Centers for Medicare & Medicaid Services
Open Door Forum: Home Health, Hospice and DME
Moderator: Jill Darling
November 4, 2020
1:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. At the end of today's presentation we will conduct a question-and-answer session. To ask a question please press Star 1. Today's conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the meeting over to Jill Darling. You may begin.

Jill Darling: Great. Thanks so much (Brandon). 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. It's great to be back.

We're getting back into the swing of things with having the Open-Door Forums again. And as always we appreciate your patience in dialing in. You know, we always try to get as many folks in as we can and but I know we're also trying to be respectful of your time as well. So I will have one brief announcement and will dive right into our agenda today.

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 have any inquiries please contact CMS at press@cms.hhs.gov. We'll begin with Susan Bauhaus who will go over the calendar year 2021 Home Health Prospective Payment System final rule.

Susan Bauhaus: Thank you Jill.

On October 29, CMS issued a final rule updating the Medicare Home Health Prospective Payment System Rates and Wage Index for calendar year 2021. CMS estimates that payments to home health agencies will increase in aggregate by 1.9% or $390 million in calendar year 2021.

This increase reflects the effects of a 2.0% home health payment update percentage or $410 million increase and a 0.1% decrease or $20 million decrease in payments due to reductions in the rural add on percentages mandated by the Bipartisan Budget Act of 2018.

The rule also updates the Home Health Wage Index including the adoption of revised OMB statistical area delineations and limiting any decreases in geographic area wage index value to no more than 5% in calendar year 2021.

The rule also finalizes, beginning January 1, 2021, permanent changes to the home health regulations as originally outlined in the March 2020 Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Interim Final Rule with Comment.

Home health agencies can utilize telecommunications technologies in providing care to beneficiaries under the Medicare home health benefit as long as any provision of remote patient monitoring or other services furnished via a telecommunications system or audio only technology are included on the plan of care.

The use of such telecommunications technology or audio only technology must be tied to the patient specific needs as identified in the comprehensive

assessment. CMS will not require a description on the plan of care regarding how such technologies will help to achieve the goals outlined on the plan of care. However, documentation in the medical record should explain how such services will help facilitate treatment outcomes.

The use of technology is statutorily prohibited from substituting for an in-person home visit that is ordered on the plan of care and cannot be considered a visit for the purpose of patient eligibility or payment. However, CMS recognizes that the use of technology may result in efficiencies in the furnishing of home healthcare, potentially resulting in changes to the frequencies and types of in-person visits as ordered on the plan of care.

This rule also expands the definition of telecommunications technology in addition to remote patient monitoring that home health agencies are allowed to report as allowable administrative costs on the home health agency cost report. These finalized policies will ensure patient access to the latest technology and give home health agencies predictability that they can continue to use telecommunications technology as part of patient care.

Lastly, this rule implements policies related to the first year of the permanent home infusion therapy services benefit to begin on January 1, 2021. The rule finalizes Medicare enrollment policies for qualified home infusion therapy suppliers, updates the home infusion therapy services payment rates for calendar year 2021 using the calendar year 2021-physician fee schedule amounts and finalizes a policy excluding home infusion therapy services from home health services as required by the 21st Century CARES Act.

Now (Wil Gehne) will discuss the correction to change request 11855 and the penalties for delayed RAP submission.

(Wil Gehne): Thanks. Back in July Medicare initially published change Request 11855 which implements the penalty for RAPs not submitted within five days of the "from" date of the home health period of care. Since then we've issued two corrections to that change request.

Now the most recent correction that went out last week simply asked the Medicare contractor requirements about coordination of benefits and does not affect home health agencies at all. But the earlier correction, the one that was issued on September 24 contained two important clarifications for HHAs so I wanted to call them to everyone's attention. The first is in regards to service date reporting on the RAP. Today the RAP must report the date of the first visit provided in a period of care except in rare cases where no visit is expected for 30 days.

Starting in 2021 HHAs may submit RAPs for second and subsequent periods of care without waiting for a visit to be provided. HHAs may report the first day of the period of care, that is the RAPs "from" date as the service date on the 0023 revenue code line on the subsequent RAPs.

