Centers for Medicare and Medicaid Services

Open Door Forum: Home Health, Hospice and DME

Moderator: Jill Darling

June 29, 2022

2:00 pm ET

Coordinator: Welcome and thank you all for standing by. At this time, all participant lines are in listen-only mode. After today's presentations, you will have the opportunity to ask questions and you may do so over the phone by pressing star 1 at that time.

Today's call is being recorded. If you have any objections, you may disconnect at this time. It is my pleasure to turn the call over to your host for today, Ms. Jill Darling. Thank you, ma'am. You may begin.

Jill Darling: Great. Thank you, (Holly). Good morning and good afternoon, everyone. I'm Jill darling in the CMS Office of Communications. And welcome to today's Home Health Hospice and DME Open Door Forum.

Before we get into our agenda today, I have one brief announcement. This open door forum is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call.

If you do have any inquiries, please contact CMS at press@cms.hhs.gov. So up first we have (Ashley), who will go over the calendar year 2023 Home Health PPS Proposed Rule Update. (Ashley)?

(Ashley): Hey, Jill. Good afternoon, everyone. On June 16, 2022 the Centers for Medicare and Medicaid services, CMS, issued the calendar year 2023 Home Health Prospective Payment System Rate Update Proposed Rule, which would update...

Jill Darling: Sorry, (Ashley). Did we lose you?

(Ashley): Oh, I'm sorry. Hi, Jill. Are you guys able to hear me?

Jill Darling: Now I can hear you, yes.

(Ashley): Okay, I'm sorry, I don't know what...

((Crosstalk))

(Ashley): I keep getting muted on a different end. I don't know if that is something (Holly) or Jill...

Coordinator: No, (Ashley). On this side your line is open.

(Ashley): Okay. Let's try this again. Hopefully it keeps auto meeting. I'm sorry. I apologize, everyone. So, on June 16, 2022, CMS issued the calendar year 2023 Home Health Prospective Payment System Rate Update Proposed Rule, which would update Medicare payment policies and rates for home health agencies.

In accordance with existing statutory and regulatory requirements, this rule includes a proposed 2.9% increase in home health payments based on the

proposed market basket for calendar 2023, a proposed permanent 5% cap on negative wage index changes, a proposal to recalibrate the case mix weight functional levels, comorbidity levels and LUPA thresholds for home health services as well as an update to the home infusion therapy service payment rates for calendar 2023.

In addition, CMS is proposing to apply a permanent prospective payment adjustment of a decrease of 7.69% to the home health 30-day period payment rate. This adjustment is required by law to account for the difference between assumed behavior changes and actual behavior changes on estimated aggregate expenditures due to the implementation of the patient driven groupings model and 30-day unit of payment.

However, the overall estimated impact is negative 4.2% in calendar 2023. CMS is soliciting comments on how best to implement a temporary payment adjustment, estimated to be $2 billion for excess expenditures for calendar years 2020 and 2021.

CMS is also soliciting comments on the collection of telehealth data on home health claims to allow CMS to analyze the characteristics of the beneficiaries utilizing services furnished remotely. Comments must be received no later than 5:00 p.m. on August 16, 2022.

And I'll hand it back to Jill.

Jill Darling: Thank you, (Ashley). Next, we have Jermama Keys who will speak on the 2022 hospice for June and 2022 home health for June as well for updates.

Jermama Keys: Good afternoon, everyone. Thank you, Jill, and thank you for joining us for this Open Door Forum. We have several updates to share with the hospice community today.

First, we would like to remind everyone about August 2022 refresh of care compare. Two new claims-based measures are being added to the HQRP, HCI and HVLDL or Hospice Care Index and hospice visits in the last day of life.

As noted in the updated HQRP Public Reporting Tip Sheet from December of '21, these measures will be publicly reported using the most recent eight quarters of data excluding quarter one and quarter two of 2020.

The August 2022 refresh will add at HCI measure score and will remove the hospice visit when death is imminent measure. This measure was replaced by HVLDL.

