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Understanding the CY 2024 Home Health Final Rule: Your agency's path forward

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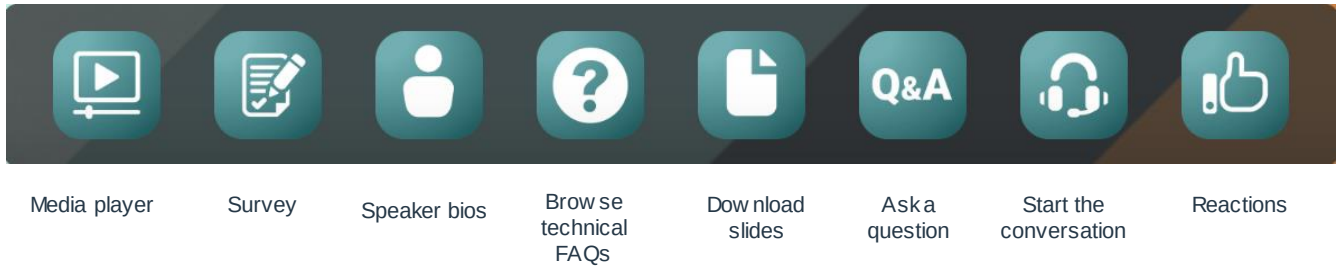

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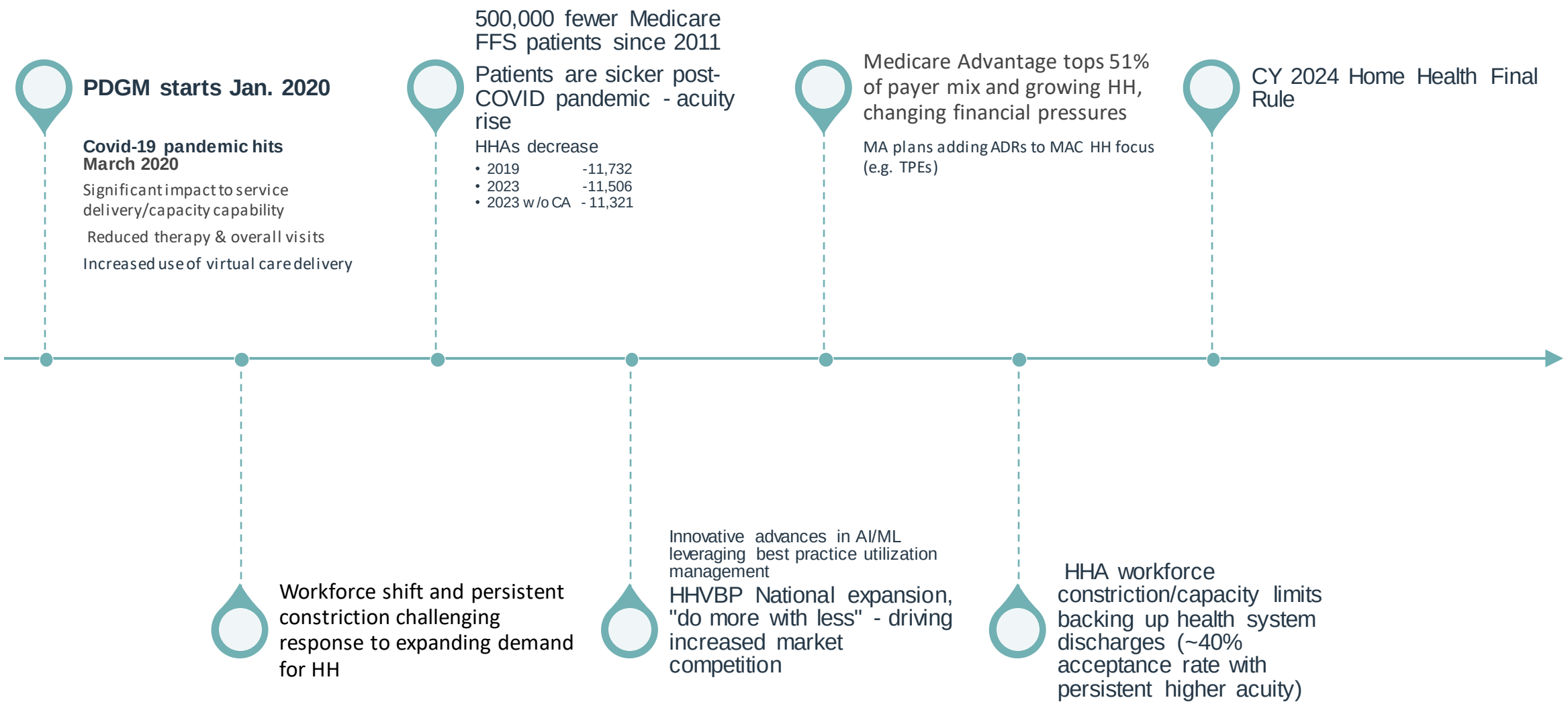
Medicare home health CY 2024 final rule

The Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS) final rule, updating Home Health and Home Infusion payment rates:

Published in the Federal Register on November 13, 2023
Federal Register: Public Inspection: Medicare Program: Calendar Year 2024 Home Health Prospective Payment System Rate Update; Quality Reporting Program Requirements; Value-Based Purchasing Expanded Model Requirements; etc.

Published as of 11/9/23: 2023-24455.pdf (federalregister.gov)

Home Health market context



CY 2024 Final Home Health Prospective Payment System Rate Update

- $140M expected spending decrease (~½ of proposed rule amount)
- 3.0% net inflation rate update ($525M increase)
- $70 million increase in outlier spending
- 2.890% permanent PDGM Budget Neutrality Adjustment ($455M reduction)
- Maintains PDGM case mix model
  - Recalibrates all 432 case mix weights and LUPA thresholds
  - Outlier FDL modified to 0.27 (increases # of outlier periods)
  - Rebase and revised Market Basket Index formula
- HHVBP modification
- QRP modification
- Provider enrollment rule changes
- Specific hospice provisions, such as Special Enrollment Program (SEP)
- DME, IVIG, and Lymphedema provision changes

Advocacy helped and is still needed ...beware those bringing gifts

Proposed Rule

- Inflation update 2.7% (3.0% Market Basket Index – 0.3% Productivity Adjustment)
- Base PDGM 30-day payment rate of $,1974.38 in contrast to the 2023 base rate of $,2010.69
- Proposed rate change included the budget neutrality adjustments for case mix weight recalibration, and wage index rebasing and revising
- The proposed rule included a 2024 rate reduction at 5.653%, the remainder of:
    - The original 7.85% rate reduction that CMS calculated as warranted under its methodology for 2020 and 2021
- Proposed rate changes would have yielded net decrease in expected Medicare expenditures in 2024 of $375 million

Final Rule

- Inflation update 3.0% (3.3% Market Basket Index – 0.3% Productivity Adjustment)
- 2024 base PDGM 30-day payment rate of $2,038.15 ($27.46 base rate increase from 2023)
- Budget Neutrality Adjustment (BNA):
    - Increased to 9.48%, with added 1.73% for 2022, leading to a full -5.779% adjustment for 2024
    - CMS reduces proposed cut in half and sets final permanent adjustment of -2.890% for 2024
- Rate change yields increase in expected Medicare expenditures of $140 million for 2024

“Budget Neutrality” required (PPS to PDGM)

TABLE B4: TOTAL PERMANENT ADJUSTMENT FOR CYs 2020, 2021, and 2022

Actual CY 2022 Base Payment Rate (Assumed Behavior)	Recalculated CY 2022 Base Payment Rate (Actual Behavior)	Total Permanent Prospective Adjustment
$2,031.64	$1,839.10	-9.48%*

Source: CY 2022 Home Health Claims Data, Periods that end in CY 2022 accessed on the CCW July 15, 2023. *This is the total permanent adjustment based on CY 2022 data which did not have any previous behavior adjustments applied. However, as described later in this section, we recognize for CY 2024 we must account for adjustments made in CY 2023.

