NHPCO
Leading Person-Centered Care

**CMS-1780-P: Medicare Program – Calendar Year 2024 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; etc.**

TO: NHPCO Provider and State Members
FROM: NHPCO Policy Team
Date: July 5, 2023 (Rev.)

**Summary at a Glance**

The Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment proposed rule was posted for public inspection in the Federal Register on June 30, 2023. It will post in the Federal Register on July 10, 2023.

This rule contains a number of hospice provisions, which are detailed below:

1. **Hospice Informal Dispute Resolution (IDR),** which allows a hospice with a condition-level survey finding to resolve disputes related to the findings informally and allow for continued participation in Medicare.
2. **Hospice Special Focus Program**, which provides details on the proposed implementation of the Hospice Special Focus Program (SFP), including selection, requirements while in the program, possible additional enforcement remedies, posting SFP participation in Care Compare, and completion and graduation from the SFP or termination from the Medicare program.
3. **Home health and hospice health equity** discussion and possible future health activities and measures.
4. **Provider enrollment proposals for hospices**, including categorical risk screening, with a high-risk designation for some hospices, fingerprint requirements, proposed 36-month rule for changes in majority ownership, deactivation timeframe changes, expanded definition of managing employees and more.

Comments on this proposed rule will be due on **August 29, 2023**. Implementation date for the final rule will be January 1, 2024.

## A. Hospice Informal Dispute Resolution

### 1. Details of the proposal

CMS is proposing regulations to implement an "informal dispute resolution (IDR) process to provide hospice programs an informal opportunity to resolve disputes related to condition-level survey findings for those hospice programs that are seeking recertification for continued participation in Medicare."

The proposal:

- Aligns with the process currently in place for home health agencies (HHAs) at § 488.1130
- Can be used following a "hospice program's receipt of the official survey Statement of Deficiencies and Plan of Correction, Form CMS-2567."
- Is an informal process to "dispute survey findings for hospice surveys from the State Survey Agency (SA) or reaccreditation from an accrediting organization (AO) for continued participation in Medicare."
- The proposed IDR process for hospices is for "condition-level survey findings that may be the impetus for an enforcement action."
- Does not apply to standard-level findings, which by themselves do not trigger an enforcement action and do not have appeal and hearing rights.
- Can also be used for a hospice "under SA monitoring (through a complaint investigation or validation survey) and those in the hospice SFP."
- Is separate from the hospice Special Focus Program (SFP).

### 2. Process for hospices certified through a CMS-approved Accrediting Organization (AO)

- For hospice programs deemed through a CMS-approved AO, the AO would receive the IDR request from their deemed facility program, following the same process and coordinating with CMS regarding any enforcement actions.
- CMS states the "AO must have a comparable survey process to the SAs."
- For deemed hospice programs, the AO communicates any condition-level findings to the applicable CMS Location.
- If a deemed hospice fails to meet the Medicare requirements or shows continued condition-level noncompliance, deemed status is generally removed and oversight is placed under the SA.

### 3. Purpose of proposed IDR process

- Provide an opportunity to settle disagreements at the earliest stage, prior to a formal hearing.
- Save time and financial resources possibly spent by the hospice, the SA, and CMS.
- The proposed IDR process may not be used to refute an enforcement action or selection into the SFP.

4. **Delay**
    - CMS also proposes the "failure of CMS, or the State or the AO, as appropriate, to complete IDR **must not delay the effective date of any enforcement action."**

5. **Process for requesting an IDR**
    - The hospice would be notified in writing about the opportunity to request an ADR when the CMS-2567 Statement of Deficiencies and Plan of Correction is issued to the hospice.
    - CMS proposes the hospice's "request for IDR must be submitted in writing (either electronically or hard copy)"
    - The request must include the specific survey findings that are disputes
    - Must be submitted **within the same 10 calendar days allowable for submitting an acceptable plan of correction.**
    - The hospice has the opportunity to "address the surveyor's findings, either by disputing them or providing additional information."

6. **Survey findings revised or removed**
    - If the State or CMS revises or removes survey findings based on IDR results, the CMS-2567 would be revised.
    - If CMS accepts the IDR results and the revised CMS-2567, CMS will also adjust enforcement actions "imposed solely due to the cited and revised deficiencies."
    - If the survey findings are upheld by CMS or the State after the IDR process is complete, the Form CMS-2567 would not be adjusted and there would be no adjustments to the enforcement actions.