The provider period reports for the August 2022 refresh were distributed in providers folders on May 25, 2022. The purpose of these reports is to give providers the opportunity to preview the claim based quality measure results and Hospice CAHPS Survey results prior to the public display on hospice Compare (unintelligible).

These two types of reports are automatically stored in provider's shared folder in CASPER. In preparation for the August refresh, you will again be able to preview the results for both claim based measures as well as those for HIS and CAHPS.

Second, we have a brief update about the fiscal year 2023 hospice final rules. The fiscal year 2023 hospice proposed comment period closed on May 31. The public comments received by CMS will be reviewed and incorporated into the forthcoming fiscal year 2023 hospice final rule.

Next, we want to remind hospice providers of the upcoming reconsideration period for the fiscal year 2023. Data submitted in 2021 impacts your fiscal year 2023 APU. If your hospices is non-compliant with the HQRP, you will be notified in two ways.

You will receive a notification of your Medicare administrative contractor, or MAC, and a notification in your facility certification and survey provider enhanced report, or CASPER, folder. Either notification is an official notice and we anticipate these letters notifying hospices of non-compliance will be distributed in mid-July.

Finally, several new resources will soon be available on the HQRP Web site. Swingtech sends informational messaging to hospices related to the QRP program via quarterly email. Their latest outreach is forthcoming and will be found on the HQRP requirement and best practices Web page.

If you would like to receive Swingtech quarterly emails add or update the email address to which these messages are currently sent. You can contact qrphelp@swingtech.com. Be sure to include your facility name and CMS certification number along with any requested updates.

CMS has also developed two new explanatory video resources. One of these videos provides an overview of the Hospice Quality Reporting Program and

the other will explain the purpose and design of the Hospice Care Index Claim Based Measure.

Please check the HQRP announcements and spotlight Web page for more information including a direct link to these videos.

In July of 2022, CMS will release a technical report, providing descriptive analysis and contextual information about the Hospice Care Index Quality Measure. The technical report will be available on the provider and stakeholder engagement Web page.

CMS will also publish an QM User's Manual on the current measures Web page. And we encourage you to monitor the announcements and spotlight pages for any additional details regarding these documents. Thank you.

Moving on to home health updates. We have several public reporting announcements about home health quality reporting, or HHQRP.

We have an update about the OASIS Draft Manual or OASIS-E Guidance manual. This updated draft and all item instruments were posted to the HHQRP Web site on May 16. Please check your home health QRP spotlight and announcements page for updates (unintelligible) and links to access the documents. (unintelligible).

In conjunction with the updated OASIS-E Manual, CMS posted an updated version of the OASIS static Q&As on May 23, 2022. Please check the Home Health QRP spotlights and announcements page for access and links to these documents as well.

We also have a public reporting announcement in reference to the July 2022 refresher, Care Compare. Provider preview reports for the July 2022 Care Compare refresh are currently available in iQies.

The purpose of these reports is to give providers the opportunity to preview their quality measure results prior to their public display on Care Compare.

Finally, we have a rulemaking announcement. The Calendar Year 2023 Home Health Notice of Proposed Rulemaking, or NPRM, was published this month. There are a few home health QRP proposals in this NPRM such as CMS is proposing to end the suspension of OASIS data collection on non-Medicare and non-Medicaid home health agency patients and to require HHAs to submit all payer OASIS data for purposes of the HHQRP beginning with the calendar year 2025 program year.

Finally, CMS is requesting feedback on health equity issues, specifically on a health equity structural measure concept and the request for information proposal. The comment period for this rule will end in mid-August. Thank you.

((Crosstalk))

Jill Darling: Great.

