Centers for Medicare & Medicaid Services
Open Door Forum: Home Health, Hospice and DME
June 30, 2021
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time you may press star 1 on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objection, you may disconnect at this time. I will now turn the call over to Michelle Oswald. Thank you. You may begin.

Michelle Oswald: Great. Thank you so much, (Denise). Good morning and good afternoon, everyone. My name is Michelle Oswald and I'm in the CMS Office of Communication filling in for Jill Darling today.

Thank you for joining us today for the Home Health Hospice and DME Open Door Forum. First, our apologies for getting a delayed start. We do appreciate your patience with us today as we get ready and kick this off.

So before we begin I do have one brief announcement. This call is open to everyone. However, if you are a member of the press, we invite you to listen but ask that you please refrain from asking questions during the call.

Those inquiries can be directed to press@cms.hhs.gov. Now, I'm going to turn the call over to Kelly Vontran to give some opening remarks. Kelly?

Kelly Vontran: Good afternoon and good morning to those of you on the call who are calling in from the West Coast. So as introduced, my name is Kelly and I'm the deputy director of the Division of Home Health and Hospice here at CMS.

We appreciate you all calling in to today's Home Health Hospice and DME Open Forum. We do have a pretty full agenda today. So I will begin by giving an update on the payment policy provisions in the calendar year 2022 Home Health Perspective Payment System Proposed Rule that went on display at the Federal Register on Monday, June 28.

This rule is subject to a 60-day comment period which closes on August 27. Now please note that we may be limited to answering certain questions on the provisions on this proposed rule, given we are currently in the 60-day comment period.

Additionally, any comments to the proposal rule can be submitted electronically through regulations.gov as well as other comment submission methods described in the proposed rule, which can be found on the HHA central web page.

So, starting with the calendar year 2022 HH PPS payment policy provisions. Beginning on January 1st of 2020, Medicare implemented the patient driven grouping's model, or PBGM, and a 30-day unit of payment as required by law in the home health perspective payment system to better align with patient care needs and safeguard that clinically complex beneficiaries have adequate access to home health care.

The law required CMS to make assumptions about behavior changes that could occur because of the implementation of the 30-day unit of payment and the PBGM.

In the calendar year 2019. HH PPS final rule with comment period, CMS finalized three behavior assumptions. One about clinical group coding, a

second assumption about comorbidity coding and the third assumption about the low utilization payment amount, OR LUPA, threshold.

This resulted in a 4.3% reduction to the calendar year 2020 national standardized 30-day payment rate. The law also requires CMS to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures, beginning with 2020 and ending with 2026.

CMS is also required to make temporary and permanent increases or decreases as needed to the 30-day payment amount to offset the difference in estimated aggregate expenditures resulting from actual versus assumed behavior changes.

This proposed rule provides preliminary analyses of the first year of the PBGM, including data on admission source, timing, clinical grouping, functional impairment level, comorbidity adjustment and the provision of therapy visits, including physical, occupational and speech therapy.

Additionally, CMS provides a detailed method on how it analyzed the difference between assumed and actual behavior changes. However, CMS is not proposing a specific method or behavior assumption payment adjustment in this proposed rule. Rather it is soliciting comments on the described method and other possible methods to determine the impact of behavior changes on estimated aggregate expenditures.

This proposed rule also includes a proposal to recalibrate the PDGM typically. As you know, each of the 432 payment under the PBGM has been associated case mix weight and LUPA threshold.

CMS' policy to annually recalibrate the case mix weights using the most complete utilization data available at the time of rulemaking.

So, in this proposed rule, CMS is proposing to recalibrate the case mix weight, the functional impairment levels and the comorbidity adjustment subgroups using calendar year 2020 data to more accurately pay for the types of patients home health agencies are serving.

Additionally, CMS is proposing to maintain the calendar 2021 with the thresholds for calendar year 2022.

Next this rule proposes routine statutorily required updates to the home health payment rates for calendar year 2022. That is, we propose to update the Home Health Wage Index, the calendar year 2022 national standardized 30-day period payment amounts and the CY2022 national prospective payment amounts by the Home Health Payment Update percentage.

The Home Health Payment Update percentage for calendar year 2022 is estimated to be 1.8%. Therefore, the proposed national standardized 30-day payment rate for 2022 is $2,013.43 for those home health agencies that estimate the required quality data.

