HEALTH DIMENSIONS GROUP

Home Care: Current State and the Future

Minnesota Home Care Association (MHCA)

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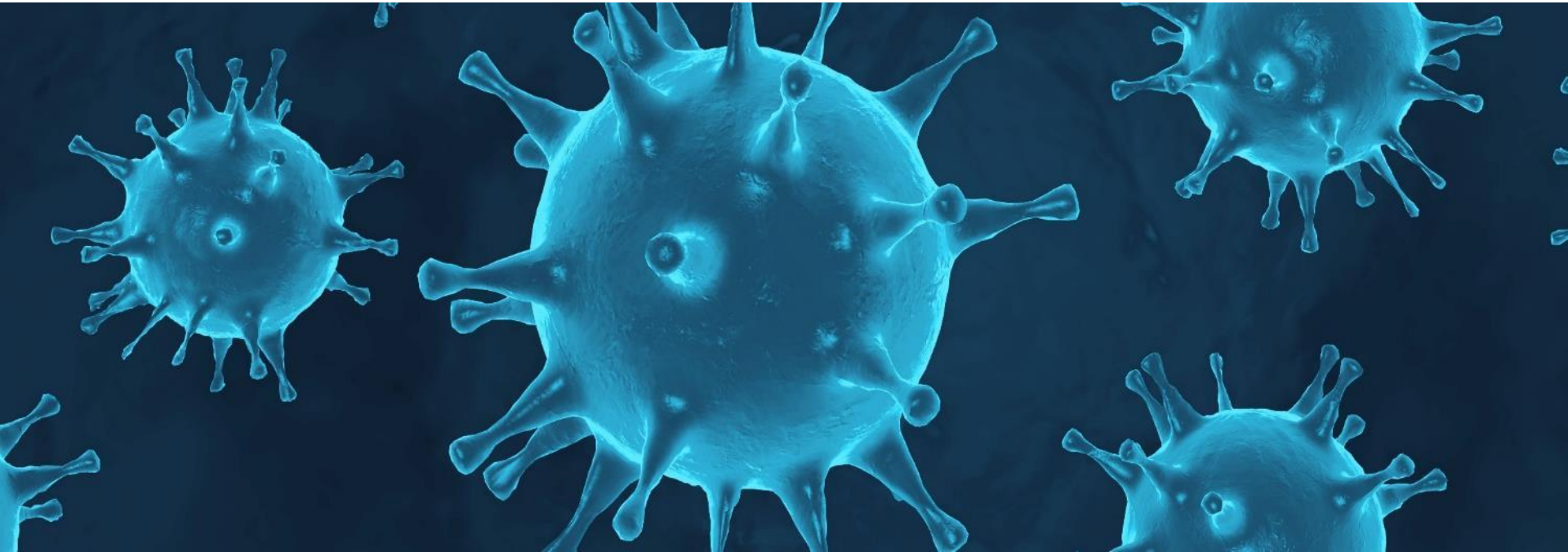
As **Vice President, Public Policy and Payment Transformation**, Brian Ellsworth has more than 35 years of experience in Medicare & Medicaid policy, payment, and care delivery transformation, with an emphasis on care integration for the chronically ill and value-based transformation. Brian has previously held leadership roles with LeadingAge NY, CT Association for Healthcare at Home, AHA and NYSDOH.

About Health Dimensions Group

HDG is a leading management and consulting firm, providing services to post-acute, long-term care, and senior living providers, as well as hospitals and health systems, across the nation

Today's Objectives

- Understand key trends affecting home care nationally and in MN
- Have dialogue and brainstorm about how the Association can help members survive and thrive
- Lay the groundwork for specific strategies and tactics to be incorporated into the Association's updated strategic plan



Home Care: Current State and Future

- Shifting Landscape for Providers
  - Changing Utilization
  - Workforce Challenges
- Return to Value-based Payments
  - HHA VBP
  - PDGM
  - Telehealth
- Driving Care to Home – Acute Care at Home, Choose Home
- State Medicaid Outlook
  - State Budget
  - Electronic Visit Verification
  - American Rescue Plan
- Review Choice Demonstration

Shifting Landscape for Providers

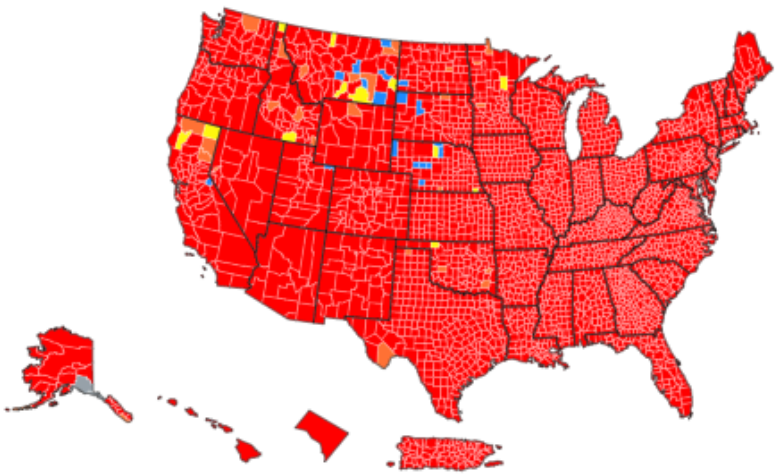
COVID-19:
A Bumpy Ride Continues

- COVID-19 has been especially harmful to vulnerable elders and is easily transmissible by asymptomatic individuals
- Over the last year and a half there has been rapid evolution in clinical practices, testing, and vaccines, as well as a transformation of markets for health care and senior services

In this context, it is important to set realistic and flexible goals and to think long term

COVID-19 Community Transmission Very High Across the Country

Level of Community Transmission of All Counties in US



Community Transmission in US by County

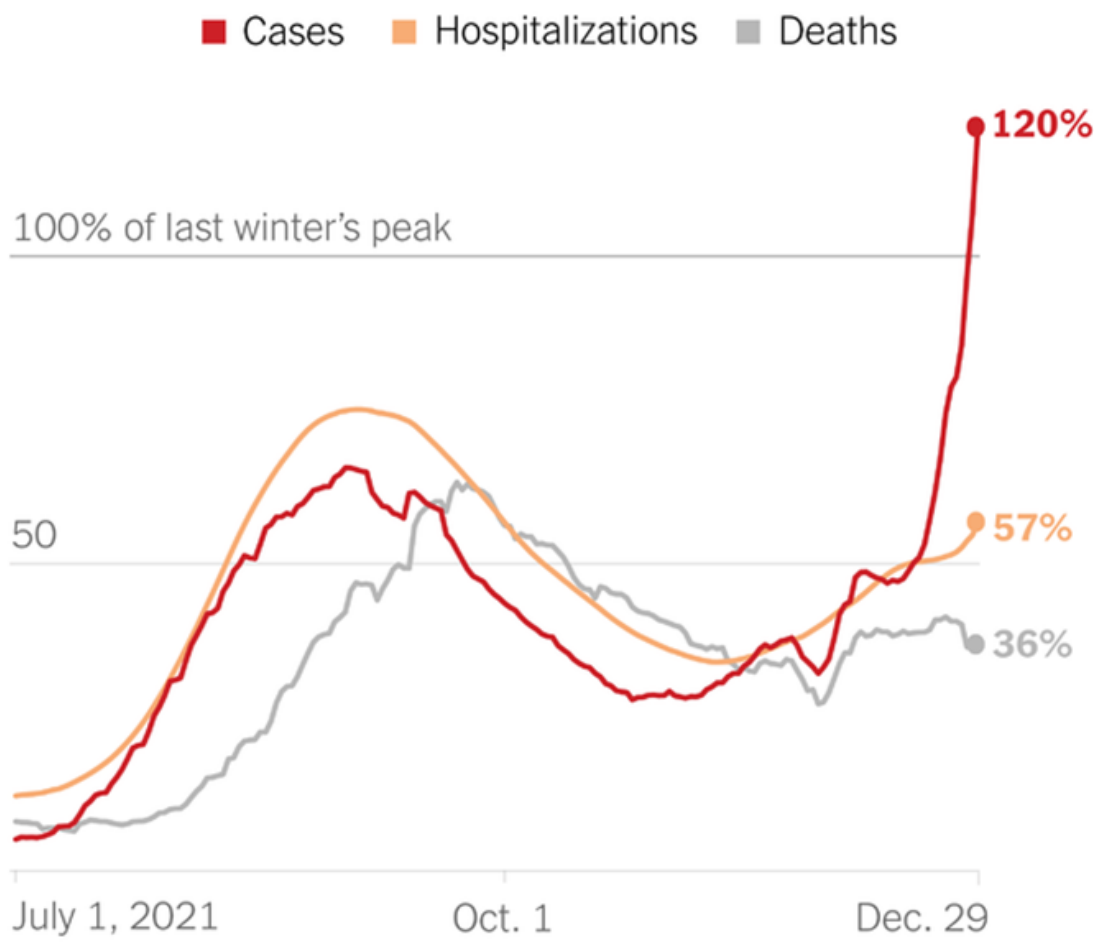
	Total	Percent	% Change
High	3123	96.93%	9.31%
Substantial	46	1.43%	-5.99%
Moderate	26	0.81%	-2.61%
Low	23	0.71%	-0.71%

How is community transmission calculated?

High Substantial Moderate Low No Data

Source: COVID-19 Data Tracker, accessed 1.05.22

How US COVID-19 Cases Compared to Last Winter



Source: NY Times, January 3, 2022

Moving from Pandemic to Endemic?

