HOMECARE & HOSPICE
National Association for Home Care & Hospice

HOME CARE & HOSPICE COVID-19 TOWN HALL

May 20, 2020

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A Bit of Context: NAHC Survey April 2020

- **41.5% of HHAs report serving actively infected COVID-19 patients. In the NY/NJ "hot spot" 85.71% of HHAs report serving such patients.**
- **85% of respondents report revenue reductions with a median reduction between 15 and 20%.**
  - **"hot spots" such as NY and NJ report reductions: 67.9% @ >15% and 46.3% @>20%**
- **79% report decreases in admissions with 56% indicating reductions greater than 15% and 37.3% reporting reductions in excess of 20%**
- **67% of all HHAs report at least a doubling of LUPAs**
- **Respondents indicate that the top three concerns about their future are:**
  - **Significantly reduced revenues**
  - **Patient safety with inadequate supply of Personal Protective Equipment (PPE)**
  - **The inability to fully utilize telehealth services as an adjunct to in-person care that is reimbursed by Medicare**

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Current Environment

- HHA revenue down; per patient costs are up
- Staff insecurity with virus and virus risks
- MDs. NPPs, Hospitals, RHCs, FQHC, and more are new and current competitors
- Instability may create environment for acquisitions and consolidations

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Current Environment

- Financial stability improved with Advance Payments, Provider Relief Fund, SBA loans/grants, etc.
- HHAs showing versatility and depth by making fast adjustments while adding Covid-19 patients into service
- Cost scalabilities evident
- MCOs learning more about home care value
- Health systems appreciating home care
- Nursing facilities and ALFs are “feared” by patients
- Technology as a real tool has taken a quantum leap

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COVID-19 Relief

- Legislative
  - Family First Coronavirus Relief Act
    - Extended sick leave
    - Expanded Family Medical Leave
    - Federal Unemployment Compensation supports
  - CARES Act
    - $100B Provider Relief Fund
    - SBA loans/grants
    - Medicare provider regulatory relief authorizations
    - Permanent NPP HH certification authorized
    - Medicare HH telehealth "encouraged"
    - Medicaid 6.2% FMAP increase
  - Stimulus 3.5
    - $75B added to Provider Relief Fund
    - $330+B added to SBA Paycheck Protection Program
  - Stimulus 4.0
    - House passed HEROES Act--$3 TRILLION in relief

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CARES Act Provider Relief Fund

- **$175 Billion**
  - **Intended to provide relief for COVID-19 related costs and lost revenues**
- **Two distributions so far**
  - **$30B to Medicare providers on 4/10 and 4/17**
  - **$20B to Medicare providers starting on 4/25 with rolling weekly distributions**
- **Further distributions in development**
- https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html

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CARES Act Provider Relief Fund

- Targeted Distributions Underway (to an extent)
  - "High Impact" areas--$10B
    - Hospital data development ongoing
  - Medicaid-- $????
    - HHS requested states supply provider-level data
- Targeted Distributions Planned
  - Rural Health
    - Health Clinics and hospitals
  - Indian Health--$400M
  - Treatment of uninsured COVID-19 patients
- Will there be more added to the fund?

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Home Health Advocacy Priorities

- Telehealth Reimbursement
- Enhanced Reimbursement
- Verbal Physician Orders
- Rural Add-on
- PPE Prioritization

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Hospice Advocacy Priorities

- Hospice role in bereavement and trauma-informed care
- Flexibilities in respite benefit – time frame and site
- Potential community-based palliative care model
- Funding – based on demonstrated need

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Hospice Advocacy Priorities

- PCHETA
- Rural Access to Hospice Act
- Role of PAs in hospice to reflect full scope of practice
- Advance Care Planning – expanded role of Social Worker

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Home Care Priorities

- Premium Pay for Frontline Caregivers
- Essential Benefits for Workers
- Medicaid HCBS Supports
- Business and Worker Liability Protections
- PPE Access

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HEROES Act: Pending Legislation

