VERMONT ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS

August 13, 2018

Ashley Berliner
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671

Sent via email to: AHS.MedicaidPolicy@Vermont.gov

RE: 18P030 Proposed Health Care Administrative Rule for Telehealth

Dear Ms. Berliner:

Thank you for the opportunity to comment on the Agency of Human Services' (AHS) proposed Health Care Administrative Rule for Telehealth. The Vermont Association of Hospitals and Health Systems (VAHHS) represents all of Vermont's not-for-profit hospitals. We appreciate AHS's efforts to implement Act 64 and ensure the responsible expansion of telemedicine for more providers and patients. We submit the following comments to help improve the rule and ensure greater access to safe, affordable telemedicine services.

3.101.1 Definitions: Reflect the statute's flexible, inclusive definition of telemedicine
The definition of "telemedicine" in the proposed rule is slightly different than the statute and may limit covered services. The definition at 18 V.S.A. § 4100k(h)(7) includes but is not limited to diagnosis, consultation, or treatment; whereas the definition in the proposed rule limits telemedicine to only evaluation, diagnosis, consultation, or treatment. We suggest adopting the statute's definition for consistency. This can be accomplished by adding the words "such as" to the definition:

"Telemedicine" means health care delivery by a provider who is located at a distant site to a beneficiary at an originating site for purposes ~~of~~ such as evaluation, diagnosis, consultation, or treatment, using telecommunications technology via two-way, real-time, audio and video interactive communication, through a secure connection that complies with HIPAA.

3.101.5 Conditions for Coverage: Refer to clinical standards to ensure rules evolve with best practices

VAHHS understands that much of this section was adopted from the Board of Medical Practice *Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.* VAHHS appreciates AHS's effort to align these proposed standards with that of existing

standards of practice; however, standards tend to evolve and change over time. VAHHS is concerned that by memorializing current clinical standards in rule, practitioners may be left with two different sets of standards if the Board of Medical Practice standards start to change. Instead, VAHHS proposes that the rule reflect the requirements from 18 V.S.A. § 9361 and reference the Board of Medical Practice standards if necessary. This will allow telemedicine standards to evolve to meet patient needs, and Vermont practitioners can improve their practice accordingly without worrying that they are out of compliance. If AHS must state specific standards, then VAHHS urges the agency to adopt the Vermont Medical Society's comments on this section of the rule for greater clarity.

Include exceptions to informed consent from Act 64 for further clarity around informed consent requirements

The proposed rule does not include the exceptions to informed consent outlined in the statute. For clarity, AHS may want to consider including the statute's exceptions to informed consent under 18 VSA § 9361(c)(4): medical emergency; second certifications of an emergency examination; and for a psychiatrist's examination to determine whether a patient needs inpatient hospitalization.

3.101.2 & 3.101.4 Telemonitoring: Rule should include coverage of effective and affordable telemonitoring

The proposed rule's current coverage of telemonitoring only includes home health services for congestive heart failure. This runs counter to Vermont's commitment towards incentivizing low-cost preventive health care services at a time of innovation in telemonitoring and payment and delivery system reform. For instance, the Brattleboro Retreat is embarking on a telemonitoring pilot project for individuals with mental health conditions. In a recent study, the same telemonitoring reduced hospital visits by 80% and emergency department visits by 76%.[1] This is the type of intervention that not only provides better treatment for Vermonters, it also saves the Medicaid program significant money. Effective telemonitoring programs should be incentivized instead of excluded. VAHHS proposes omitting 3.101.4 Beneficiary Eligibility and amending the language as follows:

3.101.2(c) Telemonitoring
(1) To be covered, services shall:
(A) Be clinically appropriate for delivery through telemonitoring,
(B) Be medically necessary, and
(C) ~~Be limited to a Congestive Heart Failure Diagnosis~~ Reliable data shows that telemonitoring services are appropriate and coverage will be budget-neutral

Additionally, AHS should not limit the definition of telemonitoring to home health agencies and nursing staff in its rule. Doing so restricts the use of telemonitoring when it could be more effective and affordable form of care. Furthermore, 33 V.S.A. § 1901g, requires coverage for telemonitoring by home health agencies or "other qualified providers as defined by the Agency

[1] Pratt, S. I., Naslund, J. A., Wolfe, R. S., Santos, M., & Bartels, S. J. (2014). Automated telehealth for managing psychiatric instability in people with serious mental illness. Journal of Mental Health, 24(5), 261-265.