## B. Hospice Special Focus Program

1. The Hospice Special Focus Program was originally required as a part of the hospice program integrity measures in Division CC, section 407 of the Consolidated Appropriations Act of 2021 (CAA 2021). This proposed rule provides the implementing regulations for the hospice special focus program (SFP) for poor performing hospices and includes:
    - the SFP algorithm (including data sources) to identify indicators of hospice poor performance
    - *the criteria for selection and completion of the SFP*
    - remedies hospice termination from Medicare
    - public reporting of the SFP

    Enforcement remedies were published in CY 2023 HH Rule here: 2021-23993.pdf (govinfo.gov)

2. **Effective date and implementation**

- CMS proposes the hospice SFP will begin beginning on the effective date of this rule, when final, with selection of hospice programs to enter the SFP during the first quarter of 2024.
- CMS also proposes to periodically review the effectiveness of the methodology and the algorithm.

3. **Hospice Special Focus Program Technical Expert Panel (TEP) convened**
   - A CMS contractor convened a TEP in October and November 2022.
   - Members of the TEP, including representatives of NHPCO and NHPCO members, provided feedback and considerations on the preliminary SFP concepts.
   - The TEP considered what methodology could be used to identify hospice poor performers, technical assistance and oversight to the hospice while enrolled in the TEP, the criteria for completing the SFP, the process for termination from the Medicare program when a hospice cannot complete the requirements of the SFP, and how SFP participation would be publicly reported.
   - The TEP published a final report, 2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report (cms.gov)

4. **Proposed Regulatory Provisions**
   Specific details on the proposed hospice SFP will be added to § 488.1135.

5. **Proposed Definitions**
   - ***Hospice Special Focus Program (SFP)*** means a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements. Selected hospices either successfully complete the SFP program or are terminated from the Medicare program.

   - ***SFP status*** means the status of a hospice provider in the SFP with respect to the provider's standing in the SFP, which is indicated by one of the following status levels:
     - Level 1 – in progress
     - Level 2 – completed successfully
     - Level 3 – terminated from the Medicare program

   - ***SFP survey*** refers to a standard survey as defined in § 488.1105 and is performed after a hospice is selected for the SFP and is conducted every 6 months, up to three occurrences.

6. **Proposed Hospice Special Focus Survey Program Algorithm**
   - CMS proposes to identify a subset of 10 percent of hospice programs based on the highest aggregate scores (lowest performers) determined by the algorithm. The hospices selected for the SFP from the 10 percent would be determined by CMS.
   - CMS has identified several indicators of "poor performance" including:

- **Survey findings:**
  - Survey reports with Condition-Level Deficiencies (CLDs)
  - Survey reports of substantiated complaints
- **Hospice Quality Reporting Program (HQRP)**
  - Hospice Care Index (HCI) composite score
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey). Questions include:
    - Help for pain and symptoms
    - Getting timely help
    - Willingness to recommend this hospice
    - Overall rating of this hospice

- Hospices would be identified for potential SFP enrollment if they —
  (1) have data from any of the data sources above;
  (2) are listed as an active provider (that is, have billed at least one claim to Medicare FFS in the last 12 months); and
  (3) operate in the United States, including the District of Columbia and U.S. territories

- CMS reports in CY 2019 through CY 2021, 5,943 hospices would have been eligible for participation in the SFP.

**7. Hospice SFP Data Sources Details**

- **Quality of Care Condition-Level Deficiencies**
  On January 27, 2023, CMS published a QSOG memo (QSO-23-08-hospice), which outlined a significant change in the hospice survey protocol to focus on the investigation of quality of care provided to hospice patients. CMS states "while each of the 23 conditions in the Medicare Hospice Condition Participation (CoPs) continues to have equal weight in the final certification decision, special attention is directed to those CoPs directly impacting patient care, including 11 quality of care CoPs in the table below which directly contribute to the quality of care delivered to patients, their caregivers and their families." CMS believes a condition level deficiency (CLD) for any of these 11 CoPs would indicate a quality-of-care concern.

  CMS did not propose including all 23 CoPs in the hospice SFP methodology but welcomes comments about incorporating other CoPs in the SFP algorithm.