(Marcie O'Reilly): Good day. I'm (Marcie O'Reilly), the coordinator for the expanded Home Health Value-Based Purchasing Model, or HHVBP. In the calendar year 2023 proposed rule that we're talking about today:

CMS is proposing to change the HHA baseline year, which is used to determine each home health agency's improvement threshold for each measure in the model from calendar year 2019 to calendar year 2022 for existing HHAs with a Medicare certification date prior to January 1, 2019 and from calendar year 2021 to calendar year 2022 for agencies with a Medicare certification date prior to January 1, 2022. This will all start in the calendar year 2023 performance year.

We are also proposing to change the model baseline year, which is used to determine the benchmark and achievement threshold for each measure in the model for all HHAs from calendar year 2019 to calendar year, 2022, starting in calendar year 2023. And we have proposed corresponding modifications to the regulation text.

As stated in the proposed rule, we believe that updating the baseline years provides home health agencies the opportunity to be scored using the most current measured data available.

Additionally, we have included a request for information related to the potential future application of health equity in the expanded Model's scoring and payment methodologies.

We look forward to receiving your comments submitted to regulations.gov. I would also like to direct agencies to the resources available on the expanded HHVBP Model Web page that will help them prepare for the upcoming calendar year 2023 performance year.

The URL for that Web page is included in the agenda within the calendar appointment for today's open door forum or you can simply Google expanded home health - or expanded HHVBP Model, and it will be the first item in the search results.

Let me name a few of the latest resources. The June newsletter and updated FAQs were posted last week. The expanded HHVBP model guide is basically a how-to manual for the model.

There is a guide to calculating the Model's composite measures. We provided an overview of the risk adjustment process and its use in the expanded HHVBP Model.

There is a podcast about leadership and communication, essential elements for quality improvement. And there's also an instructional video called, Making the Most of HHVBP Resources which helps you navigate through all of the resources we have made available to you.

Lastly in late July we plan to post a sample interim performance report and a sample annual report in iQIES. We are planning to follow this up with a webinar in August where we will walk you through each report and give you an opportunity to ask questions.

In the meantime, questions about any finalized policies and resources for the Model should be sent to our help desk at hhvbpquestions@lewin.com. Thank you. I'll now turn it over to Beth Simon.

Beth Simon: Thank you, (Marcie). I'm Beth Simon. And I'm pleased to share a few HHCAHPS Survey reminders today on behalf of (Lori Teichman).

The calendar year 2024 HHCAHPS Participation Exemption Request Form must be completed by March 31, 2023, and the form is easily accessible on the HHCAHPS Web site. This form is for home health agencies with 59 or fewer patients from April 1, 2021 through March 31, 2022.

The next HHCAHPS Survey data submission deadline is Thursday, July 21, 2022. Home health agencies are responsible for reviewing their respective data submission report accessed via their dashboard on the HHCAHPS Web site to ensure their survey data has been successfully submitted to the Web site secure portal by their HHCAHP Survey vendors.

Home health agencies may view their public reporting preview reports for HHA's portal on the HHCAHPS Web site of their respective agency survey data that will be posted in the July 2022 refresh of Care Compare on medicare.gov.

The agency's credentialed users need to be logged into the Web site to view the report. For questions about your HHCAHPS Survey data results in your preview report, contact the HHCAHPS coordination team at hhcahps@rti.org.

The July 2022 quarterly newsletter for the HHCAHPS Survey will be posted this Friday, July 1. It's informative and a good way to learn something new about HHCAHPS.

Home health agencies currently participating in the HHCAHPS Survey that are planning to change vendors should contact RTI for their assistance in this process by emailing hhcahps@rti.org or by calling RTI at 866-354-0985.

And a reminder, as always, if you have any technical assistance questions about the HHCAHPS Survey, please contact hhcahps@rti.org call them at 866-354-0985. Thank you, and I'll turn it back to Jill.

Jill Darling: Great. Thank you, Beth, and thank you to all of our speakers today. (Holly), will you please open the lines for Q&A?

Coordinator: Thank you. If you would like to ask a question, please unmute your phone, press star 1 and record your first and last name fully and clearly when prompted so I may introduce you. To withdraw your request, press star 2. Again, to ask a question, press star 1. And it may take a few moments for questions to come in. Please stand by.