- **Good news:** 1) vaccines remain effective at stopping hospitalization and deaths, and 2) immunity from severe disease appears to be relatively long-lasting for many persons (through B and T-cells)
- **Bad news:** 1) variants are much more transmissible, and 2) immunity from mild infection appears to wane, raising the question of boosters for at-risk individuals, 3) unknown effects of long-haul COVID-19

Driving Vaccination

- Over 9 billion doses administered worldwide
- Vaccine uptake with vulnerable elders has been more successful than with workforce

Nursing Home Vaccination Rates

Cohort	MN
Staff	78%
Residents	93%

- Federal and state government (as well as employer) vaccine mandates have been replacing incentives and encouragement

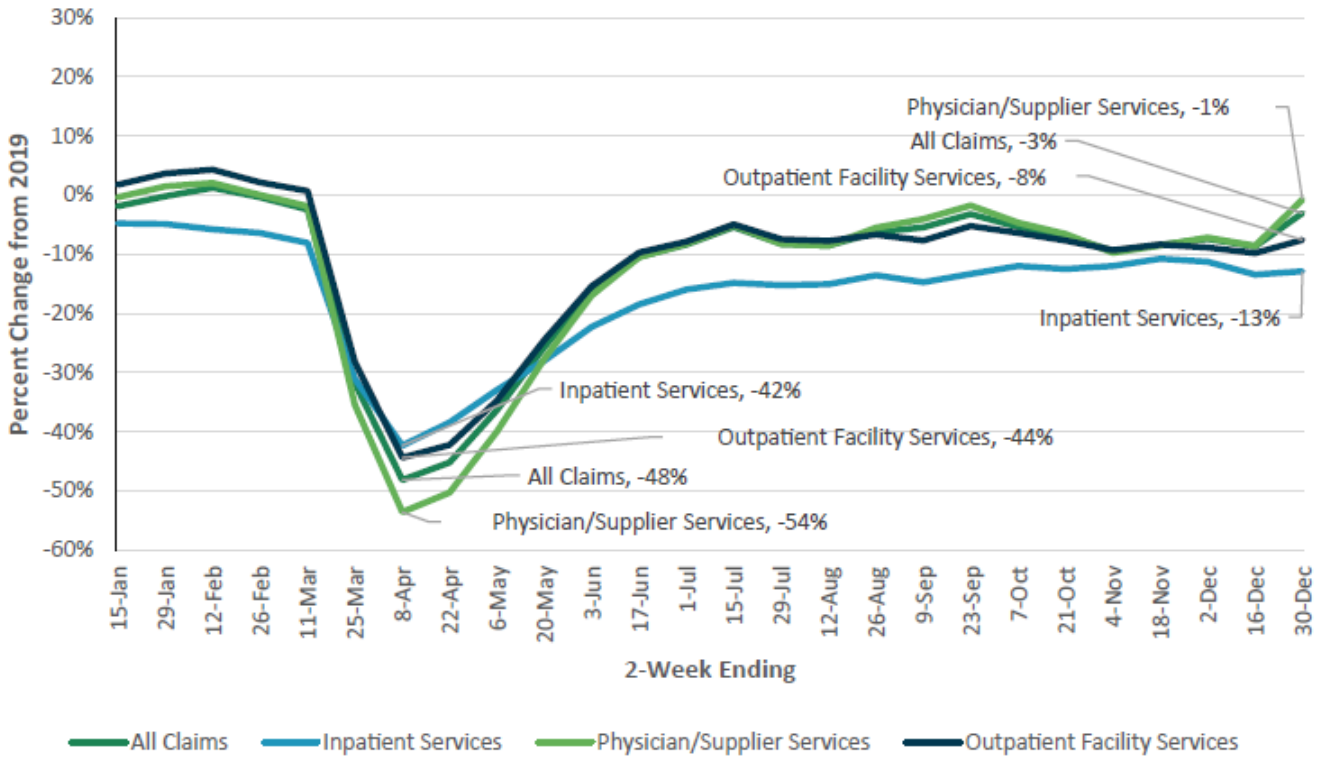
Source: https://data.cms.gov/covid-19/covid-19-nursing-home-data, accessed 1.05.22

COVID-19 Caused Tectonic Shifts in Health Care

- Telemedicine increased rapidly, but has leveled off
  - Behavioral and other providers appear to be adopting
- Flu cases dropped dramatically in 2020–2021 season, but there is now some evidence that flu is returning
- Delayed care at all levels
  - Postponed diagnostic procedures and elective surgeries
  - Delayed placement in memory care from independent settings
- Shifts in referral patterns
  - Shift from inpatient to outpatient care in some markets
  - “Skip the SNF” for rehab and go straight home with HHA

Medicare Utilization Took Big Hit in 2Q 2020, Bounced Back Somewhat Starting 2021

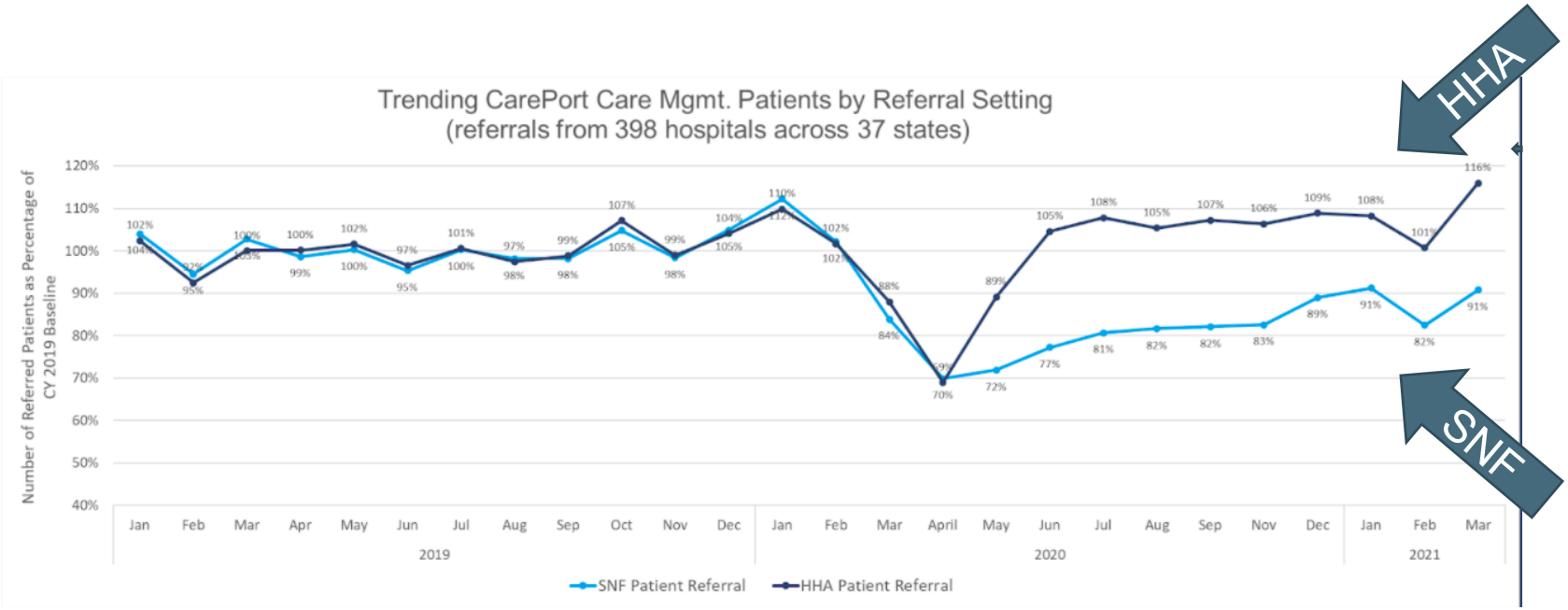
2020 Medicare Claims Compared to 2019 Baseline by Service Line



Timing of data analysis now very important

Source: U.S. Department of Health & Human Services, Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy, ASPE Issue Brief, June 28, 2021

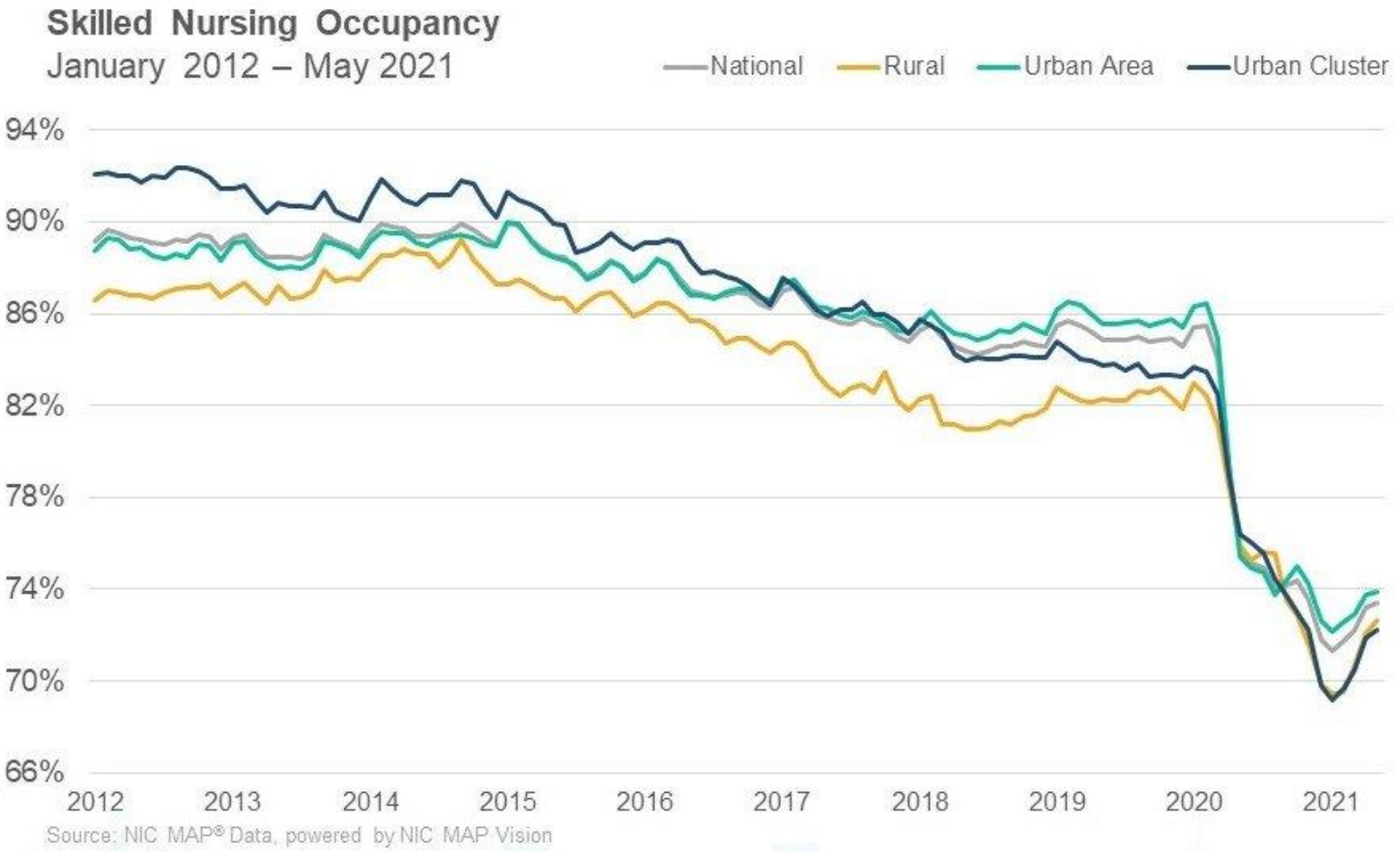
Hospital Referrals Compared to Baseline: Took Different Path After March 2020



