Reporting Hospice Quality Data: Tips for Compliance Call

Moderated by: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network call on Recording Hospice Quality Data: Tips for Compliance.

During this call, learn more about Hospice Quality Reporting Program requirements. Find out how to be compliant and successfully submit Hospice Item Set data and the Hospice Consumer Assessment of Healthcare Providers and Systems Survey in the next reporting year. A question-and-answer session follows the presentation.

Before we get started, you received a link to the call materials in your confirmation email. These materials are available at the following URL: go.cms.gov/NPC. Again, that URL is go.cms.gov/NPC.

At this time, I'd like to turn the call over to Cindy Massuda from the Division of Chronic and Post-Acute Care at CMS.

Presentation

Cindy Massuda: Hi, good afternoon, and welcome, everyone, to today's training call on the Hospice Quality Reporting Program. I am Cindy Massuda and I'm the Hospice Quality Reporting Program Coordinator for CMS. We brought you the speakers today who lead or work on the Hospice Item Set and the Hospice CAHPS®, along with additional CMS subject matter experts for the question-and-answer session.

The call today is chockfull of information with the goal of working with hospices to meet the Hospice Quality Reporting requirements. Our goal here at CMS is for all hospices to be compliant with the Hospice Quality Reporting Program requirements and receive their full annual payment update.

This call today is the first training we're doing with hospices, so we are excited that you're joining us and encourage you to engage with us on these trainings, and through our websites and our help desks. We want you to feel at all times that you're just a click away from getting the support you need for the Hospice Quality Reporting Program.

I'm going to start now with page 1 of the handouts and let you know – just to orient you for the call today that we have lots of acronyms obviously in the Hospice Quality Reporting Program and throughout CMS. So the acronyms that are the typical acronyms that are used to keep – get people comfortable with the Hospice Quality Reporting Program are all on this page. So as a reference, if you have any questions on what an acronym is, you can find them here on this page of the – of this call today.

Our objective for the Hospice Quality Reporting Program is for compliance requirements and how to avoid the 2 percent Annual Payment Update reduction. We're looking for hospices, you know, for the timely submission and compliance determination, and discuss common reasons for noncompliance and how to address them; and resources that are available to hospice providers to support compliance, including the websites and help desks.

So with that, I'm going to turn the call over to Alexis Kirk, who will be discussing the rest of the slides.

Background and Overview

Alexis Kirk: Great. Thank you, Cindy. So as Cindy mentioned, my name is Alexis Kirk, and I'll be walking us through the first portion of today's call in which we'll present an overview of the Hospice Quality Reporting Program or HQRP.

So as you turn now to slide 5 in the slide deck, we can go over a little bit of background about the HQRP. So the HQRP requires all Medicare-certified hospice providers to submit quality data to CMS. Submission of this quality data was mandated by the Affordable Care Act and helps insure the delivery of person-centered, high-quality, and safe hospice care.

So currently, there are two parts or two requirements for the HQRP. There's the Hospice Item Set – or HIS – and there's the Hospice CAHPS Survey. So as part of the HQRP, U.S. hospice providers submit HIS and CAHPS data to CMS, and CMS, in turn, uses that HIS and CAHPS data for two purposes. The first is to determine your compliance with HQRP requirements, and the second is to calculate and report quality-measured data from both the HIS and CAHPS.

And today, for this presentation, we're going to be focusing on that first thing, so compliance. And compliance is really important to understand because, if you do not submit your HIS and CAHPS data in accordance with CMS policy, then it can ultimately impact your payment rate. Specifically, non-compliance will result in having your APU, or Annual Payment Update, reduced by 2 percentage points for 1 fiscal year.

So if we look now at slide 6 and – talking about the HQRP thus far, I've thrown a few terms out there. So I've talked about data collection and submission for the HIS and CAHPS, I've talked about compliance, and I've talked about payment impact. And it's really important to understand how all of these pieces fit together.

So as you can see here on slide 6, the HQRP runs on a 3-year cycle of data collection and submission, compliance determinations, and payment impact. So right now it's 2017, and most of the hospice providers on the line should be in the process of collecting and submitting HIS and CAHPS data.

So how is CMS going to use that 2017 data to determine your compliance?

