Affordable Care Act (ACA) as well as section 1902(A)(30)(a) of the Social Security Act as the legal basis for implementing this policy. None of these provisions provides any authority for, or even reference to, the allocation of reimbursements once received by the provider of service. The absence of clear statutory authority is especially problematic given the rule's sweeping impact. CMS cannot presume a congressional delegation of authority from statutory silence or broad language.[21] In fact, the way that CMS implemented the rule appears to misrepresent the statutory language and creates undue burden on private industry outside of any legal authority. Our comment letter, jointly submitted with the Home Care Association of America, provides detailed information regarding the legal, operational, and practical implications of the Payment Adequacy Provision.[22]

Additionally, in the same rule, CMS required detailed reporting at 42 CFR §441.311(e) regarding the amount of Medicaid funds spent on direct care worker compensation. We believe that this requirement is also not supported by any statutory language and would create significant burdens on states, managed care plans, and providers to collect, analyze, aggregate, and submit this information.

Recommendation:

- We request that the Administration rescind the Payment Adequacy Provision at 42 CFR §441.301(k), the reporting requirements at 42 CFR §441.311(e), and all associated requirements for sections 1915(i), 1915(j), and 1915(k) benefits, which are located at 42 CFR §§441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi).

[20] 89 Fed. Reg. 40542
[21] *See Loper Bright Enters. v. Raimondo*, 144 S. Ct. 2244, 2265
[22] https://www.regulations.gov/comment/CMS-2023-0070-1909

B. Burdensome HCBS Person Centered Planning Rules

Medicaid home and community-based services (HCBS) require a comprehensive person-centered plan to be developed that includes all services an individual will receive as part of their benefits. Requirements at 42 CFR §441.301(c)(2)(ix) mandate that the plan, "be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation."

While we agree that it is important to establish a person-centered plan based on the needs and preferences of individuals, the requirement to share the entire plan with, and receive signatures from, every single provider is unduly burdensome and could violate privacy rights.

Recommendation:

- We recommend that the Administration retain the broader planning requirements but remove provisions requiring broad dissemination of the plan.

C. Medicaid Electronic Visit Verification

Section 1903(l) of the Social Security Act requires that states implement an Electronic Visit Verification (EVV) system for personal care and home health care services. Importantly, 1903(l)(2)(A)(i) of the Act requires the state to implement a system that, "is minimally burdensome." Unfortunately, although CMS has never released regulations that implement this section of the law, current Federal policies force states to adopt systems that are significantly burdensome on providers and participants.

Under previous administrations, CMS has leveraged the "certification" process for Federally funded Medicaid technology projects to create broad mandates on states and providers that go far beyond the scope of the statutory requirements.[23] For example, CMS has pushed states to establish onerous compliance standards that require providers to submit a certain percentage of claims with EVV or else be subject to penalties. This is not feasible in instances where connectivity is bad, such as rural and frontier regions, or where participants do not have cellular or landline coverage. EVV systems also often have rigid criteria that do not allow for modification of pre-established schedules and locations, thus undermining person-centered service delivery based on the needs and preferences of members.

[23] *See* https://www.medicaid.gov/medicaid/data-systems/certification/electronic-visit-verification-outcome-based-certification

Furthermore, the Office of Inspector General has aggressively tried to expand the scope of EVV even further than CMS, and well beyond the statutory authority, by including directives for states to, "verify that tasks recorded on in-home PCS claims match allowable tasks approved in the [person-centered service plan]."[24] States have also established requirements for each individual direct care worker to be logged into the system with their own National Provider Indicator (NPI), creating additional burden and challenges for a type of worker that has not historically needed an NPI and that may not align with the billing provider Agency's Medicaid enrollment information.

Lastly, CMS has provided states and IT vendors with information suggesting that in-home hospice services are required to use EVV. Sections 1903(l)(5)(B) and (C) define the services subject to the EVV mandate as home health, defined by 1905(a)(7) of the Social Security Act, and Personal Care, defined by sections 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115. Hospice is established by 1905(a)(18) of the Act, and is defined by 1905(o) of the Act, which is clearly not included in the statutory mandate for EVV.