  **TABLE F2. QUALITY OF CARE**
  **Tag Condition of Participation**

**TABLE F2. QUALITY OF CARE**

| Tag | Condition of Participation |
|---|---|
| | |
| §418.52 | Condition of participation: Patient's rights. |
| §418.54 | Condition of participation: Initial and comprehensive assessment of the patient. |
| §418.56 | Condition of participation: Interdisciplinary group, care planning, and coordination of services. |
| | |
| §418.58 | Condition of participation: Quality assessment and performance improvement. |
| §418.60 | Condition of participation: Infection control. |
| §418.64 | Condition of participation: Core services. |
| §418.76 | Condition of participation: Hospice aide and homemaker services. |
| §418.102 | Condition of participation: Medical director. |
| §418.108 | Condition of participation: Short-term inpatient care. |
| §418.110 | Condition of participation: Hospices that provide inpatient care directly. |
| §418.112 | Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID. |

- **Years of data considered:** CMS proposes to consider the "total number of quality-of-care CLDs from the previous 3 consecutive years of data." A large majority of hospices (88.3 percent, or 5,248, of all SFP-eligible hospices, 5,943 using the proposed algorithm) had "no quality-of-care CLDs cited over these 3 years." 341 (5.7 percent) hospices are not present in the survey data.

- **Substantiated Complaints**
  - CMS proposes to include the "the total number of substantiated complaints received against a hospice in the last 3 consecutive years of data before the release of the SFP selection list."
  - Complaints against a hospice may be filed with the SA or Beneficiary and Family Centered Care Quality Improvement Organization at any time by a patient and/or caregiver(s) and hospice staff members (Medicare SOM Chapter 5).
  - Once a complaint is filed with the SA, the SA can conduct an unannounced complaint investigation survey to substantiate or refute the complaint.
  - If the complaint is substantiated, the SA informs the hospice and submits the findings to iQIES. A post-survey revisit or follow-up survey may also occur to determine if the provider may have many complaints filed against them, but not all complaints may be substantiated upon SA review.
  - In CMS data reviewed for the period CY 2019-2021, 81.8 percent of hospice programs (4,860 out of 5,943 SFP-eligible hospices) had no substantiated complaints over the past 3 years.

8. **Hospice Quality Reporting Program (HQRP) Data**
   CMS proposes to include five publicly reported HQRP measures to identify poor performing hospices, including the Hospice Care Index (HCI) and four measures from the CAHPS® Hospice Survey Data.

- **Hospice Care Index (HCI) Overall Score**

- CMS states the "HCI overall score based on eight quarters of Medicare claims data."
- The HCI captures multiple aspects of care delivery across 10 indicators comprising a composite HCI overall score, with hospices earning a point for each indicator met (range: 0-1) so a lower score indicates lower quality of care.
- The proposed HCI overall score indicates hospice care quality between admission and discharge, based on the HCI I Technical Report.
- The HCI is based on claims data and "information is readily available for all hospices. 2019-2021 HCI data (excluding January-June 2020) found "78.3 percent of hospices (4,656 of the 4,943 SFP eligible hospices) had a publicly reported HCI score. The vast majority (86.1 percent) of those hospices had an HCI score of 8 or more out of 10.

- **CAHPS® Hospice Survey**
  - CMS proposes to use four measures from the CAHPS® Hospice Survey:
    - help for pain and symptoms;
    - getting timely help;
    - willingness to recommend the hospice; and
    - overall rating of the hospice.

  - CAHPS® Hospice Survey measure scores are proposed to be calculated across **eight rolling quarters for all hospices with at least 30 completed surveys**. Some hospices do not participate in CAHPS® as new hospices are exempt from reporting CAHPS® measures for the calendar year in which they receive their CMS Certification Number (CCN), and hospices can apply for a CAHPS® exemption if they serve fewer than 50 survey–eligible decedents/caregivers in a given calendar year.