Finally, the proposed rule proposes to update the FDL ratio to 0.41 for calendar year 2022 to ensure that outlier payments do not exceed 2.5% of total home health payments.

CMS estimates that Medicare payments to home health agencies in calendar year 2022 would increase in the aggregate by 1.7% or $310 million based on the proposed policy.

This increase reflects the effects of the proposed 1.8% home health payment update percentage, or a $330 million increase, and a 0.1% decrease in payments due to reductions made and the rule add-on percentages mandated by the Bipartisan Budget Act of 2018 for calendar year 2022, which is a $20 million dollar decrease. Of note CY2022 is the last year of the rule add-on payment.

So that sums up the payment policy provisions in the calendar year 2022, HH PPS proposed rule. So, I will now turn the call over to Alpha Wilson to discuss the status of health equity. Thank you.

Alpha Wilson: Thanks so much, Kelly, and good morning or good afternoon, everybody. My name is Alpha Wilson.

And I am a technical adviser here in the Clinical Standards Group within the Center for Clinical Standards and Quality here in CMS. And I'm going to talk a bit about advancing health equity and the conditions of participation.

CMS periodically conducts a comprehensive review of the current health and safety standards. That is, the conditions of participation, otherwise known as the COP, and conditions for coverage, otherwise known as the CFC, with the goal of evaluating the efficacy of the current standards and identifying opportunities for regulatory improvements.

The COPs and the CFCs are the health and safety standards that providers and suppliers must meet in order to receive Medicare and Medicaid payment. They apply to all individuals that receive care in a health care organization regardless of the payer type.

They vary by provider but generally cover issues such as care, planning, governance, quality assessment and performance improvement, emergency preparedness and patient, resident or client rights.

In accordance with President Biden's three Executive Orders addressing issues of health equity, we are now evaluating how we can address health equity and improve health disparities through the COPs and the CFC.

We are committed to advancing equity for all, including racial and ethnic minorities, members of the LGBTQ community, people with limited English proficiency, people with disabilities, rural populations and people otherwise adversely affected by persistent poverty or inequality.

In order to achieve these goals, we are asking for information, input and ideas from the public on ways that we can address health equity within the COPs and the CFCs.

We are asking for data research studies and any other information that can help inform any potential changes to the COPs and the CFCs that we might make in the future.

In particular we are looking for input on how health equity can be improved during the care planning process and how providers can partner with community-based organizations to improve a person's care and outcomes after discharge, ways to hold a facility's governing body and leadership responsible and accountable for reducing disparities within their facility and advancing health equity policies and efforts, how the COPs can ensure that health equity is embedded into a provider's strategic planning and quality improvement efforts.

What types of staff, training or other efforts are necessary to ensure that people receive culturally competent care? Ways to combat implicit and explicit bias in health care, how the COPs can be improved to ensure that providers are not discriminating against individuals in underserved populations, particularly racial and ethnic minorities, those with disabilities, sexual and gender minorities, people with limited English proficiency and rural populations, ways to reduce health disparities amongst rural populations and increase access to care in rural areas.

How the COPs can ensure that providers offer fully accessible services for their patients or residents in terms of physical, communication and language access and any other data or additional information on ways to ensure that a provider is addressing and reducing health disparities within their facilities.

We encourage you to submit information and your input to the following mailbox, he.outreach@cms.hhs.gov. Again, that's he.outreach@cms.hhs.gov. We will review the information that we receive and use it to inform potential future policymaking.

Now I'll turn it over to Jennifer Donovan, who will discuss updates to home health value-based purchasing.

Jennifer Donovan: Thank you, Alpha. Hello. My name is Jennifer Donovan. I work with the CMS Innovation Center, and I'll be providing an overview of policies proposed in support of the home health value-based purchasing or HHVBP model for the current or the original model and policy also proposed for the expansion of the HHVBP model.

The CMS Innovation Center operates the current model, which began January 1, 2016, in nine States. The model tests whether payment incentives can

significantly change health care providers' behavior to improve quality of care through payment adjustments based on quality performance during a given performance year.

Under the model, CMS adjusts fee for service payments to HHAs based on their performance on a set of quality measures relative to their peers.

In the calendar year 2022, HH PPS proposed rule, we are proposing to end the current model one year early and not use calendar year 2020 performance data to impact payments to the HHAs in the nine model states.