Return of elective surgeries & recovery of hospitalizations is uneven in markets across the country, with some markets having rapid bounce back & others slower

Source: *Skilled Nursing News, May 11, 2021, SNFs Continue to Battle Depressed Referrals as Hospital Inpatient Volumes Recover*

National Skilled Nursing Occupancy Took Sharp Dive, but Rebounding Somewhat



Minnesota Nursing Home Occupancy Has Dropped and Stayed Down

MN SNFs	4Q 2019	2Q 2020	1Q 2021
Total	85%	77%	74%

Source: HDG analysis of CMS and NHSN Data, analysis of common SNFs in database

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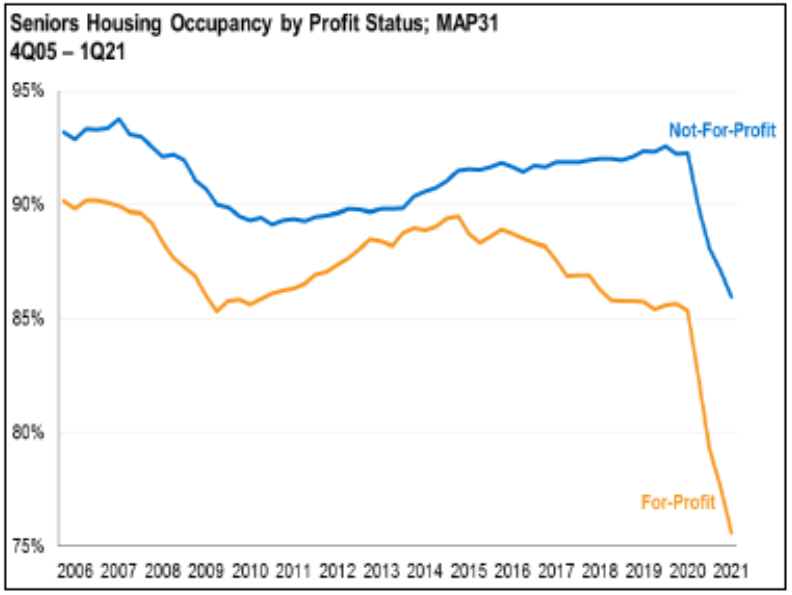
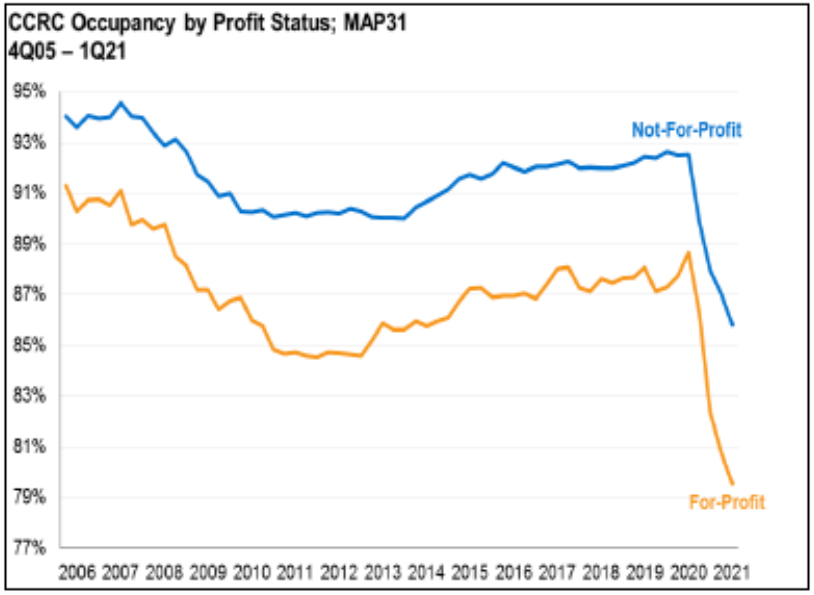
Seniors Housing and CCRC Occupancy Trends





Property Type	Q1 2021 National Occupancy (FP & NFP)
CCRCs	84.4%
Seniors Housing	78.9%
Majority IL	82.2%
Majority AL	75.5%
Majority SN	74.1%

CCRC Segment	Q1 2021 Occupancy (both FP and NFP CCRCs)
Independent Living	88.6%
Assisted Living	82.5%
Memory Care	82.5%
Nursing Care	76.5%

Source: National Investment Center

Upward Shift in Acuity

- Average age of assisted living residents is now 85
- People in this setting are dealing with complex and costly medical needs
- The number of people in the U.S. with Alzheimer’s and related dementias expected to double by 2050

Shift in Assisted Living Regulations

- More than half of U.S. states have made changes to their AL regulations, including Minnesota
- National changes include:
  - Language around abuse/neglect
  - Investigating/reporting
  - Emergency preparedness plans
  - Staffing requirements
- MN AL changes
  - Replaces housing with services model with new licensure rules
  - Dementia care separate licensure category

MN Demographics Indicate Modest Growth in 85+ Cohort for Next Five Years, More Favorable for 65 to 75+

Older baby boomers will not reach age 75 until 2021

1964

1946

Age Cohort	MN Percent Change 2020–2025	National Percent Change 2020–2025
18–20 Years	5.2%	3.0%
21–24 Years	5.8%	3.0%
25–34 Years	-2.9%	-2.7%
35–44 Years	3.6%	4.6%
45–54 Years	-1.1%	-1.6%
55–64 Years	-1.9%	0.7%
65–74 Years	20.7%	19.0%
75–84 Years	15.8%	14.0%
85+ Years	3.9%	6.2%
Total	3.5%	3.3%
65+ Years	17.1%	16.1%
75+ Years	12.1%	11.7%
85+ Years	3.9%	6.2%

Entry-level workers

Senior-level workers/Adult children

Target Population Senior Services

Target Population Senior Living

Highest Users of Services

Source: Environics Analytics and Health Dimensions Group

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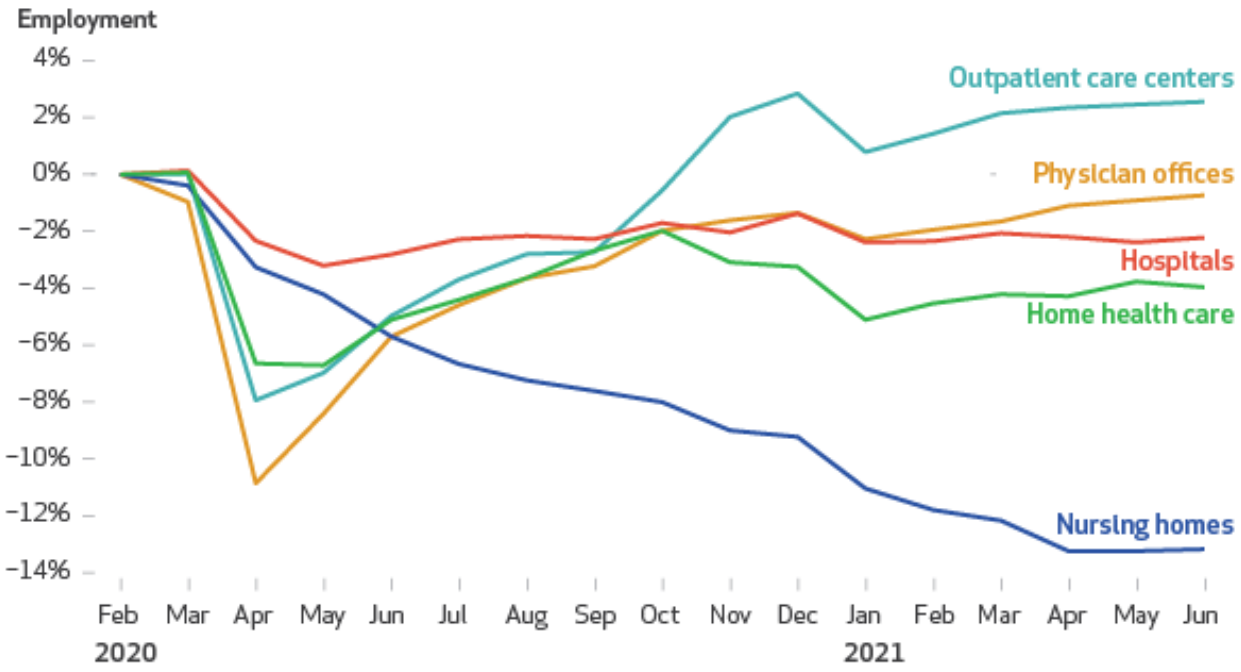
Total Monthly Employment in US Nurse Workforce in Major Sectors

Total monthly employment in the US nurse workforce in major health care sectors relative to February 2020, 2020–21



Peter I. Buerhaus et al. Health Aff 2022; 41:79

Health Affairs

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Workforce Concerns in General