This will allow for the submission of RAPs for two 30-day periods of care immediately after the start of each 60-day certification period and it will also prevent delaying the submission of the RAP for subsequent periods when the first visit in that period will be beyond the five day timeframe.

The second clarification regards corrections to previously submitted RAPs. If the RAP that corresponds to a claim was originally received timely but the HHA needs to cancel and resubmit the RAP to correct an error the original RAP meets the timeliness requirement.

But to avoid a payment penalty based on the receipt date of the resubmitted RAP the HHA will need to request an exception on the corresponding claim. So the HHA should enter remarks on the claim to indicate what happened, for example timely wrap, cancel and rebill. They should also append, modify or KX to the HPPS code reported on the revenue code 0023 line. HHAs should resubmit corrected RAPs promptly that is generally within two business days of canceling the original RAP.

Finally, I'd like to review the answers to some questions that have been asked frequently over the past few weeks about this change request. First the late RAP penalty and the instructions regarding submission of two RAPs for a given 60-day certification period apply to all certifications period, not just the initial one.

Next HHAs can submit any valid HIPPS code on the RAP so there is no need to wait for OASIS information to determine the accurate HIPPS code before submission. This has been allowable since the start of the PDGM in January of 2020. And there's no program integrity concern associated with submitting the same HIPPS code on all periods of care.

But the HHA should be sure to submit the same HIPPS code on the claim since the HIPPS code is used to match a claim to its corresponding RAP. The accurate HIPPS code for payment purposes will be determined by Medicare systems.

Also, the no RAP LUPA policy is not changing. For the claim to qualify for a LUPA payment is submitted without a corresponding RAP the penalty does not apply. And finally, the date of the first line item, the first visit line item on the claim does not need to match the date on the claims revenue code 00231.

Medicare system edits that currently require this will be relaxed starting January 1, 2021.

That's all I have. Thanks Jill.

Jill Darling: Great, thanks (Wil). Next we have Gina Longus who has some DME updates.

Gina Longus: Hello everyone. On October 27, 2020 CMS announced a single payment amount for the off-the-shelf or OTS back braces and OTS knee braces product category included in the round 2021 of the durable medical equipment prosthetics orthotics and supplies or DMEPOS competitive bidding program and began awarding contracts and certain competitive bidding areas, or CBAs.

Contract office has been made in 127 CVAs for the OTS back braces and OTS knee braces product category as Medicare expects to save $600 million with the program and beneficiary over the three-year round 2021 contract performance period.

Contracts for OTS, back braces and OTS knee braces are being awarded in certain CBAs while savings would not be achieved. Winning bidders have until 8:59 pm prevailing Eastern Time on November 10, 2020 to respond to that contract offers.

There will be no round 2021 competitive bidding contracts awarded for any product category other than OTS back braces and OTS knee braces because the payment amount did not achieve expected savings. Payments for the items where contracts will be - will not be awarded will be based on adjusted fee schedule amounts in accordance with regulation in CFR 414.210G.

Round 2021 contracts will be affected on January 1, 2021 and extend through December 31, 2023. CMS plans to announce the contract suppliers later this fall.

For more information on the DMEPOS competitive bidding program please visit the Competitive Bidding Implementation Contractor or CBIC website at www.dmecompetitivebid.com.

The CBIC is the official source for information regarding the DMEPOS competitive bidding program. Visit the CBIC website for valuable resources and tools and to subscribe to email updates.

If you have any questions or need assistance please call the CBIC Customer Service Center at 877-577-5331 between 9:00 am and 5:30 pm prevailing Eastern time Monday through Friday.

I will now pass it on to Joel Kaiser who will give an update on the DME rule. Thank you.

Joel Kaiser: All right thanks Gina.

Yes just announcing that today we published a Notice of Proposed Rulemaking in the Federal Register. It has a number proposed rules.

First, we are proposing reschedule adjustment methodologies for items and services furnished on or after April 1, 2021 using methodology for using information from the competitive bidding program to adjust the fee schedule amounts for items that are paid in noncompetitive bidding areas.

