A free weekly digest of COVID-19 news and actionable guidance for home health, hospice, and personal care providers

WellSky

Tuesday, May 12, 2020

The WellSky **COVID-19** Weekly Briefing

by **Sharon Harder**
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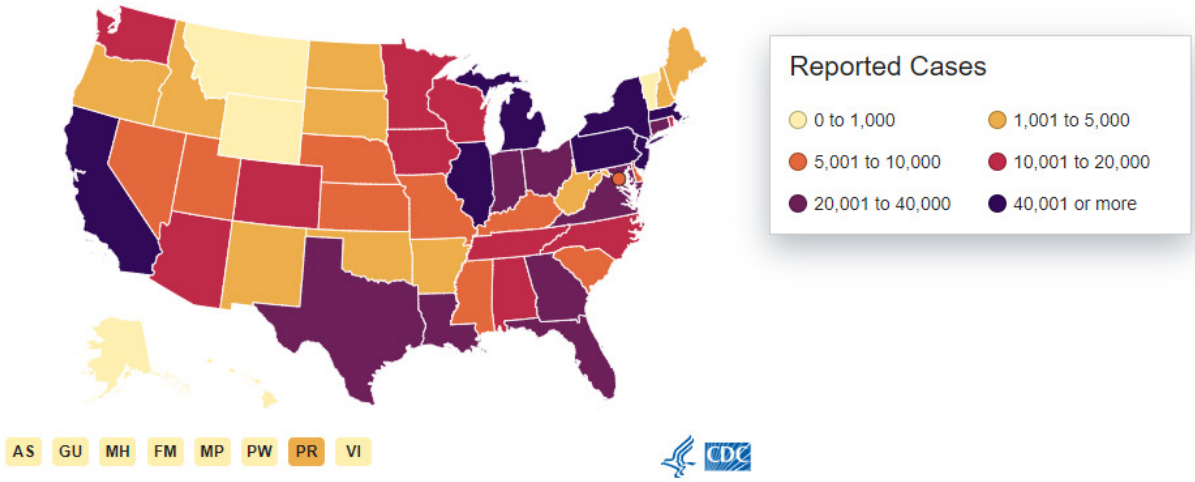
As we go to press for our eighth week of reporting, COVID-19 cases in the U.S. have passed 1.3 million, and deaths now exceed 79,000, up by 11,000 since last week. Widespread testing is finally occurring in all 50 states. As frontline workers have contracted the disease in growing numbers, we learned over the weekend that high ranking members of government are not immune. Three White House Coronavirus Task Force members — Dr. Anthony Fauci of the National Institutes of Health (NIH); Dr. Robert Redfield of the Centers for Disease Control (CDC); and Dr. Stephen Hahn of the Food and Drug Administration (FDA) — have self-quarantined due to exposure concerns. The president and vice president have not.

COVID-19 Cases as of May 11, 2020



Source: https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

Please note

As fears of the disease continue, many people who need care are foregoing it or being sent home from hospitals pending confirmation of test results. It is now common to see public service announcements urging people who feel sick to seek medical attention. Still, in some states including Florida, a surprising number of people have been found unresponsive and deceased at home. Medical examiners have reported that at least 1,600 Florida deaths were older people who died in their residences.

In the meantime, the news about the progression of the virus across the U.S. depends on location. Twenty-eight states have more than 10,000 confirmed cases of COVID-19 and only two — Montana and Wyoming — have fewer than 1,000 people infected with COVID-19. The eastern third of the country has been the hardest hit by COVID-19. However, there are new concerns about some areas in the Midwest, where cases are growing at an alarming rate. Des Moines, Iowa; Lincoln, Nebraska; and St. Cloud, Minnesota are three such areas where case numbers are rapidly rising. Conversely, the case count and mortality rates improved in Miami, Detroit, and New Orleans last week. Four states — Alaska, Hawaii, Vermont and Montana — are reporting very few new cases. Three major cities — New York, Los Angeles, and Chicago — still have a steady stream of new cases each day, although deaths are slowly declining. Even though things are getting much better in New York City, it still reports the largest number of new cases on most days and the highest death rate from the virus. It can sometimes be difficult to sift through all the media reports, most of which are alarming, but as we examine the data, things appear to be improving. The following table shows the case count and mortalities each week for the last two months of our reporting (with values pulled from reports by USA Facts [https://usafacts.org]).

Count of COVID-19 cases and deaths

Date	Total Cases	Weekly increase (cases)	Deaths	Weekly increase (deaths)
3/17	6,347	0	115	0
3/23	43,949	592%	561	388%
3/30	163,756	273%	3,045	443%
4/6	335,506	105%	9,620	216%
4/13	578,566	72%	22,874	138%
4/20	776,842	34%	42,032	84%
4/28	1,006,470	30%	57,784	37%
5/4	1,173,218	17%	67,922	18%
5/10	1,301,708	11%	78,110	15%

As reported last week, nursing homes are now required to report COVID-19 statistics to the CDC, even though more than a dozen states are still not reporting on statistics related to residents of long-term care facilities. AARP reported last week that, at last count, 16,000 nursing home residents or staff members have died from COVID-19. And although states are required to report cases and deaths, and facilities are now required to notify families about