- "***The Great Resignation***"
  - Workers leaving their jobs in a search for meaning and fulfillment
  - Early retirement for older workers
  - Burnout from prolonged stress in certain occupations, especially health care
- Continued concern about unintended incentives for people to stay at home instead of working
- Declining US labor force participation rates
-

Declining US Labor Force Participation Rate

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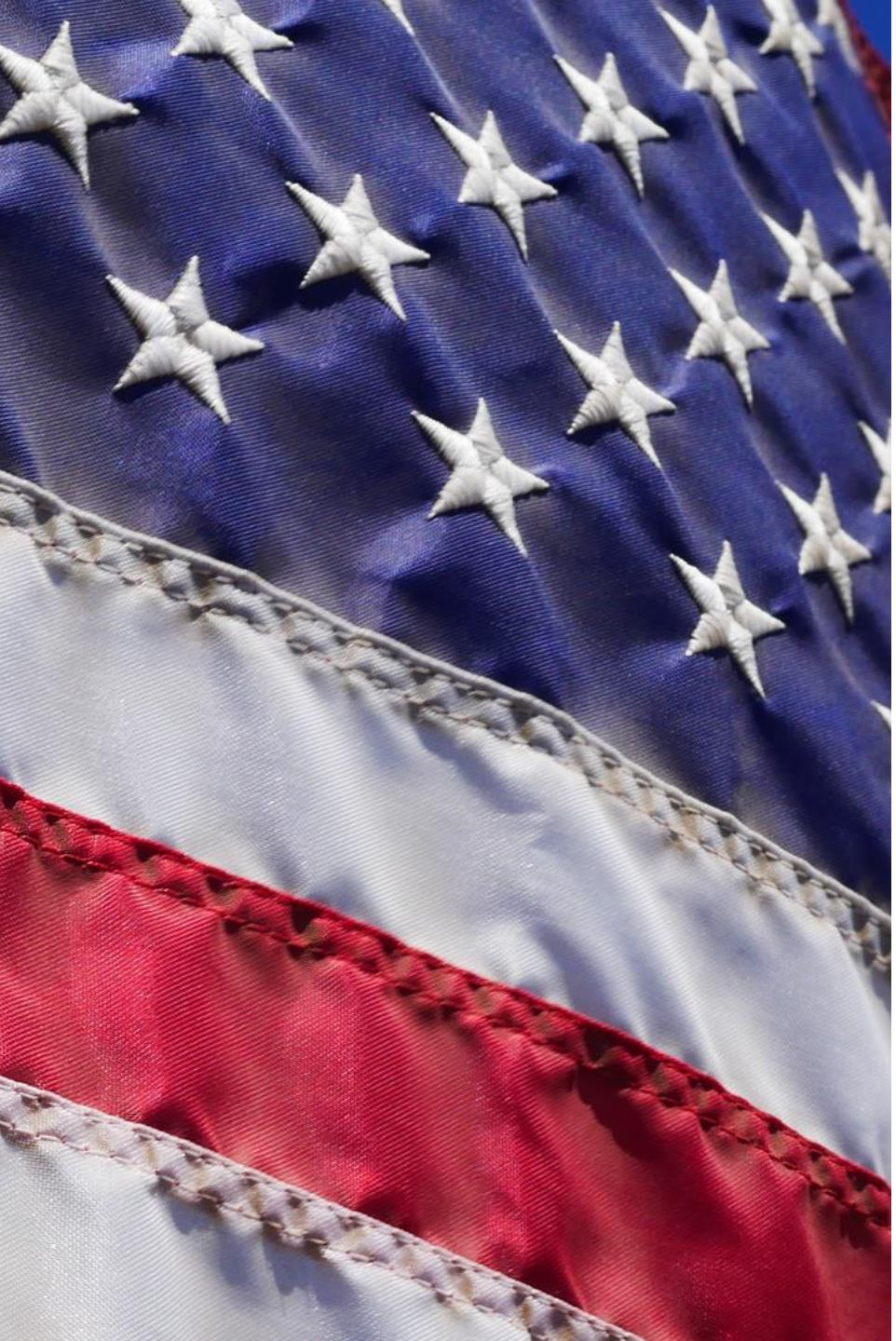
Shift in Employee Expectations

- Work/life balance
- Search for meaning and purpose
- Willingness to leave a toxic culture
- Sense of belonging
- Opportunity for development
- Flexibility/autonomy

National Workforce Trends We Are Seeing

- Flexible workplace
  - Flexibility with schedules and work/life blending
- Advancement of technology platforms
  - Video conferencing, virtual workspaces, and increased cybersecurity
- Employee health and safety
  - New and attractive benefit offerings, mental health, telehealth
- Focus on culture change
  - Enhanced orientation, among other things
- Creative wage and bonus programs
  - Many now focusing on retention of workers
  - In some cases, large increases for paraprofessionals
- Reskilling of workers

Source: www.shrm.org/hr-today/news/all-things-work/pages/the-workplace-in-2025.aspx



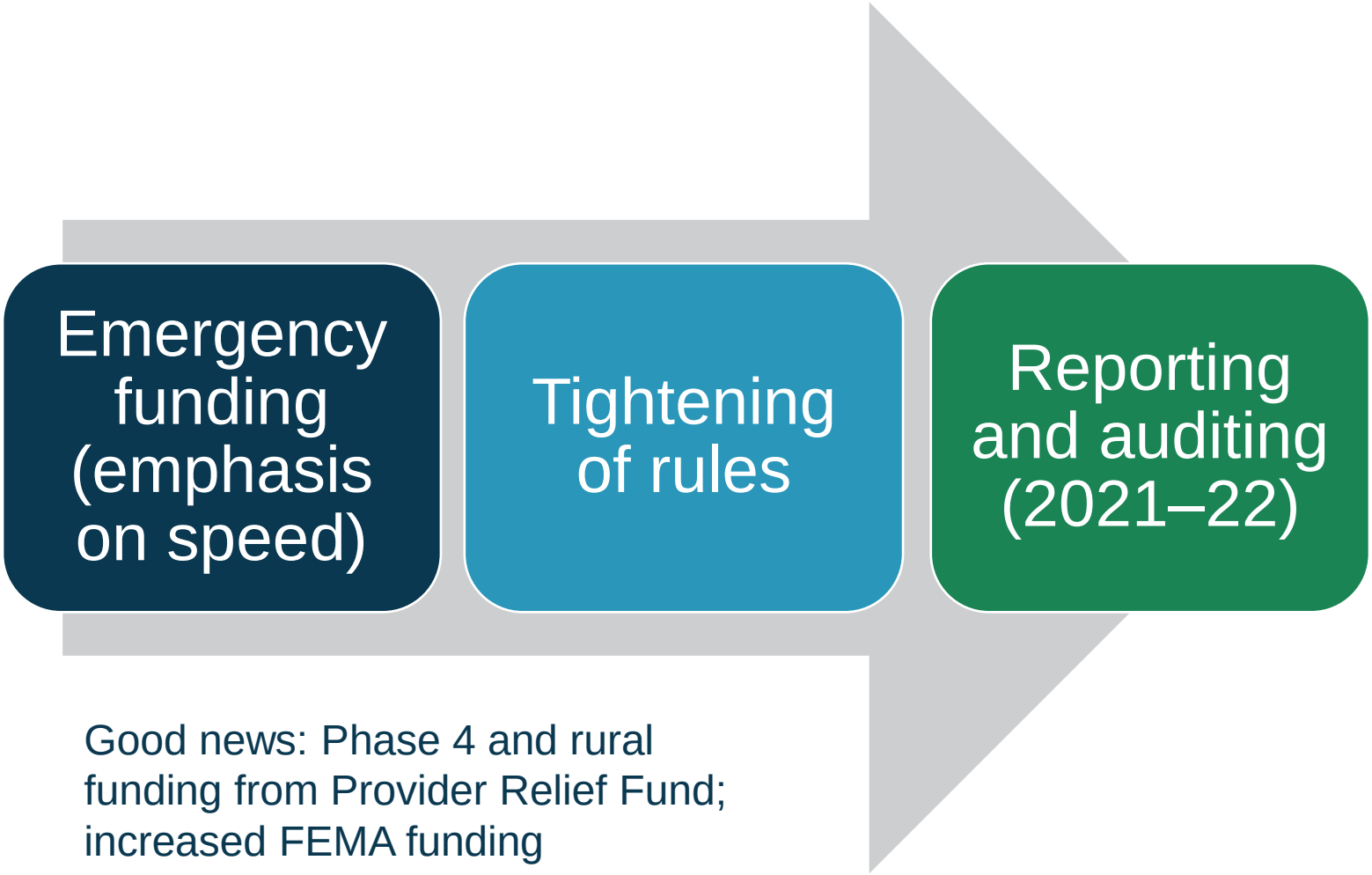
Active Federal Environment

- Home- and community-based services (HCBS) are a priority for Biden administration
  - Enhanced federal match
  - States required to submit HCBS plans to Washington
- Regulatory scrutiny is a priority as well
  - Survey scope and frequency
  - Enhanced civil and monetary penalties
- Build back Better Act
  - Negotiations challenging

Federal Regulatory Environment Considerations

- Vaccine mandates, evolving rules on testing, visitation, dining, activities
- Stepped up survey activity
  - Focus on infection control
  - Increased scrutiny of hospice
- Eventual expiration of waivers (120 days after end of PHE)
  - Aide training and supervision
  - IMPACT Act: requirements for hospital discharge planners to share quality and resource data on post-acute care
- Recovery Audit Contractors increasing document requests

Provider Relief Shifting from Funding to Accountability



Good news: Phase 4 and rural funding from Provider Relief Fund; increased FEMA funding

We Now Face New Realities

- Ongoing vigilance on infection control and virus management
- Concerns about sending high-risk patients to multiple settings unnecessarily
- New reality of revenue, expenses, marketing and workforce

