Centers for Medicare and Medicaid Services

Questions and Answers:

Home Health, Hospice and DME Open Door Forum

June 29, 2022

1. Question: CMS recently released the Home Health Value Based 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 will CMS provide the updated achievement thresholds and benchmarks.
    a. Answer: If the proposal is finalized as we state in the NPRM that the benchmark and achievement thresholds will be available in the summer of 2023.
2. Question: I was just wondering if you could repeat the date that we can see the July 2022 refresh *[for Home Health]* in iQIES. I'm actually logged into iQIES now and I don't see anything released in June.
    a. Answer: The preview reports for the July 2022 refresh have been available in iQIES since late April. However, (We also checked and confirmed that this HHAs preview reports were in the package of PPRs sent to the iQIES team for posting.) I would suggest referring this specific provider to the iQIES Help Desk for assistance with locating these reports.
3. 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. 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.
    a. Answer: 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 using the most current data is what's best for the majority of agencies.
4. Question: 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.

    a. Answer: 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 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, 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 is on our radar and access to care in any benefit for that matter is obviously always a touching point for CMS and something that 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, 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.
5. 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. When do you anticipate an updated draft of the OASIS-E data specs will be posted?
    a. Answer: 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.
6. Question: 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. 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.
    a. Answer: Your 30 days starts from your date on when you actually receive your CCN.
        i. Question: 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?

1. Answer: 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.

7. Question: 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.
    a. Answer: I do understand your concern and we are working towards being able to get those specs out to you guys as soon as possible.
8. Question: My question is about Care Compare for hospice. The new claims based measures were delayed from the May refresh to August. 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. I just wondered if you were able to comment on that. It does appear to be on all of them.
    a. Answer: 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.
        i. Comment: So, it's not going make it sound like we requested the delay when we didn't.
            1. Comment Answer: Right.
9. This is with regard to the Hospice Change Request 12619 that's going into effect on Friday for the hospice transfers. 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?

a. Answer: The submission of a new 81A will not change the existing benefit period. An 81A only have an impact of election periods. Please refer to section 20.1.6- Hospice Election Periods and Benefit Periods in Medicare Systems in the Hospice Claims Processing Manal. It provides a summary chart as a reference to help hospices understand which of their submissions will impact an election period or a benefit period.

10. 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?
    a. Answer: 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.
        i. Question: Disconnecting?
            1. Answer: Yes
                a. Commenter: No, they're not.
                b. Answer: So, if the patient - so are you saying the patient is receiving home health services, 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?
                    i. Right.
                        1. 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.
11. Question: 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? For Home Health.
    a. Answer: If any portion of the face to face was conducted via audio-visual, and was only completed via audio due to technology issues, then yes, it would be considered a valid face to face.
12. 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?

    a. Answer: 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.

13. Question: 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?
    a. If the drug is not billed to the DME MACs, but is initiated and billed under OPPS, then it would not be considered a HIT drug and would not be eligible for HIT services. In which case, the HHA could bill for the disconnect under the HH PPS if the patient is receiving care under a home health plan of care.
14. Question: 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?
    a. Answer: 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.
15. Question: 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.
    a. Answer: 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.
16. 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?

a. Answer: 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.