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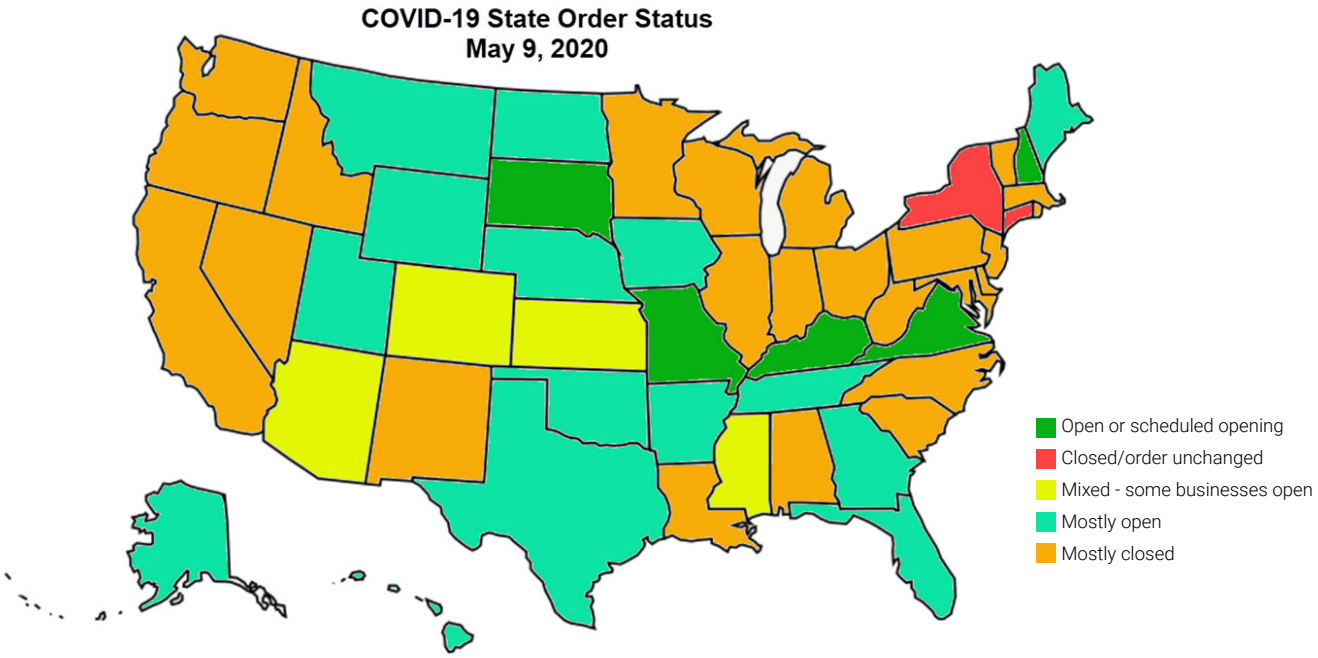
new infections, they are not required to make the information public. Even so, it's clear that a significant percentage of COVID-19 mortalities are among residents of nursing homes.

Reopening state and local economies has been a significant topic of discussion all week and promises to be front and center for the coming days. Many states have relaxed at least some of their stay at home orders. The map below shows the status of state closures and full or partial reopening trends.



The Institute for Health Metrics and Evaluation (IHME) at the University of Washington released its latest report on May 10 suggesting that, as states relax stay at home orders, mobility will be a factor in increased transmission of the virus. IHME is now estimating that, on the low end, a total of 102,783 individuals could perish from the virus between now and early August. Six states to watch, according to IHME, are Arizona, Florida, California, Mississippi, Missouri, and Connecticut. The reasons are displayed in the table below.

	Deaths per CDC 5/10	IHME projected thru 8/4	Rate of increased deaths
Arizona	191	2,987	1464%
Florida	1,715	5,440	217%
California	2,678	6,086	127%
Mississippi	430	1,236	187%
Missouri	472	1,984	320%
Connecticut	2,932	4,575	56%

The takeaway is this: We are not out of the woods yet, and there will be plenty of COVID-19 work for home health and hospice providers to do — at

least through the end of the year and likely well beyond. As elective surgeries resume in many states, we expect that census numbers will gradually pick back up, too, so that will be a welcome sign. As to when the public health emergency will end — it's anyone's guess. I have no reasonable idea, but I can safely predict that regardless of when that happens, the work of caring for patients with this disease will continue for some time to come.

Finally, before we go on to other news and COVID-19 developments, I thought our readers might be interested in an epidemiological account of the 1918 flu (sometimes called "the Spanish flu") that killed an estimated 675,000 U.S. citizens between 1918 and 1919. You've probably heard the media referring to it in the context of reopening plans for many cities because this version of the flu was even more lethal in its second eruption. The article was published in the Journal of Translational Medicine in 2004 and it can be found here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC340389/.

The outbreak of COVID-19 has often been compared to the 1918 flu. Here is what you may not know. The origin of the flu was finally traced to Haskell County, Kansas and visiting soldiers assigned to the Camp Funston army base (now known as Fort Riley). These soldiers are now thought to have carried the virus to other parts of the world during World War I. Thus, it was not China or France as initially theorized, but the U.S. that was the origin of this particular pandemic. As the article's author observed back in 2004, "if the virus did cross into man in a sparsely populated region of Kansas, and not in a densely populated region of Asia, then such animal-to-man crossover can happen anywhere. Unless the World Health Organization (WHO) gets more resources and political leaders to move aggressively on the diplomatic front, then a new pandemic really is all too inevitable." We now know that the prediction was all too true.

