Centers for Medicare & Medicaid Services
COVID-19 Call with Home Health, Hospice and Palliative Care Providers
August 11, 2020
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Operator: This is conference # 5097566.

Alina Czekai: Good afternoon. Thank you for joining our August 11th CMS COVID-19 Call with Home Health, Hospice and Palliative Care Providers. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the Office of CMS Administrator Seema Verma.

Today, we are joined by CMS leaders as well as providers in the field who have offered to share best practices with you all.

First, I'd like to turn it over to Jean Moody-Williams from the Center for Clinical Standards and Quality for an update on the agency's latest guidance. Jean, over to you.

Jean Moody-Williams: Yes, thank you so much, Alina and hello everyone. Thank you for joining the call today. Just a few updates that I wanted to give you before we get to our guest speaker and also have the opportunity for a few questions for CMS or our speaker. I think since the last time that we met CMS did announce a payment is available for physicians and healthcare providers to consultations at the time of the coronavirus disease testing.

And this counseling you may find yourself providing – it's about the importance of self-isolation after they are tested and prior to the onset of symptoms. So, we know that the transmission of COVID-19 occurs from both symptomatic and pre-symptomatic and asymptomatic individuals. And so, it's really important to highlight or emphasize the importance of education on self-isolation of the spread of the virus and it can be reduced significantly while the patient is waiting for the test results.

And that's kind of the key here. The CDC model shows that patients who self-isolate, there can be up to an 86 percent reduction in the transmission of the virus compared to a 40 percent decrease in the viral transmission, if the person does not self-isolate. So, this payment depends on E&M code and is

reimbursed to any provider who's eligible to bill for those counseling services no matter where the test is administered including office or urgent care, hospital, community drive-thru testing site.

So, that was one of the updates. The other update, I just wanted to mention is kind of hot off the press. CMS announced today a new model, innovation model is the Community Health Access and Rural Transformation model that really is looking at providing access to 57 million Americans living in rural communities. And it really – this model aims to look at addressing disparities by providing a way for rural communities to transform their healthcare system leveraging innovative financial arrangement.

So, these models could increase financial stability for rural providers, it removes some of the regulatory burdens by providing waivers that increase operational and regulatory flexibility. It also enhances beneficiary access to healthcare services by ensuring that rural providers remained financially stable for years to come.

So, the model is – has a couple of tracks, one is called the community transformation track and that enables value-based payment models which are paid for quality and outcome and through the ACO track, Accountable Care Organization track.

So, I encourage you to please take a look on our website. You'll find more information about that, depending on your practice model, your business model. These opportunities that I mentioned may be available to you.

So, today we are really fortunate to have Dr. Keith Lagnese, who had over 25 years of healthcare experience with 20 years in hospice and end-of-life care. Currently, he serves as the Chief Medical Officer for the University of Pittsburgh Medical Center Family Hospice. And this is the largest not-for-profit hospital – I mean hospice, I'm sorry in Pennsylvania.

So, his responsibilities include oversight of hospice operations for UPMC and currently operates six licensed agencies with a combined average daily census of over 700 patients. So, quite busy and as always I like to thank those of you who are participating in this call for all the service that you are providing for

patients on a daily basis but in particular during this time of the – of COVID pandemic.

And I especially want to thank, Dr. Keith Lagnese for joining us today and I told him before we start the call that we look forward to his words of wisdom. So, I'm going to turn it over to you.

Keith Lagnese: Thank you, Jean, very much for that introduction and I want to say a special hello to fellow stakeholders and a special thanks to Alina as well from CMS who is part of this – organizing this event today.

I also recently served a position as the Medical Director of UPMC Home Healthcare as well. So, I feel like I have a pretty good pulse on what's happening certainly in Pennsylvania in the home health and hospice circles. I am, again, quite honored to be a part of this call today and I'd like to not only thank CMS but the National Hospice and Palliative Care Organization for this opportunity.

So as a regional hospice and home health provider, both CMS and NHPCO had been vital to navigating through this COVID-19 pandemic. Between the regulatory flexibilities that had been granted through waivers and rulemaking to the information that had been provided regularly from these organizations via podcast, webinars, e-mails and bulletins.

Getting regular and frequent accurate information has allowed us to stay on top of all the complex and rapidly evolving information sources. Furthermore, we thank CMS for addressing the needs of the patients and the families we serve.

Lastly, I've also like to mention our Pennsylvania State Hospice Organization, PHPCN is another very supportive resource during its very trying times. So, my employer is UPMC which is a very large health system that provides healthcare and insurance benefits predominantly in Pennsylvania but they also have facilities in Maryland, New York and even overseas.