Our first question is from Cody Weaver. You may go ahead.

Cody Weaver: Thank you for taking my question. CMS recently released the Home Health Value Based (unintelligible) calendar year 2019 baseline achievement thresholds and benchmarks on iQIES with proposed rule and changes to the baseline year to the calendar year 2022. I wanted to know when we or sorry, when will CMS provide the updated achievement thresholds and benchmarks.

(Marcie O'Reilly): If the proposal is finalized as we state in the NPRM that those - the benchmark and achievement thresholds will be available in the summer of 2023.

Cody Weaver: Thank you.

Jill Darling: Next question please?

Coordinator: Okay. One moment for the next question.

Jill Darling: Hi, (Holly). Do we have any more questions in the queue?

Coordinator: We do. One moment. I'm just grabbing their name. Our next caller is Alice Black. You may go ahead. Again, Alice Black, your line is open. Please check your mute button. We're not able to hear you.

Jill Darling: We'll take the next question if they are unable to speak.

Coordinator: Okay. Our next question is from Christine Bunch. You may go ahead.

Christine Bunch: Hello. I was just wondering if you could repeat the date that we can see the July 2022 refresh in iQIES. I'm actually logged into iQIES now and I don't see anything released in June.

Jermama Keys: Is this for hospice or home health?

Christine Bunch: Oh, I'm sorry. It's for home health.

Jermama Keys: Okay. Hold on one second.

Christine Bunch: Sorry about that.

Jermama Keys: No. It's okay. It's okay.

Christine Bunch: The only release that I have that happened in June was the QAO report that was released on June 17.

Jermama Keys: So, the correction to quality of patient care filing report and that should have been updated.

Christine Bunch: It has not as of today.

Jermama Keys: I'm going to follow back up with you with that.

Christine Bunch: Do you want my phone number?

Jermama Keys: If you would like to send an email to the public reporting Web page.

Christine Bunch: Okay. Is that at the...

((Crosstalk))

Jermama Keys: We can actually log your question with the ODF.

Christine Bunch: Okay. So, do you want me to send it to the homehealth_hospice_dmeodf-l@cms.hhs.gov mailbox?

Jermama Keys: Correct.

Christine Bunch: Okay. Alrighty. Thank you.

Jermama Keys: Thank you very much.

Christine Bunch: You're welcome.

Coordinator: The next question is from (Maria Avers). You may go ahead.

(Maria Avers): Hi, yes. Thank you for fielding my question. I was wondering if you could elaborate a little bit more on the change of the year for the HHVBP from 2019 to 2022 just because we spent an awful lot of time trying to improve those numbers and make sure we understand where we are to be repositioned. It's a lot of work to have to repeat to catch up with the 2022 numbers.

So, I was wondering a little bit more of why that decision was made and the impact if they thought about on the agencies that were preparing for this prior to this day. Thank you.

(Marcie O'Reilly): Yes. And I would encourage you to go back and read our rationale in the NPRM. But we do believe that the effects of the pandemic has had a - we show on the tables the effects it has had on the measures. And we wanted to make sure that we were using data that was for the most current and is not pre-pandemic.

So, as we stayed in there, it appears that that is the most - that using the most current data is what's best for the majority of agencies.

(Maria Avers): Thank you.

Operator: Our next question from William Noyes. You may go ahead.

William Noyes: Thank you. This is Bill Noyes with the National Home Infusion Association. The January 2022 CMS Report on Home Infusion Therapy Services reveals that few suppliers are participating in the program and that just 5 of the 80 suppliers enrolled in the program supply 50% of the visits.

And this data is only through Q1 of 2021. Are there any plans to publish updated reports when more data is available? And I would add that NHI is especially concerned with patient access in light of recent announcements by two of the largest suppliers in this space that they're downsizing and closing dozens of facilities across the U.S.