COVID-19 NEWS

Unmasked part 2: FDA withdraws approval of certain respirators

Last week, I wrote about the discovery that some of the personal protective equipment (PPE) coming into the U.S. was found to be inferior. Here are some additional things that home health and hospice providers should know about PPE:

- **The cost of N95 and KN95 respirators has grown by an estimated 1,500%.** Gowns and face shields have also seen similar price jumps.

- **Many providers are now admitting that they are talking to just about anyone with a claim of supplies to sell.** A recent story in Skilled Nursing News chronicled a very reputable nursing home's contacts with "Parking Lot Guy" as its most reliable source of PPE. State governments have done similar things, delivering multi-million-dollar checks intended for supplies to middlemen in parking lots, as well as chartering flights from Asia loaded with PPE, some of which has turned out to be of very inferior quality.

Last week, the U.S. Food and Drug Administration (FDA) stepped in and withdrew approval for 60 Chinese manufacturers' N95 and KN95 masks, citing them as low-quality products. The National Institute for Occupational Safety and Health (NIOSH) found that about 60% of 67 different types of masks allowed penetration of significantly more particulate matter than U.S. standards allow. Some of the companies exporting product into the U.S. were also using unauthorized FDA logos to suggest that the masks meet U.S. standards.

Here is the list of **approved manufacturers of FDA authorized respirators**. Agencies should check their current supplies against this list and consider discarding respirators from China that are not listed here.

Manufacturer	Respirator Model(s)	Country of Manufacture
3M	9001, 9002, 9501, 9501+, 9501V+, 9502, 9502+, 9502V+, 9505, 9541, 9541V, 9542, 9542V, 9552, 9552V	China
AOK Tooling Ltd. (aka Shenzhonghai Medical)	20130040, 20130045A, 20180021, 20130038, 20190019	China
Bei Bei Safety Co. Ltd.	B702, B702V, B704, B704V	China
BYD Precision Manufacture Co. Ltd.	BYD KN95 Particulate Respirator (Model Number DG3101)	China
Fujian Kang Chen Daily Necessities Co. Ltd.	K0450, 57793	China
Guangzhou Harley Commodity Company Limited	L-103V KN95	China
Guangzhou Powecom Labor Insurance Supplies Co. Ltd.	KN95	China
HeiQ Materials AG	HVB-FFP2-01	China
Hangzhou San Qiang Safety Protection Products Co. Ltd.	9420 (FFP2), 9420V (FFP2), 9480 (FFP2), 9480V (FFP2), 9980V (FFP3), 9920V (FFP3)	China
Rizhao Sanqi Medical & Health Articles Co. Ltd.	RIZ100CVb, 3Q KN95, 3Q FFP2 NR, RIZQ100Sb, 3Q KN95 9505	China
Shangai Dasheng Health Products Manufacture Co. Ltd.	DTC3X-1, DTC3X-2, DTC3X-3, DTC3B-1	China
Suzhou Bolisi Medical Technology Co. Ltd.	BS-9501L, BS-9501FL, BS-9502C, BS-9502FC	China
Suzhou Sanical Protective Product Manufacturing Co. Ltd.	Model 8015, Model 9015	China
Weini Technology Development Co. Ltd.	RRP2 NR E-300, FFP2 NR E-680, FFP2 NR 952, FFP2 NR F-820	China

CMS & home-based outpatient services

In the COVID-19 Interim Final Rule with Comment (IFC), the Centers for Medicare & Medicaid Services (CMS) noted its intention to offer flexibility to hospital outpatient clinics for delivery of services to patients in their homes during the public health emergency. The rule establishes a patient's home as an offsite location of the hospital's clinical department. However, only registered outpatients would be able to receive care provided by the hospital team at home. These services cannot be extended to patients who are already being served by a home health agency and home health agencies are also precluded from admitting patients being cared for at home by the hospital's outpatient department. There certainly could be an element of competition for the same patients here as long as the patients themselves are considered technically homebound.

Below is the applicable excerpt from the rule. The National Association for Home Care & Hospice (NAHC) would like to know of agencies' experiences and opinions related to this change.

> **"Hospital In-Person Clinical Staff Services in a Temporary Expansion Location (which may be the home).** Hospitals also provide services that are furnished by clinical staff under a physician's or qualified NPP's *[non-physician practitioner's]* order that do not require professional work by the physician or qualified NPP, and thus, are billed only under the OPPS *[outpatient prospective payment system]* when furnished by the hospital and are not separately billable under the PFS *[physician fee schedule]*. Wound care, chemotherapy administration, and other drug administration are examples of these types of services.
>
> This flexibility enables hospitals to furnish these clinical staff services in the patient's home as an outpatient PBD *[provider-based department]* and to bill and be paid for these services as HOPD *[hospital outpatient department]* services when the patient is registered as a hospital outpatient. Because these services have to be provided in person by clinical staff, these services cannot be furnished by telecommunication technology by the hospital. In these instances, hospital clinical staff must be physically present in the patient's home or other temporary expansion location.
>
> Importantly, during the time period that the patient is receiving services from the hospital clinical staff as a registered outpatient, the patient's place of residence cannot be considered a home for purposes of home health agency services. This is because home health agencies cannot bill for services furnished in PBDs of hospitals and a patient's home has provider-based status when the patient is a registered hospital outpatient and HOPD services are being furnished.