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of Human Services." AHS should base its coverage on whether the telemonitoring service is effective and cost-neutral as opposed to limiting it to home health agencies at the outset. This can be accomplished in the rule by changing the definition of "telemonitoring" to the following:

"Telemonitoring" means a health service that enables remote monitoring of a beneficiary's health-related data by a ~~home health agency~~ qualified provider done outside of a conventional clinical setting and in conjunction with a physician's plan of care.

3.101.5(b) Qualified telemonitoring providers shall:

~~(1) Use the following licensed health care professionals to review data:~~

~~(A) Registered nurse (RN)~~

~~(B) Nurse Practitioner (NP)~~

~~(C) Clinical nurse specialist (CNS)~~

~~(D) Licensed practical nurse (LPN) under the supervision of a RN or physician assistant (PA), and~~

~~(2)~~(1) Follow data parameters established by a licensed physician's plan of care, and

~~(3)~~(2) Meet or exceed applicable federal and state legal requirements of medical and health information privacy, including compliance with HIPAA.

3.101.7 Non-Covered Services: Allow for further flexibility around coverage of effective and affordable telemedicine

The rule states that Medicaid will not cover services and procedures not covered in a face-to-face setting under Vermont Medicaid. Specifically excluding certain services by rule seems shortsighted given the changing health care landscape and the technological advances of telemedicine. Again, with Vermont's shift from fee-for-service to value-based payment, it is important to allow for flexibility around different methods of delivery health care services. We suggest omitting this section.

Thank you for the opportunity to provide comments. We look forward to working with AHS to make these rules workable for health care providers, patients and AHS. Please let us know if we can provide any additional information.

Sincerely,

Devon Green, Vice President of Government Relations
Vermont Association of Hospitals and Health Systems

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VERMONT MEDICAL SOCIETY

TO: Agency of Human Services, Medicaid Policy Unit - AHS.MedicaidPolicy@vermont.gov

FROM: Jessa Barnard, Executive Director, Vermont Medical Society

DATE: August 13, 2018

RE: VMS Comments on HCAR Proposed Rule 3.101: Telehealth

Thank you for accepting comments from the Vermont Medical Society regarding HCAR Proposed Rule 3.101: Telehealth. The Vermont Medical Society is submitting these comments on behalf of our 2000 physician and physician assistant members.

VMS Requests Changes in Conditions for Coverage, Section 3.101.5 (a)

VMS notes that several provisions in this proposed rule section are adopted from the Board of Medical Practice *Policy On the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*. VMS appreciates the consistency with the Board Policy, noting that the Policy already applies to MDs and PAs in Vermont (as well as podiatrists, respiratory assistants and anesthesia assistants.) That said, without the additional explanations provided in the Board of Medical Practice Policy, several requirements adopted for purposes of this proposed rule would not be clear to a reader who is not familiar with the Board Policy, especially those professions not regulated by the Board of Medical Practice (such as DOs and APRNs). In addition, DVHA is proposing adopting this language as a rule rather than policy, requiring clearly-understood language. Finally, because Board Policy may change more frequently than DVHA Rule, the Rules may become out of date and no longer consistent with Board Policy. For all of these reasons**, VMS suggests DVHA remove section 3.101.5 (a) as written and instead adopt or cross-reference the requirements as outlined in statute, 18 VSA § 9361(c)**. Note that § 9361(c)(1)(A) states that informed consent shall be "provided in accordance with Vermont and national policies and guidelines on the appropriate use of telemedicine within the provider's profession." A specific reference to the Board Policy or other professional policies or guidelines, while not necessary, would also be acceptable.

If DVHA does not adopt or cross-reference state statute, the following requirements in 3.101.5 (a) are vague and would require additional explanation or rephrasing:

- 3.101.5 (a)(2)(B): "The types of transmissions permitted using telemedicine technologies." It is unclear from this language what "types of transmissions" DVHA is referring to – technological or clinical. The Board of Medical Practice Policy continues "e.g. prescription refills, appointment scheduling, patient education." VMS suggests rewriting this section to state: "The types of services that will be provided using telemedicine technologies."

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- 3.101.5 (a)(2)(C): “Beneficiary agreement that the provider determines whether the conditions being diagnosed and/or treated are appropriate for a telemedicine encounter.” This phrase is confusing to the reader as it already is contained within a section outlining the elements of an informed consent, meaning the beneficiary has to agree to the terms of the consent. VMS recommends rewriting this section to: “A statement that the provider can determine whether the conditions being diagnosed and/or treated are appropriate for a telemedicine encounter.”

