Centers for Medicare & Medicaid Services
COVID-19 Call with Home Health and Hospice
Moderator: Alina Czekai
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3:00 p.m. ET

OPERATOR: This is Conference # 9466917

(Alina Czekai): Hi. Good afternoon. Thank you for joining our April 14th CMS COVID-19 call with home health and hospice organizations. This is Alina Czekai, leading stakeholder engagement here in the office of CMS administrator, Seema Verma.

I'd like to first turn our call over to Jean Moody-Williams. Jean is the Acting Director here at CMS' Center for Clinical Standards and Quality.

Jean, I'll turn it over to you.

Jean Moody-Williams: Thanks so much, and hello, everyone. We welcome you, and again, thank you for joining today. We always – we never take for granted this time that you give to us, as we update you on a few of the things that we've been doing at CMS, and then, as well, we have an opportunity to share best practices, and we will have time for questions and answers, as well.

So, as you may have heard, as previously discussed, we have issued many blanket waivers, and we've created unique flexibilities over the last several weeks. I spent a good amount of time last week walking through many of the waivers, particularly as they related to home health and hospice. But last Thursday, we announced a few new blanket waivers, so I wanted to highlight those. They were in addition to the ones that we previously released, and several of which do impact this group, to help boost the frontline staff, professional staff, organize and look at the way you can most effectively manage the current COVID-19 cases.

So, within the hospice setting, we've made two important modifications. First, we will now allow the use of what we call pseudo-patients for hospice aide competency testing, which will speed the testing process and allow new aide to begin serving patients more quickly, without affecting patient health and

safety. So, prior to this, you had to be with an actual patient for observation, but we will allow, kind of, in the lab or wherever, the pseudo-patients for you to work with, to be able to hone your skills.

Second, we are waiving the 12-hour annual in-service training requirement for hospice aides, which will allow aides and registered nurses who teach the in-service training to spend more time delivering direct patient care, so, in other words, you don't have to – we know there are certain requirements. You don't have to pull the aide away, or pull the nurse away at this current time, to do an in-service training. And obviously, once this is over, we would expect training to occur.

We've also made a key modification for home health agencies. Specifically, we are allowing occupational therapists to perform initial and comprehensive assessments for all patients, so we're waiving the requirement that occupational therapists may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility for the patient to be receiving home health care.

So what this does, it allows OTs to perform, again, the assessments for all patients receiving therapy as a part of their plan of care, whether it is OT or not, and that will – the whole that is that we will get the process of getting home health care started faster. The first therapist that gets there can get it started, do the initial assessment. When the nurse – if there are certain things that the nurse has to do, that's still required, but at least we can begin the actual process of admission.

But even with these changes, we want to be clear that the occupational therapist still is not a service that establishes the eligibility. Those requirements still must be in place. Nevertheless, we do think this will greatly expand what a therapist can do.

We are eager as to hear your feedback on these new waivers for both hospice and home health settings, and as well, I'm sure, hopefully, you've been able to tune in to our office hours to ask questions about all of the other waivers,

because they are numerous now, and we have subject matter experts on those calls that can really address some of your issues.

So before I go to our speakers, I wanted to see if we have anyone else in CMS on the line. I think maybe Joan or (Cindy) might be joining us to address some frequently asked questions.

Were you able to join us yet, Joan or (Cindy)?

(Cindy): This is (Cindy). I'm on the line.

Jean Moody-Williams: Great. So why don't I turn it over to you first?

(Cindy): Sure, good afternoon. So, for hospice, I wanted to share that we are a pay-for-reporting program, and that there are inconsistencies between the March 22nd and March 27th memoranda, and people are asking which one to follow, and we're letting you know to please use the March 27 – the March 27th MLN for any inconsistencies between the two memoranda. The quarters are accurately stated in the March 27th MLN and repeated here.

For the hospice item set, the quarters are based on submission of the hospice item set. For the admission and discharge assessments, and for the caps, the quarters are based on patient (deaths) in 2019 and 2020. So those quarters for the Hospice Quality Reporting Program are quarters four of 2019 through quarter two of 2020, which is October 1st of 2019, through June 30th of 2020.