Given the potentially destabilizing effects of the COVID-19 public health emergency on quality measures performance in calendar year 2020, as well as the pattern that we have observed in the utilization and reporting, we believe it would be most prudent to avoid using the calendar year 2020 data to apply calendar year 2022 payment adjustments under the original model to ensure that all Medicare certified HHAs nationwide begin participation in the expanded model's first performance year beginning calendar year 2022.

For the original model, we also propose not to publicly report performance data from the calendar year 2020 performance year based on our proposal to not use the 2020 data to impact payment in 2022 gets finalized.

Based on the original model's third annual evaluation report, which shows an average of 4.6% improvement in HHA' quality scores as well as average annual savings of $141 million, the CMS Chief Actuary certified and HHS Secretary subsequently determined that the model met statutory requirements for expansion.

In January 2021 we announced our intent to expand the model no earlier January 1, 2022 through notice and comment period.

The proposed model expansion presents an opportunity to improve the quality of care for our Medicare beneficiaries nationwide through payment incentives to HHAs. We propose that all HHA certified for participation in Medicare before January 1, 2021 would have their calendar year 2022 performance assessed and would be eligible for a calendar year 2024 payment adjustment.

It finalized all Medicare certified HHAs in the 50 states, the District of Columbia and the territories would be required to participate in the expanded model beginning January 1, 2022. All eligible HHAs would compete on value based on an array of quality measures.

Calendar year 2022 would be the first performance year and calendar year 2024 would be the first payment year, with the payment adjustments in 2024 based on HHA's performance in 2022.

A proposed payment adjustment for the calendar year 2024 payment year is upward or downward of 5% and would be applied to each fee for service claim submitted with a date of service January 1, 2024 through December 31, 2024.

Proposals in support of the model expansion largely mirror the original model design and incorporate changes to operationalize the model on a national scale, including moving from within states smaller and larger HHA cohort competition to national, smaller and larger volume HHA cohort competition and

To allow for a sufficient number of HHAs in each volume-based cohort for the purposes of setting benchmarks and achievement thresholds and determining payment adjustments. We are proposing to use cohorts based on all HHAs nationwide, rather than by state as under the original model.

We are proposing to redefine the cohort structure to account for state territories and the District of Columbia with a smaller number of HHAs while also allowing for the use of volume-based cohorts in determining benchmarks, achievement thresholds and payment adjustments separating smaller and larger volume HHAs and their cohorts under the expanded model would facilitate like comparisons by allowing for the majority of HHAs to receive benchmarks and compete for payment against other HHAs of similar size and based on the same set of quality measures.

HHAs would compete for payment adjustments within their national size level cohorts. As mentioned previously we propose that all HHAs certified for participation in Medicare before January 1, 2021, would have their calendar year 2022 performance assessed and would be eligible for a calendar year 2024 payment adjustment.

We are generally proposing that the baseline year would be calendar year 2019 and that new HHAs would begin competing under the expanded model in the first full calendar year following the full calendar year baseline year. The data from this baseline year would provide a basis from which each respective performance will be measured for purposes of calculating achievement and improvement points under the expanded model.

Beginning with the calendar year 2022 performance year and for subsequent years, we propose the following measure set that includes Oasis claims and HHCAHPS survey-based measures. We propose other policies related to

quality measures including measure removal, measure suspension and measure modification policy.

Many of the proposed measures overlap those within the HH QRP and HHAs would only need to submit data once to fulfill the requirements of both.

The distribution of payment adjustments would be based on quality performance as measured by both achievement and improvement across the proposed set of quality measures. We propose to award an HHA the higher of achievement or improvement only for the applicable quality measures for which the HHA meets the minimum threshold number of cases or completed, HHCAHPS Surveys.

An HHA that meets the minimum threshold on five or more measures would receive a total performance score and payment adjustment based on that performance year.

We propose that claims-based measure would be weighted 35% on OASIS-based measures 35% and the HHCAHPS Survey based measure 30% when the HHA has applicable measures in all three categories and otherwise meet the minimum threshold to receive a total performance score.

all three categories account for 100% of the total performance score. We propose to use the linear exchange function as we did for the original model because it was the simplest and most straightforward option to provide the same marginal incentive to all HHAs and we believe the same to be true for the model expansion.

The linear exchange function is used to translate an HHA's total performance score into a percentage of the value-based payment adjustment for each competing HHA.

We propose to use two types of models reports that would provide information on performance and payment adjustments. These two reports are interim performance reports and annual reports. These reports in the year of needing to be submitted to HCC under the original model.