Recommendations:
All of these requirements create undue challenges for workers and providers and extend far beyond the scope of the statute. We therefore recommend that the Administration:

- Rescind the certification requirements for EVV systems that create additional mandates beyond the statutory scope of services;
- Repeal any mandates for minimum thresholds of provider claims with EVV data attached or, at a minimum, provide relief for rural and frontier EVV locations from calculations of such thresholds;
- Withdraw OIG guidance pushing for broader data requirements in EVV, such as service tasks; and
- Remove all in-home Hospice services and/or billing codes from any guidance related to services subject to EVV.

D. Hospice Pass Through

In instances where an individual in a nursing home receives hospice services, CMS has interpreted the statute to require that states reimburse hospice providers for the nursing home room-and-board amount, and that the hospice provider is responsible for passing the room and board payment through to the nursing facility. This creates an unduly

[24] https://oig.hhs.gov/reports/all/2024/kansass-implemented-electronic-visit-verification-system-could-be-improved/

burdensome process that undermines payment integrity and utilizes unnecessary administrative resources.

Section 1902(a)(13)(b) of the Social Security Act directs states to pay for hospice care at the same level as Medicare, except for an additional payment for room and board made for individuals in a facility. Section 1905(o) further specifies that "hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care."

Language may be somewhat confusing; however, the simple reading of the statute is that services other than hospice care cannot be reimbursed for individuals who have made the hospice election, and that the hospice care reimbursement includes a supplemental amount for room and board when the individual is a resident of an institution. Nowhere does it say that the room and board payment cannot be made to the provider of the room and board care. Unfortunately, CMS has extended the interpretation to include a requirement that only the hospice can receive such a payment. We do not believe that this process is required by the language in the Act. In light of *Loper Bright*, CMS's mandate that hospices must receive the room and board payment constitutes an overreach of the agency's statutory authority. We therefore make the following recommendation.

Recommendation:

- We recommend that the Administration clarify that room and board payment for individuals in institutional settings who receive hospice services can be made directly to the institution and do not need to be made to the hospice provider.

Conclusion

We appreciate your consideration of our comments. The Alliance stands ready to support future efforts to ensure that care in the home remains accessible, affordable, and person-centered. If you have any questions, your staff should feel free to contact me at slevy@allianceforcareathome.org.

Sincerely,

Scott Levy, JD
Chief Government Affairs Officer

State association co-signers:
Arizona Association for Home Care
Association for Home & Hospice Care of North Carolina
California Association for Health Services at Home
Connecticut Association for Healthcare at Home
Delaware Association for Home & Community Care
Florida Hospice & Palliative Care Association
Georgia Association for Home Health Agencies, Inc.
Granite State Home Health & Hospice Association
Healthcare Association of Hawaii
Home Care & Hospice Alliance of Maine
Home Care Alliance of Massachusetts
Home Care and Hospice Association of Colorado
Home Care Association of Florida
Home Care Association of New York State
Home Care Association of Washington
Homecare and Hospice Association of Utah
Hospice & Palliative Care Network of Maryland
Hospice and Palliative Care Association of Iowa
Hospice and Palliative Care Association of New York State
Idaho Health Care Association
Illinois HomeCare & Hospice Council
Illinois Hospice and Palliative Care Organization
Indiana Association for Home and Hospice Care
Iowa Center for Home Care
Kentucky Home Care Association
Louisiana Mississippi Hospice & Palliative Care Organization
Michigan HomeCare & Hospice Association
Minnesota Home Care Association
Mississippi Association for Home Care
Missouri Alliance for Care at Home
Missouri Hospice & Palliative Care Association
Nebraska Home Care Association
Ohio Council for Home Care & Hospice
Ohio Health Care Association
Oklahoma Association for Home Care & Hospice
Oregon Association for Home Care
Pennsylvania Homecare Association
Rhode Island Partnership for Home Care

South Carolina Home Care & Hospice Association
South Dakota Association of Healthcare Organizations (SDAHO)
Texas and New Mexico Hospice and Palliative Care Organization
Texas Association for Home Care & Hospice
The Alliance for the Advancement of End of Life Care
The Hospice Council of West Virginia
Virginia Association for Home Care and Hospice
VNAs of Vermont
West Virginia Council for Home Care and Hospice