Providers who do not submit data for those quarters, that cover that timeframe of October 1st 2019 through June 30th 2020, will not have those quarters used when determining compliance of meeting the Quality Reporting Program requirements, that can result in the 2 percent annual payment update penalty.

We are also receiving many questions about the hospice item set, and whether telehealth visits count for completing data for section O, that relates to the Hospice Visits when Death is Imminent measure for the multi-disciplines included in that data, and please be assured, we are actively addressing this issue, and we are going to be providing additional guidance very soon.

And with that, I'll turn it over to Joan Proctor for the home health update.

Jean Moody-Williams: I'm not sure if Joan was able to get in, but we'll check (it out, if we're) ...

(Cindy): I can – I can – if you'd like, I can – so we are – I can do the home health update for Joan. She shared it with me – until she addresses the technical difficulties. So, we are receiving inquiries relative to the Home Health Quality Reporting program, and wanted to clarify a few things there.

Is CMS allowing 30 days for the completion of the comprehensive assessment, or are you allowing 30 days for the transmission of OASIS? And CMS is providing relief to home health agencies on the time frames related to OASIS transmissions, through the following – one, extending the 5-day completion requirement for comprehensive assessments to 30 days and, two, waiving the 30-day OASIS submission requirement. (Delayed) submission is permitted during this public health emergency.

Two, home health agencies have asked targeted questions relative to the exception applied for the Home Health Quality Reporting program. CMS would like to take this opportunity to clarify the exceptions being applied to the Home Health Quality Reporting program. In exempting all home health agencies for the reporting requirements, the data will not be subject to the 2 percent annual payment update penalty. Providers who do not submit data for those quarters will not be impacted by the 2 percent annual payment update penalty. October 1st, 2019 through June 30th, 2020 is the time period covered.

Does the exception granted by the Home Health Quality Reporting program waive the submission requirements of OASIS data required for the home health Medicare payment? And the response is no. A waiver has not been granted for this requirement. Home health agencies must submit OASIS data during the exemption period, prior to submitting their final claim, in order to receive Medicare payment.

There is no waiver granted relative to submission requirements for home health Medicare payment. This guidance has no impact on programs like home health, where the OASIS instrument was not waived. Because the system requirements apply to OASIS by the data submissions system, home

health agencies must submit a complete OASIS assessment for payment of Medicare claim.

The next question that we've been receiving is has CMS approved the submission of an abbreviated OASIS assessment? And CMS has not approved the submission of an abbreviated OASIS assessment. We are aware that there is language on our website relative to the types of relief CMS could provide home health agencies under the 1135 waiver authority. However, those are examples of the application of the policies, and are not being applied by CMS for the public health emergency.

And then lastly, providers recognize that home health does not need to submit data, January 1st 2020 through January 30th of 2020 for purposes of quality reporting. How do we ensure our data is not being utilized for the quality reporting during this time? And at this time, we are still determining how to most appropriately handle the public display of quality data that includes these exemptive quarters of data, and additional guidance will be forthcoming.

And with that, I'll turn it back over to you.

Jean Moody-Williams: Thank you, and we appreciate you sending in your questions, so that we can really try and get the best information out to you that we can.

So with that, I would like to turn it over to our first speaker, who will talk about some of the things that are going on in the industry, Mr. Brent Korte from EvergreenHealth Home Care. He is the Chief Home Care Officer.

Brent Korte: Hi, everyone. My name is Brent Korte. I'm joining the call from Kirkland Washington, so in the great Pacific Northwest. EvergreenHealth is a system based home health and hospice provider, with approximately 2,000 patients on census per day. At least, that was our census pre-COVID. We happened to have the first death in the United States at our system's primary hospital in Kirkland, which allowed for us to really be indoctrinated into having to prepare for COVID-19 very quickly, late in the evening on February 28th.

I'm going to quickly go through a couple of points of advice, as I know time is limited. I'm going to start by talking about PPE, and go down to two main

things. One, PPE procurement clearly is obviously very important. It's obviously very important, and I know that other folks have different challenges, and another speaker, Ken Albert, is going to be talking possibly about procurement issues that have come up.