- **Using the bottom box score**

  CMS is proposing to use adjusted bottom-box scores of the four measures described previously above to create a CAHPS® Hospice Survey Index. CMS states they will use the document, "Calculating CAHPS® Hospice Survey Top-, Middle-, and Bottom-Box Scores," to calculate CAHPS® Hospice Survey measure scores. "Bottom-box" scores are calculated for each respondent as "100" if the respondent selected the least positive response categories for the question and "0" if the respondent selected a different response category; survey respondents who do not answer a question are not included in the scoring of the question.

| **Overall assessment of hospice care** | **Weighting** |
|---|---|
| Willingness to recommend this hospice | 0.5 |
| Overall rating of this hospice | 0.5 |
| **Distinct aspects of hospice care** | |
| Help for pain and symptoms | 1.0 |

| | |
|---|---|
| Getting timely help | 1.0 |

- CMS analysis of CYs 2019 to 2021 (excluding January through June 2020) CAHPS® Hospice Survey data found 49.3 percent of eligible hospice programs (2,929 of the 5,943 SFP-eligible hospices) report the four CAHPS® Hospice Survey measures.

- **Data source preparation:** CMS proposes to compile the data for the algorithm using the data elements above to create a single score for every hospice. A Medicare-certified hospice program would be included in the algorithm if it —
  (1) is an active provider that has billed at least one claim to Medicare FFS in the last 12 months as captured in iQIES; and
  (2) has data for at least one algorithm indicator
- **When will data be pulled for SFP:** For the HCI and CAHPS® data, CMS proposes to pull the latest HCI and CAHPS® data from the Hospice PDC. For identifying the pool of hospices eligible to be in the SFP on or after January 1, 2024, CMS proposes to use 2020-2023 survey data.
- **Data counts:** Consecutive years of survey data for all relevant hospice survey types, including initial, standard, complaint, and follow-up surveys. The count will include condition-level deficiencies in the three year period and a number of substantiated complaints.
- **Missing CAHPS® data:** In CMS analysis of the CY 2019-2021 file, "only about 49 percent of all SFP-eligible hospices with CAHPS® Hospice Survey data." CMS proposes to handle missing CAHPS® hospice survey data by considering solely on all other indicators – CLDs, complaints, and HCI.

- **Standardized Values and Weighting**

  For additional details on standardized values and weighting of scores, see the proposed rule, "Special Focus Section, (a). Proposed Hospice Special Focus Program Algorithm."

- **Proposed Selection Criteria, as recommended by the TEP:**
  - The hospice would be chosen for the SFP without regard to SFP selection process utilizing a no stratification approach. The selection approach should identify the poorest performing hospices, regardless of characteristics, such as size or location.
  - Hospices with AO deemed status identified and placed in the Hospice SFP would not retain deemed status and would be placed under CMS or as needed, SA oversight jurisdiction until completion of the SFP or termination.
  - The number of hospices selected to participate in the SFP **would be determined in the first quarter of each calendar year**. The data used to determine the aggregate score is available in November of each calendar and would be used for the score calculation.

- CMS proposes a hospice selected for SFP would not be removed from the SFP until they either "meet the criteria for graduation or are terminated from the Medicare program."

9. **Proposed Survey and Enforcement Criteria**
   - Surveyed once every six months
   - One or more enforcement remedies would be applied and "progressive enforcement remedies are possible at CMS' discretion."
   - Remedies applied based on non-compliance with one or more conditions of participation could also be based on failure to correct previous deficiency findings when repeat condition level deficiencies occur.
   - Enforcement when a hospice is in SFP:
     - Remedies could apply to condition-level deficiencies on a survey and could be of increasing severity.
     - Could include a higher civil monetary penalty (CMP) than had been imposed earlier.
     - Additional enforcement remedies could be applied.
     - CMS states it would "use its discretion to determine what remedies are most appropriate given the survey results, and the hospice may be subject to remedies of increasing severity."

10. **Proposed SFP Completion Criteria**
    - To complete and graduate from the SFP, CMS proposes hospices must have:
      - No CLDs cited or IJs for any two six-month SFP surveys
      - No pending complaint survey triaged at an immediate jeopardy or condition level
      - Has returned to substantial compliance with all requirements.
      - If there are complaint investigations or a 36-month recertification survey for a hospice while in the SFP, the SFP timeline may extend beyond the 18-month timeframe.

11. **Completion date:** CMS proposes the completion date and "graduation from SFP" will be the date of the CMS letter informing the hospice of its removal from the SFP.

12. **Surveys after completion of the SFP:** Post SFP, the hospice would receive a survey one year after the completion of the SFP and would then be included in the new standard 36- month survey cycle.