We propose to issue interim performance reports or IPRs on a quarterly basis, with the first performance report anticipated to be issued in July 2022 with subsequent IPRs in October, January and April.

The first annual total performance score and payment adjustment report or annual report based on 2022 performance and 2024 payment adjustment year is anticipated to be issued in August of 2023.

We propose an appeals process where it could take away their IPR if it reflects an error in the data calculation that HHA may submit a recalculation request. The appeals process for the annual report includes the recalculation request appeal level, along with the second and final level of appeal of the reconsideration request to process.

We are proposing to publicly report certain performance data for the expanded model to begin with the 2022 performance and the 2024 payment years and for subsequent years.

Finally, we are in general proposing to adopt an extraordinary circumstance exceptions policy for the expanded model that aligns to the extent possible with the existing HH QRP exceptions and extensions policy.

That's all I have. Thank you for your time. I will now turn things over to James to talk about home health conditions participation.

James Cowher: Okay. Thank you, Jennifer. I'm James Cowher. I'm a policy analyst in the Clinical Standards Group. And today I'm going to be discussing proposed changes to the home health conditions participation, or COPs. As previously mentioned, these are the Medicare health and safety requirements.

The first thing I'll talk about are changes to the home health patient assessment requirement. Currently physical therapists and speech language pathologists are permitted to perform the initial and comprehensive assessment for Medicare patients but only in therapy only cases.

We are planning to align the patient assessment, COT, with changes that were made by the Consolidated Appropriations Act of 2021. This will allow occupational therapists to conduct the initial comprehensive assessment for Medicare patients when ordered with another rehabilitation therapy.

This proposed change is similar to a waiver that was implemented during the COVID-19 public health emergency, or PHE, but we're now proposing for it to be permanent to align with the change in statute.

The next few changes are possible related to the home health aide condition of participation. First, we'll talk about the age requirements for patients that are receiving skilled services. These are services such as skilled nursing or one of the rehabilitation therapies.

The current COPs for the HHA requires the HHA to conduct an in-person supervisory assessment of the home health aide every 14 days. The purpose of

this assessment is to assess the adequacy of the aide care plan, to listen to the patient's perception of services and to hear any concerns from the patient.

During the COVID-19 PHE we allowed for this requirement to be completed virtually using telecommunications technology. We are proposing to allow HHAs to complete supervisory visits either in person or virtually.

However, we believe that most supervisory visits should be conducted in person. So, we're proposing to limit the number of virtual visits to 2 times per 60-day period.

We believe this flexibility will allow HHAs to meet the 14-day requirement in situations when a patient cancels at the last minute or there is a last-minute scheduling issue.

The next proposed change to the home health aide requirement is for patients receiving non-skilled care. This would be when the patients are receiving aide services only.

The first thing I want to mention is that we're not proposing any changes to the frequency of the nurse supervisory visits. This will remain at 60 days, as it currently is. However, we're proposing to revise the type of visit from a direct observation of each aide while performing care to an indirect assessment. The purpose of this visit would be similar to what we require for skilled patients.

In addition, we're proposing to require that the nurse make a semiannual visit to the patient's home in order to directly observe each aide while performing care.

We believe these changes will provide the opportunity for open dialogue between the nurse and the patient while still providing the opportunity for periodic direct observation of aide skills.

For the next item we're proposing to make a very small change to the aide competency testing requirements. Currently if an aide is found to have a deficient skill, that person is required to complete retraining and competency evaluation of the deficient skill.

We're proposing to make a modification to the existing language to state that retraining and competency evaluation of the deficient skill must also include all related skills.

This is a minor change to the language of the requirement, but it ensures we capture all areas where the aide may need training and testing to verify proper skills.

The final item I have is a request for information related to the adequacy of home health aide staffing. This request is in response to a 2019 MedPAC Report that indicated a significant decline in aide services between 1998 and 2017.

Given the noted decline in visits CMS is seeking information about the adequacy of aide staffing and requests comments on several topics related to home health aides to better understand the current environment and need for services.

We appreciate any information the public can share with us on this request. That's all I have. So, I'll turn it back over to you, Michelle.

Michelle Oswald: Great. Thank you, James, and thank you, Kelly, Alpha and Jennifer for those policy updates. So next we will hear from Thomas Pryor, who will give an update on the addition of the Consolidated Appropriations Act of 2021 Hospice Provisions into the Home Health Perspective Payment System Proposed Rule. Thomas?