- 3.101.5 (a)(2)(F): “Requirement for express beneficiary consent to forward patient-identifiable information to a third party.” Release of medical information is a complex area of law and this requirement does not take into account exceptions to patient consent to release medical information found both in Vermont’s patient privilege and HIPAA. It is also unclear whether the “information” referenced refers to actual recordings of telemedicine visits (which is currently prohibited under state law) or any records generated based on a telehealth encounter. While this language is taken from the Board of Medical Practice Policy, VMS recommends telehealth records be treated consistently with all other medical records. This section should be amended to be consistent with 3.101.5 (a) (4) and require: “A statement that medical records for all beneficiaries receiving health care services through telemedicine will be maintained consistent with established laws and regulations governing patient health care records.”

- 3.101.5 (a) (6): “Ensure continuity of care for beneficiaries.” Absent the explanatory language found in the Board of Medical Practice Policy, the term “ensure” is overly broad as it could include requirements such as “ensuring” a patient attends follow up appointments or can afford follow up care. VMS suggests language such as: “Address needs for follow-up care or information by, for example, informing beneficiary how to contact provider or designee and/or providing beneficiary or identified care providers timely access to medical records.”

- 3.101.5 (a) (7): “Uphold beneficiary safety in the absence of a traditional physical examination if prescriptions are contemplated.” Again, absent the explanatory language found in the Board of Medical Practice Policy, it is unclear what is meant by “uphold beneficiary safety.” The most straightforward way to incorporate the intent of the Board Policy would be to remove this subsection (7) and instead amend 3.101.5 (a) (3) to read: “Take appropriate steps to establish the provider-patient relationship and conduct all appropriate evaluations, ~~and~~ history of the beneficiary, and prescribing consistent with traditional standards of care.

Exceptions to Informed Consent

DVHA proposes states that the informed consent requirements in 3.101.5(2) are consistent with 18 VSA § 9361(c)(1) and yet do not include the exceptions to informed consent outlined in the statute. **VMS recommends that Section 3.101.5(2) repeat the circumstances under which consent is not required**: medical emergency; second certifications of an emergency examination; and for a psychiatrist's examination to determine whether a patient is in need of inpatient hospitalization. See 18 VSA § 9361(c)(4) (A)-(C).

Scope of Services Covered

VMS appreciates that DVHA has clarified the definitions of telemedicine and telemonitoring from earlier version of the proposed rule. However, VMS objects to telemonitoring only including home health services for congestive heart failure. Our physicians believe telemonitoring in the home has many important, cost effective applications, for example, providing monitoring services for patients with diabetes and high blood pressure, among other chronic disease diagnoses. Further, telemontoring is often used within the conventional clinical setting, for example, by physicians remotely following vital signs of patients hospitalized in an ICU. VMS believes that to see the full potential of telemonitoring and provide best patient care, DVHA should cover telemonitoring in additional settings and for additional diagnoses. **VMS supports the suggestion from the Vermont Association of Hospitals and Health Systems that telemonitoring be covered in all situations when such services are appropriate and budget-neutral**.

VMS also supports the comment from the Vermont Association of Hospitals and Health Systems to not limit coverage to only those services and procedures covered in a face-to-face setting.

Thank you for considering our comments and please let us know if we can be of further assistance. We would welcome the opportunity to further address these concerns.

VNAs of Vermont
Your Nonprofit
Home Health & Hospice Agencies

TO: AHS Medicaid Policy Unit - AHS.MedicaidPolicy@vermont.gov

FROM: Jill Mazza Olson, Executive Director, VNAs of Vermont

DATE: August 13, 2018

RE: **Comments on Health Care Administrative Rule 3.101**

Thank you for the opportunity to comment on Health Care Administrative Rule 3.101. We have only two comments at this time. We look forward to a continued dialogue with DVHA about telehealth, particularly telemonitoring.

3.101.2(c) Telemonitoring

We hope these comments can be an opportunity to open a dialogue with DVHA about potentially expanding telemonitoring to patients with diagnoses beyond Congestive Heart Failure. We understand that the telemonitoring section was unchanged by the rule, but reviewing the rule highlighted our concern about this limitation. Home health agencies routinely provide telemonitoring to beneficiaries of other insurance plans and we believe telemonitoring can be an important tool for reducing hospitalizations and emergency room visits.

3.101.4 Beneficiary Eligibility

We recommend re-wording this sentence as follows: "For telemonitoring services, beneficiaries shall:
Have Medicaid as their primary insurance or ~~Medicaid and dually enrolled~~ dual enrollment in Medicaid and Medicare ~~with a non-homebound status~~ but not meet Medicare's eligibility requirements."