TABLE B5: TOTAL TEMPORARY ADJUSTMENT FOR CYs 2020, 2021, and 2022

CY 2020 Temporary Final Adjustment	CY 2021 Temporary Final Adjustment	CY 2022 Temporary Final Adjustment	Total Temporary Adjustment Dollar Amount for CYs 2020, 2021, and 2022
-$873,073,121	-$1,211,002,953	-$1,405,447,290	-$3,489,523,364

Source: CY 2020 Home Health Claims Data, Periods that begin and end in CY 2020 accessed on the CCW July 12, 2021. CY 2021 Home Health Claims Data, Periods that end in CY 2021 accessed on the CCW July 15, 2022. CY 2022 Home Health Claims Data, Periods that end in CY 2022 accessed on CCW July 15, 2023.

- CMS is required to annually assess differences between assumed and actual industry ‘behavior changes’ on estimated aggregate expenditures under PDGM from 2020-2026
- Based on this assessment, CMS intends to **"claw back" $3.4B+** in CMS-perceived HHA overpayment since shift to PDGM, reflected in Table B5
- Timetable for this adjustment not revealed – no plans noted yet for 2024

Source: CY 2024 Final Rule Tables B4, B5

Background on the behavioral adjustment

Balanced Budget Act (BBA) requires that in calculating the standard prospective payment amount the Secretary:

- Must make assumptions about behavior changes that could occur as a result of the implementation of the 30-day and case mix adjustment factors established
- Must provide a description of behavior assumptions made in notice and HHS PPS final rule with comment period
- Must annually determine impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures under HH PPS from 2020-2026
- Provide one or more temporary increases or decreases to the payment amount for a unit of HH services for applicable year

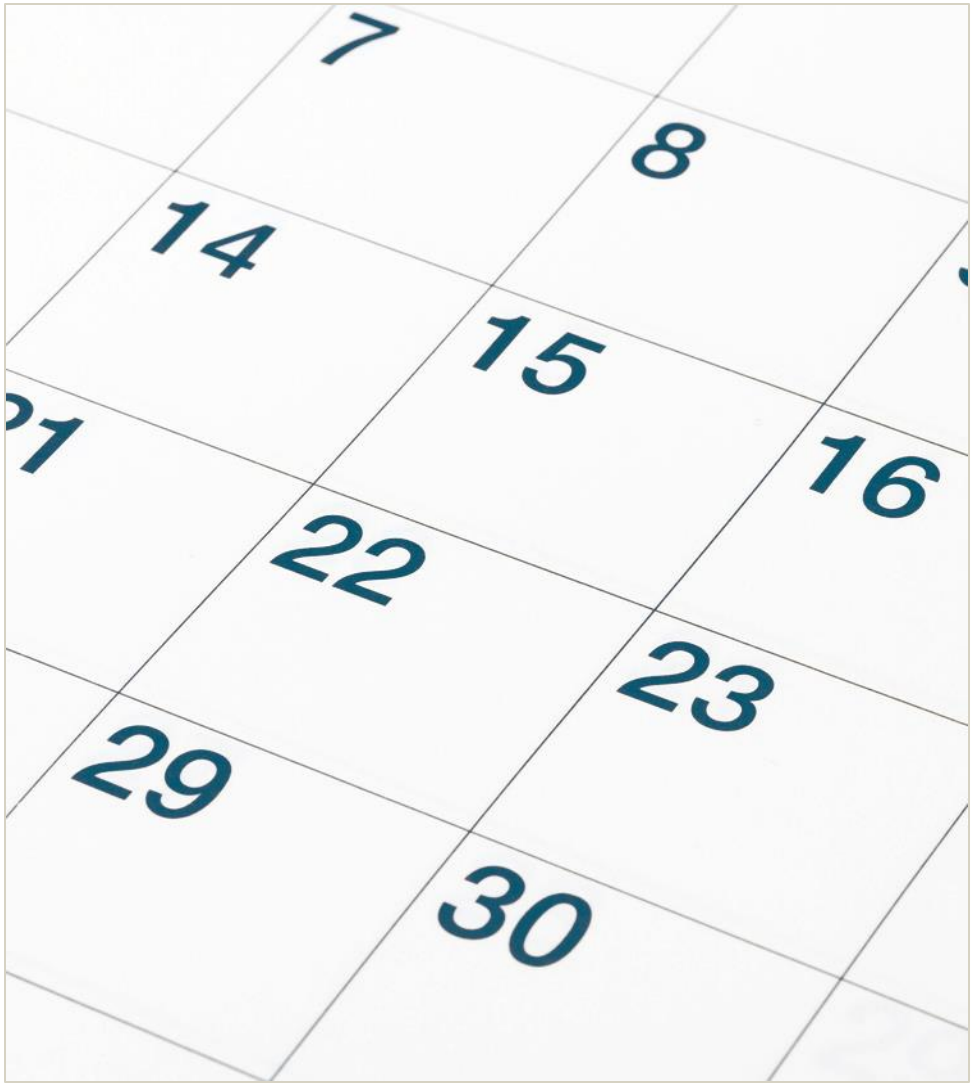
Payment amount: By 30-day period and LUPA per visit

TABLE B24: CY 2024 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2023 National Standardized 30-Day Period Payment	CY 2024 Permanent BA Adjustment Factor	CY 2024 Case-Mix Weights Recalibration Neutrality Factor	CY 2024 Wage Index Budget Neutrality Factor	CY 2024 Labor-Related Share Neutrality Factor	CY 2024 HH Payment Update	CY 2024 National, Standardized 30-Day Period Payment
$2,010.69	0.97110	1.0124	1.0012	0.9998	1.030	$2,038.13

TABLE B26: CY 2024 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2023 Per-Visit Payment Amount	CY 2024 Wage Index Budget Neutrality Factor	CY 2024 Labor-Related Share Neutrality Factor	CY 2024 HH Payment Update	CY 2024 Per-Visit Payment Amount
Home Health Aide	$73.93	1.0012	0.9999	1.030	$76.23
Medical Social Services	$261.72	1.0012	0.9999	1.030	$269.87
Occupational Therapy	$179.70	1.0012	0.9999	1.030	$185.29
Physical Therapy	$178.47	1.0012	0.9999	1.030	$184.03
Skilled Nursing	$163.29	1.0012	0.9999	1.030	$168.37
Speech-Language Pathology	$194.00	1.0012	0.9999	1.030	$200.04