Brian Slater: Hey Bill. It's Brian Slater. How are you doing?

William Noyes: Good. How are you, Brian?

Brian Slater: I appreciate the question and as you know, we would always provide monitoring data for all three of our benefits that my division oversees, one of which being the home infusion therapy services benefit.

And in order to have a more public-facing document way to showcase that data for, you know, anyone in the public, including industry providers and suppliers, we're trying to move more towards a document like you saw with some infusion therapy on the Web site.

We are planning to update that just once a year. Things might change but that's our current plan. Obviously, what you mentioned, you know, what we're obviously aware of, the recent developments, and we've also had recent discussions with folks in the department about this development.

So, it is something that obviously is on our radar and access to care in any benefit for that matter is obviously always a touching point for CMS and, you know, something that, you know, we always have our sights on.

So, we're going to be monitoring the data even if it's not seen public facing, it's something that even if you see an update in a yearly instance, it's not that we here at CMS aren't looking at that and evaluating it on a more real-time basis.

So, if there's anything that we feel that, you know, is an access to care issue, obviously we'll bring those from the industry involved and see if there's any touch points that are needed there, but also those within the agency and the department as well.

So, I appreciate you further highlighting that Bill.

William Noyes: I appreciate your response and happy to hear that we'll see some report on at least an annual basis. So, thank you so much.

Brian Slater: Yes. No problem, Bill.

Coordinator: Our next question is from (Brandy Susa). You may go ahead.

(Brandy Susa): Thank you. Thank you for taking my question. My question is currently the version of the OASIS-E data suspects that are available on CMS' Web site is back from April of 2020. And vendors rely heavily on these data specs to finish any development work in the EMR for OASIS.

So, my question is when do you anticipate an updated draft of the OASIS-E data specs will be posted?

Jermama Keys: I do not have a specific date for the data specs but it is forthcoming. There are some revisions that are being made and we will provide those specs as soon as possible.

(Brandy Susa): Okay. Thank you.

Jermama Keys: You're welcome.

Coordinator: Our next question is from Rae Cornell. You may go ahead.

Rae Cornell: Thank you for taking my call. My question is regarding timely submission of HIS for a new hospice provider. I understand that when our action plan is accepted, that would then become our first billable date for services provided to our patients that are admitted from that date forward, which that date will be different than the date that will be on the CMS letter when they issue our CCN number.

So, with the 30 days that are allowed to submit your HIS, is that countdown from the date on the letter or the date of your billable date, which you may have admissions on that a date prior to receiving your letter.

Jermama Keys: So, your 30 days starts from your date on when you actually receive your CCN.

Rae Cornell: So, if we admit patients, once our action plan is accepted, which I understand we can admit patients at that point in time, that might be before our CMS letter comes but our 30 days start on the date of the letter?

Jermama Keys: Correct. In order for you to be able to enter the information, you have to set up your profile, which is going to require your CCN.

Rae Cornell: Correct. Okay. Perfect. Thank you.

Jermama Keys: You're welcome.

Coordinator: Our next question comes from (Sherry Whalen). You may go ahead.

(Sherry Whalen): Hi. You answered the question previously regarding the OASIS-E specifications. I just want to point out we have six months left to finish our preparations for OASIS-E implementation from a technology standpoint.

But this also has to go to clients who have to educate their clinicians starting January 1. And as a part of the CMS recommendations for proposals for 2023, this now is going to include all patients in the future.

So, I can't stress strongly enough how important it is to get those specifications out as soon as possible. I really hope that you can tell me within

the next month so that all of this work can be completed by everybody else outside of the CMS realm.

Jermama Keys: I do understand your concern and we are working towards being able to get those specs out to you guys as soon as possible.

(Sherry Whalen): Thank you.

Coordinator: And our next caller is Alice Black. You may go ahead.

Alice Black: Okay. Let's see if this works. Can you hear me now? Hello, can you hear me? Okay. Sorry. I had a technical problem on my end. Actually, you guys answered my question. I am also a software vendor in the middle of doing OASIS-E using the old specs which we know are being updated because the instrument has been updated.