VERMONT LEGAL AID, INC.

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By email to: AHS.MedicaidPolicy@vermont.gov

August 13, 2018

Agency of Human Services
Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, Vermont 05671-1000

Re: Comments on OCR 18-037; HCAR Rules; 4.209 Durable Medical Equipment; 4.210 Wheelchairs, Mobility Devices, and Seating Systems

We submit these comments on behalf of the Disability Law Project (DLP), as part of the Protection and Advocacy system in Vermont. The DLP receives federal funding to provide advocacy for Vermonters with disabilities seeking access to needed medical care and access to assistive technology, including durable medical equipment, wheelchairs, mobility devices, and seating systems. We regularly represent Vermonters experiencing a range of difficulties accessing these services including, repair and replacement issues, prior approval issues, and coverage denials. The Medicaid services here are critically important to Vermonters with disabilities. We understand that the intent of the HCAR process is to update and consolidate the Medicaid coverage rules, but not to make substantive changes. Our primary concern in commenting on these proposed rules is to ensure that a beneficiary's Medicaid coverage for these services is not limited or restricted by these rule changes.

RuJe 4.209 Durable Medical Equipment

4.209.2 Covered Services

This rule states that "[i]tems of DME that are not pre-approved are subject to prior authorization review." We suggest the addition of the following language in order to be consistent with the federal Medicaid definition of equipment and appliances:

Any beneficiary may request coverage for equipment and appliances not on the pre-approved list by sending a request for coverage to the Director of the Office of Vermont Health Access (DVHA) in accordance with the procedures set out in M7104 of these rules (or any future iteration ofM7104),

4.209.4 Conditions for Coverage

Face-to-Face Visit Requirements

(a) For the initiation ofDME, the ordering physician or NPP must conduct a face-to-face encounter with the beneficiary no more than six months prior to the start of service.

Incorporating the face-to-face requirement for Medicaid is complicated. However, it appears that this section conflicts with the provision under 4.231.3(d) that allows the attending acute or post-acute physician to perform the face-to-face. Specifically, in this situation there can be two different physicians, the attending acute physician, who performs the face-to-face (usually as part of the discharge to home health services) and the "ordering" physician who completes the home health plan of care and orders services, and documents that there was a face-to-face encounter. The Medicaid regulation, 42 C.F.R. §440.70(f)(3)(v), seems to allow this split in responsibility, and that seems to be the practice, at least some of the time, for Medicare home health services and the face-to-face requirement in that program. Changing the term "conduct" to "document" would be consistent with the requirements of the federal regulation, and would incorporate the "post-acute" exception as to which physician is required to perform the face-to-face.

Rule 4.210 Wheelchairs, Mobility Devices and Seating Systems

4.210.1 Definitions

(a) "Wheelchairs and Mobility Devices" means items of durable medical equipment (DME) that enable mobility for beneficiaries unable to functionally ambulate. A mobility device, including a power operated vehicle, is an item that serves the same purpose as a wheelchair.
(b) "Functional Ambulation" means the ability to walk with or without the aid of a device such as a cane, crutch, or walker for medically necessary purposes as defined in 4.210.2(a)(l).

This appears to be the definition for what is considered to be a wheelchair or mobility device. But this is not criteria for coverage under the medical necessity criteria in 4.210.2(b). What is the purpose of having a definition for when the beneficiary is "unable to functionally ambulate" and when is that criteria applied? The criteria is also too restrictive by requiring that the individual be "unable" to walk "with or without" an assistive device. Many beneficiaries have significant mobility impairments and would require a wheelchair, but may not completely lack any ability to ambulate with a walker as an example. The definition should incorporate a similar concept from the medical necessity criteria ("significantly impairs"): " ... enable mobility for beneficiaries unable with a significant impairment of the ability to functionally ambulate." Also, the cross reference to 4.210.2(a)(l) is confusing, because there is no subsection (a)(l); the reference may be to 4.210.2(b).

4.210.2 Covered Services

(b) Wheelchairs and mobility devices are considered medically necessary when a beneficiary has a mobility limitation that significantly impairs his/her ability to:
(1) Participate in one or more MRADLs in or outside of the home,
(2) Access authorized Medicaid transportation to medical services, or
(3) Exit the home within a reasonable timeframe.

The medically necessary criteria should incorporate the concept of "functionally ambulate" from the definition. So, we would suggest adding "(4) Functionally ambulate."