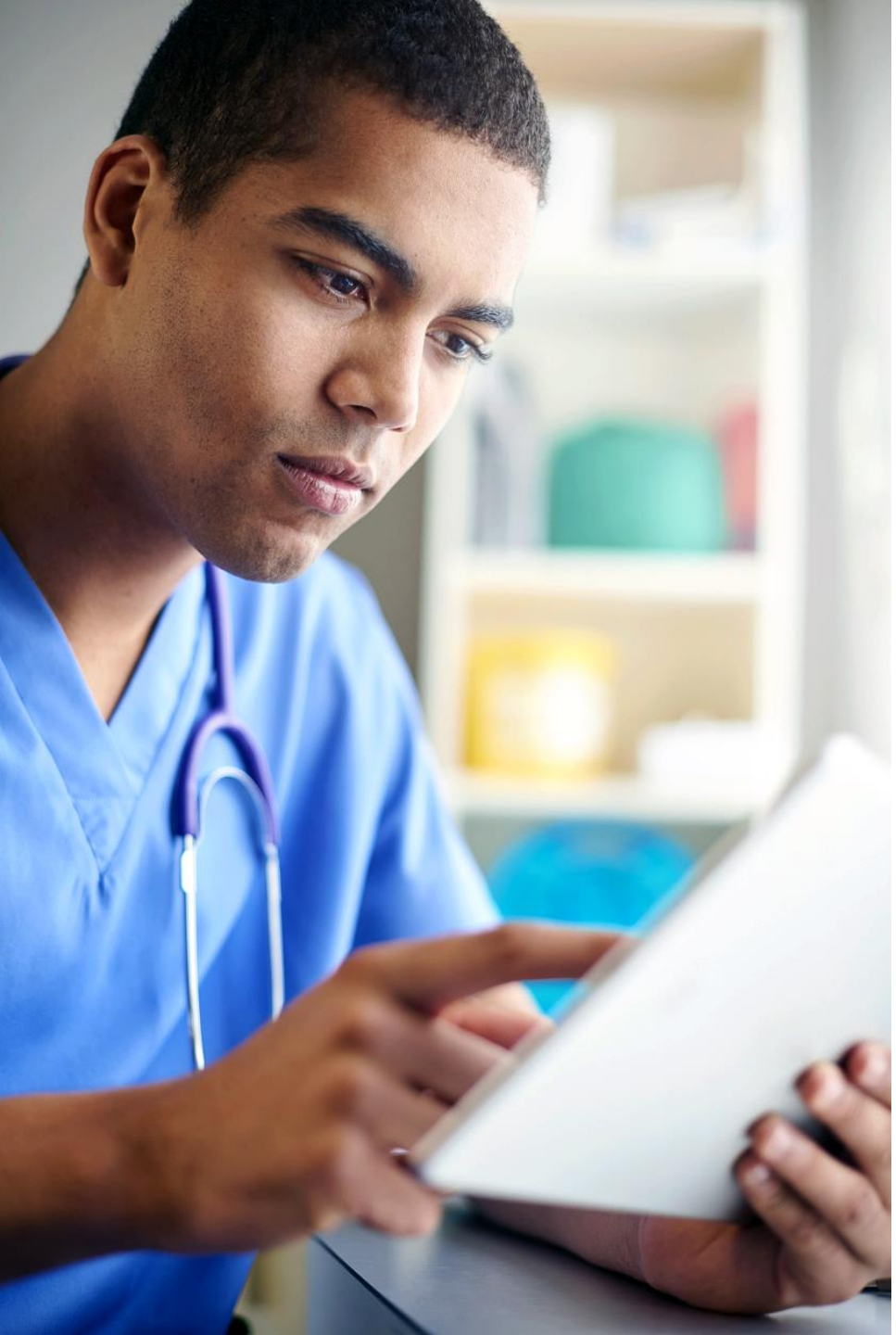
LUPA

- All 432 LUPA thresholds have been subject to modification
- LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care by the appropriate add-on factor:
  - 1.8451 for SN
  - 1.6700 for PT
  - 1.6266 for SLP
  - OT same as PT until data becomes available

  Example: Using the proposed CY 2024 per-visit payment rates for HHAs that submit the required quality data, for LUPA periods that occur as the only period or an initial period in a sequence of adjacent periods, if the first skilled visit is SN, the payment for that visit would be $310.66 (1.8451 multiplied by $168.37), subject to area wage adjustment

Outlier

- Loss-sharing ratio of 0.80 - Medicare pays 80% of the additional estimated costs that exceed the outlier threshold amount
  - Using CY 2022 claims data (as of March 17, 2023)
  - Statutory requirement that total outlier payments do not exceed 2.5 percent of the total payments
- Proposing an FDL ratio of 0.27 for CY 2023 (down from 0.35)
- Results in an increase in outlier episodes



Case mix weights: Recalibrated

- Recalibrate annually the PDGM case-mix weights using a fixed effects model with the most recent and complete utilization data available at the time of annual rulemaking
- Reflects current home health resource use and changes in utilization patterns
- Used CY 2022 home health claims data with linked OASIS data
- Reflective of PDGM utilization and patient resource use expected for CY2024

Area Wage Index changes

Top ten CBSAs with negative impact impact

CBSA Code	CBSA Name	CY 2023 Wage Index	CY 2024 Wage Index	Difference
41500	Salinas, CA	1.8035	1.7253	-0.0782
42100	Santa Cruz-Watsonville, CA	1.8458	1.7797	-0.0661
11244	Anaheim-Santa Ana-Irvine, CA	1.2835	1.2193	-0.0642
12700	Barnstable Town, MA	1.1892	1.1297	-0.0595
27060	Ithaca, NY	1.1030	1.0479	-0.0551
44300	State College, PA	1.0988	1.0439	-0.0549
34900	Napa, CA	1.5449	1.4902	-0.0547
31540	Madison, WI	1.0586	1.0057	-0.0529
47220	Vineland-Bridgeton, NJ	1.0534	1.0007	-0.0527
39740	Reading, PA	0.9929	0.9433	-0.0496

Top ten CBSAs with positive

CBSA Code	CBSA Name	CY 2023 Wage Index	CY 2024 Wage Index	Difference
13380	Bellingham, WA	1.1777	1.2999	0.1222
28740	Kingston, NY	0.9960	1.0911	0.0951
39540	Racine, WI	0.9035	0.9931	0.0896
30980	Longview, TX	0.8569	0.9415	0.0846
22020	Fargo, ND-MN	0.7853	0.8603	0.0750
21660	Eugene, OR	1.1454	1.2159	0.0705
14740	Bremerton-Silverdale, WA	1.1835	1.2524	0.0689
49700	Yuba City, CA	1.4394	1.5063	0.0669
10500	Albany, GA	0.8627	0.9288	0.0661
39100	Poughkeepsie-Newburgh-Middletown, NY	1.2231	1.2882	0.0651

Home Health Quality Reporting Program (HHQRP)

Table A1: SUMMARY OF COSTS, TRANSFERS, AND BENEFITS

Provision Description	Costs and Cost Savings	Transfers	Benefits
HH QRP		The total economic impact of these proposals including the addition of the COVID-19 QM, removal of the Application of Functional Assessment/Care Plan, and the removal of the M0110 – Episode Timing and M2220- Therapy Needs OASIS items proposed for implementation in CY 2025 is an estimated reduction in cost of $5,123,430.	The reduction of unnecessary data collection burden and the introduction of more impactful quality measures.