The other one is conservation. We worked as hard, if not harder, on conserving our PPE, surgical masks in particular, as we did at procuring it. So, a strong consideration around making very difficult choices on how to conserve the PPE that you have. The mantra that we continue to explain to our staff is that, would we rather be overprotective for two weeks, or aptly protected for a month, or for two months, or throughout the entire experience of COVID.

The next one is leadership alignment. So, alignment is critical. Wisdom is defined as knowledge, good judgment, and experience, and none of us have experience with this, so we have to rely on our knowledge, and hopefully, our good judgment. What we have found is that getting your team together, your leadership team together to discuss their approach – what they feel that their approach should be, what the team's collective ethic is around how we're going to not only provide care for these patients, but ask our clinicians to go into the line of fire, and put themselves and their families at risk by providing this care.

It's important to have that honest conversation before, if possible, before it hits you now. For many of us, it has already hit our communities, so at that point, it's probably too late, but we highly recommend that you have those conversations.

The next bit of advice I have is relying on science for decision making. Public health officials are highly trained. This is what they do, and we have worked very hard to encourage our staff and ourselves to rely not on news media or spin, but more importantly, public health and medical advice. So our off-the-cuff advice has been, if the individual on television has a white coat on, then you should probably listen to them. If they're from public heath, we should probably listen to them, and make decisions in that regard.

The other bit is, after we make decisions based on science, there's really a lot of compassion for your staff and your patients. There's a lot of fear out there. Everyone on this call is probably experiencing some level of fear, and we are likely more informed than the general community that doesn't work in healthcare. So it couldn't be more important for us to make sure that we go at this with compassion and understanding with our staff.

Two more points. One, communicate, communicate, communicate. We highly recommend that you find multiple ways to communicate with your staff, with the community, with your patients, and do it often. People are consistently asking questions, very often the same questions, and it couldn't be more important that you keep in touch with folks via email. We're holding weekly town halls, and I can tell you that as a leader of about 600 folks, staff members for our home care operations, that any time I've been reached out to individually, they've received a call or an email from me directly, just in order to make sure that folks go supported.

We also are fortunate. As a home health and a hospice provider combined, we are fortunate to have an excellent spiritual care team, and our spiritual care professionals have been reaching out. Our chaplain team effectively have been reaching out to our entire staff, and now they've actually spoken with every one of our 600 staff members, just to check in on them, and that's been quite helpful. It's also been a way for us to learn how people are feeling.

In the last 30 seconds, I just want to emphasize that our perspective at EvergreenHealth, in Washington, has been that we have to protect our staff first. We are fortunate to have an absolutely amazing and excellent care team of 600 folks out in the community, people supporting, of leaders, physicians, and if we don't protect them, they can't protect our community, so that's been our main focus.

And those are my comments.

Jean Moody-Williams: Thank you, Mr. Korte, and that was great getting information. I can remember that February 28th day myself. I think we were all called to action, so we really appreciate all that you have been doing, and particularly your

emphasis on the people that you are working with, to ensure that they are protected and safe. With that, I'd like to turn to Mr. Ken Albert, who is the president and CEO of Androscoggin Home Healthcare and Hospice. I'm not sure if I've pronounced that correctly.

Ken Albert: You did a pretty good job. Hello, again, I am Ken Albert. I'm the president and CEO of Androscoggin Home Healthcare and Hospice, which is located in central and western Maine. We are an independent home care and hospice that affiliates with six or seven hospitals and systems in our state to provide home healthcare and hospice services, with a census of about 2,200 on a daily basis, and that's with a staff of about 480 to 490 folks.

Again, I agree with Brent's comments around advocating for your staff aggressively, and ensuring that they have the right amount of communication that they need. I think one of the things that I've heard from providers across the country is – a lesson learned is that they've over-communicated, and so you've got to be able to manage the communication effectively, both in volume and in substance, and it should be a consistent, routine communication that your staff are familiar with receiving.

