CONNECTICUT ASSOCIATION FOR
HEALTHCARE 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 Connecticut Association for Healthcare at Home (CAHCH) appreciates the opportunity to submit comments on the Trump Administration's Request for Information on identifying unduly burdensome, duplicative, or outdated regulations. CAHCH is the united voice for our Connecticut care-at-home providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of licensed home health, hospice and non-medical homemaker-companion agencies across our state—including non-profit, for-profit, standalone, national companies and large system-run agencies. Connecticut also serves a variety of communities including inner city/urban, suburban, and rural across a wide variety of ethnicity, cultures, and financial status. Approximately, 25% (just under one million) of our population (primarily low-income, aging and those with disabilities) receives Medicaid covered services. Of those whose healthcare is covered by Medicare, we have a 63% penetration of Medicare Advantage versus traditional Medicare.

We appreciate the administration's efforts to reduce burdensome requirements and better streamline regulations to promote a more effective and efficient healthcare system. We, too, are aligned in this goal, we do not support reducing regulation when it may have an adverse impact on quality. We do support fair and appropriate regulation that does not interfere with providers' efforts to support their communities and deliver care in the home.

CAHCH is a member of The National Alliance for Care at Home who has submitted lengthy comments including citations of current regulations as well as recommendations moving forward. Please note that CAHCH is in full support of the

Alliance's comments and has signed on to their letter but would also like to submit the below recommendations to reinforce their comments. Please refer to the Alliance's letter for the details and cited regulations.

Home Health

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)

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. Connecticut is a state with such permissions.
- 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

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.

A. Physician Narrative Requirements

§ 424.22(a)(1)(i) - Eliminate the physician narrative requirement for Management and Evaluation of the Care Plan

Recommendation:

- CMS should eliminate the physician narrative requirement under 424.22(a)(1)(i).

Outcome and Assessment Information Set (OASIS)

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

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.
- CMS should revise the policy to make the new certification optional for HHAs in cases where a new SOC OASIS is required for administrative reasons, such as a payer change from Medicare to Medicare Advantage.
- CMS should also consider eliminating the M1800 items from the OASIS assessments as the GG function items are the common post-acute metrics to drive QRP and discharge function.

B. Patient Assessments

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

Recommendation:

- CAHCH 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.

Acceptance to Service

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

Recommendation:

- CAHCH 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.

Medical Review

Modify Burdensome Medical Review Audits

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

Certification of Terminal Illness

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

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)

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 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

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.

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Telemedicine Prescribing of Controlled Substances

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

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.
- Do not finalize Prescription Drug Monitoring Program (PDMP) nationwide verification requirements.
- Allow audio-only prescribing in cases of prescribing 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.

Hospice Outcome & Patient Evaluation (HOPE) Tool Implementation

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.

Home Care

C. Companionship Services Exemption

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

Recommendations:

CAHCH 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.

Medicaid

A. Medicaid Access Rule

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).

B. Medicaid Electronic Visit Verification

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; Home Health should not be included in the 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.

C. Hospice Pass Through

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

In summary, CAHCH's recommendations mirror much of the Alliance's suggested amendments to both regulations and statutes pertaining to Home Health, Hospice and Home Care. We appreciate your consideration of our comments.

Respectfully submitted,

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