Implications for the Future of Home Care

- COVID-19 has the likelihood of evolving from pandemic to endemic due to vaccine effectiveness, increase in natural immunity and infection control measures, which will also have spillover effect for other illnesses (e.g., flu)
- Much of the short-term emphasis on aging-in-place will persist after the pandemic, affecting referral patterns until the 85+ cohort population demographics take over and drive care patterns
- Assume increased pressure from Medicare for value-based care over time, which ultimately requires assumption of downside risk in fee-for-service and increased dealings with managed care plans

Implications for the Future of Home Care

- The short-run picture for Medicaid LTC spending is *less unfavorable* than usual due to federal stimulus funds and reduced spending from pandemic; over time, home and community-based (HCBS) models will increase pressure on freestanding institutional providers
- In many markets, ongoing labor challenges will require a proactive, multi-pronged approach, including specific strategies to attract and retain younger and older workers, enhanced compensation, flexible work environments and organizational culture change

Return to Value-Based Payment

Pending Insolvency of Medicare Trust Fund Means More Pricing Pressure to Follow

- Medicare Trust Fund is projected to become insolvent by 2026, meaning tax increases and/or spending cuts will be necessary
- Only the second time in 30+ years that we have been within 5 years of insolvency
- Medicare can only pay 90% of benefits after 2026 absent action

Reinvigorating the March towards Value-Based Care: Recent CMS Innovation Center "Strategy Refresh"

- Innovation Center Strategy Refresh: https://innovation.cms.gov/strategic-direction-whitepaper
- CMS has announced that it expects all Medicare beneficiaries with Parts A and B to be in an ACO-type arrangement for quality and total cost of care by 2030
- At the same time, the "vast majority" of Medicaid beneficiaries will also be treated by a provider in one of these value-based care models at the same
  - CMS will provide tools and support for other payors besides Medicare to develop and implement aligned value-based payment approaches

Source: https://revcycleintelligence.com/news/cms-lays-out-new-strategy-for-advancing-value-based-care-apms

Home Health Value-Based Purchasing Adopted

- New national program modeled after 9 state pilot, adopted for implementation on January 1, 2023
- Plus/minus 5% adjustment to Medicare rates for 2025 based on 2023 performance
- **Achievement** or **Improvement** score calculated based on performance on 8 measures compared to national norms:
  - Patient assessment data (35% weight)
  - Medicare claims (35% weight)
  - Patient satisfaction survey (30% weight)

Final Rule Will Help HHAs Prepare for Broad-Based VBP, Hospitalization About 25% of the Weight

Home Health Value-Based Purchasing Metrics

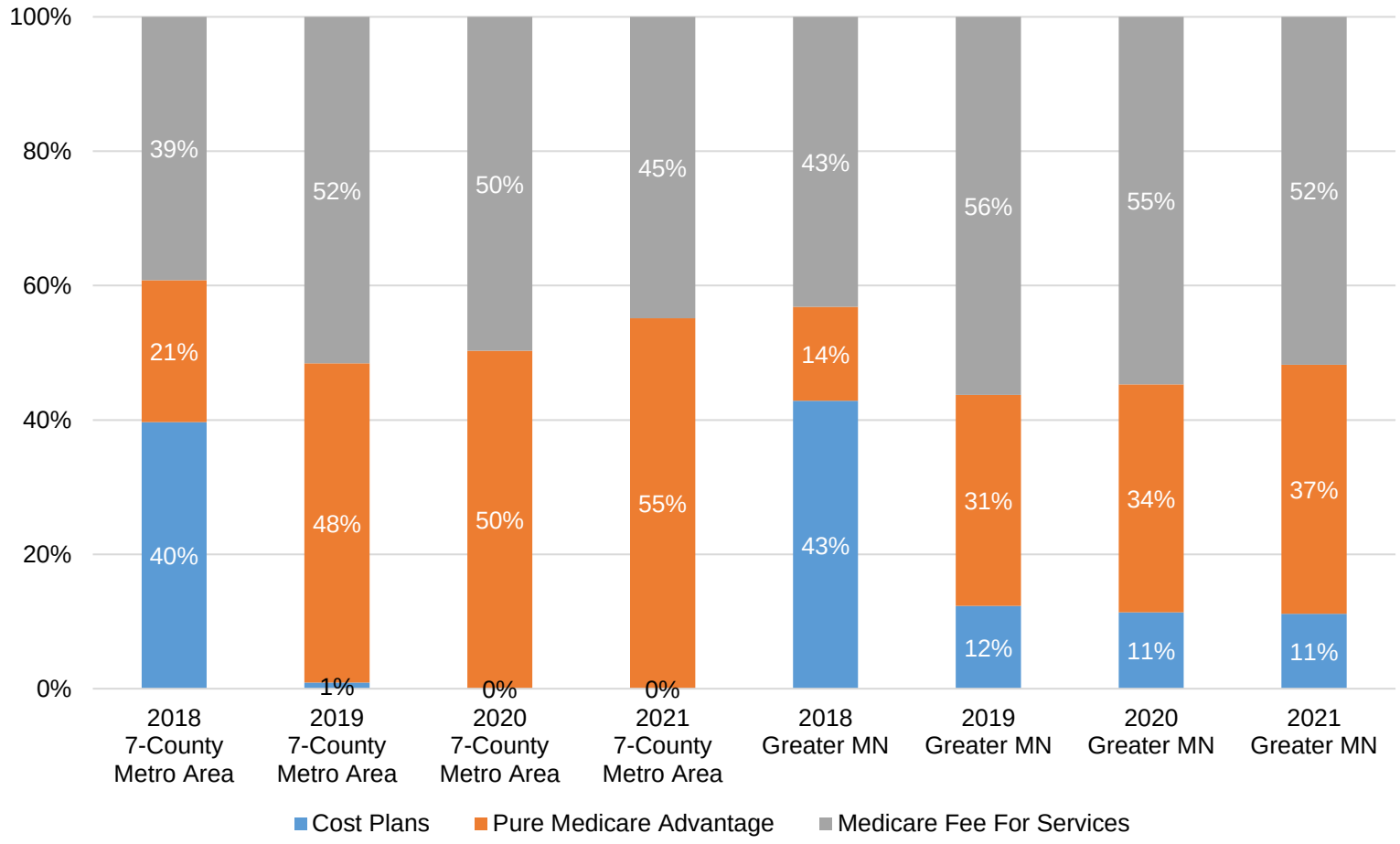
Domains	Measure	Data Source
Clinical Quality of Care	Improvement in Dyspnea (Shortness of Breath)	Patient Assessment
Communication & Care Coordination	Discharged to Community	Patient Assessment
Patient Safety	Improvement in Management of Oral Medications	Patient Assessment
Patient and Family Engagement	Total Composite Score Change in Mobility*	Patient Assessment
Patient and Family Engagement	Total Composite Score Change in Self-Care**	Patient Assessment
Efficiency & Cost Reduction	Hospitalization During First 60 Days of Home Health Use	Medicare Claims
Efficiency & Cost Reduction	ED Use without Hospitalization During the First 60 Days of Home Health Use	Medicare Claims
Patient & Caregiver-Centered Experience	Home Health Consumer Assessment Healthcare Providers and Systems (HHCAHPS) Survey	Patient Satisfaction

Patient Driven Groupings Model (PDGM)
Heading to Year Three

Opportunities	Challenges
• 2.6% net increase in base rates • Better payment for medically complex care • No-pay RAPs moving to NOA in 2022	• Coding accuracy • Managing second episode LUPAs • Moratorium on 2% sequestration set to expire next July • Recovery audit contractors resuming efforts after pause

PDGM imperatives: full and accurate coding and managing trajectory of care over multiple episodes