- Provider Relief Fund Adds $100 Billion
- Medicaid
  - FMAP increase of 14%
  - MFAR block
  - HCBS 10% increase
- Accelerated and Advanced Payments

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HEROES Act: Pending Legislation

- Premium Pay for Essential Workers
- Family Care Benefit
- HEROES Fund Grants
- Price Gouging Prevention – PPE and supplies
- Paycheck Protection Program

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HEROES Act: Pending Legislation

- Paid Sick and Family Leave
  - Tax Credit Extension
  - FMLA Eligibility Criteria Suspension
  - Emergency Family Leave Extension
  - Removes DOL's Exemptions Regulations on Size and "Health Care Provider"

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Medicare and Medicaid Regulatory Waivers and Flexibilities

- Regulatory
  - 1135 Waivers (example)
    - Conditions of participation (CoPs)
    - Health Insurance Portability and Accountability Act (HIPAA)
    - Provider enrollment
  - New regulations
    - Interim Final Rules with Comments (IFC)
      - Two rules issued --3/30 and 4/30
- Sub-regulatory
  - Policy changes and other regulatory authority
    - Guidance documents
    - FAQs

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1135 Waivers: Home Health

- 484.45(a) Flexibility with the comprehensive assessment 30-day submission time frame – Does not specify a time frame
- 484.55(a) Initial evaluation visits conducted remotely or through medical review—help with 48-hour rule
- 484.55 (b)(1) Extends the 5-day window for completing the comprehensive assessment to 30 days
- 484.55(a)(2)and(b)(3) Permits OT, PT, and SLP to conduct the initial and comprehensive assessment when therapy ordered
- 484.58(a) Discharge planning – HHAs not required to use quality and resource use measures to assist patients when transferring to post acute care

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1135 Waivers: Home Health

- **484.65 Quality Assurance and Performance Improvement program (QAPI) (HH&H)**
  - **Focus on infection control**
  - **Adverse events**
- **484.80(d) 12hour annual in-service training (HH&H)**
  - **Postponed until 1st quarter after PHE ends**
- **484.80(h) 14-day onsite visits for HHA aide supervision (HH&H)**
  - **Encourages HHA to conduct**
- **484.80(h)(1) Annual on-site supervisory visits (HH &H)**
  - **Postponed until 60 days after PHE ends**
- **484.110(d) Clinical records**
  - **10 days rather than 4 days or next visit**

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1135 Waivers: All Providers

- **HIPAA**
  - **Waives enforcement of noncompliant technologies used for patient encounters**
    - **Covered providers may use any non-public facing remote communications product- e.g. Skype, Face time, Zoom**
- **Provider enrollment**
  - **Waives screening requirements: fees, site visits, criminal background checks**
  - **Postpone revalidations**
  - **Expedite application process**

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Medicare Interim Final Rules--3/30

- **Homebound**
  - **Medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19**
    - **Dual eligible**

- **Telehealth**
  - **Implements lifting the geographic location and originating site restriction (CARES Act)**
    - **Enables the physician F2F encounter for HH certification to be conducted in the home, HIPAA allows the F2F to be non-public facing products**
  - **Telehealth visit must be included in the HH POC, not replace on site visit, Non-billable**
  - **HHA may enter into an arrangement with physician to provide home visits as incident to the physician's services –not under a HHPOC**
  - **Therapist may bill for telehealth under Part B – non-homebound patients**

Comments: reimbursement and joint visit by HHA and physician

- **RHC/FQHC may conduct home nursing visits in all areas in which they are located**
  - **HHAs may become overwhelmed**

Comments: challenge CMS' rationale

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Medicare Interim Final Rules--4/30

- **NPPs (NP, PA, CNS) may certify and order home health services**
  - **permanent; retroactive to March 1, 2020; updated regulations; state laws apply; Medicaid**

- **HHVBP : Aligns with the reporting exceptions for the HHQRP, and HCAHPS**
  - **No reporting required for the 4th quarter of 2019 and 1st and 2nd quarter 2020**
  - **May need to develop a new method for HHVBP TPS calculation- 2022 payment year**