4.210.4 Conditions for Coverage
(a) The requirements in 4.209 Durable Medical Equipment apply to wheelchairs.

This cross reference to the DME rule is potentially confusing because it does not clarify which aspects of the DME rule apply to wheelchairs. An example of a difference is that there is a different definition of medical necessity for DME than for wheelchairs. Does the DME rule on purchasing DME vs renting DME apply to wheelchairs?

4.210.5 Prior Authorization Requirements
(a) Prior authorization is required for the purchase, rental, or replacement of wheelchairs and mobility devices.

Access to wheelchairs is a long standing problem in Vermont and in other states. These access problems often relate to medical supplier concerns about reimbursement rates, particularly for Medicare and Medicaid dually eligible beneficiaries. In order to address access concerns for wheelchairs, DVHA has adopted an exception to the general requirement that Medicare be billed first on an "assigned" basis for the purchase and repair of wheelchairs and seating systems. *See* Green Mountain Care Provider Manual 11.7. Under the exception process, the provider may submit a prior authorization request to DVHA for provisional authorization, before billing Medicare. A reference to this exception process should be incorporated into this rule in order to clarify this billing practice: "For beneficiaries eligible for Medicare, providers may submit a claim for provisional authorization before submitting the claim to Medicare on an unassigned basis as set out in the provider manual." As the HCAR rules process may be updated to include Third Party Liability (TPL) (DVHA rule 7108) it is important to clarify how the TPL requirements apply to the submission of claims for wheelchairs.

Additionally, the proposed rule removes the limitation on the requirement for prior authorization for rentals of wheelchairs to those rentals for a period in excess of three months. Under the proposed rule, prior authorization is required for *any* rental of a wheelchair or mobility device, no matter the duration of the rental. Such a requirement is overly burdensome for short term rentals and should be removed. We suggest the

language of the existing rule be retained and that prior authorization be required only for wheelchair rentals lasting longer than three months.

Finally, we note that the prior authorization requirement is removed for "the initial purchase of a standard manual wheelchair with sling seat." (M7506.4). We are curious as to why this change was made.

Rule 4.210.6 Non-Covered Services

We note the addition of "Cushions that are not integral to a seating system" as a non-covered service. We request clarification of why this exclusion was added and whether this exclusion would apply to gel cushions.

Thank you for consideration of these comments. Please us a copy of the final rule and the response to comments when you have completed that review process.

Sincerely,

Nancy Breiden
Project Director
Disability Law Project
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VERMONT LEGAL AID, INC.

SENIOR CITIZENS LAW PROJECT

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By email to: AHS.MedicaidPolicy@vermont.gov

August 8, 2018

Agency of Human Services
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280 State Drive, Center Building
Waterbury, Vermont 05671-1000

Re: Comments on GCR 18-037; HCAR Rules 4.231 Home Health Services; 4.209 Durable Medical Equipment; 4.210 Wheelchairs, Mobility Devices, and Seating Systems

We submit these comments on behalf of the Vermont Long Term Care Ombudsman, the Senior Citizens Law Project of Vermont Legal Aid, and the Community of Vermont Elders. The Medicaid services here are critically important to older Vermonters. We understand that the intent of the HCAR process is to update and consolidate the Medicaid coverage rules, but not to make substantive changes. Our primary concern in commenting on these proposed rules is to ensure that a beneficiary's Medicaid coverage for these services is not limited or restricted by these rule changes.

Home Health Services

4.231.4 Conditions for Coverage
(a) General Conditions
(2) Coverage of home health agency services are not contingent upon the beneficiary needing nursing or therapy services.

This provision appears to be new, but is based on the federal regulation, 42 C.F.R. §440.70. We support this concept. We also note that understanding the intersection of personal care provided under this home health benefit with personal care covered by waiver services like Choices for Care is confusing. The Department should clarify how and when a beneficiary may receive personal care under one or both coverage options. The Department could provide clarification in this rule and/or within the Choices for Care rules. Such clarification would be beneficial to many seniors, and their health care providers, both of whom may not be aware that seniors can receive personal care in their home when medically necessary, without first being required to apply for long-term care Medicaid.

In addition, in order to receive personal care by an aide under this rule, those services must be supervised by a skilled nurse or therapist. Our view is that the supervision of unskilled care is a skilled service. Medicare coverage rules are explicitly clear that supervision can be a skilled

The Senior Citizens Law Project Is Jointly Funded by the Vermont Area Agencies on Aging and Vermont Legal Aid, Inc.

service. The intent of this section then should be read in light of the supervision requirement: personal care by a home health aide is not contingent on receiving skilled nursing in addition to supervision.