13. **Proposed termination from the Medicare program criteria**
    - An SFP hospice would be considered for termination from the Medicare program if:
      - The hospice fails any two SFP surveys by having any CLDs on the surveys in an 18-month period
      - The hospice has pending complaint investigations triaged at IJ or condition-level

    - The hospice is not able to achieve substantial compliance at any time during the 18 months, they would be considered for termination from the Medicare program
- Providers unable to resolve the deficiencies that brought them into the SFP and cannot meet the proposed completion criteria of having no CLDs cited for any two SFP surveys during an 18-month period, would be placed on a termination track.

**14. Public Reporting of SFP Information**

- CMS proposes to publicly report, at least on an annual basis, the hospice programs selected for the SFP under proposed § 488.1135(b). Initially, this information would be posted on a CMS public-facing website at Hospice Special Focus Program | CMS. The website will include (at a minimum):
    - general information
    - program guidance
    - a subset consisting of 10 percent of hospice programs based on the highest aggregate scores determined by the algorithm
    - SFP selections from the 10 percent subset as determined by CMS
    - SFP status as proposed in the definitions at § 488.1105

## C. Home Health and Hospice Health Equity

### a. Technical Expert Panel (TEP)

- The TEP was charged with providing input on a potential cross-setting health equity structural composite measure concept as set forth in the CY 2023 Home Health Payment Rate Update proposed rule (87 FR 66866) as part of an RFI related to the HH QRP Health Equity Initiative. Specifically, the TEP assessed the face validity and feasibility of the potential structural measure. The TEP also provided input on possible confidential feedback report options to be used for monitoring health equity.
- The TEP published final recommendations

### b. Anticipated Future Health Equity Activities

- **Using SDOH data elements:** Commentary on using social determinants of health (SDOH) data items in home health. CMS recognized SDOH will be different than the SDOH items used in acute care as health equity quality measures.
- **Future health equity measure:** CMS will consider a future health equity measure like screening for social needs and interventions, as well as addressing SDOH and encouraging providers to identify specific needs and connecting patients and families with community resources.
- **Rulemaking and sub regulatory guidance:** CMS expect to consider providing more information through rulemaking and also through sub regulatory channels, "such as Open-Door Forums (ODF), Medicare Learning Network (MLN), and public summary reports such as TEP reports or information gathering reports (IGR)."

## D. Provider and Supplier Enrollment Requirements

1. **Use of the 855**
   The 855 is used for a variety of provider enrollment transactions, including the following:
   - **Initial enrollment** – The provider or supplier is –
     (1) enrolling in Medicare for the first time;
     (2) enrolling in another Medicare contractor's jurisdiction; or
     (3) seeking to enroll in Medicare after having previously been enrolled
   - **Change of ownership** – The provider or supplier is reporting a change in its ownership.
   - **Revalidation** – The provider or supplier is revalidating its Medicare enrollment information in accordance with § 424.515. (Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must revalidate their enrollment every 3 years); all other providers and suppliers must do so every 5 years.)
   - **Reactivation** – The provider or supplier is seeking to reactivate its Medicare billing privileges after it was deactivated in accordance with § 424.540.
   - **Change of information** – The provider or supplier is reporting a change in its existing enrollment information in accordance with § 424.516.

2. **Uses of provider enrollment rules**
   CMS states "these rules were intended not only to clarify or strengthen certain components of the enrollment process but also to enable us to take action against providers and suppliers who are:
   - engaging (or potentially engaging) in fraudulent or abusive behavior;
   - presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or
   - otherwise, unqualified to furnish Medicare services or items

3. **Hospice-Specific Provisions**
   CMS states the provisions in this proposed rule for hospice related to hospice enrollment, ownership and deactivation of providers and suppliers.

   a. **Categorical Risk Screening**
      - Three levels of screening in § 424.518: high, moderate, and limited.
      - Medicare Administrative Contractor (MAC) conducts the following screening functions upon receipt of an initial enrollment application, a revalidation application, an application to add a new location, or an application to report a new owner:
        - Verifies the provider or supplier meets all applicable federal regulations and state requirements for their provider or supplier type
        - Conducts state license verifications

        - Conducts database checks on a pre- and post-enrollment basis to ensure providers and suppliers continue to meet the enrollment criteria for their provider or supplier type
    - Providers and suppliers at the moderate and high categorical risk levels must also undergo a site visit.