Comment: recommend suspending the last year HHVBP

- **OASIS E: Delayed until Jan 1 one full year after the PHE ends**

- **Hospital at home: Expands locations for HOPD- registered outpts. may receive services in the home**
  - **Open to a HHPOC, prohibits OPD services**
  - **Open to OPD, prohibits HHPOC**

Comment: These patients should be admitted to HH since they meet eligibility criteria; skilled need and homebound

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Medicare Policy and Other Regulatory Flexibilities

- RAP auto cancel extension time frame by 90 days from the paid date of the RAP
- HHQRP and HHCAHPS exception for reporting data last quarter of 2019 and 1st and 2nd quarter of 2020
- Cost reporting filing delayed by 2-3months- flexibility already exits in the regulations.
- Accelerated payments reevaluated and suspend advanced payments
- Halting TPE and ADR requests for all providers (MACs , RACs, CERT and SMRCs)
- Review Choice Demonstration paused in IL, OH and TX 3/29
  - will not proceed in NC or FL as scheduled
- State Surveys suspended – HH and hospice targeted for IC
- Update to the home health grouper for Dx codes for vaping related disorder and COVID-19

  -- Advocating to allow Z20 codes or symptom codes for symptomatic, non-confirmed COVID-19 HH beneficiaries.

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Medicare HH PPS Proposed Rule

- CY 2021 Home Health Prospective Payment System Rate Update and Quality Reporting Requirements
- Under Review at Office of Management and Budget (OMB) 5/6
- Expecting Publish mid-June to early July
- Should include:
  - Rate updates
  - Quality reporting
  - NPP?
  - Home infusion therapy supplier benefit?

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Medicare Hospice FY2021 Proposed Rule

- **Payment Update Percentage: 2.6% subject to change**
- **Wage index refinements - limit loss in value from previous year to 5%**
- **Aggregate Cap: $30,743.86 projected**
- **Service-Intensity Adjustment (SIA): proposed elimination of budget neutrality adjustment to payment calculation**

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Medicare Hospice NPRM: Election Statement & Addendum

- **Finalized in FY2020 rule - effective October 1, 2020**
- **Hospices must modify the election statement, and**
- **Provide an election statement addendum, when requested**
  - **Patient Notification of Hospice Non-Covered Items, Services, and Drugs**
  - **Eight required content items**

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Medicare Hospice NPRM: Election Statement & Addendum

Provision of addendum/timing:

- **Patient/representative**
  - **If requested at admission, within 5 days after election**
  - **If requested during course of care, within 72 hours**
  - **When changed (updates to plan of care affecting items)**
- **Non-hospice providers – upon request**
- **MAC – upon request**

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Medicare Hospice NPRM: Election Statement & Addendum

- **Expansive new requirements; much more detail supplied on April 16 webinar: https://www.nahc.org/event/hospice-proposed-rule-fy21/**

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Medicare Hospice NPRM: Election Statement & Addendum

Concerns:

1. **Implementation date**
2. **Further guidance and updated burden estimate needed**
3. **Beneficiary's financial responsibility – respite and drug copay**
4. **"Appeal" used in conjunction with immediate advocacy**
5. **Lack of consistent guidance on signatures**

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Medicare Hospice Waivers and Flexibilities: Telecommunications & Telehealth

During PHE, telecommunications technology may be used for RHC visits:

- **Part of per-diem payment**
- **Not reported on claim (except medical social services calls)**
- **Plan of care must include:**
  - **Visit/type of technology**
  - **Description of how technology helps to achieve goals outlined on plan of care**

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Telecommunications & Telehealth

- Can include audio only if IDG deems appropriate
- CMS: most initial and comprehensive assessments should be completed in person; technology may be used as long as it results in a full assessment of patient/caregiver needs and "informs an individualized plan of care"
- Report technology for COVID costs separately

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Hospice F2F

F2F encounter requirement for third and subsequent benefit periods:

- During PHE
- Two-way, audio-visual, real time technology may be used by hospice physician or NP for F2F if sole purpose for encounter
- Audio only NOT permitted
- Not billable

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Telehealth Visits

- **During PHE**
  - **Home may be originating site for telehealth**
  - **Hospices may bill Part A for medical services performed by hospice physician or hospice NP provided the clinician is the designated attending physician**

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Technology – Looking Ahead

- **NAHC letter to CMS: Time to plan for delivery of hospice care in post-COVID world**
  - **Clarify that hospices may use technology-based visits**
  - **Develop codes/modifiers for reporting visits on claims**
  - **Clarify that technology-based visits should be reported on HIS discharge record**
  - **Permanently allow use of telecommunications technology for F2F encounter**

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HQRP

Hospices not required to submit HIS or CAHPS data:

- **October 1, 2019–December 31, 2019 (Q4 2019)**
- **January 1, 2020–March 31, 2020 (Q1 2020)**
- **April 1, 2020–June 30, 2020 (Q2 2020)**

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Hospice Conditions of Participation

- **418.78(e)Volunteer services**
- **418.54 Comprehensive assessment update**
- **418.72 Non-core services – PT, OT, SLP**
- **Aides**
  - **418.76(h) Onsite supervision every 14 days waived**
  - **418.76(d) 12-hour in-service requirement waived**
  - **418.76(c)(1) Pseudo patients**
  - **418.76(h)(2) Annual onsite competency evaluation postponed**

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Conditions of Participation

- **418.100(g)(3) Annual assessment and training of caregiving staff postponed**
- **418.58 QAPI: Narrow scope of QAPI program**
  - **concentrate on infection control issues, with**
  - **continued focus on adverse events (aspects of care most closely associated with COVID-19)**
  - **must retain an effective, ongoing, agency-wide, data-driven QAPI program**

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Hospice Conditions of Participation

Hospice Inpatient Units – Physical Environment:

- **Allows for flexibilities related to frequencies for inspection, testing and maintenance of equipment and facilities at 418.110(c)(2)(iv)**
- **Life Safety Code at 482.41(d)(1)(i) and (e)**
- **Outside window/door at 418.110(d)(6)**
- **Alcohol-based hand rub dispenser (ABHR) at 418.110(d)**
- **Fire drills at 418.110(d)(4)**

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Hospice Access to Nursing Facility Residents

- Which hospice staff should be allowed access?
- Hospice staff should:
  - Pass any facility screenings
  - Utilize proper PPE
- Modifications to visit frequency
- CMS QSO Memo: QSO-20-14-NH

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Private Duty and Medicaid HCBS Issues: (FFCRA)

- FFCRA exempts "health care providers" from PHE sick leave and family leave expansions
  - DOL defines "health care providers" to include home health care direct care and administrative staff
  - NY lawsuit challenging FFCRA "healthcare provider" exemption regulations
  - The HEROES Act includes a provision that would drop the exemption overall
- Dilemma: patients/clients need caregivers vs. staff coping with impact of Covid-19

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Federal Pandemic Unemployment Compensation (FPUC)

- **CARES Act provides $600 federal UC benefit for anyone unemployed with connection to Covid-19**
- **State UC may also be available**
- **UC may bring higher compensation that actual wages for some home care workers**
- **Financial incentive to leave work**

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NAHC Advocacy Position

- Incentivize working
  - Frontline worker wages
  - Childcare support
  - Health care access
- Access to PPE
- Enhance Medicaid support for caregivers
- Liability protection

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"Advocacy is for Everyone"

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"Help Home Care & Hospice Communities Rise to the Challenge"

- **<u>Four Key Priority Areas</u>**
  - **Increase Medicare Home Health Reimbursement by 15%**
  - **Establish in-home care providers as a priority in PPE Distribution**
- **Waivers to allow telehealth visits to be reimbursed within the home health benefit**
- **Waive or suspend Medicare requirement that HH orders and eligibility verification be signed/dated by a provider during the PHE in favor of verbal orders and certifications**