Now Notice of Proposed rulemaking also addresses classification and payment for continuous glucose monitors. It also addresses classification of external infusion pumps under the DME benefit. It also addresses the features for making benefit category determinations for new items and services. And finally there are proposed rules related to the HCPCS coding process.

So I just wanted to let everyone know that that proposed rule was published today.

Back to Jill. Thank you.

Jill Darling: Great. Thank you Joel.

Up next, we have Stephanie Collins who will talk about the nationwide expansion of lower limb prosthetic codes in the DMEPOS PA program.

Stephanie Collins: Good afternoon everyone. This is Stephanie Collins from the Center for Program Integrity. I will be providing an update on the required prior authorization list for certain DMEPOS items.

Beginning September 1, 2020 CMS required prior authorization for six lower limb prosthetic codes for beneficiaries in the states of California, Michigan, Pennsylvania and Texas.

Beginning on December the 1, 2020 prior authorization as a condition of payment will expand nationwide and be required for these six codes in all remaining US states and territories. Suppliers in the additional states may begin requesting prior authorization from the DME MAC on November 17, 2020.

The six selected lower limb prosthetic codes are L5856, L5857, L5858, L5973, L5980 and L5987. Again, the codes are L5856, L5857, L5858, L5973, L5980 and L5987.

Nationwide prior authorization for these codes were originally to begin October 8, 2020 and was postponed due to the COVID-19 public health emergency. The updated required prior authorization list and additional operational guidance may be found in the download section of the CMS DMEPOS prior authorization website. That website is go.cms.gov/dmepospa. Again that website is go.cms.gov/dmepospa.

Questions and comments may be sent to our DMS mailbox at DMES - dmepospa@cms.hhs.gov. Again the mailbox address is dmepospa@cms.hhs.gov.

I will now turn the call over to Joan Proctor for an update regarding the Home Health Quality Reporting Program. Thank you.

Joan Proctor: Thank you. This is Joan Proctor.

Today we have several announcements about the OASIS and public reporting for the Home Health Quality Reporting Program. We'd like to announce that CMS has provided notifications to home health agencies that were not compliant with the HHQRP requirements for calendar year 2019 which will affect their calendar year 2021 annual payment update.

Noncompliance notifications were distributed by the MAC and placed into each home health agency's MyReports folder in iQIES on October 7, 2020. Home health agencies that receive a letter of noncompliance may submit a request for reconsideration to CMS via email no later than November 6, 2020.

If you received a notice of noncompliance and would like to request a reconsideration see the instructions in your notification and on the Home Health Quality Reporting Reconsideration and Exception Extension webpage.

Next you can find several new HHQRP training materials on our webpage. There is a new Web-based training called Introduction to the Home Health Quality Reporting Program, which provides a general overview of the program as well as a variety of links and resource for additional information. Please visit the HHQRP Training page to access this resource.

Next, there is an updated version of the guide to the home health desk which is now available on our website. This document it's a comprehensive one-page guide directing providers to available home health desk for questions related to a variety of topics.

This updated version includes removal of the OASIS tech issues help desk and redirection of HHA software vendor technical questions to the new iQIES helpdesk and redirection of iQIES's registration request to the HCQIS Access Rules and Profile or HARP system.

The updated guidance available in the Home Health Quality Reporting Program help desk webpage. And finally, we have or I believe we've posted as of today the HHQRP QM users manual.

The QM user's manual reflects all the measure changes since August 2019 including measure additions, removals, corrections and clarification. Please visit the Home Health Quality Measures webpage to access the updated manual.

Cindy Massuda: This is Cindy Massuda actually for the Hospice Quality Reporting Program. So good afternoon. We have several updates related to our program.

First we'd like to start with a few reminders about the Annual Payment Update or APU requirements. On October 1, 2020 which starts the Fiscal Year 2021, any hospice determined to be noncompliant based on meeting the calendar year 2019 quality data requirements will be subject to the 2% reduction in their APU for Fiscal Year 2021.

We posted the list of compliant hospices for Fiscal Year 2021 on our Hospice Quality Reporting webpage.