**b. High screening level**: The MAC performs two additional functions under § 424.518(c)(2):
    - The MAC requires the submission of a set of fingerprints for a national background check from all individuals who have a five percent or greater direct or indirect ownership interest in the provider or supplier.
    - The MAC conducts a fingerprint-based criminal history record check of the Federal Bureau of Investigation's Integrated Automated Fingerprint Identification System on these five percent or greater owners.
    - These additional verification activities are meant to correspond to the heightened risk involved.
    - There are currently only five provider and supplier types that fall within the high categorical risk category.

**c. Categorical Risk Designation – Hospices**

Currently, hospices fall in the moderate risk category. However, CMS states they "believe that certain provider enrollment measures are necessary to help address issues of fraud and abuse. One of these measures involves closer screening of the owners of hospices."

**d. Proposal to move some hospices into the high level of categorical screening:** CMS proposes to move the following categories of hospices to the high level of screening category:
    - Initially enrolling hospices
    - Hospices submitting applications to report any new owner (as described in the opening paragraph of § 424.518)

**e. Fingerprint requirement:** Fingerprinting is proposed to be required for "all hospice owners with 5 percent or greater direct or indirect ownership to submit fingerprints for a criminal background check."

**f. Moderate level of categorical screening:** The moderate level of categorical screening would include revalidating hospices.

**4. 36 Month Rule**

**a. Increase in changes in hospice ownership:** CMS has seen an increase in the number of hospice changes in ownership in recent years, and a number of these ownership changes have occurred within the applicable 36-month timeframe. CMS also states

some changes have taken place after a few months of enrollment or previous CIMO, similar to the "flipping" practice identified for home health some years ago.

b. **New hospices may not comply with Medicare hospice Conditions of Participation:** In many hospice ownership changes since 2018, CMS does not have information on the new ownership and leadership and whether the hospice is compliant with the hospice CoPs. CMS has identified this as a significant vulnerability, and it is possible many millions of dollars have been improperly paid to newly purchased hospices not adhering to Medicare requirements.
c. **Comprehensive survey needed:** CMS states a comprehensive survey would be the most effective means of confirming newly purchased hospices are meeting the CoPs and are positioned to provide quality care and protect beneficiaries.
d. **Include hospices in the Change in Majority Ownership (CIMO) regulations:** CMS is proposing to "expand the scope of § 424.550(b)(1) to include hospice CIMOs and add hospice to the definition of change of majority ownership. As defined in 42 CFR 424.502, a "change in majority ownership" occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment or most recent CIMO. CMS proposes that during the 36 months following a hospice's initial enrollment or the most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new hospice owner.
e. **GAO study on CMS Oversight of Hospice Providers:** In October 2019, the Government Accountability Office (GAO) issued a report titled, "Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers" (GAO-20-10).
    a. The GAO observed the number of:
        - Medicare hospice beneficiaries had almost tripled from 2000 to nearly 1.5 million by 2017
        - Medicare hospice providers had doubled
    b. The GAO stated in light of this growth: "It is imperative that CMS' oversight of the quality of Medicare hospice care keeps pace with changes so that the agency can ensure the health and safety of these terminally ill beneficiaries."
f. **Four exceptions to the 36-month rule:**
    An HHA undergoing a CIMO is not required to meet the requirements at § 424.550(b)(1) for the HHA enroll as a new HHA and undergo a survey or accreditation if any of the following exceptions are implicated:
    - The HHA submitted two consecutive years of full cost reports since initial enrollment or the last CIMO, whichever is later.
    - The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.
    - The owners of an existing HHA are changing the HHA'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 an HHA dies.

CMS is proposing to allow hospices the same accommodations.

5. **Additional Hospice Ownership Categories**
    a. CMS is proposing to revise the Form CMS-855A Medicare provider enrollment application (Medicare Enrollment Application--Institutional Providers; (OMB Control No. 0938-0685) to collect from providers/suppliers (including hospices) important data such as, but not limited to:
        - Requiring the provider/supplier/hospice to specifically identify via a checkbox whether a reported organizational owner is itself owned by another organization or individual.
        - Requiring the provider/supplier/hospice to explicitly identify whether a listed organizational owner/manager does or does not fall within the categories of entities listed on the application (for example, holding company, investment firm, etc.), with “private-equity company'' and “real estate investment trust'' being added to this list of organization types.