Published as of 11/13/232023-24455.pdf (federalregister.gov)

- Two new measures
- Remove one existing measure
- Remove of two OASIS items
- Begin public reporting of four measures in the HHQRP
- Update on closing the health equity gap
- Codifying into regulation the 90% data submission threshold policy

HHQRP

- Two new measures
  - Discharge (DC) function score
  - COVID-19 vaccine
- DC function score
  - GG 0130 and GG0170
  - # of HHA's episode where the observed discharge score ≥ expected discharge score x 100 total number of HHA episodes

HHQRP COVID-19 vaccine

COVID-19 vaccine: Percent of patients/residents who are up to date

- CMS Measures Under Consideration (MUC) List
- No exclusions
- CDC “up-to-date” definition potential change
- Not consensus-based entity (CBE) endorsed
- Requires a new item to the OASIS
- Begin reporting with discharges -January 1, 2025

HHQRP CY2025 Measure Removal

Measure removed – CY 2025 HHQRP

- " Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function"
    - Topped out
    - *Replace with* DC Functional score

End reporting: April 2024

- Self-Care Discharge Goals (GG0130, Column 2)
- Mobility Discharge Goals (GG0170, Column 2)

Data items removed from OASIS, effective January 1, 2025

- M0110 Episode Timing
- M2200 Therapy Need

A little more about the DC function score

- The observed discharge function score is the sum of individual function items at discharge
- The expected discharge function score is computed by risk adjusting the observed discharge function score for each home health episode
- Activity not assessed (ANA) – statistical imputation to estimate the item score for that item based on the values of other data and which are otherwise similar to the assessment with a missing value
- Uses the eating, oral hygiene, and toileting hygiene from GG0130 self-care items

Timing updates for performance measurements

Measure	Data Period	Data Period Used for Model Baseline Year*	Data Period Used for Performance Year	Payment Year
OASIS-based Measures				
Improvement in Dyspnea	1-year	CY 2023	CY 2025	CY 2027
Improvement in Management of Oral Medications	1-year	CY 2023	CY 2025	CY 2027
DC Function	1-year	CY 2023	CY 2025	CY 2027
Claims-based Measures				
Potentially Preventable Hospitalizations	1-year	CY 2023	CY 2025	CY 2027
Discharge to Community-Post Acute Care	2-year	CY 2022/2023	CY 2024/2025	CY 2027
HHCAHPS Survey-based Measures				
Care of Patients	1-year	CY 2023	CY 2025	CY 2027
Communications Between Providers and Patients	1-year	CY 2023	CY 2025	CY 2027
Specific Care Issues	1-year	CY 2023	CY 2025	CY 2027
Overall Rating of Home Health Care	1-year	CY 2023	CY 2025	CY 2027
Willingness to Recommend the Agency	1-year	CY 2023	CY 2025	CY 2027

*Beginning with performance year CY 2025, the baseline year and AT/BMs will be updated to CY 2023 for all remaining measures from the initial measure set.

HHQRP public reporting

- Public reporting:
  - January 2025 Care Compare refresh or as soon as feasible
  - Transfer of Health Information to the Patient Post-Acute Care
  - Transfer of Health Information to the Provider Post-Acute Care
  - DC Function measure April 1, 2023 – March 31, 2024
    - January 2026 Care Compare refresh or as soon as feasible
  - COVID-19 vaccination: Jan 1, 2025 – March 31, 2025

HHQRP and health equity

- Update on health equity
  - Request for information in 2023 rate update rule
  - TEP convened to develop health equity quality measure
  - Anticipated future health equity activities, pursue additional SDOH and continue with quality measure development

Note: Health Related Social Needs (HRSN) emerging within AI/ML fueled predictive analytics, focusing risk-based care planning support

Home Health Value Based Purchasing (HHVBP)

- Beginning with reporting year 2025/ payment year 2027
  - Change the baseline year to CY 2023

- Remove the following measures:
  - OASIS-based Discharged to Community (DTC)
  - OASIS-based Total Normalized Composite Change in Self-Care (TNC Self-Care)
  - OASIS based Total Normalized Composite Change in Mobility (TNC Mobility)
  - Claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH)
  - Claims-based Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use)

HHVBP (continued)

- Finalized the following measures:
  - Claims-based: Discharge to Community-Post Acute Care (DTC-PAC) Measure for Home Health Agencies
  - Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure
  - OASIS based: Discharge Function Score measure

HHVBP Performance Measures proposed changes

Final CY 2023 Measures

Source	Quality Measure
OASIS-based	Dyspnea
	Discharged to Community
	Management of Oral Medications
	Total Normalized Composite Change in Mobility
	(M1840) Toilet Transferring
	(M1850) Bed Transferring
	(M1860) Ambulation-Locomotion
	Total Normalized Composite Change in Self-Care
	(M1800) Grooming
	(M1810) Upper Body Dressing
	(M1820) Lower Body Dressing
	(M1830) Bathing
	(M1845) Toilet Hygiene
	(M1870) Feeding/Eating
Claims-based	Acute Care Hospitalization
	Emergency Department Use without Hospitalization
HHCAHPS Survey-based	Professional Care
	Communication
	Team Discussion
	Overall Rating
	Willingness to Recommend

Removing

- TNCs
- OASIS-based DC to community
- ACH in first 60 days
- ED use without hospitalization in first 60 days

Proposed CY 2025 Measures

Source	Quality Measure
OASIS-based	Dyspnea
	Functional Discharge (GG Item Set)
	Management of Oral Medications
Claims-based	Potentially Preventable Hospitalization (PPH)
	Discharged to Community
HHCAHPS Survey-based	Professional Care
	Communication
	Team Discussion
	Overall Rating
	Willingness to Recommend

Adding

- OASIS based DC Function Score (GG items)
- Claims-based DC to Community Post Acute Care (DTC-PAC)
- Claims-based HH Within-Stay Potentially Preventable Hospitalization (PPH)

Measures & weights (Beginning CY 2025)

Source	Quality measure	All measures	No HHCAHPS
OASIS-based	Dyspnea	6.00%	8.571%
	Management of Oral Medications	9.00%	12.857%
	DC Function	20.00%	28.571%
	Total %	**35%**	**50%**
Claims-based	DTC-PAC	9.00%	12.857%
	Home Health Within Stay Potentially Preventable Hospitalization (PPH)	26.00%	37.143%
	Total %	**35%**	**50%**
HHCAHPS survey-based	Professional Care	6.00%	0%
	Communication	6.00%	0%
	Team Discussion	6.00%	0%
	Overall Rating	6.00%	0%
	Willingness to Recommend	6.00%	0%
	Total %	**30%**	**0%**