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"Protect & Support Home Care Front Line Workers"

- **Caregiver Support Principles**
  - **Sufficient Financial Reward**
  - **Allocation of Funds for Recruitment**
  - **Equity in Eligibility in Essential Worker Pay**
  - **Enhanced pay delivered w/ expedience and efficiency**
  - **Minimal employee/employer burden**
  - **Minimize cash flow disruption**

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"Advocacy is for Everyone"

STEP ONE

Visit & Click on Featured Campaigns

STEP TWO

Enter Your Info & Click Send

STEP THREE

Share & Pass It On

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LEGISLATIVE and REGULATORY OUTLOOK

- Uncertainty rules at this point
  - Length of PHE
  - Status of economy
  - Health care infrastructure stress level
- Congress is preparing, but trigger-point TBD
- Regulatory bodies implementing relief and flexibility
  - "hands full" already
- Looking at potential permanent reforms
- Stimulus 4.0 forecast
  - State and local supports
  - Medicaid
  - Worker protections
  - Business liability immunity
- Stimulus 5.0 ?????

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Looking Forward

- **Short-term**
  - Financial stability risks
  - Workforce unsettled with care risks
  - New competitors outside of current home care
  - Opportunity to show breadth and depth
  - Regulatory and payer flexibilities
  - Routine regulatory challenges on top of Covid-19 ones
- **Long-term**
  - What do want to make permanent
  - Technology advances embraced
  - Home care value perception improved
  - Better pandemic planning
  - New partners/new competitors
  - Regulatory challenges (as usual)

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Looking Forward

- Turbulent upcoming months
  - Unknown duration
  - Varied across the country
  - Restart of elective procedures not uniform; question on pent-up demand factor
- Patient hesitancy will diminish over time
  - Favorable news reports on home care safety
  - PPE availability growing
  - Climate changes with business/life re-openings
- Enduring hesitancy towards congregate care

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Looking Forward: Outcomes

- Patient census returns/increases
- LUPAs decline
- CMS makes positive changes permanent
  - Telehealth
  - Reduced red tape/administration
- Care delivery models change
  - Joining of service and technologies driven by data knowledge
  - Earlier integration of care at home pre-acute, acute, and post-acute
  - Palliative care added
  - Physicians and NPP as partners and competitors
- Some return to the usual
  - Payment rates
  - Staffing
  - Oversight
- Perception of home care as a positive grows

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SMARTER GROWTH.
HEALTHIER OUTCOMES.

Speaker

Tyler Rardin
VP of Sales at Trella Health

About Trella Health

- Leader in post-acute analytics
- Helping PAC providers compete on quality and accelerate growth

Trella's Data

- Deemed 'Innovators' under CMS's Virtual Research Data Center program
- 100% of Part A and Part B with approximately a 4-month lag
- Analyze 1.2 billion Medicare claims annually to build solution

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The Purpose

Quantifying hospice's end of life impact

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Hospice Market Challenges

- Poor Utilization
- Low ALOS
- Rise of Value-Based Care
- MA Hospice Carve-in
- COVID-19
  Placing Additional Strain on Healthcare System

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The Methodology

- **Patients included in the study:**
  - Medicare Fee-for-Service (FFS) beneficiaries
  - Death date between July 2018 and June 2019
  - Patients had at least one hospitalization within one year prior to death
  - Total patient count: 904k
- **Population divided into cohorts based on the length of hospice enrollment prior to death:**
  - Early hospice (longer than three months)
  - Moderate hospice (longer than two weeks but less than three months)
  - Late hospice (less than two weeks)
  - No hospice enrollment prior to death
- **End of life cost and utilization metrics collected over three time periods:**
  - 1 month prior to death
  - 3 months prior to death
  - 6 months prior to death