4.231.4 Conditions for Coverage
(a) General Conditions
(3) The beneficiary's condition shall be either an episode of acute illness or injury, or a chronic condition requiring part time or intermittent home health care

This general provision includes reorganized concepts from the old rule, but also adds new content. Two issues are important for beneficiaries. First, as currently drafted this provision preserves the antiquated concept that conditions are either "acute" or "chronic". Most beneficiaries receiving home health services have complex and significant needs that include experiencing acute episodes as part of managing their overall "chronic" condition. Further, classifying the beneficiary as "acute" or "chronic" may perpetuate the mistaken belief that Medicare does not cover skilled nursing or therapy services for beneficiaries that are "chronic" and/or not expected to improve.

Vermont Legal Aid was co-counsel in a national class action lawsuit, *Jimmo vs. Sebelius*, that challenged this Medicare practice of systematically denying coverage on this erroneous basis. Following the class action, Medicare coverage policy rejects the classification between "acute" and "chronic" and explicitly covers maintenance nursing (*see* Medicare Benefit Policy Manual Ch. 7 40.1.1). To the extent that the Department needs a description of the beneficiary's condition as a general condition for coverage, it would be better to reframe that concept in light of *Jimmo*: "(3) The beneficiary's overall condition, without regard to whether the condition is acute, chronic, terminal, or expected to extend over a long period of time, shall be considered in evaluating the need for part-time or intermittent home health care to maintain the beneficiary's current condition or prevent or slow further deterioration".

This rule change also adds "part-time" to the general conditions of coverage. We support that addition, but want to emphasize that the requirement is "part-time **or** intermittent". Therefore, under the proposed rule, a beneficiary may require, and would be entitled to coverage under Medicaid for daily skilled nursing, as long as the skilled nursing care being provided remained below the level considered to be "full-time" care.

4.231.4 Conditions for Coverage
(b) Plan of Care Requirements

(C) A long-range forecast of likely changes in the patient's condition

This language is carried over from the existing rule; but it is not clear what the basis is for the language or for the plan of care requirement. What is the basis? What is the purpose of the requirement? Our concern is that the language may be interpreted as requiring a change to the patient's condition as a condition of coverage. Indicating that changes in condition are required for coverage conflicts with the core principle of the *Jimmo* litigation: that coverage for skilled nursing and therapy services can be reasonable and necessary to "maintain" the beneficiary's

condition *without* changes. It may be more accurate to revise this concept to "(C) the patient's long term prognosis as a result of the treatment".

4.231.4 Conditions for Coverage
(c) Face-to-Face Visit Requirements

(1) For the initiation of home health agency services, the ordering physician or NPP must *conduct* a face-to-face encounter with the beneficiary no more than 90 days prior to, or 30 days after, the start of service.

Incorporating the face-to-face to requirement for Medicaid is complicated. However, it appears that this section conflicts with the provision under 4.231.3(d) that allows the attending acute or post-acute physician to perform the face-to-face. Specifically, in this situation there can be two different physicians, the attending acute physician, who performs the face-to-face (usually as part of the discharge to home health services) and the "ordering" physician who completes the home health plan of care and orders services, and documents that there was a face-to-face encounter. The Medicaid regulation, 42 C.F.R. §440.70(f)(3)(v), seems to allow this split in responsibility, and that seems to be the practice, at least some of the time, for Medicare home health services and the face-to-face requirement in that program. Changing the term "conduct" to "document" would be consistent with the requirements of the federal regulation, and would incorporate the "post-acute" exception as to which physician is required to perform the face-to-face.

4.231.4 Conditions for Coverage
(h) Requirements Specific to Therapy Services

(1) Physical therapy, occupational therapy, and speech language pathology services are (A) Directly related to an active treatment regimen designed or approved by the physician, and require a level of complexity such that the judgment, knowledge, and skills of a qualified therapist are required, and covered for up to four months per medical condition, based on a physician's order. Provision of these services beyond this initial four-month period requires prior authorization. Therapy services must be: (B) Reasonable and necessary under accepted standards of medical practice for the treatment of the patient's condition.