It is the largest, nongovernmental employer in Pennsylvania with approximately 90,000 employees. Currently, UPMC operates six Medicare

licensed hospice agencies and seven licensed home health agencies predominantly in Western and Central Pennsylvania. In addition to over 700 hospice patients, we care for 7,000 home health patients on any given day. We provide care in urban and rural settings in over 40 counties in Pennsylvania and also operate two inpatient hospice units.

In regards to how COVID-19 has affected the state of Pennsylvania in the delivery of hospice and home care, we've seen up-to-date information, 120,000 confirmed cases in Pennsylvania with little over 7,300 deaths as of today. And unfortunately, nearly 5,000 of these deaths have occurred among residents of long-term care facilities.

There has been a predominance of prevalence in death in the eastern portion of our state centered around Philadelphia but we had recent resurgences in Western PA which has had to keep us on our toes to say the least. There was definitely a spike early on in March and April with some decline in May and June but we like many other parts of the country are seeing a resurgence, very much centered in not only young people but long-term care facilities.

Death rates have risen but they're still significantly lower than they were in Pennsylvania – in Western Pennsylvania earlier on in the pandemic. From a hospice provider perspective, we've actually been fortunate in many ways. Being part of a large healthcare delivery system, it has not been affected by COVID-19 like many of our colleagues and providers in urban New York as well as current areas like Texas, Arizona and Florida.

In fact at family hospice to date, we've only cared for a very small number of end-of-life COVID-19 patients, in fact three to be exact. On the home health side, we've cared for slightly over 80 patients and those are mostly recovering from the illness. Likewise, we only had a handful of staff who contracted COVID-19 and are very fortunate in this regard. We have had dozens who had been exposed and it required quarantining which is definitely been challenging at times from a staffing and HR standpoint.

In regards to patient census, both homecare and hospice have dropped about 10 to 15 percent, a little more in home health due to the canceled surgeries

when they were shutdown in April and early May. Fortunately, we've not had to furlough or terminate any staff to date and begun to see a rebound in both home health and hospice censuses.

In complying with the governor stay at home orders, most of our staffs have continued to work remotely from our administrative offices. All meetings from a leadership and interdisciplinary team perspective have been run virtually since March. This certainly has been a challenging transition for everyone but fortunately UPMC, it already invested heavily in our IT infrastructure, allowing for Microsoft Teams access for all staff.

This has allowed for live video interactions in a HIPAA compliant manner. Effective communication and support of all clinical staff has been imperative. Quick adoption of weekly town halls and daily information updates via UPMC Corporate Infonet had been vital at getting accurate information to all staff. Making sure staffs have remained, safe, educated and engaged remains one of our top priorities.

Although like many areas in our country, our healthcare system in region have experienced significant issues related to shortage and PPE in COVID-19 testing. Considering our large service area with multiple administrative office sites, one of the early things we initiated which has been extremely helpful was centralizing both inventory and distribution of all PPE supply chain at our 13 agencies.

This was an onerous manual process in order to provide for nearly 1,000 clinicians but it has worked well. We continue to adopt and implement all evidence-based masking requirements that have occurred at the system, local, regional and national levels. We are very fortunate that resources within the larger UPMC system have remained, able to meet our needs.

The ability to quickly implement technology for patient care in hospice and home care – in home health has been absolutely critical to continue to protect staff and patients during this pandemic. The declaration of a public health emergency by the administration in March as well as the recent extension as well as flexibilities of telehealth utilization by all disciplines and for the face-

to-face by CMS under Administrator Verma's leadership has allowed us to continue to provide high quality end-of-life care for our hospice patients.

Likewise, for home health, the flexibilities for the face-to-face encounter and homebound status criteria has also been critical for the safety of patients and staff and we remains grateful to CMS in this regard. Just as importantly, it has allowed our physicians, nurse practitioners, nurses, social workers, chaplain and bereavement staff to interact with our patients in a live video on-demand format.

We've also found remote monitoring to be beneficial in our COVID positive home health population with about 25 percent utilization which is significantly more than our non-COVID positive patient home health population. A remote monitoring has a separate call center and nursing support team for all enrolled home health and hospice patients. Granted, there remained barriers and limitation to all these technological methods of human interaction and healthcare delivery.

But, they continue to redefine how all us safely and efficiently provide for care of our most fragile and isolated patient populations. Considering that many more patients are now dying alone in hospitals and long-term care facilities due to COVID visitation restrictions, we have found virtual bereavement care to be vital to our community, particular for those who are not able to elect the hospice benefit.

Our bereavement staff had been extraordinarily busy but also a critical resource to our community and greatly appreciated by patients' families as well as facilities that lean on us for bereavement services. We are filling a gap as they really have nowhere else to go. The coordination and collaboration of care for our hospice patients who reside in nursing homes has never been more challenging than it is today during the pandemic.