6. **Deactivation for 12-Months of Non-Billing**
    a. **Definition of deactivation:** Deactivation means 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. Also, per § 424.540(c), deactivation does not impact the providers or suppliers
        - **Proposal to change the non-billing timeframe to 6 months:** CMS proposes to change the timeframe for non-billing in § 424.540(a)(1) from 12 months to six months.
        - **Fraud schemes detected involving extended periods of non-billing:** CMS has detected many fraud schemes which involve multiple enrollments with multiple billing numbers, moving from one billing number to another if one becomes the subject of investigation, among other schemes.
        - CMS states “to protect the Trust Funds against improper payments, [CMS] must be able to move more promptly to deactivate these “spare” billing numbers so the latter cannot be inappropriately used or accessed.

7. **Definition of "Managing Employee"**
    - **Current definition:** “The 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.”

    - **Adding hospice administrator and hospice medical director to definition of “managing employee”:** CMS is proposing to further revise the definition at § 424.502 in the present proposed rule by “adding [hospice] in the following language

immediately after (and in the same paragraph as) the current 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.** This change would be reflected in the first paragraph of the revised definition of this term as proposed in the February 15, 2023 proposed rule.

- Any individual who meets the definition of managing employee in § 424.502 must be reported irrespective of the precise amount of managing control the person has.

**8. Previously Waived Fingerprinting of High-Risk Providers and Suppliers**

- CMS previously waived the finger printing requirement for the COVID-19 public health emergency. This CMS proposal may waive this requirement for future emergencies for the high-risk category of providers, including hospices in future waivers.
- The proposed rule establishes a revised paragraph which includes the moderate risk revalidation for DMEPOS suppliers, HHAs, OTPs, MDPPs, SNFs, and hospices that underwent FBCBCs:
    (1) when they initially enrolled in Medicare; or
    (2) upon revalidation after CMS waived the FBCBC requirement (under the circumstances described in paragraph (c)(1)(viii)) when the provider or supplier initially enrolled in Medicare.
- This second provision is to clarify that the providers and suppliers referenced in paragraph (c)(1)(viii) do not remain in the high-screening category in perpetuity solely because they were not fingerprinted upon initial enrollment.
- Once the provider or supplier is fingerprinted upon revalidation, it would move to the moderate-risk category unless another basis exists under paragraph (c) for retaining it within the high-risk category.

**9. Proposed timeframe for revalidation of Medicare enrollment**

- DMEPOS suppliers – Medicare revalidation required every three years.
- HHAs, OTPs, MDPPs, SNFs, and **hospices** must do so every five years.
- CMS can perform off-cycle revalidations. If the proposed rule becomes final, CMS would "reserve the right to conduct off-cycle revalidations of FBCBC-waived high-risk providers and suppliers.

**10. Expansion of Reapplication Bar**

- CMS states the "existing maximum length of a reapplication bar under § 424.530(f) is 3 years."
- CMS is proposing to expand the maximum length of reapplication to 10 years to account for severe provider or supplier conduct. CMS states they "must be able to prevent such problematic parties from repeatedly submitting applications over many years with the goal of somehow getting into the program."

- Section 424.530(a)(3)(ii) states a denial based on a felony conviction is for a period **not less than 10 years** from the date of conviction if the individual has been convicted on one previous occasion of one or more offenses.

**11. Ordering, Referring, Certifying, and Prescribing Restrictions**

- **Provider subject to a reapplication bar** may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs.
- **Medicare does not pay:** CMS proposes in § 424.530(f)(3) for Medicare not to pay for any covered service, item, or drug ordered, referred, certified, or prescribed by a provider or supplier currently under a reapplication bar.
- **Physician or other eligible professional with a felony conviction:** CMS proposes a physician or other professional, regardless of whether they are or were enrolled in Medicare, who has had a felony conviction within the previous 10 years that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs.

NHPCO will continue to analyze the proposed rule and will be discussing this rule with the NHPCO Regulatory Committee. Please send any questions or comments to regulatory@nhpco.org with 'CY 2024 HH rule' in the subject line.