The four month coverage period before prior authorization is required was carried over from the existing rule. What is the basis for setting a four month limit on therapy services? Medicaid coverage includes maintenance therapy services. Maintenance therapy services may be reasonable and necessary on an ongoing basis (meaning such services can extend for longer than a four month period), in order to preserve strength and capabilities or to slow or prevent decline in functioning. This important principle should be incorporated into this section by adding to the end of 4.231.4(h)(1)(4) "…treatment of the patient's condition, or to establish or continue a maintenance therapy program."

Durable Medical Equipment

4.209.4 Conditions for Coverage

This section has the same issue about implementation of the face-to-face requirement as described above. This should be revised to clarify that the post-acute physician can perform the face-to-face encounter and the ordering physician can document that encounter when ordering the DME.

Wheelchairs, Mobility Devices and Seating Systems

4.210 Wheelchairs, Mobility Devices, and Seating Systems
4.210.1 Definitions
(a) "Wheelchairs and Mobility Devices" means items of durable medical equipment (DME) that enable mobility for beneficiaries unable to functionally ambulate. A mobility device, including a power operated vehicle, is an item that serves the same purpose as a wheelchair.
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This appears to be the definition for what is considered to be wheelchair or mobility device. But this is not criteria for coverage under the medical necessity criteria in 4.210.2(b). What is the purpose of having a definition for when the beneficiary is "unable to functionally ambulate" and when is that criteria applied? The criteria is also too restrictive by requiring that the individual be "unable" to walk "with or without" an assistive device. Many beneficiaries have significant mobility impairments and would require a wheelchair, but may not completely lack any ability to ambulate with a walker as an example. The definition should incorporate a similar concept from the medical necessity criteria ("significantly impairs"): "…enable mobility for beneficiaries ~~unable~~ with a significant impairment of the ability to functionally ambulate." Also, the cross reference to 4.210.2(a)(1) is confusing, because there is no subsection (a)(1); the reference may be to 4.210.2(b).

4.210.2 Covered Services

(b) Wheelchairs and mobility devices are considered medically necessary when a beneficiary has a mobility limitation that significantly impairs his/her ability to:
(1) Participate in one or more MRADLs in or outside of the home,
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The medically necessary criteria should incorporate the concept of "functionally ambulate" from the definition. So add "(4) Functionally ambulate."

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4.210.5 Prior Authorization Requirements
(a) Prior authorization is required for the purchase, rental, or replacement of wheelchairs and mobility devices.

Access to wheelchairs is a long standing problem in Vermont and in other states. These access problems often relate to medical supplier concerns about reimbursement rates, particularly for Medicare and Medicaid dually eligible beneficiaries. In order to address access concerns for wheelchairs, DVHA has adopted an exception to the general requirement that Medicare be billed first on an "assigned" basis for the purchase and repair of wheelchairs and seating systems. *See* Green Mountain Care Provider Manual 11.7. Under the exception process, the provider may submit a prior authorization request to DVHA for provisional authorization, before billing Medicare. A reference to this exception process should be incorporated into this rule in order to clarify this billing practice: "For beneficiaries eligible for Medicare, providers may submit a claim for provisional authorization before submitting the claim to Medicare on an unassigned basis as set out in the provider manual". As the HCAR rules process may be updated to include Third Party Liability (DVHA rule 7108) it is important to clarify how the TPL requirements apply to the submission of claims for wheelchairs.

Thank you for consideration of these comments. Please us a copy of the final rule and the response to comments when you have completed that review process.

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Elder Law Unit
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VNAs of Vermont
Your Nonprofit
Home Health & Hospice Agencies

TO: AHS Medicaid Policy Unit - AHS.MedicaidPolicy@vermont.gov

FROM: Jill Mazza Olson, Executive Director, VNAs of Vermont

DATE: August 13, 2018

RE: **Comments on Health Care Administrative Rule 4.231**

Thank you for the opportunity to comment on Health Care Administrative Rule 4.231. We have surveyed our members for questions and concerns they've identified since the policy went into place on April 1 and have several recommendations to clarify the rule. Our general comments are below, and some specific draft revisions are attached.

Covered Services

We recommend clarifying this section to reduce confusion in the field about to whom the policy applies, particularly regarding the face-to-face requirement. This issue was the subject of most of the comments we received from members. Specifically:

(1) Rename the policy "Home Health Services." The term "Home Health Agency Services" is confusing and, in our view, inaccurate. Home health agencies provide many services that are not subject to rule 4.231. As we understand it, only acute home health services are subject to the rule.

(2) Incorporate section 4.231.4(a) "Conditions for Coverage General Conditions" into section 4.231.2 "Covered Services." Attached please find proposed edits. We believe these changes better align the Medicaid policy with Medicare guidance available at https://www.medicare.gov/coverage/home-health-services.html.