Medicare Advantage Market Has Been Undergoing Change in MN for Years

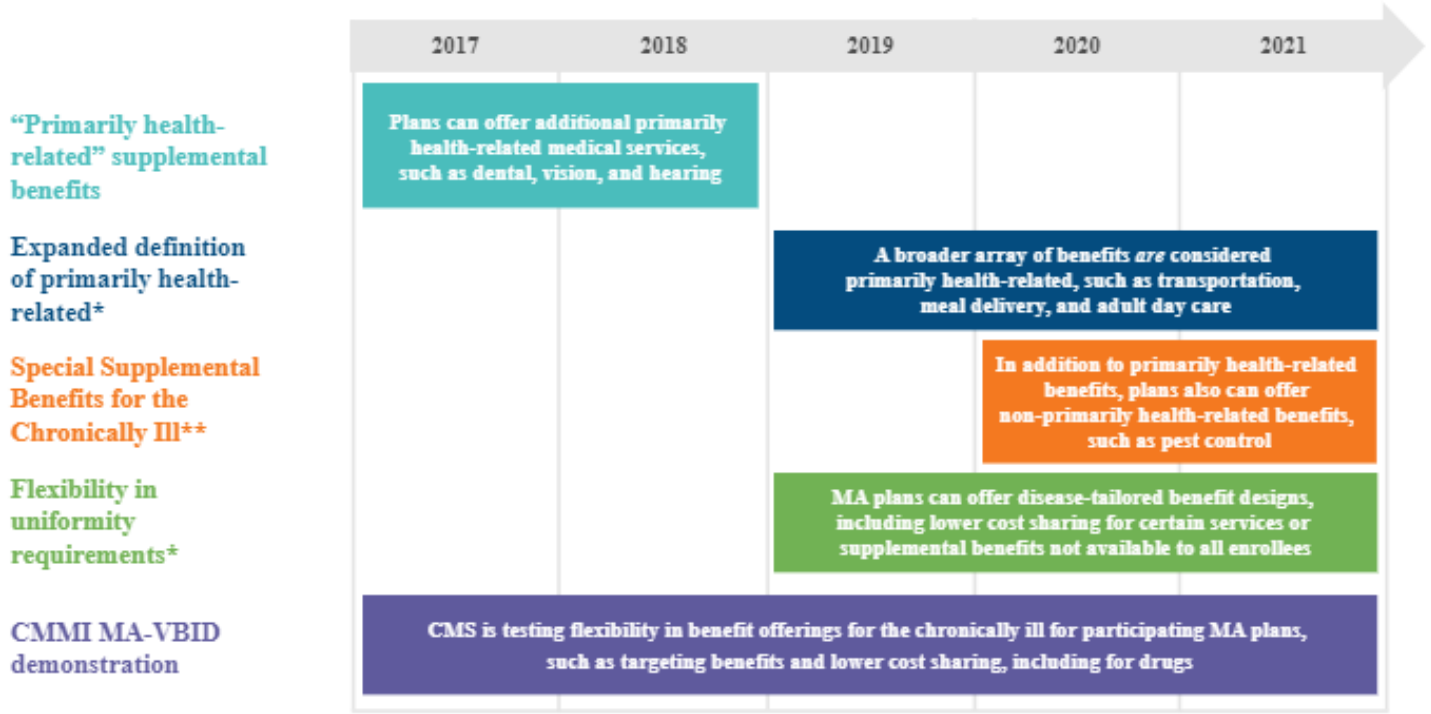


As Medicare Advantage Grows, It Is Evolving Too

- For the last 2 years, Medicare Advantage plans have been allowed to add "**supplemental benefits**" for services not covered by Medicare, such as adult day care, non-emergency transportation, and in-home support, providing new opportunities for innovative partnerships with LTC providers
- Some Advantage plans flexibly responded during the pandemic, allowing telemedicine and payment flexibilities
- A small number (32) of Medicare Advantage plans are participating in the "Hospice Care-in" demonstration through VBID program
- Unfortunately, as these plans grow, pressures on providers can increase accordingly: slow or inadequate payments, administrative hassles, or out-of-date contracts are just a few of the issues that may arise
  - As revenues tighten and managed care expands, it will be vital to make sure contracts and administrative processes are in order

Source: www.bettermedicarealliance.org

Timeline of New Medicare Advantage Plan Flexibilities



Notes: Years correspond to when policy changes took effect. MA = Medicare Advantage; CMMI = Center for Medicare and Medicaid Innovation; VBID = Value-Based Insurance Design; CMS = Centers for Medicare and Medicaid Services.
* Included in CY 2019 Rate Announcement and Final Call Letter.
** Enacted as part of the CHRONIC Care Act, BBA of 2018.

Source: Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment* (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/345k-kc32

Types of Medicare Advantage Supplemental Benefits

Traditional primarily health-related benefits (2018 and earlier)

- Vision
- Dental
- Hearing
- Fitness
- Over-the-counter benefits
- Limited additional services, such as:
  - rides to medical appointments
  - certain number of meals following inpatient stays
  - home-based palliative care

Expanded primarily health-related benefits (starting in 2019)

- All traditional primarily health-related benefits
- Expanded additional services, such as:
  - more-generous meal benefits
  - additional rides
- New services, such as:
  - adult day care
  - community-based services
  - caregiver support

Special Supplemental Benefits for the Chronically Ill (starting in 2020)

- Complementary therapies
- Pest control
- Food and produce
- Meals
- Nonmedical transportation
- Structural home modifications
- Service dog support
- Social needs benefit
- Transitional/temporary supports
- Indoor air quality equipment and services

Source: Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment* (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/345k-kc32

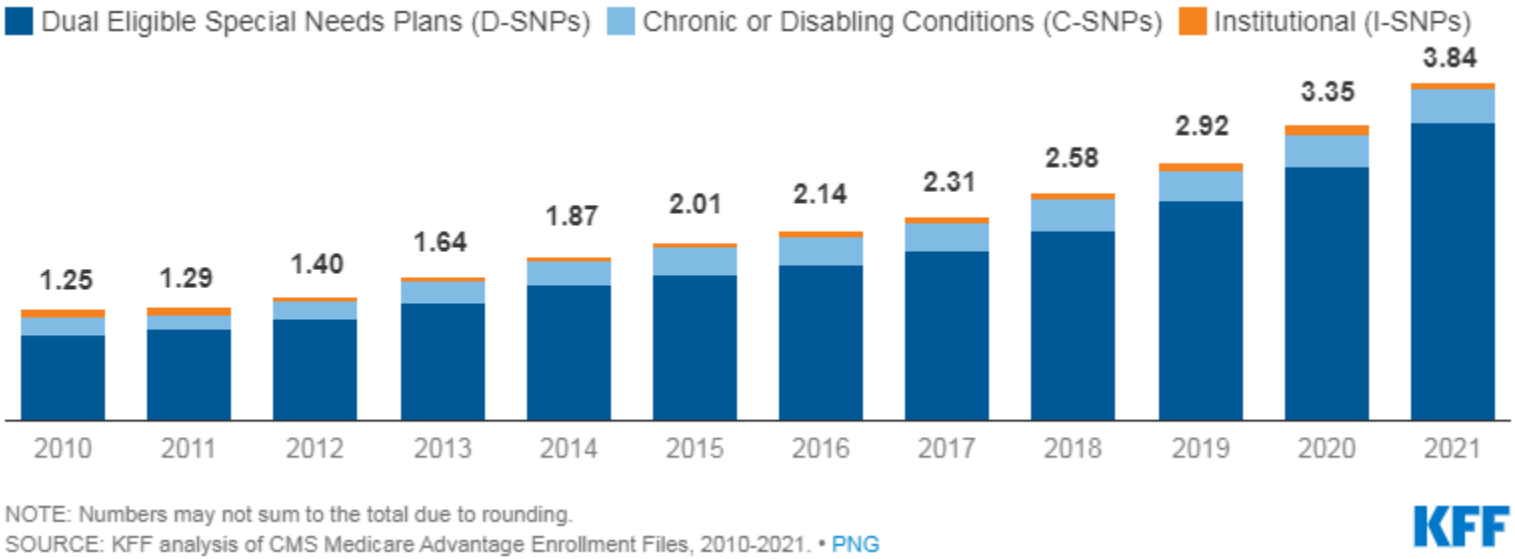
In-Home Support Services Growing Rapidly as a Medicare Advantage Supplemental Benefit

BENEFIT	CY 2020 PLANS	CY 2021 PLANS	CY 2022 PLANS
Adult Day Health Services	63	88	42
Home-Based Palliative Care	58	128	141
In-Home Support Services	148	296	544
Support for Caregivers of Enrollees**	77	87	144
Therapeutic Massage	180	152	160
Total	351	575	824
Plans offering more than one benefit	96	175	202

* Excludes EGWPs, Cost plans, MSA plans, MMPs, and dual-eligible special needs plans (D-SNPs); D-SNPs excluded as these benefits were previously allowable benefits for D-SNP beneficiaries; 4,583 plans in CY 2022 are subject to this reinterpretation.

** Support for caregivers of enrollees classified differently in CY 2019.

Increase in Medicare Advantage SNPs Expected to Continue



Source: Kaiser Family Foundation

MN Home Care Agency Forms Joint Venture with Managed Care Plan

- Minnesota's largest Medicare Advantage plan (UCare) recently made a "strategic investment" in Lifespark, a home care, hospice, and senior living company
- First direct investment in a provider for UCare
- Lifespark brings to the table:
  - Focus on holistic and longitudinal care
  - EMR and analytics platform that includes social determinants of care
  - A portfolio that now includes 35+ senior living properties
- UCare is now able to differentiate itself in the Medicare Advantage marketplace

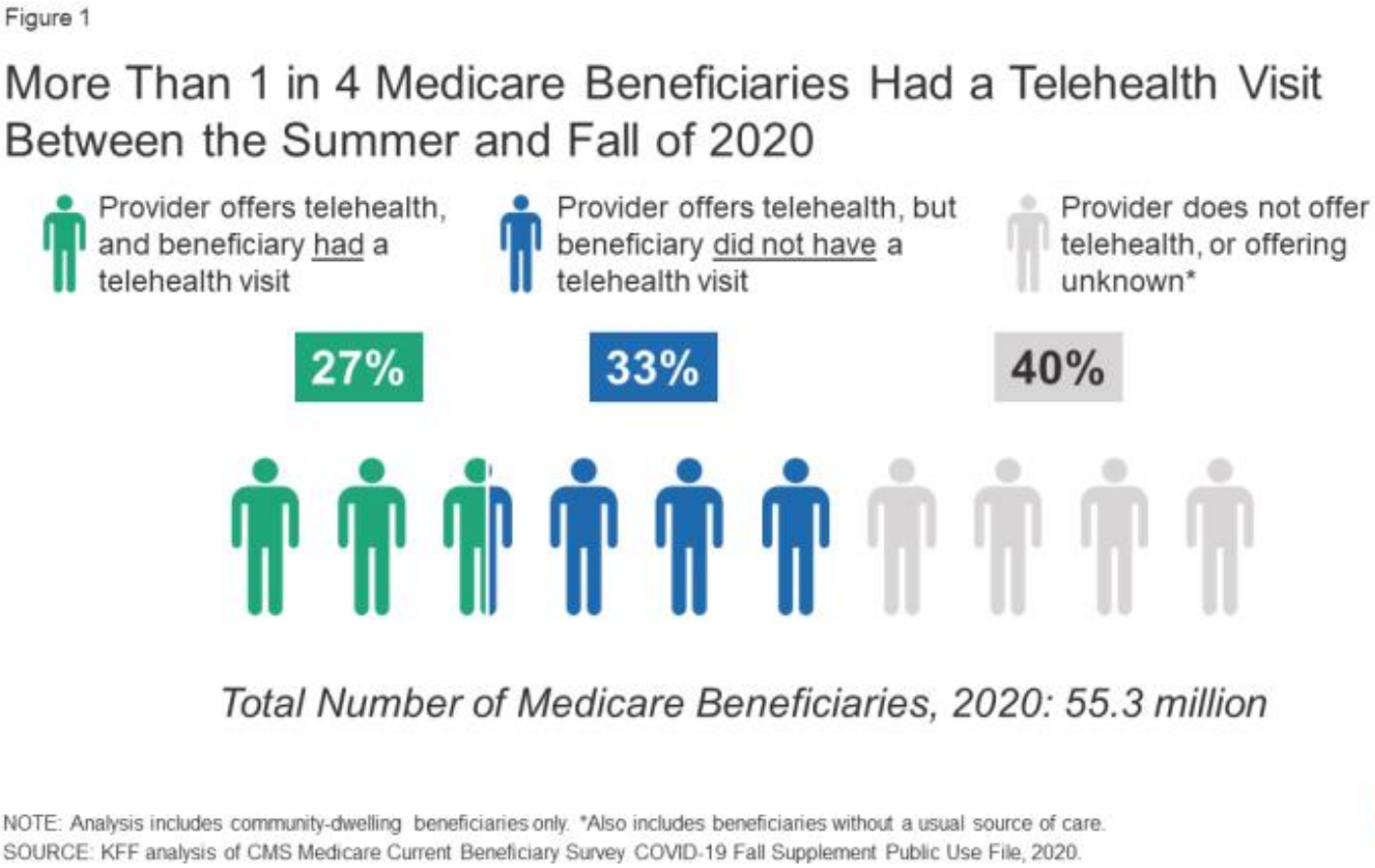
Innovative Programs/Risk Arrangements on the Rise