The hospital should be aware if the patient is under a home health plan of care, it must not furnish services to the patient that could be furnished by a [home health agency] while the plan of care is active. That is, to the extent that there is some overlap between the types of services an [home health agency] and a HOPD can provide, and the patient has a current home health plan of care, the hospital should only furnish services that cannot be furnished by the [home health agency]."

"Hospital Services Accompanying a Professional Service Furnished Via Telehealth. For many professionals, the HOPD is the usual location where they furnish services. For the duration of the COVID-19 PHE and effective March 1, 2020, when a practitioner who ordinarily practices in a HOPD furnishes a telehealth service to a patient who is located at home (or otherwise not in a telehealth originating site), they would submit a professional claim with the place of service code indicating the service was furnished in the HOPD."

COMPLIANCE HIGHLIGHTS

Waiver update

Late Friday CMS updated the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf) to include physical therapists and speech language pathologists among those who can provide the home health initial and comprehensive assessments even when nursing services are contemplated along with therapy. Here is the amended language:

"Allow Occupational Therapists (OTs), Physical Therapists (PTs) and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients (revised). CMS is waiving the requirements in 42 CFR §484.55(a)(2) and §484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary blanket modification allows any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the

extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. The existing regulations at §484.55(a)(2) and §484.55(b)(3) would continue to apply; rehabilitation skilled professionals would not be permitted to perform assessments in nursing only cases. We would continue to expect HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible.Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice. Expanding the category of therapists who may perform initial and comprehensive assessments provided HHAs with additional flexibility that may decrease patient wait times for the initiation of home health services."

Additional waiver information was offered for hospice inpatient units as follows:

"Multiple Providers: Specific Life Safety Code (LSC) Waiver Information: CMS is waiving and modifying particular waivers under . . . §418.110(d) for inpatient hospice... Specifically, CMS is modifying these requirements as follows:

- Alcohol-based hand rub (ABHR) dispensers: We are waiving the prescriptive requirements for the placement of alcohol-based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area.

In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by §418.110(d)(4).

- Fire drills: Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area.

- Temporary construction: CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients.

Provider relief funds: Part 3

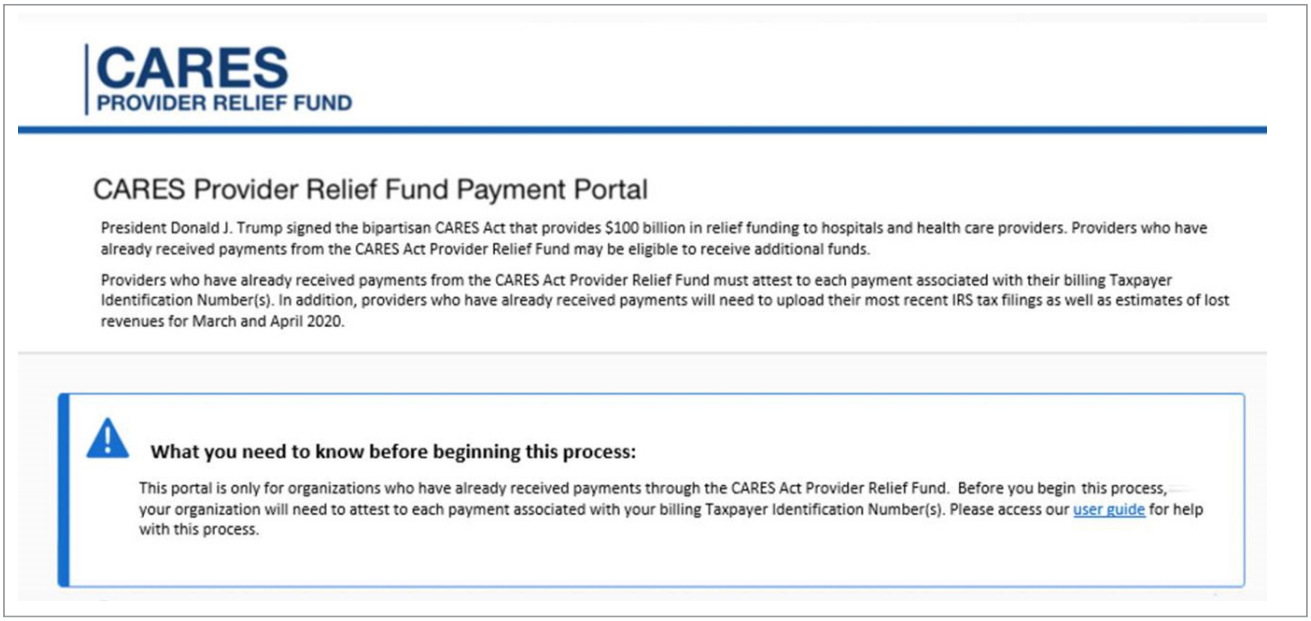
New FAQs and funding formula changes

One reader kindly brought to my attention last Friday afternoon an experience that she had with a representative of UnitedHealth Group (UHG) on the subject of the provider relief funds her agency received. She indicated that the advice she received from the UHG representative was contrary to information that she read in last week's briefing. I can appreciate her confusion and concern because this is yet another area where the guidance seems to be shifting significantly from one day to the next. In fact, since last week's briefing, new information has emerged. Here is what we know based on guidance from NAHC and revised FAQs related to the Provider Relief Fund. The May 6 version of the U.S. Department of Health and Human Services (HHS) FAQs can be found at https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

