Stabilize the Medicare Home Health Care Delivery System During the Public Health Emergency Through Expedited Funding or Rate Adjustments

ISSUE: The Covid-19 pandemic has triggered an unprecedented disruption in the home health agency (HHA) infrastructure. HHAs report that patient admissions have dropped significantly while service costs have increased due to reduced staff productivity, infection control expenses, increased administrative burden due to closures of physician offices and other partners, and isolation/quarantining of caregivers suspected of exposure to the virus. In many parts of the country, HHAs have a higher number of Covid-19 infected and suspected infected patients than hospitals as those hospitals take steps to free up beds for ICU level patients.

The National Association for Home Care and Hospice (NAHC) conducted a survey regarding the impact of Covid-19 in March 2020, at the beginning of the growth in Covid-19 infections. At this early stage of infections, 41.33% of HHAs already report they are serving Covid-19 positive, confirmed infected patients.

In addition, the study shows that a staggering number of non-Covid-19 patients are refusing care or reducing their in-person visits by HHA staff to minimize risks of transmission of the virus. Over 87% of HHAs report that prospective patients are refusing admission to care and 97% of HHAs report that patients are refusing visits due to concerns with transmission of the virus. Patient admission volume overall has also decreased significantly, partly due to the suspension of elective surgeries, such as joint replacements, which had been an important part of an HHA patient census. Two-thirds of HHAs indicate a 10% or greater drop in patient admissions; 56% report a drop of greater than 15%; and 38% indicate a reduction of patients of more than 20%.

A further consequence of refused visits is that the proportion of claims subject to a Low Utilization Payment Adjustment (LUPA) have proportionately increased from a 7% average to over 15%. Many HHAs report a LUPA proportionate increase to over 20%. For example, 75% of HHAs at the 7% national average in March 2019, report that LUPAs have increased in March 2020, with 52% of that cohort indicating a doubling in the volume of LUPAs.

As a result, Medicare home health reimbursements have significantly dropped with an average decrease in Medicare revenue of approximately 20% while the costs of maintaining operations have decreased only slightly. Notably, the study shows that 31.42% of HHAs report expecting a greater than 20% decrease in revenue in 2020. Rural HHAs are not immune to the impact of Covid-19. The study data indicate comparable impact on HHAs serving rural patients on all counts.

The financial relief provided through the CARES Act emergency fund was a helpful short-term solution that helped to temporarily stem the impact of this crisis on HHAs. With this funding of 6.2% of 2019 Medicare fee-for-service revenue, a step was taken toward mitigation of the estimated 20% in overall

losses to HHAs due to Covid-19. However, additional financial relief is needed to continue to stabilize the financial foundation and infrastructure of home health agencies. Without significant financial supports, the HHA delivery system is at risk of significant long-term harm from these factors beyond their control. The ultimate level of impact will be affected by the time length of the pandemic.

RECOMMENDATION: The home health community asks for additional temporary relief to mitigate the losses to the home health care delivery system. NAHC and the Partnership for Quality Home Healthcare (PQHH) ask for the following relief measures to support the infrastructure and operations of HHAs. NAHC and PQHH recommends:

- **Increase Medicare 2020 financial support by 15%.** The NAHC survey data shows that financial impact from COVID-19 is reducing HHA revenue by 20-25%. The earlier CARES Act emergency fund allocation and the upcoming suspension of the 2% sequestration took steps to address these losses but unfortunately more assistance is needed to ensure HHAs can continue delivering care to patients. A temporary additional 15% in funding is needed during the Public Health Emergency (PHE) period to stabilize HHAs. This will prevent widespread agency closures, staff layoffs, and maintain access to care throughout the pandemic and thereafter. This temporary relief could be provided through continued relief supplied to HHAs through the CARES act funds, or through a temporary PHE rate enhancement (or a combination). The need is for both rural and non-rural based HHAs. Rural HHAs may warrant special consideration beyond this request as the entire infrastructure of care delivery in rural areas had been weakened even before the pandemic.

RATIONALE: Home health services are increasingly needed during the pandemic and are a vital part of our nation's health care system. Currently, 3.5 million Medicare beneficiaries receive home health care. The relief sought is intended to help address the massive revenue losses triggered by COVID-19. With respect to the rate increases, Medicare overall is protected by an existing budget neutrality requirement that ensures that these changes do not unnecessarily increase Medicare spending over the next several years. As such, a temporary rate enhancement request simply accelerates the rate setting process rather than adding to current payment rates. An expedited approach to payment rate setting is needed now as delaying such action to 2021 is not sufficiently timely to ensure continued operations.

