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
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

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
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

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
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?

Home Health Advocacy Priorities

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

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
Home Care Priorities

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

HEROES Act: Pending Legislation

• Provider Relief Fund Adds $100 Billion
• Medicaid
  – FMAP increase of 14%
  – MFAR block
  – HCBS 10% increase
• Accelerated and Advanced Payments
HEROES Act: Pending Legislation

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

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”
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

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
1135 Waivers: Home Health

- **484.65** Quality Assurance and Performance Improvement program (QAPI) (HH&H)
  - Focus on infection control
  - Adverse events
- **484.80(d)** 12-hour 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

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
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

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
**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 2-3 months—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?
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

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
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

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/
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

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
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

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
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

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
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)

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
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

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)
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

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
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

NAHC Advocacy Position

• Incentivize working
  – Frontline worker wages
  – Childcare support
  – Health care access
• Access to PPE
• Enhance Medicaid support for caregivers
• Liability protection
“Advocacy is for Everyone”

“Help Home Care & Hospice Communities Rise to the Challenge”

- **Four Key Priority Areas**
  - 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
“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/ expediency and efficiency
  - Minimal employee/employer burden
  - Minimize cash flow disruption

“Advocacy is for Everyone”

STEP ONE
Visit & Click on Featured Campaigns

STEP TWO
Enter Your Info & Click Send

STEP THREE
Share & Pass It On
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 ?????

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)
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

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
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
The Purpose

Quantifying hospice’s end of life impact

Hospice Market Challenges

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

Overall Cost Results
Overall Cost Results

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)

Inpatient Utilization
Inpatient Utilization

Hospice’s Impact on Inpatient Visits

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

ER / Observation Utilization

Hospice’s Impact on ER/Observation Visits
Hospice's Impact on End of Life Cost for Respiratory Patients

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