Early last week, I indicated in the briefing that "it appears that there may be some discrepancy between the instructions that appear on the portal [the CARES Act Provider Relief Fund Payment Attestation Portal] and what the Department of Health and Human Services intends." Indeed, the portal indicated last week that providers should not "attest if the payments you have received already exceed your estimated total allocation [under the revised formula]. Please contact the CARES Provider Relief hotline at (866)569-3522 if you believe you have received an overpayment."

What we now know is that last week Bill Dombi, president of NAHC, was in discussions with HHS Deputy Secretary, Eric Hargan, in which Hargan "confirmed that HHS does not intend to take back any of the funds from the first distribution based on the calculation determined under the second formula. Instead, any take back would be limited to a later reconciliation based on the provider's use of the money." Also, Hargan indicated that the reference to the overpayment in the attestation portal was meant to address situations "where the provider knows that the fund distribution was in error." For example, an error related to data input of 2019 Medicare reimbursement. Hargan also indicated that HHS would be issuing additional FAQs to clarify the situation.

Mid-week, the information on the portal changed again. The message we saw early in the week about calling the hotline had been removed. Also, the landing page for the relief fund (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html) now shows that the attestation timeframe has been moved to 45 days.



Late in the week, we found newly minted FAQs with additional information added on May 6, 2020. You can read the FAQs at https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. There are three "new" questions/answers that home health and hospice providers should know.

Question: What should a provider do if a general distribution payment is greater than expected or received in error?

Answer: Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions with 30 days of payment (note the change to 45 days was apparently made without updating the FAQ). Generally, if a provider does not have or anticipate having COVID-related lost revenues or increased expenses equal to or in excess of the relief payments received, they should return the funds. If a provider believes it was overpaid or may have received a payment in error, it should reject the entire general distribution payment and submit the appropriate revenue documents through the general distribution portal to facilitate HHS determining their correct payment. If a provider believes they are underpaid, they should accept the payment and submit their revenues in the provider portal to determine their correct payment.

Question: Does HHS intend to recoup any payments made to providers not tied to specific claims for reimbursement, such as the general distribution payments?

Answer: The Provider Relief Fund and the Terms and Conditions require that recipients be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have

been reimbursed from other sources or that other sources are obligated to reimburse, exceed total payments from the Relief Fund. Generally, HHS does not intend to recoup funds as long as the provider's lost revenue and increased expenses exceed the amount of the Provider Relief funding a provider has received. HHS reserves the right to audit Relief Fund recipients in the future to ensure that this requirement is met and collect any Relief Fund amounts that were made in error or exceed lost revenue or increased expenses due to COVID-19. Failure to comply with the Terms and Conditions may also be grounds for recoupment.

Question: What is the definition of individuals with possible or actual cases of COVID-19?

Answer: Unless the payment is associated with specific claims for reimbursement for COVID-19 testing or treatment provided on or after February 4, 2020 to uninsured patients, under the Terms and Conditions associated with payment, providers are eligible only if they provide or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19. Not every possible case of COVID-19 is a presumptive case of COVID-19. For clarification as it relates to presumptive COVID-19 cases, refer to the frequently asked question that defines a presumptive case of COVID-19.

Attestations

Based on the latest news, it appears that HHS does not intend "generally" to attempt to recoup funding differences from home health or hospice providers based on the change in the revenue formula. Thus, there is no money that is "owed back" to the government at this time. Nonetheless, it seems that there is a bit of elasticity in the wording of the FAQ, so I am hopeful that HHS will make it clearer as to if, when, and how a recoupment would proceed if a provider is found to have received more funding than deserved based on the guidance we have so far.

In the meantime, the main question may be whether providers want to retain the funds and go through the hassle of working to keep detailed information needed to demonstrate the use of funds. For most, I would guess that the answer is "yes," but we need to be aware that these guidelines have already changed once and may change or be "clarified" again. Given that the attestation deadline was moved to 45 days, there is no rush to attest just yet. As Robert Markette has already told us, it would be wise to seek an opinion of counsel before attesting to anything.

Upon review of the data that HHS has made available regarding the providers who have attested, it would appear that most home health agencies and hospices are taking a "wait and see" approach. The distributions that have been made public so far range from a low of $35 to more than $16 million.

The total that can be traced to home health and hospice providers based on entity names is $264,709,502 which has been disbursed to 2,132 entities. Based on our estimates, this represents about 14% of the total funding that should have been available, and it appears that only about 12% of providers have attested thus far.

New SBA rules for the EIDL program

Last week, the Small Business Administration (SBA) all but closed down its portal for application under the Economic Injury Disaster Loan Program (EIDL) which is a long-standing vehicle for the SBA to disburse emergency funds in the aftermath of a disaster. Remember that this program is not the same as the Paycheck Protection Program (PPP) which was approved as a part of the CARES Act.