And we are currently just manually making changes, which always makes me nervous. So, I will just throw my hat in the ring and say the sooner we can get the updated draft specification the better. Thank you.

Coordinator: Okay. And our next question is from (Cheryl Stessa). You may go ahead.

(Cheryl Stessa): Hello. Thank you. My question is about Care Compare for hospice. The new claims based measures were delayed from the May refresh to August. But on the Compare Web site for where those measures are going to be they were suppressed by CMS upon request from the agency.

I'm not aware that we made any of that request. It just makes us feel like we were hiding something I guess in that terminology. So, I just wondered if you were able to comment on that. It does appear to be on all of them.

Jermama Keys: There is an additional update to the footnote that is going to be pushed out. And it should provide some additional clarity in reference to your request.

(Cheryl Stessa): So, it's not going make it sound like we requested the delay when we didn't.

Jermama Keys: Right.

((Crosstalk))

(Cheryl Stessa): That would be really great. Thank you.

Jermama Keys: Thank you so much.

Coordinator: And the next caller is Peg Cavender You may go ahead.

Peg Cavender: Hi. Thank you for taking my question. This is with regard to the Hospice Change Request 12619 that's going into effect on Friday for the hospice transfers.

So, we've had a question asked of us. If the discharging hospice assumes that it's going to be a transfer out, but the receiving hospice cannot admit the patient on that same day, we understand that instead of sending in a Transfer Notice of Election, an 81-C, they're required to send in an 81-A.

What impact does that have on the benefit period? So, if I'm in Benefit Period 2 and I have 30 days left and the patient transferred, do they just get the remainder of Benefit 2 even with an 81-A or do they then lose the rest of that benefit period because of it becoming an A now instead of a C and they're required to go to Benefit Period 3?

Because from a vendor perspective typically we allowed the C's and that was the only time that they would be entering in the same benefit period. But if it was an admission, they are going to be starting in a new benefit period.

So, I didn't know from CMS' perspective, do they still get the remainder of Benefit Period 2 even with an 81-A because the admission couldn't occur on the same day?

Brian Slater: Hey, this is Brian. Just to make sure that we have - you said a lot of numbers and letters there, which I was trying to follow, but I'm not sure if I accurately did.

So, if you wouldn't mind summarizing the issue because I think it's more of a claims issue. And we don't have our claims expert from our provider billing group on today. That way we can most appropriately address it and get back to you in an expeditious fashion.

Peg Cavender: Okay. So, do you want me to send it into the email address?

Brian Slater: Yes. Do you have that from the agenda?

Peg Cavender: Yes. I can find it on the agenda.

Brian Slater: Yes. It's the homehealth_hospice_dmeodf-l@cms.hhs.gov.

Peg Cavender: Okay. All right. Well thank you. You know, it's just one of those things that from, you know, clients are starting to ask.

And I went back through and read the MLN matters and we didn't see that, you know, how they are to address the benefit periods and the remaining days, you know. All that was basically stated is that you're required to do a new admission as opposed to sending in a transfer notice.

Brian Slater: Yes, 100%, I get it.

Peg Cavender: So, I will send that through the email. Thank you.

Brian Slater: Great. Thank you so much. I appreciate your question.

Coordinator: I have no additional questions at this time. But again, if you would like to ask a question, please unmute your phone, press star 1 and record your first and last name clearly when prompted so I may introduce you.

Jill Darling: I will just give it a few more seconds in case anyone queues up.

Coordinator: Please stand by for the next question. Our next question is from (Hanlon Kurdin).

(Hanlon Kurdin): Hi, yes. Thanks for taking my question. I have a question on the home infusion benefit. Are agencies allowed if the medication is being administered

is one on the list. And they were hooked up in the clinic. So, one day they go to the clinic, get hooked up and then the home health goes out that night and disconnects.