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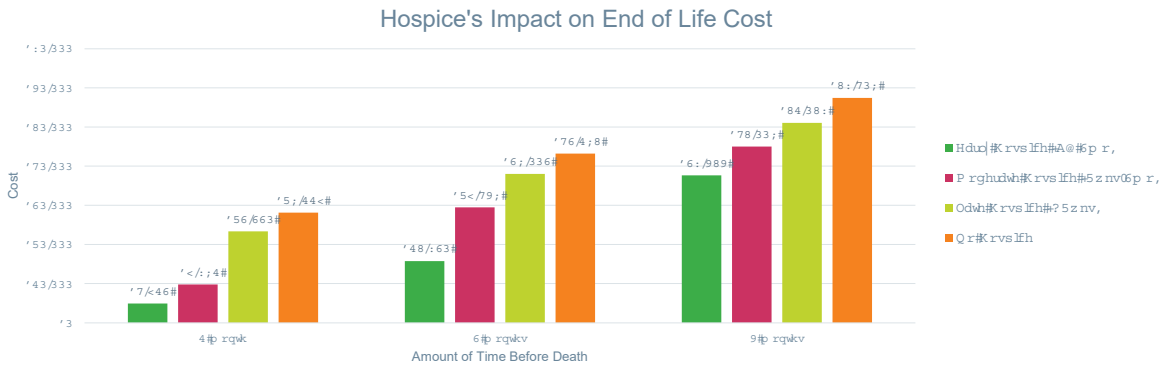
Overall Cost Results



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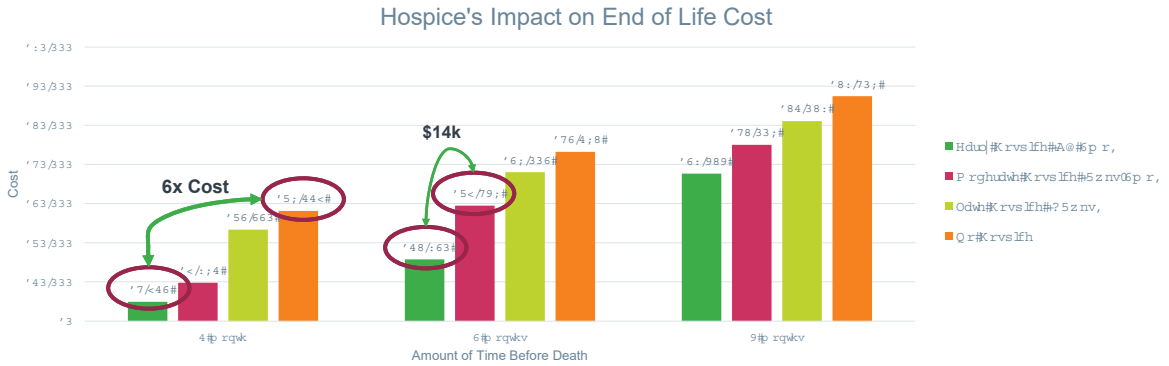

Key Observations:

- *~6x higher cost for no hospice vs. early hospice during last month of life*
- *~Hospice ALOS strongly correlated to cost impact ($14K 3-month savings when comparing early & moderate hospice)*

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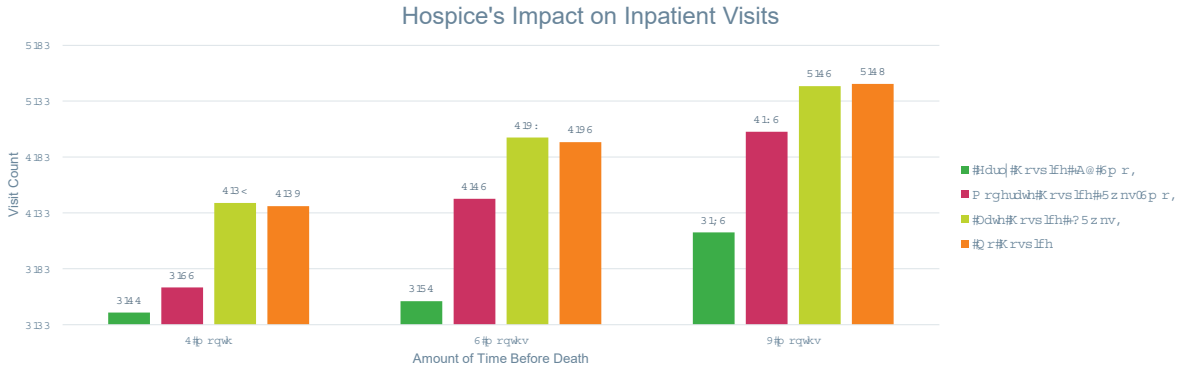
Inpatient Utilization