Thomas Pryor: Thanks, Michelle. Can you hear me okay?

Michelle Oswald: Yes, I do.

Thomas Pryor: Great. Thanks, everyone. Again, this is Thomas Pryor. I serve currently as the hospice survey and certification lead within the Division of Continuing and Acute Care Providers, a component within the Quality, Safety and Oversight Group or QSOG.

And as Michelle mentioned, we refer you to Section 7 of the proposed rule for information on survey enforcement requirements for hospice programs. And as Kelly mentioned earlier in the opening remarks were unable to provide additional guidance or clarification that is not currently in the proposed rule and formal comments should be received using the instructions provided and are published in the Federal Register.

As far as the rule proposed, we are implementing the Consolidation Appropriations Act of establishing survey enforcement requirements for hospice programs. And that's located in Section 407 of the Act.

Essentially there are nine provisions related to survey enforcement activities. These proposed changes will help strengthen oversight, enhance enforcement and establish consistent and transparent survey requirements in hospice care.

And it's kind of broken into three general areas that I'm going to go over, one being strengthening oversight and then enhancing enforcement and increasing transparency.

So, under enhancing - or excuse me, strengthening enforcement, we propose requiring training for state and national surveyors and any surveyor employed by an accrediting organization.

Secondly, we propose disqualifying state surveyors from surveying hospices for which they have a conflict of interest. States may not use anyone who has a member of staff of the surveyed hospice within the past two years or anyone with a financial interest in the hospice of the surveyor.

We are proposing requiring hospice surveyors that are conducted by more than one surveyor to be conducted with a multi-disciplinary team of professionals to increase one RN with hospice experience.

We propose addressing hospice programs identified who have a history of serious deficiencies to enter a special focus program. Those hospice programs within the special focus program would receive surveys every six months. Additionally, we are proposing to define the criteria that would initiate the special focus program before performing hospices and include remedies or actions that will be taken for continued non-compliance.

Lastly, we're proposing that requiring the implementation of programs that will measure the accuracy and consistency of survey results, excuse me, among surveyors.

The second area of enhancement enforcement, we propose requiring each state to establish a toll-free hospice hotline to collect and maintain claim information and questions received concerning hospices within the state.

Secondly, we are proposing authorization of the use of federal enforcement remedies for non-compliant hospices and procedures for appealing determinations regarding these remedies.

The third area of increasing transparency, we're proposing requiring accrediting organizations to report survey deficiency results on the form CMS-2567which is what's currently used by our state agency surveyors.

We propose requiring the publication of certification survey results to be done by state survey agencies and accrediting organizations, honesty and this website. The results will be published in a manner that is prominent, easily accessible and readily understandable and searchable.

In closing off, and I'll just close out with a couple of the effective dates for these provisions. Provisions requiring the new hospice program hotline is effective one year after the Consolidated Corporations Act legislation. Most other provisions are effective on October 1, 2021, including the following.

The requirement to use multidisciplinary survey teams, the prohibition of conflict of interests, expanding CMS-based surveyor training to include accrediting organizations and their requirement for accrediting organizations within CMS approved hospice accreditation programs to begin to use the form CM2-2567.

The public disclosure of survey information and the requirement to develop and implement a range of enforcement remedies is effective no later than

October 1, 2022 and the other provisions in the legislation were effective upon enactment of the Consolidated Corporations Act of 2021.

With that, I'll close my comments and turn it back to you, Michelle.

Michelle Oswald: Great. Thank you, Thomas. Next, we will hear from Joan Proctor and Charles Padgett with updates on the Home Health Quality Reporting Program. Joan?

Joan Proctor: Hi. Thanks, Michelle. I'm the Home Health Quality Reporting Program Coordinator and I have several announcements relative to the Home Health Quality Reporting Program that I would like to share with you today.

First, we're going to start off with a discussion on the proposals within the NPRM for - calendar year 2021 NPRM. The NPRM includes three proposals and two requests for information relative to the Home Health Quality Reporting Program.

We're proposing to remove the drug education on all medications provided the patient caregiver during all episodes of care measure and the related OASIS item M2016 beginning with calendar year 2023.

Home health agencies would no longer be required to submit OASIS Item 2016 as of January 1, 2023 if finalized. CMS would remove the drug education measure from public reporting after July of 2024.