I've asked several different consultants and I get a different answer every time. Are we allowed, the home health allowed, to bill that on their claim as they always did in the past?

(Woman): If the home health agency is accredited and enrolled as a home infusion therapy provider then yes, they could bill for going out - and did you say disconnecting the infusion or connecting the infusion.

(Hanlon Kurdin): Disconnecting?

(Woman): Disconnecting.

(Hanlon Kurdin): And no, they're not.

(Marcia Reilly): Okay. So, if it is a - I'm sorry. Can you hear me?

(Hanlon Kurdin): Yes.

(Woman): Okay. So, if the patient - so are you saying the patient is receiving home health services, but they're also - but they have gone and gotten hooked up in an outpatient clinic to receive say like chemotherapy and it's one of the HIT drugs?

(Hanlon Kurdin): Right.

(Woman): Okay. So, the home health agency cannot bill for the disconnection of that drug if they are not enrolled as a home infusion therapy supplier.

(Hanlon Kurdin): Okay. Thank you.

(Woman): Sure.

Coordinator: And our next question is from (Lillian Gomez). You may go ahead.

(Lillian Gomez): Hi. Thank you for taking the call. I have a question about a face-to-face that we received from a physician that says that the face-to-face was started with audio and visual. And then halfway through they had a technology problem, and it had to be finished only by visual and phone. And then again it says that they lowered the visual. Would that face-to-face be considered invalid?

Jermama Keys: I'm sorry. This is for...

(Lillian Gomez): Home health. I'm sorry.

Jermama Keys: Okay. So, if you could direct your specific question...

(Lillian Gomez): Okay. The question is on our face-to-face that we received, and it stays that it was performed on the audio and visual. And halfway through the performance of the face-to-face, they had a technology problem and it had to be finished by phone. Is that face-to-face, would it be considered valid or invalid?

Jermama Keys: Right. I understand your question, but if you could direct your question the Home Health Quality Questions Help Desk that way we can take a look and give you the best response. It's going to be homehealthqualityquestions -- all one word -- at cms dot hhs dot gov.

(Lillian Gomez): Okay. Thank you.

Jermama Keys: Thank you.

Coordinator: And our next question is from Cody Weaver. You may go ahead.

Cody Weaver: Thank you for taking a second question. In the calendar year 2022 final rules CMS finalized the replacement of the acute care hospitalization during the first 60 days of home health, NQF 0171 Measure as well as the ED or emergency department use without hospitalization during the first 60 days of home health, which is NQF 0173.

Both of those measures were finalized to be replaced with the Home Health Within State Potentially Preventable Hospitalization Measure beginning with the calendar year 2023 HHQRP.

In the proposed rule for calendar 2023 one of the tables lists the '20 HHQRP measures and it includes the ACH and ED Use Measures. So, our question is, are these two measures no longer planned for replacement by a PCH in HHQRP?

Jermama Keys: They still are planned for replacement. If it is in reference to Table 4, there are some updates that are going to be also coming out that are technical for those tables. Does that answer your question?

Cody Weaver: We will look for the updates and yes, I believe that came from Table 4.

Jermama Keys: Thank you.

Coordinator: Our next question is from William Noyes. You may go ahead.

William Noyes: Yes. I have a follow-up question to the question that was asked about home health's ability to bill for a drug that is initiated in an outpatient clinic.

A drug initiated in an outpatient clinic is billed to the AB MAC but not the DME MAC. Therefore, it's not a HIT drug. There's no claim to bump it against. In that scenario, can a home health agency bill for the disconnect in the home?

Brian Slater: Hey, Bill. This is Brian again. I think we're going to have to think about that one. We'll circle back and we'll ensure that if it's the opposite of what we had said previously we'll update on the transcript and then we can follow up with you accordingly.

William Noyes: I've had that same question too and there's a lot of confusion about the intersection of home health purchased HIT services and what drugs does it apply to, does it not apply to and even if there's a drug in the HIT benefit, but the patient doesn't qualify under that benefit can home health provide those services?