Measures & weights (Current through CY 2024)

Source	Quality measure	All measures	No HHCAHPS	No claims	No claims or HHCAHPS
OASIS-based	Dyspnea	5.83%	8.33%	8.98%	16.67%
	Discharged to Community	5.83%	8.33%	8.98%	16.67%
	Management of Oral Medications	5.83%	8.33%	8.98%	16.67%
	Total Normalized Composite Change in Mobility	8.75%	12.50%	13.46%	25.00%
	Total Normalized Composite Change in Self-Care	8.75%	12.50%	13.46%	25.00%
	Total %	**35%**	**50%**	**54%**	**100%**
Claims-based	Acute Care Hospitalization	26.25%	37.50%	0.00%	0.00%
	Emergency Department Use without Hospitalization	8.75%	12.50%	0.00%	0.00%
	Total %	**35%**	**50%**	**0%**	**0%**
HHCAHPS Survey-based	Professional Care	6.00%	0.00%	9.23%	0.00%
	Communication	6.00%	0.00%	9.23%	0.00%
	Team Discussion	6.00%	0.00%	9.23%	0.00%
	Overall Rating	6.00%	0.00%	9.23%	0.00%
	Willingness to Recommend	6.00%	0.00%	9.23%	0.00%
	Total %	**30%**	**0%**	**46%**	**0%**

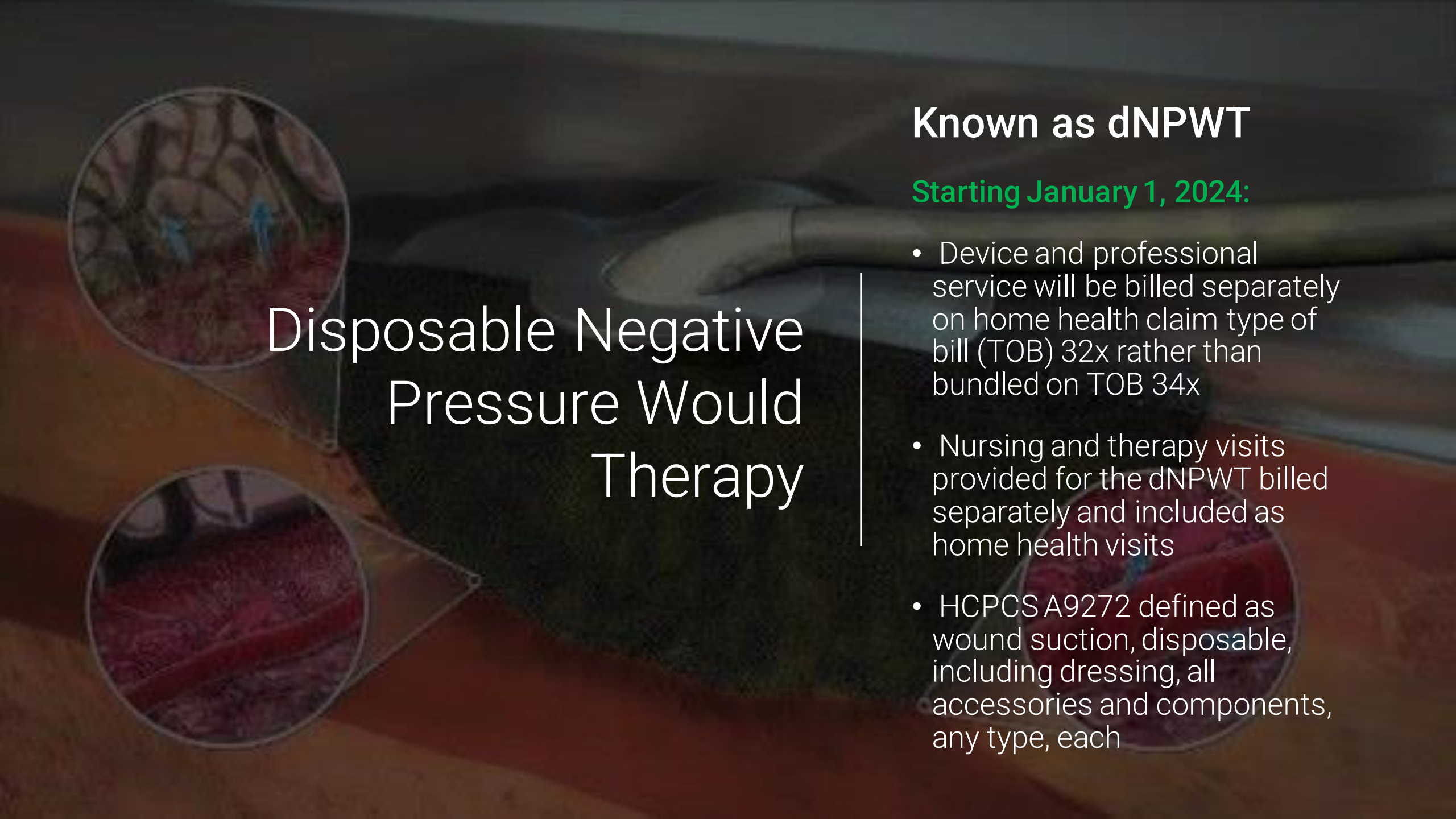
Know your numbers to understand your opportunity

Total Performance Score %	Large Cohort TPS
25th percentile	14.648
50th percentile	23.362
75th percentile	34.061
99th percentile	68.395

Source: CMS October 2023 IPR

Larger – volume cohort (6,792)

Where does your agency lie?
Your choices now, matter.



Disposable Negative Pressure Would Therapy

Known as dNPWT

Starting January 1, 2024:

- Device and professional service will be billed separately on home health claim type of bill (TOB) 32x rather than bundled on TOB 34x
- Nursing and therapy visits provided for the dNPWT billed separately and included as home health visits
- HCPCS A9272 defined as wound suction, disposable, including dressing, all accessories and components, any type, each

Intravenous Immune Globulin (IVIG)

- In demonstration project since 2014
- CAA, 2023 permanent program
- **Effective January 2024**
- Coverage and payment related to administration of IVIG in patients home as bundled payment
- Dx of primary immune deficiency disease (PIDD)
- Covered under DMEPOS benefit (with standard co-pays and deductibles applying)
- **Patients under Medicare home health POC not eligible**

Lymphedema Therapy Benefit

- New Part B benefit category – CAA, 2023
- Effective January 2024
- Standard and custom fitted gradient compression garments and other approved items (bundled) are covered
- Enrolled DMEPOS supplier with quality standards applying - subject to competitive bidding
- Billed to DME MAC
- Gradient compression stockings/wraps as surgical supplies for venous stasis ulcers
    - New HCPCS codes for gradient compression stockings/wrap to reflect surgical dressings (currently A6531, A 6532, and A6545
    - New HCPC codes and pricing noted for lymphedema items