- Medicare Advantage plans increasingly turning to value-based arrangements, especially with large systems and their CINs
- Development of provider-sponsored Special Needs Plans (SNPs) continuing; I-SNPs with SNFs and Institutional-Equivalent for AL
- Hospice carve-in model with select Medicare Advantage plans
- Increasing arrangements between ACOs and LTC providers: see, for example, LTC ACO sponsored by Genesis
- Direct Contracting model with physicians for high-risk populations
- Acute Care at Home demonstration and Choose Home proposed legislation pushing inpatient care to home setting

Telehealth – Home Health Implications

- CMS finalized the April 6, 2020, publication, which will allow HHAs to continue to utilize telecommunications technology to provide care to beneficiaries beyond the COVID-19 Public Health Emergency Interim Rule (PHE). The care must be a covered Medicare home health benefit.
  - The requirements will be in effect as long as the telecommunications technology is:
  - Related to the skilled services being furnished
  - Outlined in the plan of care
  - Tied to a specific treatment goal indicating how such use would facilitate treatment outcomes
- The use of technology may not be used:
  - To substitute an in-person visit required by the patient's plan of care
  - As a visit for eligibility and payment
- HHAs may continue to report the cost of telecommunications technology as allowable administrative costs on the HHA cost report beyond the PHE.

Telehealth – Bigger Picture



Source: Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/

Driving Care to Home

Acute Hospital at Home

- The Acute Hospital Care at Home program is an expansion of the CMS Hospital Without Walls initiative launched in March 2020 as a part of an effort to increase hospital capacity and combat COVID-19
- This program creates additional flexibility that allows for certain health care services to be provided outside of a traditional hospital setting and within a patient's home
- **53 health systems, 116 hospitals in 29 states** are currently included within the program

Acute Hospital at Home – Program Requirements

- Appropriate screening protocols in place before care at home begins to assess both medical and non-medical factors
- Physician or advanced practice provider evaluate each patient daily either in-person or remotely
- RN evaluate each patient once daily either in-person or remotely
- Two in-person visits daily by either RNs or mobile integrated health paramedics based on the patient's nursing plan and hospital policies
- Capability of immediate, on-demand remote audio connection with an Acute Hospital Care at Home team member who can immediately connect either an RN or MD to the patient

Acute Hospital at Home – Program Requirements

- Ability to respond to a decompensating patient within 30 minutes
- Tracking several patient safety metrics with weekly or monthly reporting, depending on the hospital's prior experience level
- Establishing a local safety committee to review patient safety data
- Using an accepted patient leveling process to ensure that only patients requiring an acute level of care are treated
- Providing or contracting for other services required during an inpatient hospitalization

Patients will only be admitted to the program from emergency departments and inpatient hospital beds, and an in-person physician evaluation is required prior to starting services at home

MN Acute Care at Home Participants

- Allina Health – approved January 13, 2021
  - Abbott Northwestern Hospital
  - Mercy Hospital
  - St. Francis Regional Medical Center
  - United Hospital
- HealthPartners - approved January 25, 2021
  - Regions Hospital

Other Hospitals Participating Through Medicare Advantage?

Choose Home Proposed Legislation
Introduced July 2021 Referred to Senate Finance

- **Choose Home**: Designed for those who are clinically appropriate for health care in their own home but need more services than existing Medicare HHA benefit
- **Goal**: Promote a safe, effective recovery, increased patient and family satisfaction, and reduced exposure to infectious diseases, as well as significant cost savings to the Medicare program compared to SNF
- **Eligibility**: Controlled carefully by use of an assessment tool that includes consideration of an individual's place of care preferences, functionality
- **Choose Home Option**: Patient meets SNF benefit eligibility • Patient resides at home • Receive traditional HH benefit services AND for 30-days – an expanded package of services, including transportation, meals, home modifications, remote patient monitoring, telehealth services, and PC services • No cost sharing
- **Payment** combines home health amount and fixed add-on for expanded services, add-on payments for expanded services are capped at 80% of the SNF 30-day payment amount, assuring savings under Choose Home of about $4,623/patient

Choose Home Proposed Legislation (continued)

- **Mechanics**: Eligible patients would be referred to a Home-Based Extended Care qualified Home Health Agency that offers the Choose Home benefit. Starting from the hospital discharge, Choose Home services are covered for 30 days, and home health services continue beyond the initial 30 days as clinically indicated
- **Financing**: Providers receive a combination of the home health benefit episodic payment and a four-level, 30-day fixed episodic payment where providers share financial risk with Medicare
- **Savings**: legislation will generate Medicare savings of $144–$247 million per year with $1.6-2.8 billion in savings over 10 years, according to Dobson Davanzo, an independent health economics firm

State Medicaid Outlook

MN State Budget Outlook Significantly Improved

- A general fund budget surplus of $7.7 billion is now projected for the FY 2022-23 biennium.
  - Strong growth in income, consumer spending and corporate profits drove extraordinary revenue growth in FY 2021, and higher tax receipts to date in FY 2022 combine with an improved outlook for income, consumer spending and corporate profits to raise the revenue forecast for the current biennium.
  - Estimates for state spending are down slightly in the current biennium.
- The improved budget forecast triggers a statutory allocation to the budget reserve, leaving the reserve balance at $2.656 billion.
- While economic uncertainty and the pandemic pose significant risk to the forecast, the improved outlook carries into FY 2024-25 planning estimates.

American Rescue Plan Provides Significant One-time Funding for HCBS Care in States

- Section 9817 of the American Rescue Plan (enacted March 2021) provides states with a one-year 10% increase in the federal medical assistance percentage (FMAP) for certain home and community-based services funded under Medicaid
- The enhanced FMAP applies to allowable expenditures for services provided between April 1, 2021, and March 31, 2022
- States must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of activities to enhance, expand, and strengthen HCBS under the Medicaid program

These state funds must be spent by March 31, 2024

Source:
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-329821

MN Submitted HCBS Plan to CMS in June 2021

- The Minnesota Legislature has authorized approximately $685 million in spending to implement a range of activities that enhance, expand and strengthen HCBS, categorized as follows:
  - Increasing provider rates to strengthen access to HCBS
  - Expanding services available under HCBS
  - Supporting people who receive HCBS to live in their own homes
  - Planning and implementing reforms to expand, enhance and strengthen the Medicaid HCBS service system
  - Supporting and strengthening the infrastructure for HCBS in MN
- CMS has approved about 60% of the plan, negotiations ongoing

HCBS FMAP Funded Proposals (PDF)

Electronic Visit Verification (EVV)

- The 21st Century Cures Act, Public Law 114–255 (PDF), signed in December 2016, requires providers of personal care, including personal care assistance (PCA) and some waiver services (beginning in 2020) and home health care providers (beginning in 2023) to use electronic visit verification to be eligible for full federal Medicaid matching dollars
- The Minnesota EVV system will verify:
  - Type of service performed
  - Who received the service
  - Date of service
  - Location of service delivery
  - Who provided the service
  - When the service begins and ends

Source: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/evv/

DHS To Implement a “Hybrid” EVV Model

- DHS has selected a hybrid EVV model. With the hybrid model, providers may select either the DHS-provided system or an EVV system of their choosing
- DHS has selected HHAeXchange to be Minnesota’s EVV vendor: https://hhaexchange.com/mn/
- If providers choose another EVV system, it must be able to submit data to the state EVV vendor’s system; DHS will not charge providers to access the state-selected system, but providers might need to spend time and resources to make this change and comply with the law
- DHS is **delaying** the implementation date for PC service providers. Dec. 1, 2021, is no longer the go-live date for those providers to connect to the HHAeXchange system. A new go-live date will be determined later; DHS is working with HHAeXchange to adjust the implementation plan to address questions and concerns (source DHS website Oct. 25, 2021)
- Applications for small grants to assist providers in connecting third party EVV systems to HHAeXchange are due by February 18, 2022

Review Choice Demonstration

Review Choice Demonstration for HHA: *Background*

- The Review Choice Demonstration for Home Health Services (RCD) provides flexibility and choice for Home Health Agencies (HHAs), as well as risk-based changes to reduce burden on providers demonstrating compliance with Medicare home health policies. HHAs will select from three initial choices:
  1. Pre-claim review
  2. Post-payment review
  3. Minimal post-payment review with a 25% payment reduction
- After a 6-month period, HHAs demonstrating compliance with Medicare rules through pre-claim review or post-payment review will have additional choices, including relief from most reviews except for a review of a small sample of claims. (To be eligible, HHAs must meet a 90% target full provisional affirmation rate based on a minimum 10 requests/claims submitted.)
- This program reduces the number of Medicare appeals, improves provider compliance with Medicare program requirements, should not delay care to Medicare beneficiaries, and does not alter the Medicare home health benefit