And I know that it's partially addressed in the Q&A or the FAQs but not fully. So, I appreciate that.

Brian Slater: Yes. Thanks for jumping back in.

Coordinator: And I show no additional questions at this time but again if you would like to ask a question please press star 1. And please stand by for our next question. Our next caller is (Sandra Pierce). You may go ahead.

(Sandra Pierce): Hi. Thanks for taking my call. This is in relation to OASIS data submission for all payers. Can you speak to the privacy of that as far as individuals that don't have Medicare and their information is being submitted to Medicare? Thank you.

Jermama Keys: Unfortunately, I cannot speak to the specifics in reference to the proposal because we are still in rule season. But the final rule is when the rule becomes final. There should be some updated information that would clarify those specifics in reference to the payer.

(Sandra Pierce): Thank you.

Jermama Keys: You're welcome.

Coordinator: And I show no additional questions at this time but again star 1 to ask a question. Please stand by for our next question. The next question is from (Christy). You may go ahead.

(Christy): Hi. I just wanted to ask. Every year I believe the proposed PPS rule for home health always occurs around October, November, but this time it's summertime, which I believe is the perfect time.

Is that you think something that's going to happen every year now and hopefully we can request it happens around this time and not wait until fall when typically, a large association by that time that they need almost always the rule is not out yet.

Brian Slater: Hey. This is Brian Slater. So, the home health proposed rule annually - well it usually goes out - I think this is one of the earlier years in June, but it's usually out between the end of June and somewhere in the middle of July for the proposed rule and then the final rule is usually out by November 1 each year.

(Christy): I'm sorry. I was on mute. Thank you.

Coordinator: I show no additional questions at this time. But again, star 1 to ask a question. Our next question is from (Maria Avers). You may go ahead.

(Maria Avers): Hi. Yes. Thank you for fielding a second question. I was wondering about the all payers. If you have a financial assistance program at your facility would the no payer patient clients require the OASIS assessment be transmitted as well?

Jermama Keys: And again, in reference to the proposal, I'm not able to really speak on the specifics because we are currently in rulemaking. However, if you would like to provide a comment or a question in reference to the proposal on the actual

proposed rule, you can always add a comment or send a comment in through the Federal Register.

(Maria Avers): Great. Okay, thank you.

Jermama Keys: You're welcome.

Coordinator: And I have no additional questions at this time, but again star 1 to ask a question.

Jill Darling: All right, everyone. Well we - oh I'm sorry. Go ahead.

Coordinator: Did you want to take your last question?

Jill Darling: Sure. We can.

Woman: Hello?

Jill Darling: Yes. Go ahead.

Woman: Okay. I have a question about the hospitalization claims data. And I just needed clarity on something. Everywhere that I read it says that Medicare fee for service is what is calculated in your hospitalization data.

However, I was always under the impression that it was Medicare, Medicaid and managed Medicare. So, I'm just a little bit confused by the terminology fee for service. Can you please verify that? Hello? Did you hear my question?

Brian Slater: Yes, I think you - hey, this is Brian. I think you were breaking up a little for me at least. I'm not sure if we have anyone on the call today that can answer that. And since you were breaking up slightly, it was tough for me to hear you so if you wouldn't mind summarizing your question and putting into the mailbox we'll ensure that it gets triaged accordingly.

Woman: Okay. Thank you.

Brian Slater: Yes. Thank you so much.

Jill Darling: (Holly), are there any more questions in the queue?

Coordinator: Sorry. I have no additional questions at this time.

Jill Darling: Okay. Well thank you everyone for joining today's Home Health Hospice and DME Open Door Forum. As always if you do have any questions or comments, please feel free to send them into the mailbox. It is always listed on the agenda. It's homehealth_hospice_dmeodf-l@cms.hhs.gov.

And thank you for your time, and we will talk with you next time. Thank you.

Coordinator: And this concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers, please stand by.

[End]