Last week, the agency quietly dropped the loan ceiling which was originally set at $2 million to just $150,000 and also changed the initial emergency grant from $10,000 to just $1,000 per employee. The changes were not publicly announced. At this point, according to the SBA, only agricultural businesses are being allowed to submit applications based on congressional pressure to prioritize farmers and agricultural companies for loans.

Here is what home health and hospice providers should know. If the provider has submitted an application for EIDL funding in excess of $150,000 it will likely be rejected. If the loan was requested prior to April 15 and was below the newly placed cap, it will be processed in the order received. It is expected that not all loans will be funded.

Paycheck Protection Program: loan forgiveness and new IRS rules

Kristen Harder, SPHR, SCP-SHRM
Principal & co-founder, C3 Advisors, LLC

According to **Kristen Harder, SPHR, SCP-SHRM**, of C3 Advisors, many employers are struggling with the rules under the PPP and how to determine if their loans will be forgiven in the end. Much of the confusion comes from uncertainty about how loan forgiveness calculations will be performed. It doesn't help that the SBA has changed some of the PPP rules as time has gone on and that specific FAQs that address loan forgiveness have not yet been issued.

Here are some things agencies should know:

Calculating the FTEs to determine loan forgiveness

From a reading of the CARES Act, PPP loan forgiveness will depend on a count of full-time equivalents (FTEs) as opposed to an employee headcount. According to the FAQs found at https://home.treasury.gov/system/files/136/Paycheck-Protection-Program-Frequently-Asked-Questions.pdf, for purposes of loan forgiveness, the CARES Act uses the standard of "full-time equivalent employees" to determine the extent to which the loan forgiveness amount will be reduced in the event of workforce reductions. Unfortunately, the FAQs don't tell us exactly how this will work.

It occurs to us that, for agencies with a drop in census, and less need for visiting staff as a result, there could be a de facto workforce reduction.

To figure out the extent to which the PPP loan would be forgiven, count the FTEs (total number of hours worked per week divided by 40 hours) for the following periods:

1. The number of employees during the eight-week period following the initial disbursement of loan proceeds
2. The number of FTEs from February 15, 2019 through June 30, 2019
3. The number of FTEs from January 1, 2020 through February 29, 2020

Divide #1 by both #2 and #3. Take the highest value of the two. If it is equal to or greater than 1, the agency has maintained its FTE count. If not, the requirement is not met, and forgivable principal would be adjusted accordingly.

Exemption for rehires

If the agency offers to rehire a previously furloughed or laid off employee and the employee chooses not to come back to work because they are making more money on unemployment, the agency may be allowed to exclude the employee's hours/salary when calculating the amount of the PPP loan that would be forgiven. To take advantage of this option, the agency must do two things:

1. Make a written, good faith offer to rehire the employee at the same salary or rate of pay with an expectation that the employee will work the same number of hours or days as previously.
2. Document in writing the employee's refusal to return to work.

By the way, if this happens, the employee will likely want to stay on unemployment but will be technically ineligible in most states.

Payroll requirements

For the loan to be forgiven, the employer must pay at least 75% of the total

salary or wages paid in the most recent quarter to each employee. If this requirement is not met, the amount of the loan forgiveness will be reduced by the difference between what was most recently paid and 75% of the pay previously received by the employee.

Grace period for rehires

The legislation establishes that, if the agency rehires any member of the staff and/or reinstates any pay that was decreased by more than 25% by June 30, 2020, the requirements for forgiveness of the loan will have been met.

Forgiveness calculation examples

Agency A has a total of 20 FTEs and its payroll obligations prior to the public health emergency totaled $125,000 per month. It applied for and received a loan of $300,000. Agency A has rent and utility obligations of $25,000 per month. The company furloughed some of its workers and later rehired them but only 80% of the workforce FTEs were restored.

Agency A's payroll for the two-month period came to $200,000 which together with its overhead expenses amounted brought Agency A's allowed expenditures under the program to $250,000. Since only 80% of the FTE count was reinstated, only $240,000 of the $300,000 PPP loan can be forgiven.

Agency B has the same FTE count, the same payroll obligations and rent/utility load but Agency B elected to maintain its full complement of staff. However, it did so at reduced pay rates to ensure its ability to operate with a reduced census. The employees took a 20% pay cut across the board. In this case, the pay reduction forgiveness requires that workers be paid at least 75% of their prior pay and Agency B has met the standard. Therefore, the entirety of the $300,000 PPP loan is forgiven.

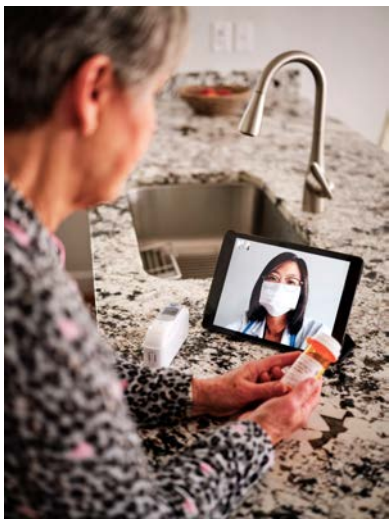
We would like to reiterate that the SBA has not yet released detailed calculation rules. These calculations are based on our reading of the legislation. Knowing what we know about the changes that are occurring, readers should anticipate that the arithmetic could change.