When I say advocacy, I also mean knowing who your local state and federal officials are that you need to be in communication with, advocating certainly for changes to CMS, changes at the state level, waiver opportunities, and also advocating for the distribution of PPE within your states, ensuring that home care and hospice providers are clearly articulated for within emergency management agencies as recipients of PPE, as it is being distributed out there. Also tap into your normal supply chains for PPE and make sure that you're understanding what your par levels need to be, based on your volume and based on your burn rate. That's critically important.

Again, to support our staff as a number one priority. Clinically, I would also add that we need to focus on some screening opportunities. We need to make sure we have the right team members on our COVID treatment teams. Currently in Maine, we are taking care of more patients in the home and community based settings, who are COVID positive or PUIs. They are now currently being cared for in the hospital setting, and so we need to make sure

that our care teams are coordinated well with other providers in the healthcare continuum, most notably our long-term care settings and our acute care hospital settings. Triage protocols are important.

Another area I'd focus on is access to your patients, so we know, as home care and hospice providers, that fear does exist. It exists, I wouldn't say as a strategy, but certainly for our patients in their home. Navigating communication with patients and their families about the lengths to which we are going to maintain infection control practices is critically important for their wellbeing, for their understanding about the care we are delivering.

Also, with facilities, we've heard nationally that access to patients in facilities is getting very tough, as facilities are trying to prevent the transmission, which you certainly understand. At the same time, this is a Medicare or Medicaid benefit, which the individuals are eligible for, and we need to ensure that we are advocating for appropriate access to patients to provide those care and services.

So, finding ways to partner and maintain open lines of communication is critically important with facilities. For example, today, we did a go-to meeting with 10 or 12 of our larger facility based referral sources, and met with the Director of Nursing, and administrative leadership, just to talk about ways that we could collaborate to manage the care of patients in their facilities.

I also want to touch briefly on some financial aspects. You have to be monitoring waivers that are coming out, and making decisions, whether or not they are voluntary or they are mandated, and then, ensuring that your workflows are adjusted accordingly. You've got to create a tool that's monitoring those waivers, so that you can effectively communicate workflow changes out to the appropriate workforce.

I also think you've got to have a good financial dashboard, looking at metrics to make sure that your financial wellbeing is in order, as well. You've got to be looking at day's cash-on-hand, you need to be looking at visit volumes by discipline, both in home care and in hospice. For home care, you've got to be looking at your LUPA trends, at your percentages. Some companies are

spiking up to 30, 40, 50 percent LUPA rates right now. You've got to be designing strategies to ensure that the visits that are ordered and are authorized, are being delivered in the home.

You have to be looking at telehealth strategies, as well. I appreciate everything that CMS is doing around expanding telehealth services and opportunities, and I would encourage CMS to continue to do so. You need to be looking at days on RAP. Also be watching your earn time utilization in comparison to your overall staff capacity, and make sure that the federal and state opportunities for emergency leave are being employed appropriately within your organization.

If the payroll Paycheck Protection Program is applicable to you, under the small business administration – it was for us. We took advantage of that. I would strongly encourage you to do so. And also defining a compliance plan around the stimulus distribution under the CARES Act, ensuring that you are compliant with all of the reporting requirements, the spending requirements, specifically for COVID-19, and ensuring that those dollars are being monitored and expended in a way that can be reported appropriately to the secretary of HHS.

So, overarching, I would say that the two things we are – I'm also a former public health official, and we know that in a public health crisis, there are some really important strategies to employ, and that number one is communication, so effective communication. We've hit on that a couple of times.

The other is compliance. As workflows change, having a centralized repository of all communication that staff can go to to re-evaluate prior communications and updates is really important, and setting workflows in place to ensure that any changes we're making are – that we can create a culture of compliance around both clinical and financial opportunities to manage more effectively in this pandemic.

Jean Moody-Williams: Thank you so much. That was a lot of information in a short period of time, and I think one of the overarching things that we heard with both

presentations is, you can't communicate enough, so appreciate that. Let's take a few questions. Operator, if you can open up the line for questions.