The drug education measure performance among HHAs has been very high on variants barring such meaningful distinctions in performance and improvements can no longer be made.

Second, we've identified another HH QRC measure, the improvement in management of oral medication for patients which better address all quality issues of medication education and has better performance measure properties.

We also are proposing to remove the acute care hospitalization during the first 60 days of home health and the emergency department use without hospitalization during the first 60 days of home health or typically referred to as ED use measure and replace this with a home health within stay potentially preventable hospitalization or PPH measure.

The PPH quality measure reports the risk adjusted inpatient hospitalizations and observation stays that occur during a home health stay that are determined to be potentially preventable by home health agency intervention.

The current ACH and ED use measures assesses hospitalizations and emergency department visits regardless of whether any HHA action could have prevented these visits.

Conversely the PPH measure focuses on only the subset of states for conditions that HHA action could potentially limit or prevent.

Technical expert panel, or TEPs, input help to outline hospitalizations or observation stays that were preventable based on specific conditions where HHA intervention could impact the outcome.

If this proposal is finalized, the PPH measure will be added to the HH QRC in calendar year 22023 with the provision of confidential feedback reports to HHA providers. The ACH and ED use measures will be retired in calendar year 2024, again if finalized in our final rule.

We also have proposed to revise the compliance date for certain reporting requirements. We propose to start data collection for the transfer of health measures and a standardized patient data element beginning January 1, 2023. And we propose with that to establish the implementation of OASIS E as of January 1, 2023. That if this policy were finalized, we would adopt OASIS E beginning on January 1, 2023.

And there are similar proposals in the NPRM for the Earth and LTEC Quality Reporting Programs, whereby we propose to establish the collection of the TOH and the standardized patient assessment data elements beginning October 1, 2022.

We also have two requests for information. The first request for information was relative to - or relates to the digital quality measures, measurement or DQM. DQM is defined as quality measures that use one or more sources of health information that are faster and can be transmitted electronically via interoperable systems.

CMS is inquiring about the following. We are inquiring about the health electronic record or IT systems used in HHAs. The HHAs participation in health information exchanges. SCOH screenings in EHRs in HHA, incentivizing HIT systems in HHAs, HHA resource needed, collect report measures using (FIRE) standards and HHA's interest in participation in pilot to model.

The second RFI relates to closing the health equity gap, which I think you heard a little bit about health equity earlier on through our partners over in the survey and certification area. CMS is seeking input on several issues related to the health equity gap, including additional data elements to assess social

determinants of health, you know, beyond the ethnicity, preferred language, interpreter services, health services, transportation and social isolation.

Recommendations for how CMS can promote health equity and outcomes among HHA patients and methods that commenters or other organizations use in employing data to reduce disparities and improve patient outcomes include the sources of data used and the use of health data for addressing social determinants of health.

And finally, we'd like to make an announcement - I'd like to make an announcement here about an upcoming webinar discussing OASIS interim guidance. On July 29 CMS will hold this webinar to highlight important OASIS guidance refinements that have become available since the current OASIS D Guidance Manual became effective on January 1, 2019.

And now I'm going to turn it over to Charles for the remainder of the update. Charles, please take it away.

Charles Padgett: Thank you, Joan. Hi. My name is Charles Padgett and I lead the post-acute care public reporting effort here at CMS, including home health public reporting.

We have just a public reporting reminder to share here. Five home health measures will be removed from Care Compare in July 2021. The five measures are one, depression assessment conducted. Two, diabetic foot care and patients/caregiver education implemented during all episodes of care.

Number three is a multifactor fall risk assessment conducted for all patients who can ambulate. Four is pneumococcal polysaccharide vaccine ever received. And the fifth measure is improvement in the status of surgical

wounds. And you can look for those to be removed from our Care Compare site in late July 2021.

And that's all I have for public reporting and I'm going to pass on further updates to my colleague (Will Gehne).

(Will Gehne): Thanks, Charles. Two notes about our software releases. First, regarding the home health PC Pricer. The home health PC Pricer was released later than usual this year. I wanted to make sure everyone is aware that the software is available on the CMS Web site. It was posted on April 27.

In 2020 users needed to download three different versions of the PC Pricer to accommodate the transition to the PDGM. This year since all 2021 dates of service are paid under the PDGM, there's only one home health PC Pricer. The mainframe software for the Pricer is also available on the same site.