IRS guidance on PPP – elimination of tax benefits

In its Notice 2020-32 (https://www.irs.gov/pub/irs-drop/n-20-32.pdf), the Internal Revenue Service has opined that taxpayers receiving PPP loans that are forgiven must include such amounts in their gross income for tax purposes. This is contrary, as many attorneys have pointed out, to the CARES Act which, in its Section 1106(i), addresses federal income tax consequences from amounts that are forgiven. This section of the act provides that for purposes of the Internal Revenue Code, any amount that is forgiven under the PPP would be "excluded from gross income." It seems that Congress' intent to provide a tax-free benefit has been reversed, at least for the moment, by the IRS.

CLINICAL MANAGEMENT HIGHLIGHTS

Telehealth tips



Last week, **Robert Markette** of Hall, Render, Killian, Lyman & Heath, PC; **Jill Dyer, BSN, RN, HCS-D, HCS-O**; and I delivered a WellSky webinar on telehealth and COVID-19 [https://info.wellsky.com/telehealth-covid19.html]. Here are the primary takeaways:

1. Telehealth cannot be used to supplant needed in-person visits and telehealth cannot be billed by any home health discipline.
2. Telehealth services must be provided for in the patient's plan of care. We suggested that in addition to the required visit frequencies for in-person visits, telehealth encounters also be specified with frequency expectations and tied to the interventions that are to be addressed through telehealth.
3. As agencies cover the elements of the plan of care with the patient and his/her caregiver(s) or representative, care should be taken to include how telehealth services will figure into the care plans. While not absolutely required, it won't hurt to add an acknowledgement to the consent form that telehealth services may be arranged in conjunction with the care planning process.
4. Telehealth encounters should be just as carefully and thoroughly documented as in-person visits. That means including start and end times, the identity of the clinician conducting the encounter, vital sign measurements, intervention(s) addressed, patient response, and plans for the next visit/encounter. Just as with visit documentation, telehealth documentation should be signed and dated by the clinician who conducted the encounter and available in the patient's medical record.
5. Each agency should establish detailed policies and procedures around the use of telehealth. Those should include at a minimum:
    a. When and how remote encounters are planned and used
    b. Who can conduct remote encounters
    c. How the encounter should be documented for the record
    d. Patient and physician follow-up
    e. Clinical review of encounter documentation in the context of compliance and quality assurance reviews
    f. Outcomes and performance improvement monitoring

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Later as records are selected for additional documentation requests (ADRs) and other forms of medical review, there will be three things that reviewers will be looking for:

1. That the encounters are tied to the patient's specific skilled needs and measurable goals
2. That the encounters are specifically provided for in the patient's plan of care and approved by the physician along with other visit frequencies
3. That it is clear what interventions are meant to be addressed in person and which are meant to be addressed remotely.

Frontline insights

Early last week, I started thinking about news videos I'd seen of patients leaving the hospital after their recovery from the virus. We don't hear or see much about how these patients, especially those who are elderly, fare at home after their hospital discharges and what care they need to return to their prior levels of function. So, last week I posed five related questions to both **Cindy Campbell, MHA, BSN, RN, COQS** and **Catherine Dehlin, RN, BSN, CHPN, CHCM, COQS**. Both Cindy and Catherine are with WellSky Services — Cindy works mainly with home health providers, and Catherine focuses mainly on hospice. Here is what they had to report from their interactions with providers on the front lines.

Cindy Campbell, MHA, BSN, RN, COQS
Director Operational Consulting, WellSky

Catherine Dehlin, RN, BSN, CHPN, CHCM, COQS
Director of Hospice and Palliative Services, WellSky

Q: To what extent have these 'recovering' patients been affected by the virus? Is the deconditioning and weakness associated with COVID much more severe than with flu induced pneumonia?

Catherine: I'm hearing both extremes, one provider says that it has been able to successfully wean patients off oxygen in the first five days and their patients are recovering rather rapidly, while others tell me that they are finding most COVID-19 patients severely functionally deconditioned, requiring frequent and intensive therapy.

Cindy: On the home health side, we are hearing reports of significant weakness and concern over multi-system impact, and that is complicating care and staffing requirements.

Q: Are the reports of patients with significant cardiac and kidney damage being over hyped, or is this a real concern in terms of overall prognosis and expectations of full recovery?

Catherine: Some feel that complications have been somewhat exaggerated — they haven't seen the severe cardiac or kidney damage, even among patients in hospice care.

Cindy: One clinical leader I spoke to did note the impact on renal function, but in all cases, clinical teams are reporting that they have to increase monitoring for COVID-19 patients with multiple comorbidities.

Q: What are the challenges of caring for these patients at home following their discharge?

Catherine: Staffing in the sense of how to mitigate exposure to staff is a big concern. One provider told me that it is sending two nurses to all visits in facilities solely for the purpose of helping with donning and doffing of PPE and completing documentation. Clinically, many in hospice are also challenged by secretion management options.