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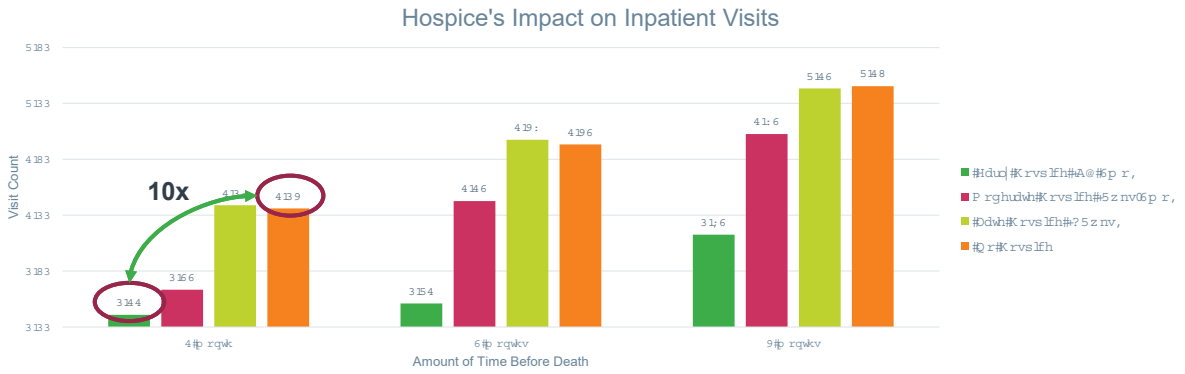

Key Observations:

- *~10x more hospital visits if no hospice or late hospice vs. early hospice last month of life*
- *~Late hospice ALOS of 5.8 days – patients likely coming straight from hospital*

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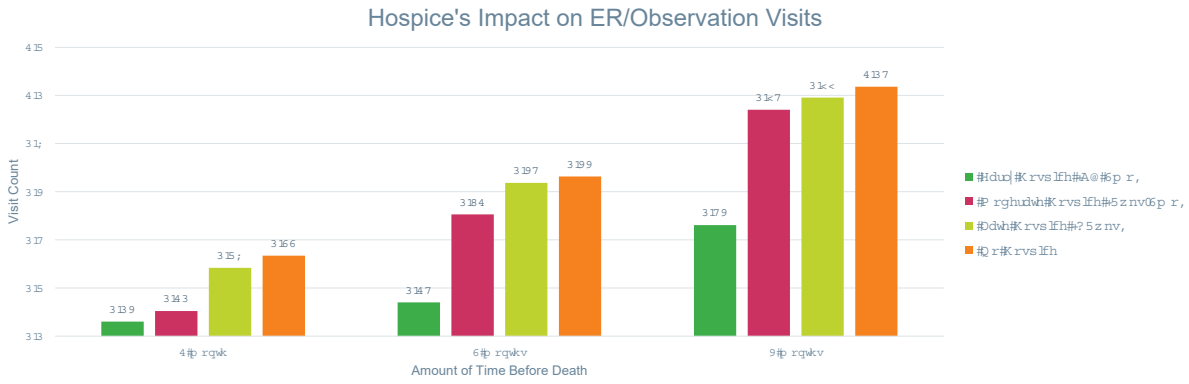
ER / Observation Utilization