A quick note about public beta testing of the Grouper. Each year before the Home Health Grouper Program is updated in October, CMS and our software maintainer 3M release a beta test version of the program. Testers must sign up each year to participate in testing.

This year's beta Grouper was released earlier this week on June 28. So if you signed up to be a beta tester this year, please make sure you've received the release and can begin testing now.

Finally, I want to call everyone's attention to a new resource about our efforts to modernize Medicare's claims processing software. On your agenda is a link to a fact sheet summarizing our progress and describing upcoming releases of Java versions of various programs.

The home health Grouper has been in a Java version for years. Home, health agencies should note that we expect to convert the Home Health Pricer to a Java version in January 2022.

CMS is not aware of many agencies or software vendors who use the current mainframe version of the Home Health Pricer. But if you do, you should take steps now to prepare to support a Java program instead.

For users of the PC version of the Pricer, this transition should make things easier. You'll no longer need to download your own copy of the PC Pricer software each year and then possibly download it again if there are updates. The PC Pricer will become a Web hosted program, which everyone will be able to access on the CMS Web site so the Web Pricer will always use the most current updates automatically.

We look forward to providing this more convenient service to providers next year and I hope you'll find it user-friendly.

Two Inpatient Pricers are already on the Web Pricer page so you can look at those and get a general sense of what the interface will look like. The link to that page is in the fact sheet on your agenda.

That's all I have, Michelle.

Michelle Oswald: Great. Thanks, (Wil). And thank you, Joan and Charles. So next, I'm going to turn it over to Carla Douglas to talk about a reminder of the option to submit hospice notices of election via EDI. Carla?

Carla Douglas: Thank you, Michelle. Hello, everyone. This is just a quick reminder to hospices to take advantage of the option to submit hospice notices of election

via EDI. That option has been available since 2018 with the implementation of CR-10064 yet only a small percentage of type of bills 8XA through 8XE have been submitted via EDI since.

The hospice industry requested that Medicare implement submission of NOEs via EDI to reduce administrative burdens so we would like to remind and encourage hospices to take advantage of this option.

You may refer to the Companion Guide for NOE transmissions, which can be found at the hospice center Web page. This guide will provide instructions about how to use the 837 health care claims as NOE.

That is all I have, Michelle. And I'll turn it back over to you.

Michelle Oswald: Great. Thanks, Carla. And next we'll turn it back to Joan for some hospice updates and public reporting. Joan?

Joan Proctor: Hi. Thanks, Michelle, again. We have several updates today to provide for you on the HOPE development. In May and June of 2021, CMS recruited Medicare certified hospices from each of the four census regions, Northeast, South, Midwest and West to participate in a beta test of the HOPE.

We received a wonderful response to our call for applications and thank you to the hospices that applied to participate in beta testing. We greatly appreciate your interest in this important work and recognize that we can only progress this work with your support.

We've finished selecting hospices for the beta test and selected Hospice's will receive additional information about their participation and next steps for the testing.

During the HOPE beta test hospices will complete the HOPE process through a secure Intranet portal rather than integrating the beta version of HOPE into the hospice's EMR system.

Hospices participating in the beta test will receive additional information about the secure Intranet as part of their beta test training.

We've also received a number of questions about HOPE implementation in relation to the HIS. HOPE is intended to be more comprehensive than the current year's, which only captures data from admission and at discharge.

HOPE will capture patient and family needs in real-time and throughout the hospice stay. Once implemented, HOPE will incorporate data from the HIS. Hope through future rulemaking is expected to become the one tool for the hospice industry.

We will also share more about how HOPE will be submitted to CMS prior to implementation.

We would also like to remind hospices about the processing timeline for APU, the annual payment update or reconsiderations process. Any hospice that is determined to be non-compliant with the hospice quality reporting program requirements will be subject to a 2% reduction or APU through fiscal year 2023. Beginning in fiscal year 2024 this APU penalty will increase to 4%.

In hospices found to be non-compliant, they will receive a letter of notification and instructions for requesting a reconsideration of the decision. Hospice's may file for reconsideration if they receive a letter of non-compliance and believe the findings are in error.

The estimated reconsideration timeline is as follows. In July, we issue the notices of non-compliance to hospices who failed to meet the highest hospice quality reporting program. Any reconsideration requests are due to CMS 30 days after the date on the notification of non-compliance.