Note: CMS making other DMEPOS conforming changes required by the CAA 2023

Provider enrollment

- § 424.527(a) New provider defined for provisional period of enhanced oversight (PPEO)
  - A newly enrolling Medicare provider or supplier – A certified provider or certified supplier undergoing a change of ownership
  - A provider or supplier (including an HHA or hospice) undergoing a 100 percent change of ownership via a change of information.
- § 424.527(b) The effective date of the PPEO's commencement is the date on which the new provider or supplier submits its first claim rather than the date the first service was performed or the effective date of the ownership change
- Propose in new § 489.52(b)(4) that a provider may request a retroactive termination date, but only if no Medicare beneficiary received services from the facility on or after the requested termination date.
- Propose to revise § 424.540(a)(1) to change the 12-month time frame to 6 month for deactivations related to non-billing.
- Propose to add new § 424.518(c)(1)(viii) that would incorporate within the high-screening category revalidating DMEPOS suppliers, HHAs, OTPs, MDPPs, and SNFs for which CMS waived the FBCBC requirement when they initially enrolled in Medicare (e.g., PHE)

Provider enrollment

- Proposed to extend the maximum length of a reapplication bar under § 424.530(f) to 10 years from 3 years – denials
- Propose that a provider or supplier that is currently subject to a reapplication bar may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs
- Propose that Medicare does not pay for any otherwise covered service, item, or drug that is ordered, referred, certified, or prescribed by a provider or supplier that is currently under a reapplication bar

Hospice Special Focus Program: Strong provider and industry criticism of design

Hospices will be identified for potential SFP enrollment if they

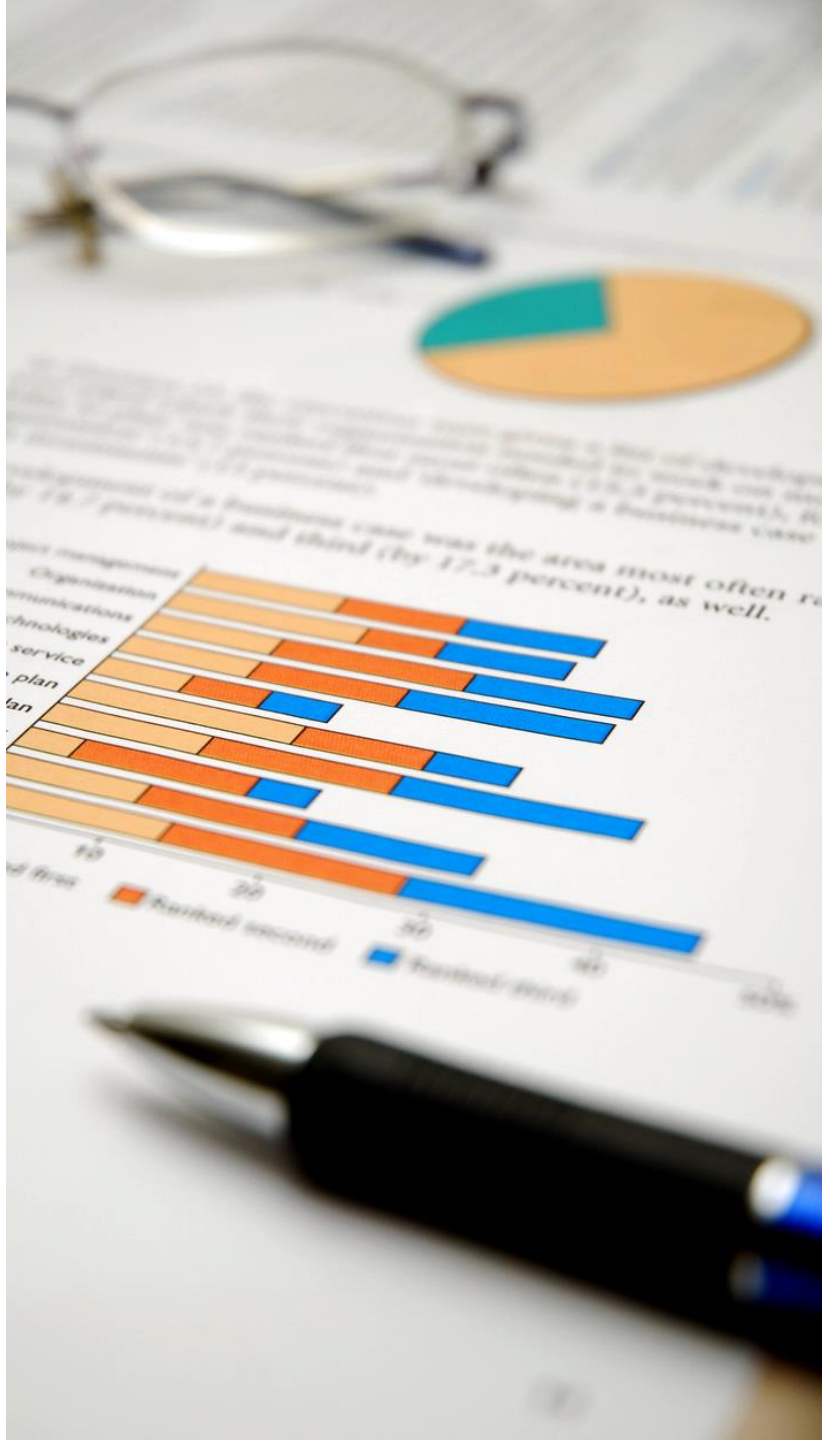
- (1) Have data from any of the below data sources (see table F1);
- (2) Are listed as an active provider (that is, have billed at least one claim to Medicare FFS in the last 12 months);
- (3) Operate in the United States, including the District of Columbia and U.S. territories

TABLE F1. PROPOSED PRIMARY MEDICARE DATA SOURCES AND INDICATORS IN THE SPECIAL FOCUS PROGRAM

Data Source	Hospice Surveys	Hospice Quality Reporting Program (HQRP)	
		Claims Data	CAHPS® Hospice Survey Measures
Indicators	Quality-of-Care Condition-Level Deficiencies	Hospice Care Index (HCI)	Help for Pain and Symptoms
			Getting Timely Help
	Substantiated Complaints		Willingness to Recommend this Hospice
			Overall Rating of this Hospice

Hospice Special Focus Program

- Survey data will be from the last 3 years of available data
- HCI will be the score from the most recent eight quarters of Medicare claims data
- CAHPS data will be the most recently available pulled from the Provider Data Catalog
- The SFP algorithm will identify the bottom 10% of hospices based on these inputs into the algorithm
- From that bottom 10%, CMS will then pick specific hospices to enter into the SFP program



CMS did not address hospice community's recommendations for how to improve SFP

Including:

- Scaling the survey data by hospice size
- Accounting for the large number of hospices that do not have reportable HCI scores or data for the 4 CAHPS measures
- Reducing the weight given to CAHPS data in the SFP algorithm
- Providing transparency into exactly how SFP hospices will be chosen from the list of bottom 10% performers
- Providing SFP hospices with technical assistance to support quality improvement
- Going back to the SFP TEP to address technical shortcomings of the proposed design
- Giving hospices a preview period so they could better understand their SFP scores before the program was fully implemented