Next year, in 2018, CMS will review the data that you've submitted for 2017 and make a determination about whether or not you are compliant. After they complete this review process, sometime in summer of 2018, CMS will notify you of your compliance status. And if you do receive a final determination of non-compliance, this will ultimately impact your payment rate or APU for the fiscal year 2019. So, really, what you should take away

from this slide is that, the data that you're submitting now in 2017 ultimately impacts your payment rate 2 years from now; so in the fiscal year 2019.

So a little mental trick that I like to use is whatever year it is right now, just add 2 to that, and that's the APU that's going to be affected if you're found non-compliant. And we refer to this whole 3-year cycle – so the graphic here on slide 6. We name it by the payment year. So we refer to this as the fiscal year 2019 Reporting Cycle, and that's how you'll hear me refer to it today.

Moving on to slide 7. We can talk a little bit more now about the requirements for both HIS and CAHPS. And, really, the first and most important thing to keep in mind with respect to compliance is the little equation listed here in the graphic. And that's the fact that the HQRP equals HIS and CAHPS. For the purposes of compliance, you must meet the requirements of both HIS and CAHPS in order to avoid the 2 percentage point reduction in APU. So there's no partial credit. If you meet HIS only or CAHPS only, you will be considered non-compliant for the HQRP overall and receive the payment reduction.

The other thing to keep in mind is that the compliance requirements for HIS and CAHPS are different. So it's really important to understand the requirements of each individually so that you can ensure your hospice is compliant with the HQRP overall.

So you'll notice in the PowerPoint presentation for today that we've included hyperlinks to several resources that we think providers may find helpful. And the first one is provided here at the bottom of slide 7. And this is a link to a "Getting Started with the HQRP" Fact Sheet that will be made available this week on the CMS website. So make sure to go and review that later on this week.

So if we look now at slide 8, because the requirements of HIS and CAHPS differ, we wanted a quick visual queue that we could use throughout the remainder of the presentation today so that it was easy for you to quickly identify whether the content on a slide relates to HIS, CAHPS, or both. So you'll see these checkmarks at the bottom left-hand corner of each slide throughout the rest of the presentation today.

HIS Requirements

Turning now to slide 9. We can move into what the specific requirements are for both HIS and CAHPS. And I'm going to start out with HIS. First and foremost, all Medicare-certified hospice providers must submit HIS data. There are no exemptions from HIS reporting for things like size or newness. Second, you are required to submit an HIS admission and HIS discharge record for all patient admissions and discharges.

And although there aren't any exemptions for HIS reporting, we often get questions from new hospice providers about when they are required to begin submitting HIS data. And for new hospices there are really two things to keep in mind.

The first is when you must begin HIS data submission. So providers are required to begin submitting data for patient admissions on or after the date in your CCN notification letter letterhead. So when you receive your letter from CMS that contains your CCN, if you look at the top of the letter, there's going to be a date in that letterhead. And that's the date on which you should begin reporting and submitting HIS data.

The second consideration is when you will be subject to the APU determination for HIS purposes. If you are a new provider and the date in your CCN notification letterhead is on or after November 1st, you will not be subject to the 2 percentage point reduction for HIS purposes for that one reporting cycle only.

Looking at slide 10, we can talk a little bit about how you submit HIS data. CMS requires hospice providers to submit all of their HIS data electronically. And although electronic submission of data is required, you do not need to have an electronic medical record or EMR to submit HIS data to CMS.

And data submission really occurs in two steps. So first, you have to create the electronic file that you're going to submit to CMS. And the proper electronic file format is in XML. And you can create these files either using a vendor software – so if you do have an EMR, you can use your vendor software – or you can use the CMS HART software, which is available to all hospice providers free of charge. And a link to the HART software has been provided here on slide 10.

Once you have your HIS data in the proper XML format, you need to then submit those files to CMS. All hospice providers use the QIES ASAP, or QIES system for short, to submit data to CMS. This is the only system available for data submission and, like HART, it's available to providers free of charge.

On slide 11, we can talk a little bit about the compliance criteria for HIS. Compliance with HIS is based on timely submission of HIS data. Remember, all hospice providers are required to submit an HIS admission and HIS discharge record for each patient admission and discharge. To be compliant with HIS requirements, you must submit your HIS records in a timely manner. Specifically, HIS records should be submitted and accepted by the QIES ASAP system within 30 days of the target dates.