The calendar year 2020, quality data required for Fiscal Year 2022 APU determination is based on the hospice items set and the CAHPS hospice survey data reflecting July 1, 2020 through December 31, 2020. And then for our upcoming calendar year that starts January 1, 2021 the data collection for hospice and the CAHPS hospice data begins on January 1, 2021 and impacts Fiscal Year 2023 payments.

Please review the materials found on our Best Practices and Education and Training webpages to learn or refresh yourself about the Hospice Quality Reporting Program requirements and deadlines. We would now like to share updates related to the ongoing development of the Standardized Hope Patient Assessment which is the Hospice Outcome and Patient Evaluation or HOPE.

So last year at this time in November of 2019 we convened our first annual meeting of the technical expert panel to support the Hospice Quality Reporting Program quality measure development efforts. And that report

summarizing this in-person meeting is available on the HOPE webpage. It includes background on the focus of this technical expert panel and the purpose of developing the HOPE, its role in quality measurement and some quality measure considerations including outcome and claims-based measures.

At this time we are currently in the alpha testing stage of HOPE. And CMS completed provider enrollment in the alpha test back in June and we began that alpha testing. And it's underway and we'll be sharing those – that information later in the spring as we have analysis of that alpha testing.

We now have also recently added some resources that are available on the CMS website. We added some Web-based training about hospice, the quality - the Hospice Quality Reporting Program education and training resources by topic with a hot link for easy access.

This course offers hospice providers with a brief tour of the many training resources that we have available 24/7 365 days a year with a summary broken down by topic including their hotlinks for easy access to ensure success in complying with the requirements of the Hospice Quality Reporting Program.

Please visit our Hospice Quality Reporting Program Training and Education Library webpage to access this Web-based training. Further, at back in August we hosted the August 2020 Hospice Quality Reporting Program Forum to present a new claims-based composite quality measure concept that CMS is considering for the Hospice Quality Reporting Program.

Materials from that forum are included on the Web – on our download section of the HOPE page. It has the recording with the presentation and transcript and encourage people to look for these resources.

With that I'm going to turn it over to my colleague Charles for the public reporting updates.

Charles Padgett: Thank you Cindy.

This is Charles Padgett. I'm going to give some updates for hospice public reporting.

Early last month the provider preview period for - related to the November 2020 Hospice Compare Refresh ended and we are on track now to provide that refresh later this month.

In November a compare refresh for hospice covers health - HIS quality measure results from Quarter 1 2019 through Quarter 4 of 2019 and facility level CAHPS hospice survey results from Quarter 1 2018 through Quarter 4 2018.

Due to the COVID-19 public health emergency CMS made the decision not to publicly report Quarter 1 and Quarter 2 of 2020 quality data. Data for these quarters were frozen. In September this year we released a tip sheet providing practical and useful information about public reporting that have the need to freeze Quarter 1 and Quarter 2 quality data.

The tip sheet is available for download on the Hospice Quality Reporting Program Best Practices webpage.

And we also recently updated the Key Dates for Providers webpage that reflects CMS's decision not to publicly report data from Quarter 1 and Quarter 2 2020. This means public reporting of hospice's data in calendar year 21 will freeze beginning with the November 2020 refresh.

The key date for provider's webpage has been updated to reflect the status of the public reporting through November 2021.

On September 3 of this year we were very excited to launch the new Care Compare site which is a streamlined redesign of the eight existing CMS healthcare compare tools available on Medicare.gov including Hospice Compare.

The Care Compare provides a single user-friendly interface that patients and caregivers can use to make informed decisions about healthcare based on cost, quality of care, volume of services and other data.

In conjunction with the launch of Care Compare additional improvements have been made to other CMS data tools to help Medicare beneficiaries compare costs such as the provider data catalog.

The provider data catalog now makes quality data sets available to an approved application-programming interface allowing innovators in the field too easily access and analyze the CMS publicly reported data and make it useful for patients.

Lastly, I have an important announcement. The Hospice Compare site, our legacy site will soon be going away. But, you'll still be able to find the exact same information about hospices and other health care providers on our Care Compare site on Medicare.gov.

The Provider Data Catalog on CMS.gov will also make it easier for you to search and download our publicly reported data. We encourage you to start using these tools today.