Hospice Informal Dispute Resolution (IDR)

CMS is finalizing the hospice IDR as proposed

- The IDR process for hospice programs, like that of HHAs, is for condition-level survey findings which may be the impetus for an enforcement action
- Standard-level findings alone do not trigger an enforcement action and are not accompanied by appeal and hearing rights
- The finalized IDR process would provide hospice programs an informal opportunity to resolve disputes regarding survey findings for those hospice programs seeking recertification from the SA, CMS, or reaccreditation from the AO for continued participation in Medicare
- Additionally, the finalized IDR may be initiated for programs under SA monitoring (either through a complaint investigation or validation survey) and those in the SFP. For hospice programs deemed through a CMS-approved AO, the AO would receive the IDR request from their deemed hospice program, following the same process and coordinating with CMS regarding any enforcement actions

Change in majority ownership
New prohibitions: the 36-month rule

- ***Prohibiting a hospice that is undergoing a change in majority ownership (CIMO) by sale within 36 months after the effective date of the hospice's initial enrollment in Medicare, or within 36 months after the hospice's most recent CIMO, from conveying the provider agreement and Medicare billing privileges to the hospice's new owner (the "36-month" rule)***
- **CMS is finalizing the hospice 36-month rule proposal without modification**
- **Notes concerns:** Lack of scrutiny on new hospice owners, issues with entities and individuals "flipping" Medicare certifications before a hospice has ever seen a Medicare beneficiary or hired an employee, CMS is extending the "36-month" rule that applies to home health agencies to hospices
    - Exceptions to the 36-month rule for hospices exist. Specifically, even if a hospice undergoes a CIMO, the requirement in § 424.550(b)(1) that the hospice enroll as a new hospice and undergo a survey or accreditation *does not apply if any of the following four exceptions are implicated*:
        - The hospice submitted 2 consecutive years of full cost reports since initial enrollment or the last CIMO, whichever is later
        - A hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation
        - The owners of an existing HHA are changing the hospice's existing business structure (for example, from a corporation to a partnership (general or limited)), and the owners remain the same
        - An individual owner of a hospice dies

CMS is finalizing the hospice high-risk screening proposal without modification

- Given ongoing and recent concerns about hospice program integrity issues, CMS will now subject initially enrolling hospices and those submitting applications to report any new owner to the “high-risk” screening requirements
- In addition to all the other requirements that the lower-tier “moderate-risk” providers must undergo, “high-risk” hospices will now also be required to submit a set of fingerprints for a national background check from all individuals who have a 5% or greater direct or indirect ownership interest in the hospice
- CMS will also conduct a fingerprint-based criminal history record check of the FBI's Integrated Automated Fingerprint Identification System on these 5% or greater owners

More hospice regulation updates
Goal to identify and inhibit bad actors

- ***Hospices can be "deactivated" for 6 months of non-billing (as opposed to prior standard of 12 months)***
- "Deactivation" means that the provider's or supplier's billing privileges are stopped but can be restored (or "reactivated") upon the submission of information required under § 424.540. A deactivated provider or supplier is not revoked from Medicare and remains enrolled. Per § 424.540(c), deactivation does not impact the provider's or supplier's existing provider or supplier agreement; the deactivated provider or supplier may also file a rebuttal to the action in accordance with § 424.546. Nonetheless, the provider's or supplier's ability to bill Medicare is halted pending its compliance with § 424.540's requirements for reactivation.
- Due to its recent concerns with fraud and program integrity issues in certain areas, CMS is reducing the 12-month timeframe for deactivation currently in § 424.540(a)(1) to 6 months. CMS states in the final rule that one of its concerns involves the following situation: a provider that (1) establishes multiple enrollments with multiple billing numbers; (2) abusively or inappropriately bills under one billing number; (3) receives an overpayment demand letter or becomes the subject of investigation; (4) voluntarily terminates the billing number in question; and then (5) begins to bill via another of its billing numbers that is dormant (for example, 6 consecutive months without billing) but nevertheless active, repeating the same improper conduct as before. The problem in this case is that CMS cannot deactivate the dormant billing number (hence rendering it unusable and inaccessible pending a reactivation) under § 424.540(a)(1) because the applicable 12-month period has not yet expired. CMS feels that it must be able to move more promptly to deactivate these "spare" billing numbers so the latter cannot be inappropriately used or accessed.

More hospice regulation updates
Goal to identify and inhibit bad actors (cont.)

- ***Adding hospice administrators and medical directors to the definition of "managing employee"***
- **CMS is finalizing the change to this definition as proposed with one exception**
- Providers and suppliers are required to report their managing employees via the applicable Medicare enrollment application to enroll in Medicare. We currently define a "managing employee" in § 424.502 as a "general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier (either under contract or through some other arrangement), whether or not the individual is a W-2 employee of the provider or supplier."
- CMS states that, in their experience overseeing the Medicare provider enrollment process, hospice administrators and medical directors indeed exercise managing control over the hospice, and they have long required that they be reported as managing employees. Accordingly, CMS is adding the following language immediately after (and in the same paragraph as) the current managing employee definition: "*For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director*."

Industry actions in response

- Grassroots advocacy – making noise!
- Coordinated submission of comments and recommendations on the proposed rule made a difference
- NAHC believes methodology to calculate budget neutrality is non-compliant with Medicare law – yielding NAHC v. Becerra, US District Court for the District of Columbia
- Congressional action to eliminate or reduce permanent and temporary rate adjustments: S.2137, H.R.5159 - end of year effort to pause the cuts