Home Care and Hospice Need a Share of the Personal Protective Equipment

ISSUE: The Covid-19 pandemic has created a nationwide shortage of Personal Protective Equipment (PPE), including gloves, masks, gowns, face shields and respirators. The Federal Emergency Management Agency (FEMA) has been charged with distribution to states of these items from the federal stockpile. Manufactures globally are trying to step up production. US manufacturing companies of all types have stepped up to help. However, a recent survey indicates that over 45% of home care agencies have less than a ten day supply with many indicating they have no supply. At the same time, the survey indicates that 42% of these providers are providing care to Covid-19 confirmed infected patients. In some locations, more Covid-19 patients are in home care than in institutional and hospital settings. Still, more of these patients can be effectively cared for at home if PPE were made available.

Despite the fact that home care providers serve more than 12 million very vulnerable patients each year and that the demand to serve Covid-19 patients is increasing every day, home care is not considered a priority at any level to receive PPE. As a result, hospital beds are scarce and nursing facilities are overtaxed.

Home care providers have taken all alternative steps such as extreme conservation, using garbage bags as gowns, empty soda bottles to make face shields, and homemade masks. However, creativity and ingenuity has its limits when it comes to worker and patient safety.

RECOMMENDATION: Congress should establish that providing access to PPE for home care and hospice is a national policy priority.

RATIONALE: One of the most effective mitigation strategies to control the spread of the virus is to isolate at home. PPE is essential not only to care for those infected with Covid-19, but also for the additional 12 million homebound individuals who are highly susceptible to the transmission of the virus.
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Permit Medicare Payment to Home Health Agencies for Telehealth Services

ISSUE: The recent relief efforts instituted by Congress and CMS to accommodate the demands of the Covid-19 pandemic include significant expansions of Medicare coverage of telehealth services. A primary source for essential telehealth services in the home are home health agencies. Telehealth has been part of the tools employed by HHAs for two decades. HHAs can use telehealth for evaluation and assessment of a patient's condition, teaching and training of self-care and rehabilitative activities, wound care, direct therapy services, medication management, and more. In the recent CARES Act, Congress instructed CMS to encourage HHAs to utilize telehealth.

However, unlike for other providers and practitioners, Medicare does not pay for an HHA's use of telehealth. In fact, the use of telehealth as a physician-ordered alternative to in-person visits can reduce the level of reimbursement significantly to HHAs. This occurs because HHAs receive a payment for a bundle of services for a 30-day period except when the number of in-person visits falls below a care-specific "low utilization" level. Accordingly, an HHA that combines telehealth with in-person visits can dramatically cut its reimbursement while not correspondingly reducing its costs. While a physician, nurse practitioner, physician assistant, therapist, or other caregivers would receive payment for each and every telehealth encounter in the home, an HHA cannot.

It is notable that many Medicaid programs do pay for telehealth by HHAs. In addition, Mediocare Advantage plans do as well. Recently, one of the largest plans announced that it would pay for HHA telehealth on a basis equivalent to an in-person visit during the Public Health Emergency. https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-home-health.html

RECOMMENDATION: Congress should waive:

1. Section 1895(e) during the emergency period to permit payment to an HHA for the use of physician-ordered telehealth services under the home health benefit.
2. Section 1834(m) to permit payment to HHAs for physician-ordered telehealth for patients who do not otherwise qualify for the home health services benefit.
3. Mandate that CMS expeditiously establish a payment structure for telehealth services within the home health services payment mode for the duration of the public health emergency..

RATIONALE: HHAs have proven that telehealth services can effectively meet the needs of homebound patients, particularly when combined with in-person visits. Doing so during the pandemic provides a way to reduce risk of transmission of the Covid-19 virus while helping to reduce the need for hospitalizations and Personal Protective Equipment (PPE). A key to taking full advantage of these benefits of telehealth in the home is to institute a payment for telehealth provided by HHAs. There are a multitude of ways to do so within and outside the current payment model, yet CMS has indicated that it is blocked by existing law from doing so. Congress needs to act to remove any such barriers.

PERMIT HOME HEALTH SERVICES BILLING UPON VEBAL ORDERS FROM THE PATIENT'S PHYSICIAN DURING THE EMERGENCY PERIOD

ISSUE: Medicare allows a home health agency (HHA) to initiate and fully provide care to its patients based upon verbal orders from the patient's attending physician. The use of verbal orders to start care ensures a timely delivery of needed nursing and therapy services that are vital for the patient's recovery and safety. These verbal orders are taken directly by health care professionals at the HHA and are fully documented in writing by nurses or therapists. Throughout an episode of care, these professionals maintain frequent contact with the patient's physician by phone, telehealth, email, and text messaging.