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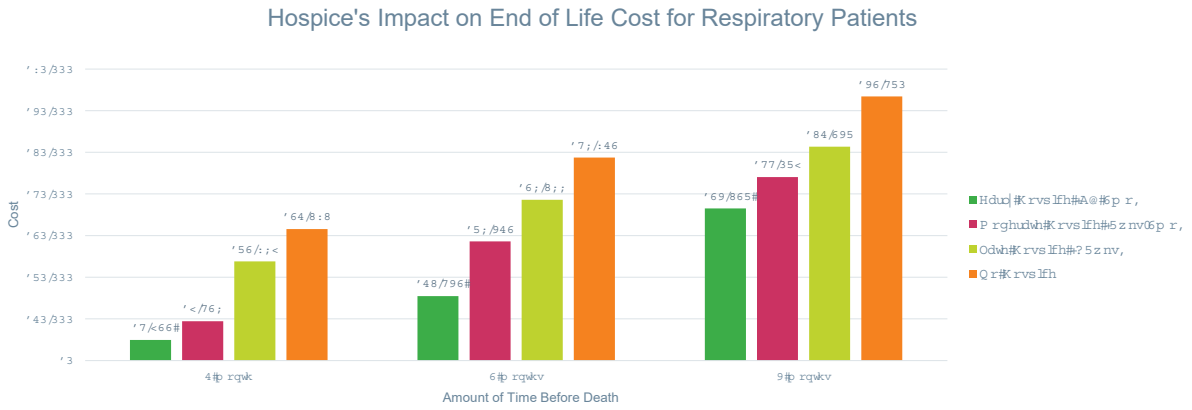
Hospice Cost Impact - Respiratory



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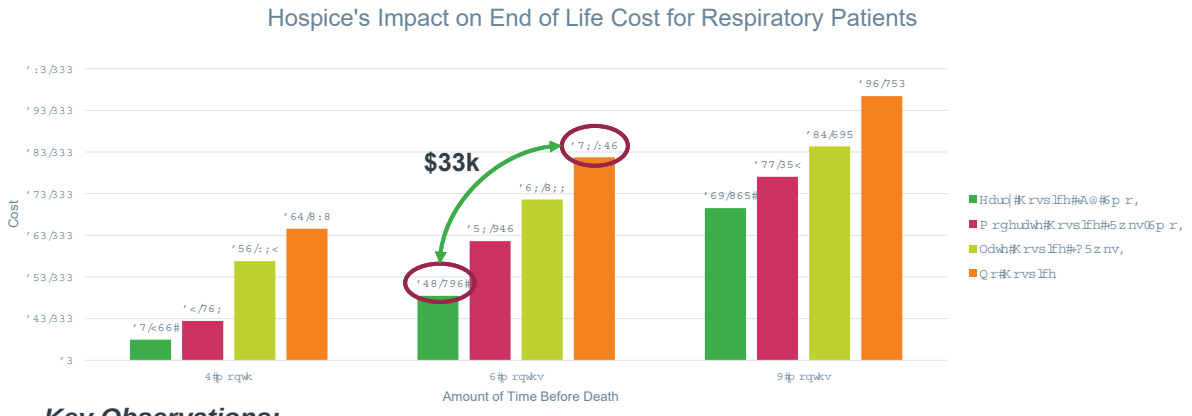
Hospice Cost Impact - Respiratory



Key Observations:

- *~No Hospice incurs $33k more cost than early hospice in the last 3 months of life*

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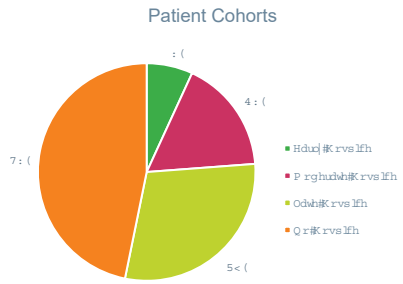
Summary of Findings

- Hospice has a **dramatic impact on end of life cost**
  - No hospice = 6x higher cost and 10x more hospital visits than early hospice for last month of life
- Hospice significantly **reduces hospital visits** at the end of life
- The value of hospice has a **strong correlation to length of stay**
- Only **7% of patients** received the full benefit of hospice *(90+ day LOS)*



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Thank You!

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