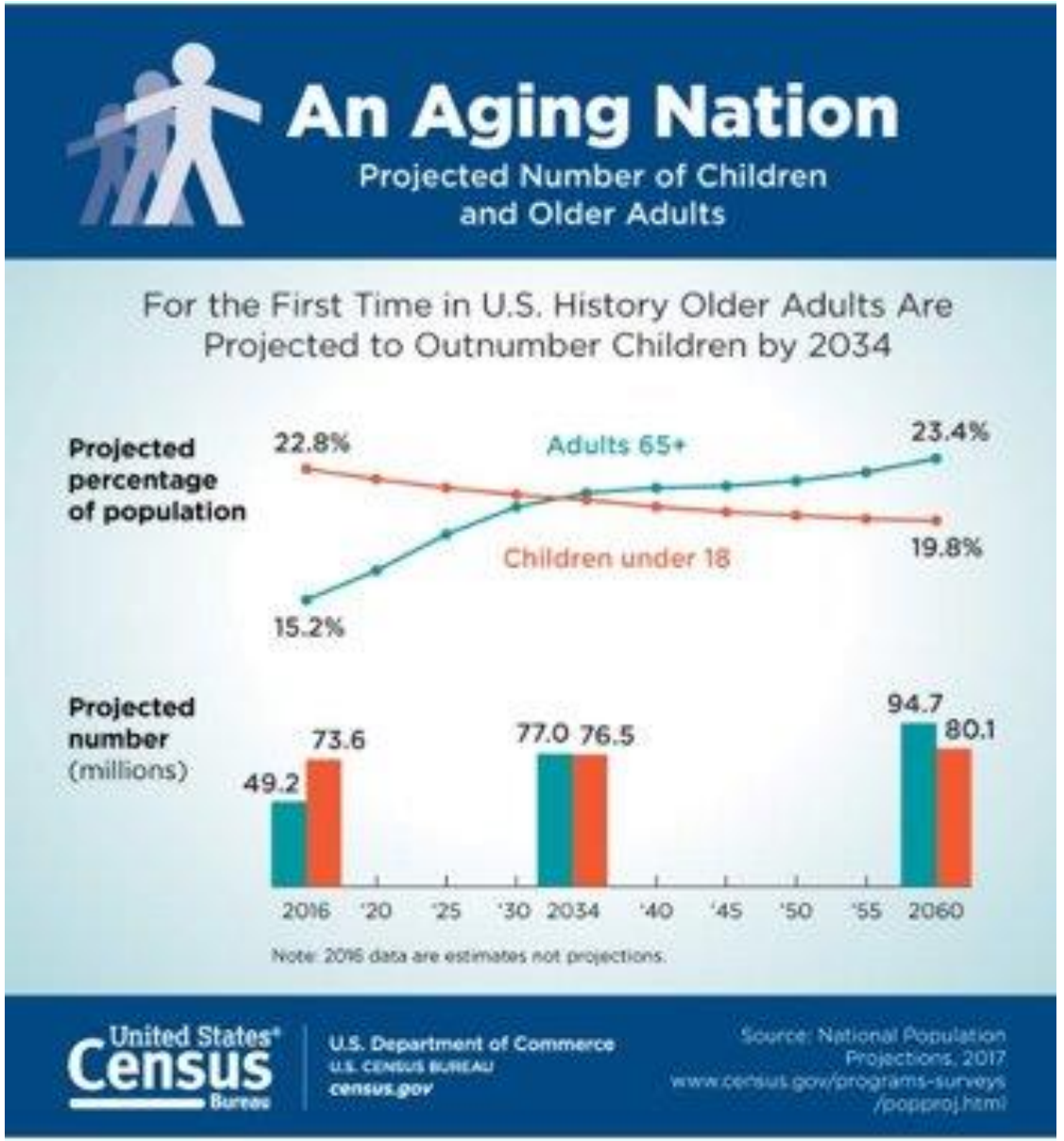
Now what?

Leadership – eyes wide open and leaning into innovation!

Context for operating within today's care provision in the home:

- Accelerating demand
- Dwindling supply of caregivers/clinicians, relative to demand
- Payment cuts and persistent change
- Increased pressure to drive high value care, with measurable outcomes that prove it:
    - HHVBP
    - Medicare Advantage Personal Care market penetration – appealing partnerships to meet HRSNs
    - Market consolidation, yielding shifts in competitive landscape
    - The answer?

Mindful stewardship of a mission through expansive period of change



The leader's challenge and opportunity

- Leverage foundational leadership theory:
  - Clear expectations of performance
  - Provide tools to meet the expectation
  - Have methodology to review adherence to desired process/behaviors
  - Hold folks accountable
- Now embrace the reality of change when evaluating and implementing the tools you need, and now have available, to get the job done
- Work to integrate innovative, data-fueled insight and supports into daily actions
- Collaborate along service lines, lending depth of care and enhanced outcome:
  - Palliative care and hospice
  - Personal care

Expect change as a constant – expect to be normalizing new ‘behaviors’

Rising demand, constricting resources and continued change, anticipate the market to adapt and innovate to meet growth in real-patient need/overall demand for increased care at home

Expect to see:

- Continued demand driving risk-based, best-practice utilization management, and clinical decision support
    - Normalized use of best practice performance and real-time predictive analytics in field and office
- Analytics applied to workforce support and capacity management solutions
- Normalized use of virtual care/communications and RPM integration into examples of specific patient cohort management: leveraged, today – advancing as we learn, tomorrow
- Effective leaders navigating the known turf of change, pro-actively and thoughtfully
- Competition will actively leverage innovation to adapt as we grow in service of demand
- **Home health is a growth market of need, compelling agile decision-making**
- **We are bullish on this market!**

Manage into risk: Integrate intelligent care management

Take a stand and use innovative tools to manage into risk and gain efficiency – can only help future performance!

Maximize HHVBP performance – promise of future revenue impact and immediate market positioning/competitive lift:

- Establish OASIS competence in assessment and data capture
- Achieve excellence in coding and review, targeted clinician micro-training based on patterns of documentation
- Integrate real-time, predictive analytics to:
  - ✓ Guide QAPI Performance Improvement Projects (PIPs)
  - ✓ Triage daily schedule to risk
  - ✓ Stack clinician skills in revised team conference
  - ✓ Leverage field use of analytics - "take five in the drive"
  - ✓ Benchmark to visits needed to achieve top results
- Integrate virtual telecommunications methodology and RPM to better connect with patients – aiding in reducing risk of ACH while building satisfaction

Manage into risk, gaining efficiency, and reducing cost

- Reduce avoidable staff turnover – utilize predictive workforce analytics

- Train leadership in functional/situational leadership theory and apply it, guided by data added to instinct

- Sniff out workarounds to operational problems left unsolved – gain efficiency through review of current operations and clinical modeling

    - Process engineer to LEAN and optimal use of EMR technology

    - Form follows function: do not inflate org structure based on inefficiencies

    - If concerned, consider operational/organizational review

ALERT!

Tell Congress to **STOP** cuts to home health.

WellSky

Be a voice – your community needs you!

- ✓ Contact your state and national trade associations - ask how you can add to grassroots advocacy
- ✓ **Our voice will be louder** if everyone makes a call, sends a letter, and reaches out to their representatives
- ✓ Go to **www.nahc.org** to watch for legislative advocacy opportunities
- ✓ Collaborate regionally and nationally to amplify our message

NAHC has put together an official email template, where providers can advocate to stop cuts to home health. You can find it here.

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"The conditions [man] tries to adjust to are going to change, and change so darned fast that he never will actually adjust to a given set of conditions. He'll have to adjust in a different way: he'll adjust to an environment of change."

— John W. Campbell

Thank you for what you are doing to carry our care into the future

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Improve documentation efficiency by 59%

Timely, accurate documentation is essential to providing quality care. **WellSky** software helps agencies **improve documentation efficiency** by an average of **59% in the first year**.

Source: *Average 1st year impact from a survey of WellSky clients*

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MEDTECH BREAKTHROUGH AWARD 2023

WellSky CareInsights helps providers **improve patient outcomes** through **fewer, more efficient visits.**

A recent study found that top users of WellSky CareInsights for Home Health experience:

26% lower 60-day acute care hospitalization rates*
45% lower visits per admission*

**Compared to non-users*

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Use your data to its fullest potential with WellSky Insights solutions for home-based care

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- **Accelerate growth**
- **Engage and manage staff**

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