However, Medicare requires that the HHA obtain a Plan of Care, any changed care orders, and a certification of Medicare eligibility fully signed and dated by the physician prior to billing Medicare for the services the HHA had provided. In normal times, securing signed and dated paperwork from physicians is challenging for HHAs. Many times the HHAs must travel to the physician's office with hand delivered documents and wait until the physician has the time to provide the required signature and date.

These are not normal times. Today, many physician offices are closed with the physicians operating remotely in their continuing care of patients. HHAs often offer electronic portals for the exchange of documents, but interoperability with physician systems is not the norm as each physician may have a different system than the HHA. Due to the inability to obtain signed and dated written orders and eligibility certifications from physicians, HHAs are incurring significant additional care costs without reimbursement. That creates a dangerous barrier to continued care availability and HHA operations at a time when their services are needed more than ever to reduce the need for hospitalizations and use of institutional care settings.

RECOMMENDATION: Congress should waive or suspend the Medicare requirement that HHAs secure signed and dated physician orders and eligibility certifications during the Covid-19 pandemic emergency. Medicare billings based on verbal orders and certifications should be permitted, provided the HHA maintains detailed documentation of the orders and certifications by professional staff at the HHA.

RATIONALE: During this emergency time, HHA personnel should be dedicated to direct patient care rather than paperwork. If licensed, professional clinicians can be trusted to provide care to their patients based on a physician's verbal orders, they can also be trusted to maintain accurate documentation of those orders to justify Medicare payment during this emergency period.

DRAFT LEGISLATIVE LANGUAGE ON STIMULUS 4.0 HOME HEALTH PRIORITIES

Telehealth

(A) Subsection (b) of Section 1135 of the Social Security Act (42 U.S.C. 1320b– 5) is amended by adding the following new paragraph—

"(9) in the case of home health services (as defined in section 1861(m)) furnished in an emergency area (or portion of such an area) during any portion of any emergency period that is declared by the Secretary as a public health emergency described in subsection (g)(1)(B) involving an infectious disease such as pandemic influenza or COVID-19 infection, section 1895(e)(1)(A) and (B) may be waived, as determined appropriate by the Secretary. The Secretary shall determine the manner and amount of payment for care provided by telecommunications through any reasonable method in consideration of the emergency."

(B) Section 1135 of the Social Security Act (42 U.S.C. 1320b-5) is amended by inserting "and shall permit such services to be provided by any health care provider as defined in subsection (g)(2)" after "1834(m).

Temporary Rate Adjustment

1. Stabilizing Rate Adjustment (if this route is chosen)

Section 1895(b)(3)(A)(iv) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)(iv)) is amended by adding at the end thereof---

"Notwithstanding any other provision in this Part, the Secretary shall increase the payment amounts set out in 84 Fed. Reg. 60478 (November 8, 2019) by 15% for home health services furnished during any portion of any emergency period that is declared by the Secretary as a public health emergency described in subsection (g)(1)(B) involving an infectious disease such as pandemic influenza or COVID-19 infection."

2. Rural Add-on

In general.--Section 50208 of the Bipartisan Budget Act of 2018 (Public Law) is amended in subsection (b)(1) by adding following paragraph (C) –

"(D) (1) Notwithstanding any other provision in this Part, the Secretary shall increase the payment amount otherwise made under such section 1895 for home health services furnished in a county (or equivalent area) in a rural area (as defined in such section 1886(d)(2)(D) by 3% during any portion of any emergency period that is declared by the Secretary as a public health emergency described in subsection (g)(1)(B) involving an infectious disease such as pandemic influenza or COVID-19 infection

Written Physician Certification and Plan of Care

Subsection (b) of Section 1135 of the Social Security Act (42 U.S.C. 1320b– 5) is amended by adding the following new paragraph—

"(10) in the case of home health services (as defined in section 1861(m)) furnished in an emergency area (or portion of such an area) during any portion of any emergency period that is declared by the Secretary as a public health emergency described in subsection (g)(1)(B) involving an infectious disease such as pandemic influenza or COVID-19 infection, any condition of payment or condition of participation that requires a written, signed and dated plan of treatment, orders for care, documentation of a face-to-face encounter, and certification of benefit eligibility may be waived, as determined appropriate by the Secretary, provided that the home health agency has documented the receipt of verbal orders for care and certification of benefit eligibility."

Personal Protective Equipment

"Sec. _____. For the emergency declared on March 13, 2020, by the President under section 501 of the

Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5191), priority status shall be granted to post-acute care settings and community-based settings including; home and community based services, hospice, home health, skilled nursing facilities, palliative care, and disability services providers to access personal protective equipment and related supplies, which are necessary for the delivery of health care services and long-term services and supports essential to protect patients, health care workers and communities, and for ensuring continuity of functions critical to public health and safety, as well as, economic and national security."