Review Choice Demonstration: *Latest Updates*

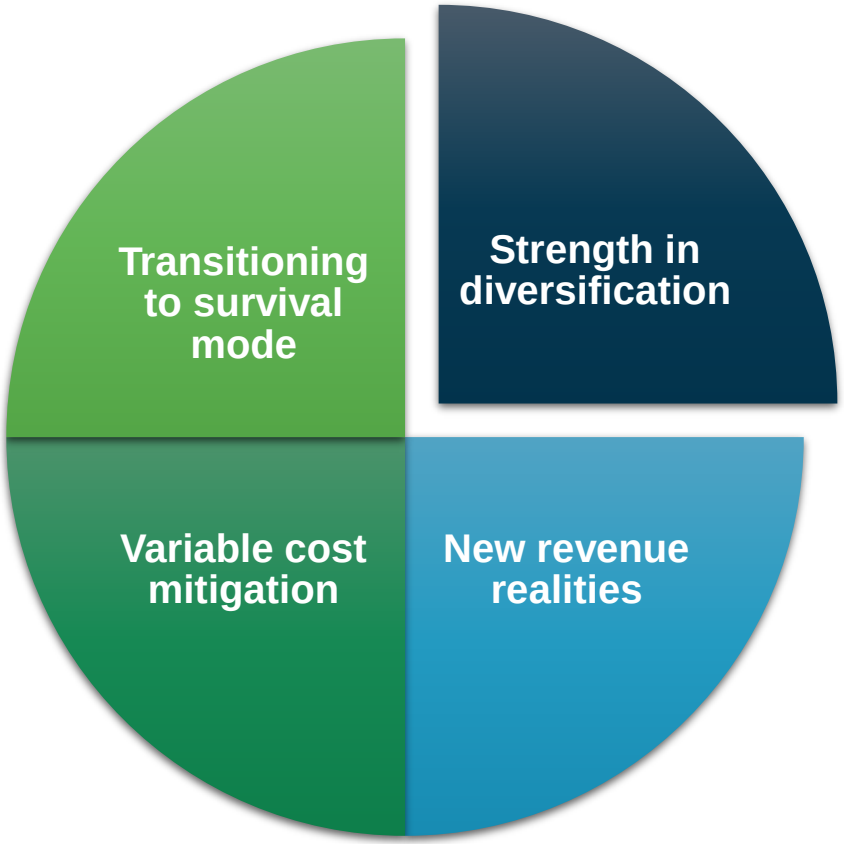
- Full implementation of the Home Health (HH) Review Choice Demonstration (RCD) will begin effective September 1, 2021, for HH providers in NC and FL
- CMS will discontinue exercising the phased-in participation for HH RCD providers in these states
- In preparation for full implementation, there will be an additional mid-cycle selection period, as detailed below:
  - Selection Period Start Date: August 1, 2021
  - Selection Period End Date: August 15, 2021
  - New Selection Effective Date: September 1, 2021
- CMS will resume applying the 25% payment reduction where applicable in all five demonstration states - Illinois, Ohio, Texas, Florida, and North Carolina
- *Additional Resources:*
  - Pre-Claim Review Initial Episode Checklist
  - Pre-Claim Review Subsequent Episode Checklist

Hope for the Best, Plan for the Worst

Strategic Considerations to Ensure Survival

- Service line assessment
- Resource stamina
- Market re-evaluation for new service opportunities
- Partnership, joint ventures, consolidations, and divestitures

Recalibrating Service Offerings



It’s Elementary, My Dear Watson!

- Within every organization lies dormant opportunities
- Muster the tactical, creative, and innovative approaches to reshape day-to-day operations
- Relinquish old standards and think anew

Bottom Line?

A better future is likely within reach.

Afternoon

Strategic Discussion & Brainstorming

Strategic Discussion and Brainstorming

- Explore strategic questions
- Place into categories for MHCA
  - Advocacy
  - Education
  - Member Assistance
- Prioritize
- Identify key tactics

For More Information

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HDG Solutions

- Management services
- Strategy
- Pre-development and pre-opening
- Operational performance
- PACE and value-based transformation
- Revenue cycle management
- Financial advisory
- Workforce solutions
- COVID-19 support

Disclosure

The information provided here is of a general nature and is not intended to address the specific circumstances of any individual or entity. In specific circumstances, the services of a professional should be sought.

HDG refers to Health Dimensions Group, an independently owned, for-profit entity.

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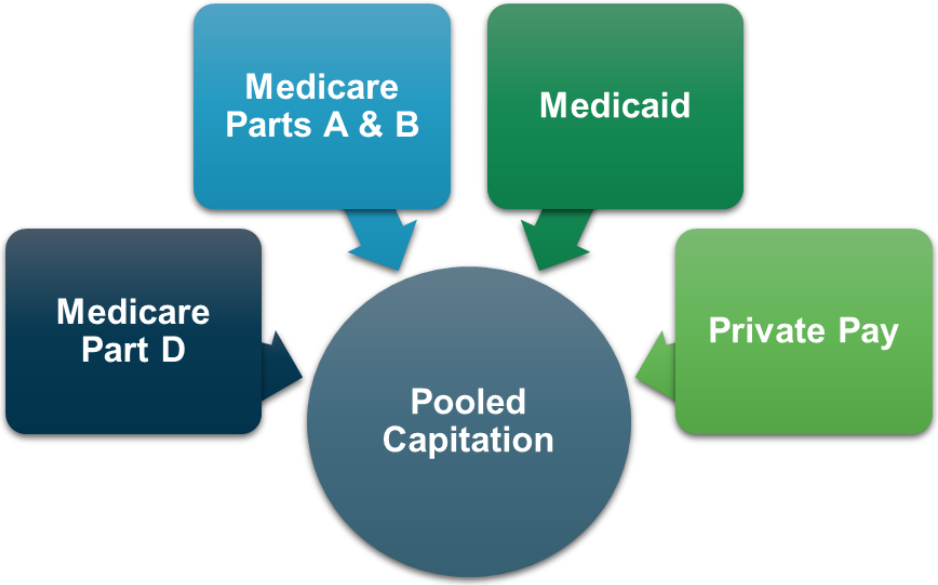
Appendix

PACE Expanding in Existing and New States

- In the past year, we have seen expansion efforts in states that currently have PACE, such as California, Florida, Indiana, Louisiana, Maryland, New Jersey, and Virginia
- In addition, PACE is under development in states that do not currently have PACE, such as Illinois, Kentucky, and Missouri
- With interest and support at an all-time high, now is the time to explore the feasibility of development or expansion of PACE, whether as a sole sponsor or in partnership with other organizations

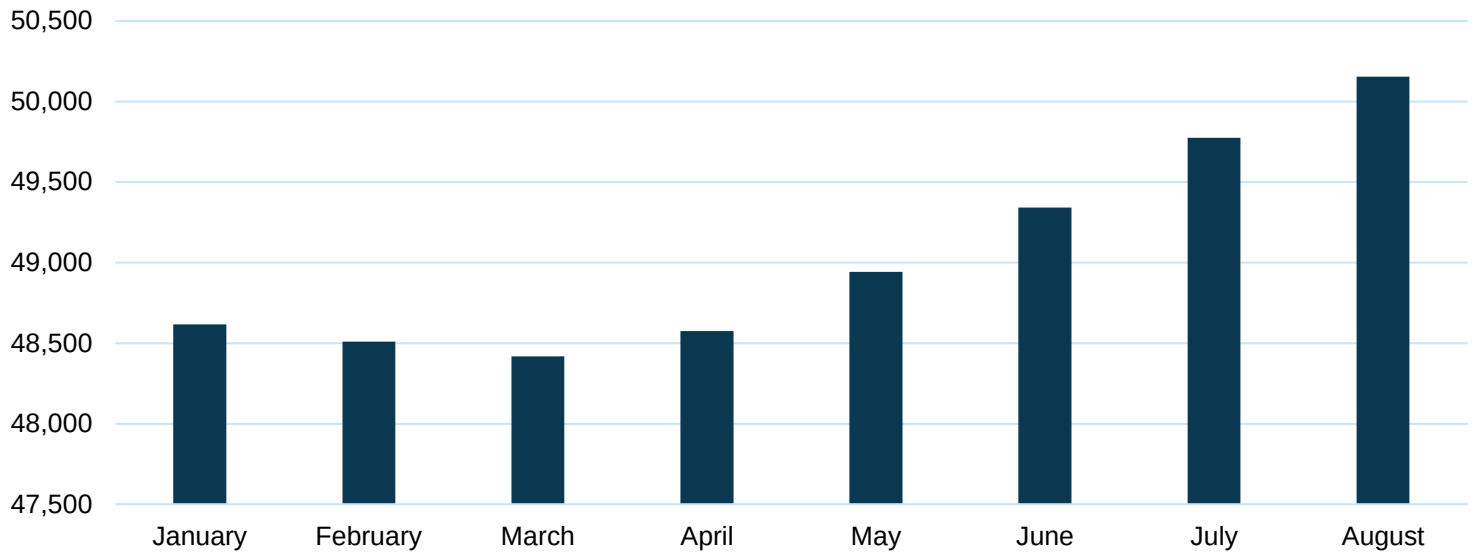
Program of All-Inclusive Care for the Elderly (PACE) During COVID-19

- PACE, like all providers, was impacted during COVID-19 but was able to adapt by repurposing PACE centers and providing more telehealth and in-home services
- All-inclusive and capitated financing provided the flexibility for the PACE model to adapt to new circumstances



Source: Centers for Medicare & Medicaid Services

National PACE Dual-Eligible Enrollment in 2021



- Enrollment has increased 3.2 percent from January through August
- Decline from January through March, but continued increase since

Source: Centers for Medicare & Medicaid Services

Hospice Carve-In included for 32 Medicare Advantage Plans as Part of VBID Program

- In CY 2021, the Medicare Part A hospice benefit is incorporated into MA as an optional part of the VBID Model for CY 2022.
- CMS is testing the impact on payment and service delivery of incorporating the Medicare Part A hospice benefit into Medicare Advantage for a seamless transition.
- As part of this Model test, MA plans that participate will also be able to offer their enrollees additional services, including **non-hospice palliative care** for those not eligible for hospice care, **transitional concurrent care** to help ease enrollees' transition to hospice, and hospice supplemental benefits to provide coverage, items, services, or supplies to support hospice enrollees.
- For MA plans that volunteer to be part of the Hospice Benefit Component, CMS will evaluate the impact on cost and quality of care for MA enrollees.