Operator: At this time, if you'd like to ask a question, press "star" followed by the number "1" on your telephone keypad, and that's "star" followed by the number "1" to ask a question, and we'll pause for just a moment. And our first question comes from (Sheila Clarke). (Ms. Clarke), your line is open. Please go ahead.

(Sheila Clarke): Good morning, and thank you for all you are doing for us and our patients and families. I'm calling regarding a follow-up on the face-to-face visit recertification by a physician or a nurse practitioner. The guidance that we've received so far is that this visit is to be done via telehealth, which is voice and video. Is that still the case?

Jean Moody-Williams: So, it can be done. It doesn't have to be done, obviously, that way. Also, we have been including telephone as a part of our telehealth.

(Sheila Clarke): So to clarify ...

Female: (Inaudible). Sorry, Jean, I'm going to jump in. So the face-to-face recert for a hospice physician or a nurse practitioner, that, for right now, has to be done via the two-way audio-visual with real-time interaction between the patient and the clinician, by virtue of this thing called the face-to-face encounter requirement.

(Sheila Clarke): I understand. Thank you for that clarification. So, to follow-up and ask an additional question, the updated comprehensive assessment and the initial assessment can be done voice-to-voice. Is that correct?

Jean Moody-Williams: I don't know the answer to that. Does someone on the line have that answer? If not, we will have to get back to you.

(Danielle): This is (Danielle). I can take it. The CoPs don't have a specification of how any visit or interaction must take place. The requirements really look to the fact of, can whatever method you are using actually do the job at hand, so can

it provide you with all of the information that would be required as part of a comprehensive assessment, or as part of an updated assessment.

And that's really going to be an individual decision that's based on your technology capabilities, the patient's technology capabilities, the status of the patient, and what's going on with them, and what their needs are. So there is no simple yes or no answer there. It's a possibility, but it's going to depend on the unique circumstances.

(Sheila Clarke): Absolutely, and I understand that, and I should have prefaced with, if it's what best for the patient and the family. And again, I appreciate all you are doing and all of our California providers. Thank you so much.

Jean Moody-Williams: Thank you. We have time for one more question, please.

Operator: Our next question comes from (Christopher Toflemedo).

(Christopher Toflemedo): Good afternoon. Two questions, but one, since it's clear that the assessments can be done via telehealth in hospice, and thank you for the last answer. Does that also apply to the home health assessments for the comprehensive assessment and assessment updates? And the second question is, I know many of the physicians in the part B service world have received some of the stimulus payments directly into their bank accounts. On behalf of them, thank you so much. Are hospices eligible for that, and will they start to see payments?

Jean Moody-Williams: Sure, I'm not sure if we have anyone that can answer the stimulus question, but let's go back to the home health. Do we have anyone on the line that can address that?

Ken Albert: This is Ken. I can say that the stimulus – when I was talking about the CARES Act, and having a compliance plan for the stimulus, that is exactly what I'm talking about, so as a provider, we have received our portion of that stimulus, and it's ensuring that we have a compliance plan around spending that down and reporting based on what the requirements are to the secretary of HHS.

(Christopher Toflemedo): Wonderful. Good to talk to you, Ken. And for the home health assessments, comprehensive assessments and assessment updates, are we able to use telehealth – I understand that that means real-time audio-visual – for home health?

Ken Albert: I'm not aware that we have been approved under CMS for the use of telehealth for that purpose as of yet. It is definitely a strategy that we're discussing at the national level, though.

Jean Moody-Williams: Again, tune in to our office hours. We have new information coming out almost daily, and telehealth is one of the main topics, so we are working on additional guidance to get out to everybody on that. So, with that, I want to turn it back to Alina to close this out.

(Alina Czekai): Great, thanks Jean, and thanks, everyone, for joining our call this afternoon. As Jean mentioned, we are continuing to host office hours every Tuesday and Thursday at 5:00 p.m. Eastern, and that's an opportunity for you to ask questions of all of our CMS subject matter experts, as it applies to the many guidance and new flexibilities, as we address COVID-19.

So I appreciate everyone's time. Have a great rest of your afternoon. Thanks again.

Operator: Thank you for joining today's conference call. Thank you for your participation. You may now disconnect.

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