So let's take that requirement and break it down a little bit. First, 30 days is always the submission deadline for all HIS records regardless of whether it's an admission record or a discharge record. Second, you'll notice that data submission for HIS is rolling or ongoing. So you should be submitting your records as patient admissions and discharges are occurring at your hospice. Finally, you'll notice here on slide 11 that we've bolded this phrase "and accepted." So there is a distinction between your data being submitted and it being accepted. And I'll go over what that means in a lot more detail later.

On slide 12, we can talk about some of the specific compliance thresholds. So, although ideally you should submit all of your HIS records within the 30-day timeframe and that should definitely be your target, CMS understands that this is simply not possible for every single record that you submit. So because of this, CMS implemented the Timeliness Compliance Threshold to determine compliance with HIS requirements. This policy requires providers to submit a minimum percentage of HIS records on time for any given reporting year.

So currently it's 2017, which 2017 plus 2 means that we're in the fiscal year 2019 reporting cycle. So for the fiscal 2019 cycle, at least 80 percent of your HIS records must be submitted and accepted on time. For the next reporting cycle, so the fiscal year 2020 cycle and for all reporting cycles after that, that threshold is going to increase and remain at 90 percent.

CAHPS Requirements

On slide 13, we can now start to go over some of the requirements for CAHPS. And remember, HIS and CAHPS requirements are different. So it will be important to know the rules of each of individually in order to ensure that you're overall compliant. Medicare-certified hospices with 50 or more survey-eligible patient/caregiver pairs are required to submit Hospice CAHPS data. And unlike HIS, for CAHPS, there are two exemptions for reporting. There's a newness exemption and a size exemption.

The newness exemption is a one-time exemption, and it's available to hospices who receive their CCN on or after January 1st of that year. So if you received your CCN at any time in 2017, you are exempt from reporting CAHPS data for 2017 and will not be subject to the corresponding APU reduction, which is the fiscal year 2019. This newness exemption is automatically granted to you by CMS, so there's no form or action required on the part of your hospice.

The second CAHPS exemption is a size exemption available to hospices with fewer than 50 survey-eligible decedents. The size exemption is available to you on a yearly basis. But it's important to note that if you are small provider and you want to maintain your size exemption, you must apply for it each year. To apply, you fill out the size exemption form by the deadline for that year. And the size exemption form is available on the CAHPS website linked here on slide 13. If you would like to apply for the 2017 size exemption, you must do so by December 31st of 2017. And you would be eligible for the 2017 exemption if you served fewer than 50 survey-eligible decedents/caregivers in 2016.

Turning now to slide 14, we can talk a little bit more about the data submission for CAHPS. And this is again another way that the HIS and CAHPS requirements differ. For CAHPS, hospices must contract with a CMS-approved vendor. The vendor will conduct the CAHPS surveys on behalf of your hospice, so they'll collect the data. And the vendor also submits the required CAHPS data to CMS on your behalf. CAHPS data is submitted electronically to CMS via the CAHPS data warehouse. Additionally, CAHPS data submission, unlike HIS, is not rolling. CAHPS data is submitted quarterly. So your vendor will submit CAHPS data four times throughout the year to CMS.

Slide 15 goes over the compliance criteria for CAHPS. To be compliant with CAHPS reporting requirements, your data submission must be complete and it must be timely. Compliance with CAHPS is determined based on whether or not your vendor submits a total of 12 months' worth of data to the hospice CAHPS data warehouse by each of the four quarterly deadlines for that year. This means that to be compliant, each quarterly submission must be complete; so it must have 3 months' worth of data. And each quarterly submission must be submitted and accepted by the appropriate quarterly deadline. And the quarterly deadlines are the second Wednesday of February, May, August, and November.

Looking now at slide 16, I've mentioned several times thus far throughout the presentation some of the differences between the HIS and CAHPS requirements because they are different. Here on slide 16, we have a table that can be a quick visual reference that you can use at your hospice to highlight some of the differences between HIS and CAHPS with your staff.