Cindy: Home health providers are reporting very high frustration with not being able to gain access to assisted living facilities to see their patients. Unless the patient is on hospice, they simply are not allowed in. Another agency spoke to low numbers of COVID-19 patients now. However, their area was just "lighting up" with the outbreak. Concerns over sustainability of PPE were very real, in large part due to the deference being given to acute care systems by distributors of PPE. As one Montana leader told me, "After six weeks of constant struggle with PPE, we are finally getting some supplies. We received only one very small shipment from the national stockpile. In the first month, nothing we ordered would get shipped. Until last week, we only had 100 surgical masks. We reached out to a group that was making the 3D plastic masks with filters that most of our clinical staff are using. We are trying to get enough surgical masks to allow visiting staff that option. In the past week, we have begun to get shipments of N95/K95s, surgical masks, and gowns. We also have a group making face shields from 3D molds. The amount of time spent trying to procure PPE has been incredible."

Q: How do agencies correctly balance telehealth/virtual care with the need for onsite, hands on interventions for patients that have been so ill? Are there pitfalls to overusing telehealth to the detriment of the patient?

Catherine: All the hospices I spoke to are very wary of providing "too much" telehealth. They are concerned that agencies are going to come under scrutiny for overusing remote services. They are also experiencing difficulties while doing face-to-face visits virtually to get the patient set up with their end of the technology.

Cindy: Home health use has definitely increased, especially with nursing. Most agencies are committed to the concept of best use of staff now, to connect, provide skilled monitoring, and guide intervention. Frustration was voiced by other disciplines who aren't necessarily using remote services now, especially social workers.

Q: Are patients generally getting to the right care providers upon discharge? In other words, are we doing a good job of discharging to the care modality that makes the most sense for the patient or are we simply making blanket assumptions (everyone who is still alive goes to home health, for example)?

Catherine: All the hospice providers I spoke with are seeing appropriate selections of providers. They did note a significant decrease in referrals from all referral source types, except from emergency department encounters. There are high numbers of COVID-19 patients being referred with other end stage illnesses because they visit the emergency department with symptoms.

Cindy: Home health agencies I talk to are concerned about not being able to see folks whom they know would benefit from care. That said, I did not hear of inappropriate referrals or patterns because most home health agencies I talk with seem to think that the patients are getting to the right providers based on their needs.

Frequently asked questions

Q: We heard during a CMS briefing that all telehealth services must be consented to by the patient. However, I didn't see that information in any of the home health guidance that came out from CMS. Do we need to add this to our consent form? And if we have provided telehealth services without the patient's specific consent, will that likely be a survey issue for us?

A: I do not know of any specific regulation that establishes that a home health or hospice provider must obtain direct written consent from the patient or patient representative to enable remote or virtual services. However, because there are HIPAA concerns here (even though for the moment the privacy rules have been relaxed) and because there are statements that suggest that the patient and his/her caregivers must be comfortable and involved with planning for the care that is to be delivered, it only makes sense to ensure that there is consent to provide remote services and that they are also clearly set forth in the version of the care plan or schedule that is given to the patient and family.

Q: I am very confused about the money that our agency received from the CARES Act emergency relief fund. I have been told that we cannot return just the portion of the funds that we may not be able to use specifically for COVID-19 purposes and that we must either keep everything or return all of the money, rather than just the portion we might not be able to qualify for based on our projections of our revenue losses and expenses. Is this true?

A: Strangely enough, the only reason for returning the funds is if the provider believes that they have been deposited in error. There does not seem to be a vehicle for simply returning a portion of the amount that was deposited. Thus, the agency will have to decide whether it wants to keep the money or send it back. And if you do keep it, there is a high probability that there will be an audit of some sort where the agency will be asked to account for the use of the funds. Also, remember that you cannot attest to the agency's right to the funds if it has not treated a COVID-19 patient at the time of the attestation. According to the survey conducted by NAHC, only 41% of all home health agencies had, as of a few weeks ago, treated a COVID-19 patient. This is one of the reasons we think the attestations are so low as agencies wait to see if they will be receiving referrals of COVID-19 patients.

In closing

I keep thinking that things will slow down one of these days, and by Friday, I'm always surprised at the amount of information that has come through that providers need to know about. So, like you, we are plugging along and trying to glean everything that we can find to keep you informed. Things are changing quickly though, and I'm certain that as the briefings continue and as HHS, CMS, the SBA, the IRS, the Department of Labor (DOL), and others get into the act, things will change again and again. So, stay tuned and keep downloading so that you have the most up-to-date and best information that we have.

My sincere thanks to the reader who reached out to me on Friday to get some clarification on last week's offering about the Provider Relief Fund. If you have a question or concern about something that is included here, please let me know at sharonh@c3advisors.com. I don't promise to always be absolutely right, but I do promise to try.

As always, I am very grateful to Cindy Campbell, Catherine Dehlin, Robert Markette, Jill Dyer, and Kristen Harder for their help in putting together this edition of the briefing.

As we close for the week, I am amazed at the resiliency and compassion of those who care for patients every day. It is not lost on me that this briefing is published during National Nurses Week, so please know that you really are our heroes. You can count on our support. Be safe and be well. I know I speak for the team at Wellsky as well as myself – we think of you every day.

About the author

Sharon S. Harder has over three decades of executive management experience in the healthcare industry. She has served in financial and operational leadership roles in a variety of healthcare organizations ranging from a major healthcare professional association to large post-acute healthcare providers. As President of C3 Advisors, LLC Sharon engages with clients to develop and implement the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare marketplace.

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