We're also recommending that you bookmark your Compare webpage. The link is included in the agenda for today's open-door forum.

I will now turn it back to Cindy who's providing the CAHPS hospice updates for (Deborah).

Cindy Massuda: Thank you very much.

Here's a few reminders for the CAHPS Hospice Survey. If you're a hospice that qualifies for the size exemption for this data collection year please be sure to fill out and submit the Size Exemption Form. It can be found on the CAHPS Hospice Survey website.

As Charles mentioned, public reporting of the Hospice Quality Reporting Program date including CAHPS Hospice Survey data will freeze for calendar year 2021. However, survey data collection continues unchanged for the CAHPS Hospice Survey. You must continue to collect CAHPS Hospice Survey data as normal during calendar year 2021.

The CAHPS Hospice Survey upcoming data submission deadline in calendar year 2021 are also included on the key dates for providers webpage that Charles mentioned. Please review that website page.

If you're thinking about changing your survey vendor please email the CAHPS Hospice Survey Technical Assistance Team and ask for help before you start the process. This is for your benefit. Shifting vendors can be a tricky business. Let us help you do it successfully.

And if you have any questions about the CAHPS Hospice Survey you can certainly email our Technical Assistance Team. They are more than happy to help. In addition we have our Web - we have on our website a series of podcasts specifically for hospices to help them with various aspects of the survey. You may want to check them out.

And with that I will turn the call back to Jill Darling. Thank you very much.

Jill Darling: Thank you Cindy. I believe our last topic will be from Joan Proctor.

Joan Proctor: Thanks Jill.

There are two other topics that I was planning to cover today. I'm sorry we kind of went out of order. These are back on the Home Health Quality Reporting Program.

Similar to the public reporting announcement that Charles made early we launched a Care Compare in the Provider Data Catalog, a streamlined redesign of eight existing CMS healthcare compare tools available on Medicare.gov including Home Health Compare.

Care Compare provides a single user-friendly interface that patients and caregivers can use to make informed decisions about healthcare based on cost, quality of care, volume of service and other data. The Home Health Compare Tool will be going away soon but you'll be still able to find the same information about home health and other healthcare providers on care compare on medicare.gov.

The provider data catalog on cms.gov also makes it easier for you to search and download our publicly reported data. Start using these tools today.

Second, the October 2020 refresh of home health data that has occurred on the new Compare and Provider Data Catalog website as well as on Home Health Compare in these - in this data providers will see a measure change reflecting finalized rule proposals specifically a - I apologize for that. Specifically a new skin integrity measure will be reported for the first time and the previous pressure also measure will be removed.

Due to the COVID-19 public health emergency CMS made a decision not to report publicly report Quarter 1 and Quarter 2 2020 quality data and thus we will not refresh data on Care Compare in 2021. We published a COVID-19 Public Reporting Tip Sheet on September 8 to help providers understand the impact of these COVID-19 exemptions on the HHQRP. Please visit the HHQRP training webpage to download this tip sheet.

Lastly for the HHQRP or relatedly because we will not refresh data in 2021, we will not release provider preview reports. You can continue to access on-demand reports through iQIES. If you have any issues finding your reports please contact the iQIES help desk.

And also I have an update for the HCAHPS survey that (Laura Teichman) would normally provide but she is out of the office today. The first item she wanted to remind you of is the training dates for the annual training for new vendors and currently approved vendors for the HCAHPS survey are now posted on the HCAHPS website.

On December 1, 2020 we will open the training registration links. The intro to training will be a self-directed training with a certification at the end only for applicant vendors. The update training will take place on Friday, January 29, 2021 from 12:00 noon to 2:00 pm.

Update training is required for all currently approved HCAHPS survey vendors. All training slides updated protocols and guideline manuals and updated data submission manual will be posted January 18, 2021 on the HCAHPS's website.

Every HHA is responsible for submitting a monthly list of home health agencies to their respective HCAHPS survey vendor so the sampling and data collection of their agency's patients can occur according to schedule. If an HHA does not have any patience for the month then the HSA must notify the vendor so the vendor can record there are no patients for the month.