So just to review, as you can see here on slide 16, HIS and CAHPS differ on their exemptions. So HIS does not have any exemptions for newness or for size whereas CAHPS does. HIS and CAHPS differ on whether or

not a vendor is required to collect and submit your data. HIS does not require a vendor and CAHPS does. And they also differ in their data submission systems and their data submission deadlines. So for HIS, remember that the data submission is rolling, and that you submit your data to CMS through the QIES ASAP system. For CAHPS, data submission is quarterly, and your vendor will submit the data to the CAHPS data warehouse. And this table may be a good reference for you to either cut and paste out of this PowerPoint presentation or print it out and hand it out to staff at your hospice so that they can use it as a reference as well.

So here on slide 17, we have our first little quiz question where you can check your knowledge of what you've learned thus far in the presentation. And we don't have any electronic methods available for polling or for you to submit your answer online. But if you want to just take a minute and read through this question and just jot down your answer, then we can go over the correct answer in just a second. So this question is about a new hospice provider who received their CCN notification letter with the date in the letterhead being November 5th, 2017. And the question is, which reporting requirement is this hospice exempts from for 2017 or the fiscal year '19 reporting cycle? So I'll give everyone a minute to think about their answer and then go over the correct answer in just a second.

So the correct answer here is B, CAHPS only. So this hospice, because they received their CCN notification letter and the date in the letterhead was in 2017, they would be exempt from CAHPS through the newness exemption. And this exemption, as you may remember, will be granted automatically by CMS, and it's good only for the year that you receive your CCN. So it's good only for 2017. For HIS, this provider would be required to begin submitting data for patient admissions occurring on or after the date in their letterhead, which again was November 5th. However, since they received the CCN notification letter and the date in the letterhead of the letter was after November 1st, this provider would not be held to an APU reduction due to non-compliance with the Timeliness Compliance Threshold through HIS.

Common Reasons for Non-Compliance and How To Address Them

With that, we can move into the second portion of our presentation for today, where we'll go over some common examples of reasons for non-compliance. And we've put together a list of 10 common examples. And for each of these 10, we're going to make sure to tell you the action that you need to take at your hospice to ensure compliance.

Before we dive into those 10 common reasons for non-compliance, though, I wanted to take a minute and go over exactly what a final determination of non-compliance means to your payment rate.

So as you can see here on the slide 19, we've listed out the payment rates for compliant and non-compliant providers for the fiscal year 2018. So this slide is a good reference for you to see how a determination of non-compliance will play out in terms of actual dollars with respect to your payment rate. And the payment rates for each fiscal year are published annually in the final rules. So it's important to review the final rules to get that information so you can see what the exact payment rates are for any given fiscal year.

Reasons for Non-Compliance That Apply to Both HIS and CAHPS

Slide 20 goes over our first reason for non-compliance. And this one is pretty simple and something that we've touched on already: not meeting both the HIS and CAHPS requirements, So remember our little equation,

HQRP equals HIS and CAHPS, and you must meet the requirements of each individually in order to avoid the APU reduction. Also, keep in mind that HIS and CAHPS requirements are different. And we've talked a lot about the differences between the two already. So remember that CAHPS is the only requirement with exemptions for newness and size, and also keep in mind that timelines for data submission and timeliness criteria are also different between the HIS and CAHPS.

On slide 21, we've listed out some actions that you can take in order to avoid this common reason for non-compliance. So you should make sure that your staff understands the requirements for both HIS and CAHPS, and you should make sure that you're taking the proper action to meet the requirements for both.

For more information on the current cycle's reporting requirements, the requirements for the fiscal year 2019, there is going to be a fact sheet made available on the CMS HQRP website later this week at the link on this slide.

The second common reason for non-compliance is listed on slide 22. And this reason is assuming that a prior hospice owner's actions have no impact on you. Like example 1, this reason applies to both HIS and CAHPS. If you are considering buying a hospice or undergoing a CHOW, or change in ownership, you should look into the hospice you're planning to buy first. If the prior owner was noncompliant with either HIS or CAHPS, you as a new owner will be subject to the APU reduction for that reporting cycle due to their non-compliance.

In order to avoid this, you should take action to investigate the prior or current owner's compliance with each reporting requirement. And some specific actions that you can take are listed here on slide 23. For HIS, you can check their preliminary performance on the Timeliness Compliance Threshold by reviewing the appropriate report in CASPER. And that report is called the Timeliness Compliance Threshold Report. For CAHPS, you should find out who their current CAHPS vendor is. You can also reach out to the CAHPS technical assistance team using the contact information provided here.