COVID-19 continues to ravage our vulnerable patient populations in many long-term care facilities in Pennsylvania and throughout the nation. Despite declarations from the Pennsylvania Department of Health as well as CMS, the hospice and home healthcare workers are essential providers. And even when

our staff have the right PPE, it is unfortunate that fear and misinformation has led to poor decisions by long-term care facilities in regards to access for our staff.

And in more recent weeks as COVID is locally searched in nursing facilities, our staff have been expected to provide proof COVID negative personal results. This has required additional significant financial and operational burden as we balance caring for our hospice patients and such a tenuous environment.

Our procedural administrative task that our hospice agencies began early on has been keeping meticulous spreadsheets for all of our contracted nursing facilities where we provide care.

In regards to up-to-date visitation restrictions, current outbreaks and available technology for visiting our patients virtually, although extremely challenging and frustrating at times to keep this list accurate and up-to-date with our staff, it has allowed us to not discharge any hospice patients who reside in a long-term care facility due to inability to access as well as being able to provide appropriate oversight and update and appropriate hospice plan of care.

And lastly as we continue to evolve, each and every one of us during this pandemic, personally and professionally, it appears to be more likely that many of our current practices, both at the office and at the bedside, will indeed not be temporary. As hospice and home health providers, it is imperative that we continue to get the support for reimbursement and utilization of technology from CMS to provide safe and compliant end-of-life care for all of our Medicare beneficiaries. Thank you very much.

Jean Moody-Williams: Thank you for just a wealth of information. We really appreciate all that you brought to us. And the – interesting to hear how you've used technology in the virtual visit to meet the needs as well as some of the challenges, you continue to face. I know early on there were challenges as you work with the long-term care facilities. I thought those had started to kind of ease up a little bit but it sounds like there's still challenges that are out there that we need to address.

We have these provider calls with all settings and so I think we have one with long-term care facility in the next day or so, so we'll continue to stress the importance of access to residents and others to get the needed services. So again, thank you.

Let me open it up to see if there are any questions from anyone. Operator, could you please open up?

Operator: All right, so as a reminder to ask a question, you will need to press star one on your telephone. To withdraw your question, press the pound key. Again, that is star one on your telephone. Please stand by while we compile the Q&A roster.

We do have a question from Thomas Pryor. You are now live.

Thomas Pryor: Hello. Can you hear me?

Jean Moody-Williams: Yes.

Thomas Pryor: Thanks, Jean. Again, this is Thomas Pryor with the survey and cert team, hospice team lead. I was interested in hearing a little bit more from our presenter how they maybe trying to mitigate some of the challenges of access with long-term care. Have they found any certain techniques or communications or other things, guidance currently out there that have helped and mitigate some of that ongoing challenge?

Keith Lagnese: Yes, great question. Thank you very much, Tom. You know, basically keeping accurate lists because of how rapidly this information changes have been really key. So, knowing where our hot spots are, knowing where our biggest challenges are. An agency with our size having – in any given moment perhaps hospice patients in dozens of facilities, it's extremely important to know when we – when we can get in, how we can get in and if we can get in, who we contact, who are the right people, maybe the nurse.

And likewise when our staffs are at the doorstep and they have the right PPE and they have a negative test or whatever the facility is requiring and making sure that in a polite manner that the facilities are reminded that we are

essential healthcare workers. I think also knowing the technology available at the facility. We found that to be very challenging, like some facilities allow FaceTime and our agency has been unable to use that technology.

So although it's easy and accessible to a lot of different people, it's often required. I know one face-to-face encounter I did at a facility that was not allowing us to come in, even though they had no apparent good reason in my mind. They had no outbreaks and they had a recreation/activities person who had Vidyo and it was another technology platform that we were able to use and she assisted to kind of complete the face-to-face encounter.

So it's – I don't have any golden tickets or pearls, it just takes persistence and commitment to our patients and to working collaboratively with the facilities. Thank you.

Jean Moody-Williams: Great. Thank you for that. Do we have any other questions?

Operator: There are no any other questions on queue. You may continue.

Jean Moody-Williams: OK, great, thank you. Well again, thank you all for joining the call. We really appreciate your input and learning from each other and I'm going to turn it back over to Alina to close us out.

Alina Czekai: Great, thanks Jean and thanks everyone for joining our call this afternoon. As always, feel free to submit any questions or comments to CMS via our COVID-19 mailbox which is covid-19@cms.hhs.gov. Again, we appreciate all that you're doing for patients and their families around the country as we continue to address COVID-19 as a nation.

This concludes today's call. Have a great rest of your day.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

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