If an HHA does not notify the vendor and the vendor in turn does not report that there were no eligible patients for the month then CMS will assume that the HHA did not participate in HCAHPSs for that month.

All HHAs need to monitor their data submission reports in their for HHA secure portal on the website. This is the best way to find out if you HCAHPS vendors have submitted all of your HCAHPSs data to the HCAHPS's data warehouse.

If you're HHA needs help changing their HCAHPS vendor please contact RTI by emailing hhcaps@rti.org for assistance. We highly recommend that you do this as soon as intend to sign a contract with another HCPCS or HCAHPSs vendor.

Thanks Jill.

Jill Darling: Thank you Joan. That concludes today's agenda and (Brandon) will please open the lines for Q&A.

Coordinator: Thank you. We will now begin the question-and-answer session.

If you'd like to ask a question please press Star 1. Please unmute your phone and record your first and last name clearly when prompted. Your name is required to introduce your question.

To withdraw your question you may press Star 2. Once again at this time if you'd like to ask a question please press Star 1. One moment please for first question. Our first question is from (Suzanne Clark). Your line is open.

(Suzanne Clark): Hi. Yes this question is about the Home Health Quality Reporting Program publicly reporting. So we were refreshed on Home Health Compare in October 2020. And am I understanding you correctly that the next time it will refresh will not be until January 2022?

Charles Padgett: Hi. This is Charles and yes that - you are correct. The October 30 refresh was the last refresh and that will be followed by four quarters during which we hold that data constant on the website. We will then resume public reporting on Home Health Compare with the January 2022 refresh.

(Suzanne Clark): Okay. So there is no update to any - this is what it is right now it's going to stay, all the star ratings for the patient experience CAHPS surveys as well as the quality star ratings and hospitalization, everything stays until 2022?

Charles Padgett: That's correct, yes.

(Suzanne Clark): Okay. Thank you.

Charles Padgett: You're welcome.

Coordinator: Our next question is from (Cody Reber). Your line is open.

(Cody Reber): Yes, when will the updated risk adjustment model be published on the HQRP website which is based on items such as 1242, the frequency of paying being voluntary or optional?

Joan Proctor: We are working with the contractors who are going through a transition period. So they have all the specifications and as soon as we can get it up.

We definitely hope to be able to have it up by January 1 at which time we well post the documentation to explain our changes on our website.

(Cody Reber): Great, thank you.

And then a quick follow-up if possible. When will the home health risk-adjusted model be reflected in iQIES reporting?

Joan Proctor: Actually that's the reference I was making to the changes to the specification we handed them over to the contractor and trying to get it scheduled so that they can make the changes within the system.

(Cody Reber): And around that time we'd expect the publication on the (HHQRP) website as well?

Joan Proctor: That's correct. And then they would make all of the changes necessary for all of the dates of service (M0090 of January 1, 2021 and later.

(Cody Reber): Thank you.

Coordinator: Our next question is from (Mike Garcia). Your line is open.

(Mike Garcia): Yes hi, just wanted to find out if a RAP goes into an RTP how long do we have to correct it before it - while it's still being considered timely?

(Wil Gehne): Hi. This is (Wil). It's the same five-day period you'd want to work in the RTPs.

(Cody Reber): Okay thank you.

Coordinator: The next question is from (Patricia Dearena). Your line is open.

(Patricia Dearena): Yes hi, good afternoon. I was just wanting to clarify her something further on the home health publicly reporting date, that I understand that it will be frozen until January 2022 where then it will be publicly reported again.

My question is regarding some of the data for the time period that will be reported in January 2022 will still technically include Quarter 1 and Quarter 2 of this year during the public health emergency. And has Medicare - have you guys been able to come up with a decision on how you will use or not use that data when that January report comes out?

Charles Padgett: Hi. This is Charles. Thanks for the question.

Actually we made a decision and we issued this in a memo back in March that with respect to Quarter 1 and Quarter 2 of 2020 we would not use any of that data for the purposes of public reporting.

So if you will, the pause in our publicly reported data has to do with, you know, those two quarters running through the period of performance.