(3) Explicitly state that the policy applies only to acute home health services and does not apply to hospice or to other Medicaid programs. Attached please find proposed edits.

Conditions for Coverage

(1) 4.231.4(b)(3) appears to limit the documentation of verbal physician orders to "registered nurses." In practice, verbal orders are documented by therapists, nurses and LPNs. We do not believe the Medicare Policy Manual limits the documentation of verbal orders to RNs.

(2) 4.231.4(f) references routine supplies but doesn't define the term or provide examples, which would be helpful. New Hampshire defines routine supplies as "those supplies used incidentally in the course of a visit and include gloves, alcohol wipes, blood drawing supplies, adhesive and paper tape, and non-sterile dressings."

4.231 Home Health ~~Agency~~ Services

4.231.1 Definitions

(a) **"Home health agency"** means a public or private agency or organization, or part of either, that meets the requirements for participation in Medicare, and complies with the Vermont regulations for the designation and operation of home health agencies.

(b) **"Home health ~~agency~~ services"**, for the purposes of this rule, means the services described at 4.231.2~~(a)~~ that are provided by a home health agency.

4.231.2 Covered Services

(a) Medically necessary home health services are provided to Medicaid beneficiaries to treat an acute illness or injury or a chronic condition.

(b) ~~Home health **agency** services are covered when medically necessary.~~ Services that are covered include:

(1) Part-time or intermittent nursing services,
(2) Part-time or intermittent home health aide services,
(3) Medical supplies for use at home, ~~and~~ durable medical equipment, or injectable osteoporosis drugs
(4) Physical therapy, occupational therapy, or speech language pathology services, and
(5) Medical social work services.

(c) Home health services are not limited to services furnished to beneficiaries who are homebound.

(d) Services covered under other Medicaid programs are not home health services subject to section 4.231 of this rule. Other programs include:
(1) Hospice
(2) Choices for Care
(3) Children's Integrated Services, including Early Intervention
(4) Prevention and wellness-oriented maternal-child health programs
(5) Adult or pediatric high-tech services

4.231.3 Qualified Providers

(a) Home health agency providers must be Medicare certified and enrolled in Vermont Medicaid.

(b) Home health ~~agency~~ services must be ordered by a physician who is enrolled in Vermont Medicaid and working within the scope of his or her practice.

(c) The following non-physician practitioners (NPP) may perform the face-to-face encounter as required in 4.231.4(c) of this rule:

(1) A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in

collaboration with the ordering physician, or

(2) A physician assistant under the supervision of the ordering physician.

(d) For beneficiaries admitted to home health ~~agency~~ services immediately after an acute or post-acute stay, the attending acute or post-acute physician may perform the face-to-face encounter.

4.231.4 Conditions for Coverage

~~(a) General Conditions~~

~~(1)) Home health agency services are not limited to services furnished to beneficiaries who are homebound.~~

~~(2)) Coverage of home health agency services are not contingent upon the beneficiary needing nursing or therapy services.~~

~~(3) The beneficiary's condition shall be either an episode of acute illness or injury, or a chronic condition requiring part time or intermittent home health care.~~

Commented [JO1]: Several members found this sentence confusing. We do not believe it is necessary when combined with the "Covered Services" section since that section explicitly lists services beyond nursing and therapy.

(b) Plan of Care Requirements

(1) Items and services shall be ordered under a written plan of care approved by the ordering physician. The plan of care shall include the following:

(A) The diagnosis, and a description of the patient's functional limitation resulting from illness, injury, or condition,
(B) The type and frequency of medically necessary home health services,
(C) A long-range forecast of likely changes in the patient's condition,
(D) The ordering physician's certification that the services and items specified in the plan of care can be provided through a home health agency.

(2) Initial orders for home health services shall include documentation that the face-to-face visit occurred, as required in 4.231.4(c).

(3) Any changes in a plan of care shall be signed by the physician, or by a registered nurse on the agency staff pursuant to the physician's oral orders.

(4) The plan of care shall be reviewed by the physician, in consultation with home health agency personnel, at least every 60 days.

(c) Face-to-Face Visit Requirements

(1) For the initiation of home health ~~agency~~ services, the ordering physician or NPP must conduct a face-to-face encounter with the beneficiary no more than 90 days prior to, or 30 days after, the start of service.

(2) The face-to-face encounter must be related to the primary reason the beneficiary requires home health ~~agency~~ services.