And CMS will provide email acknowledgement within five days of receiving a reconsideration request. And we'll notify hospices of the agency's decision in September. APU reductions for hospices, determined to be non-compliant will be applied on October 1, 2021.

We would also like to announce several new or updated resources that are available in the Hospice Quality Reporting Program Web site.

On June 2 CMS hosted a webinar providing an overview of the hospice quality composite measure and how it differs from individual quality measures. Materials from this webinar are now available on the Hospice Quality Reporting, Training and Education Library Web page.

On August 4, CMS expects to hold the next talks in this quality reporting program forum, which will highlight topics related to the fiscal year 2022, Hospice Final Rule.

On August 31, CMS will host a webinar discussing the fiscal year 2022 Hospital Final Rule in detail. Please watch for a registration announcement on the Hospice Quality Reporting Program announcements and spotlight Web page.

And so now I'm going to turn it over to Charles, who has some public reporting announcements. Charles?

Charles Padgett: Thank you, Joan. Just a few announcements here for hospice. On May 26, 2021, CMS conducted the annual update of the information on Care Compare. That comes from the hospital and post-acute care provider utilization and payment public use file, or PUB file as we call it.

Care Compare now displays PUB information for 2016 through 2018. CMS also added new additional information to Care Compare, such as the hospice care compliance status for each provider.

The questions and answers and fact sheet documents were also posted to the Hospice Quality Reporting Program Public Reporting Background and announcements Web page. Please visit the HPRP Web site for further information on this.

And that's all I have for hospice. I think I'm going to hand this back to Michelle.

Michelle Oswald: Great. Thank you again, Joan and Charles, and thank you to all of our speakers today. Before we take a couple of questions, I first want to just take a pause and see if my CMS colleagues have any additional updates that they wanted to make at this time.

Woman: I don't think there's any.

Michelle Oswald: Great. Thank you. (Denise), we are going to go ahead into the Q&A portion of the call so please take it from here. Thank you.

Coordinator: And thank you. At this time to ask a question, please, press star followed by the number 1 on your touchtone phone. Unmute and record your name clearly

as prompted to be introduced. Again, with any questions press star followed by the number 1. Our first question is from Golden Home Care. The line is open. Golden Home Care, the line is open. One moment, I'll move on to the next question. Ann Brown, your line is open.

Ann Brown: Hi. Thanks for taking my call. I'm calling about parenteral and enteral nutrition pumps. And I want to make sure I'm reading the claims manual correctly. This would be from Chapter 20 regarding capped rentals.

So at the end of the rental period, if the beneficiary doesn't choose the purchase option, is it correct that we maintain ownership of those pumps or are we required to transfer ownership like the other capped rental items?

Michelle Oswald: Do we have anyone from DME on the call that might be able to answer that question?

(Gina Longus): Hello. Hi. This is (Gina Longus). And I am in the division of new post, competitive bidding. Could that question be sent to the mailbox and we can address it as a team and get back with you, please? Thank you.

Ann Brown: Sure. I can do that. I can do that.

Coordinator: Are we ready for the next question?

Michelle Oswald: Yes, please, and I'll provide the mailbox at the end of the call. Thank you. I think we have time for one more question.

Coordinator: All right. Our next question is from (Marcie). Your line is open.

(Marcie Cody): Oh, yes. (Marcie Cody) from the Visiting Nurse Association. I had a question about the value-based purchasing and the new measures that we were submitting in the prior demonstration. Are we going to have to be doing that anymore in the new one?

Jennifer Donovan: Hi, (Marcie). This is Jennifer Donovan. Now those measures that the nine states were self-reporting under the original model are not proposed under expansion. So, they would no longer be reported.

(Marcie Cody): Okay. Great. Thank you.

Jennifer Donovan: You're welcome.

Michelle Oswald: Great. So, we are at time. Let me first give the email address for this Open Door Forum. It's homehealth_hospice_dmeodf-l@cms.hhs.gov. And that should also be in your appointment. And I'm going to turn it back over to Kelly for any closing remarks. Kelly?

Kelly Vontran: Again, just a thank you to everyone for joining the call today. I know it was a lot of information. So, I know that you have been given the mailbox to submit any questions and we'll certainly triage those to the appropriate components to try to get those questions answered for you as soon as possible. So, thanks again, everyone. Have a wonderful afternoon.

Coordinator: And thank you. This does conclude today's conference call. You may disconnect your lines and thank you for your participation.

END