As you know we - our measures are based on either four or eight rolling quarters of data depending upon the measure. And as those quarters roll through the periods of performance, you know, we'll be pausing any reporting on the site.

So when we begin public reporting again we will be beyond those two quarters and will be within Quarter 3 and Quarter 4 and so forth. So the period of performance that we use for the January 2022 refresh will not include either of those two quarters.

(Patricia Dearena): Because I guess the – specifically the measure of the hospitalizations in the Star quality patient care that would usually be an entire calendar year of 2020. So are you saying that the first two quarters would be just excluded when you're using that measure for reporting?

Charles Padgett: Yes.

(Patricia Dearena): Okay thank you.

Charles Padgett: Yes, you bet.

Coordinator: Our next question is from (Kathy Duckett). Your line is open.

(Kathy Duckett): Good afternoon. Thank you. Could you tell me again where I can find the written documentation on the final role on the telehealth visits? Hello?

(Kelly Vontran): Hi. This is – Hi this is Kelly from CMS. If you want to look at the calendar year 2021 HHPPS final rule you can find it on the Home Health Agency

Center webpage. There is a link there that you can click on that will take you to the final rule.

(Kathy Duckett): Thank you.

Coordinator: Our next question is from (Gabrielle Williams). Your line is open.

(Gabrielle Williams): Hi, good afternoon. Yes I would just like to verify, you know, data for 2021 that we as an agency will still have the availability of all of our reports in the iQIES system?

Charles Padgett: Hi. This is Charles. Yes you will. We will still be issuing those confidential feedback reports and you will still have access to all of your data during the period.

(Gabrielle Williams): Great, thank you.

Charles Padgett: You're welcome.

Coordinator: Our next question is from (Mary Winterfeld). Your line is open.

(Mary Winterfeld): Yes hi. Thank you. I was – wanted to clarify on the RAP penalties a couple of things. So you said just to make sure I understood right the first visit date no longer needs to match what comes across on the final, is that right?

Charles Padgett: Yes the - on the RAP you can report the firm date, the first day of 30-day period as the line item date on the Revenue Code 00239. And then the first visit date, say the first nursing line, that date no longer needs to match what was submitted on the 0023 line.

(Mary Winterfeld): Okay. And then sorry one more. And it was kind of gone over kind of quick so I kind of missed it. Did you say that we don't need to wait for the starter care OASIS to be accepted before we could submit the RAP?

Charles Padgett: Look you don't need to use the always this information to calculate the HPPS code. So you can submit any valid HPPS code value on the RAP.

(Mary Winterfeld): Okay. Okay I think that answered my questions. Thank you.

Charles Padgett: Sure.

Coordinator: Our next question is from (Mike Garcia). Your line is open.

(Mike Garcia): Thank you. So going back to the RAP going into RTP if it was submitted timely within five days but goes into RTP that would still be considered timely submitted if corrected within two business days? Is that correct or do we need to…

((Crosstalk))

Charles Padgett: No you would need to correct it within the 5-day period. And…

(Mike Garcia): Within the 5-day okay.

Charles Padgett: Right. And the circumstance of RAPs being RTP'd, you know, should be fairly infrequent but, you know, if that happens you need to, you know, turn them around and resubmit them right away.

(Mike Garcia): Okay thank you.

Coordinator: And at this time I'm showing no further questions.

Jill Darling: All right well wonderful, great. Thanks everyone for joining today. If you have a question and you couldn't think of it during the call right now please feel free to send in your question or comment into the Home Health Hospice and DME Open-Door Forum email. It is listed. It's always listed on the agenda. It's homehealth_hospice_DMEODF-L@cms.hhs.gov.

(Brian) do you have any closing remarks?

(Brian): No, I don't Jill. But I appreciate everyone's updates today and hopefully that we will have more frequent ODFs moving forward but, you know, COVID threw a little wrench into that regular process.

So appreciate everyone on the other and hang in there and again like Jill said if you have any questions or thought about them after the fact feel free to leverage that mailbox and we'll triage them accordingly.

Jill Darling: Thanks everyone. Stay safe and have a wonderful day.

Coordinator: Thank you for participating in today's conference. All lines may disconnect at this time.

Woman: Thank you.

End