The third common reasons for non-compliance is listed here on slide 24, and that is failure to submit a request for exemption or extension for extraordinary circumstances in a timely manner. And I want to pause here and talk a little bit more about exactly what this exemption or extension for extraordinary circumstances is because it's different and it's separate from the exemptions that we've talked about thus far for CAHPS.

So this exemption or extension is available to all hospice providers, and it's available for both the HIS and CAHPS. And it's available to providers who experience an extraordinary extenuating circumstance that is outside of the hospice's control. And this would be things like a natural disaster, such as a hurricane, but it could be also a manmade disaster. And if this disaster prevents you from collecting or submitting HIS or CAHPS data, you can apply for this special exemption or extension request within 90 days of the extraordinary event or circumstance.

If you are granted an exemption or extension for extraordinary circumstances, you will have leniency from compliance with reporting requirements for a specified period of time. And essentially what this policy does is it recognizes the fact that you have been a victim of an extraordinary circumstance and it allows me to submit some data late or not at all for a limited period of time without an impact on your APU.

Slide 25 goes over a lot of what we just covered. Remember, this extraordinary circumstances exemption or extension is available for both HIS and CAHPS, and it is different and separate from the CAHPS size and newness exemption. Providers have 90 days from the date of the event to submit this request.

On slide 26, we'll go over some of the details of how you apply for this special exemption or extension for extraordinary circumstances. So to apply, you submit a request via email to the email address listed on this slide. And it's really important to make sure that your email request follows all of the instructions outlined on the appropriate CMS HQRP webpage, which is linked here.

And because we've had a couple of major hurricanes in the past month, I want to take just a second to talk about this policy in the context of large-scale disasters that affect entire regions. So usually how this policy works is individual providers must submit a request and they must apply for it. So they must take proactive action to initiate a request and submit it to the email address listed on this slide.

However, if there occurs a large widespread disaster like the hurricane, CMS does have the authority to grant these special exemptions or extensions for extraordinary circumstances to entire geographic areas that were impacted by the disaster without you having to request it. So CMS has done this for Hurricanes Harvey and Irma. And we recommend that hospice providers impacted by these hurricanes check the Spotlight & Announcement page on the CMS HQRP website to see if their region or locale has been issued an exemption or extension under one of these special region-wide exemptions or extensions. And again, you can find more information about that on the Spotlight & Announcement page of the CMS HQRP website.

Reasons for Non-Compliance Specific to HIS

Example 4 for non-compliance is found on slide 27, and this example relates to HIS only and occurs when data submission to QIES is unsuccessful. So you may remember earlier in the presentation, I pointed out that distinction between data that had been submitted and data that have been accepted. And now I'll go over exactly what that means.

So when you go to submit your HIS data to QIES, you'll upload your XML files to the QIES system. When you complete this initial upload in QIES, you're going to get a "submission received" confirmation message. After your data have been uploaded, QIES will do what we call this "errors check" to make sure that there aren't any fatal errors in your data. Fatal errors would be things like an incorrect patient identifier or a logical inconsistency in your data, like saying that the patient was discharged before they were admitted. If there are fatal errors in any of your HIS records, QIES is going to reject those records that have fatal errors, and you'll then have to fix the errors and resubmit the data.

When you have fatal errors and the record gets rejected, really what it means is that your data have been submitted but they have not been accepted. So although you attempted to submit your data, CMS never received it because it was not accepted. Data that have been submitted but not accepted could result in a determination of non-compliance. And what we see happen a lot of times is that people go to QIES, they upload their data, and they assume that just because it's been successfully uploaded that that means their submission was accepted. And this is not the case. In order to verify whether or not your submission was actually accepted, you have to go through an extra step. And I'm going to go over what that is in just a second.

So on slide 28, we can start walking through the data submission process and how you can verify that submitted data have been accepted. What's displayed here on slide 28 is that initial confirmation message that you'll get to verify that your data have been submitted and uploaded. As noted on the slide, this message does not mean that your data have also been accepted. This just means your file has been uploaded and it's now being checked for errors.

On slide 29, I can walk through that extra step or process that you have to go through to verify whether your data have been accepted. So the process for this, for completing this verification is for you to log in to CASPER and review what's called your Final Validation Report. The Final Validation Report is available after that errors check has been performed. And what it's telling you is essentially the results of that errors check. So it tells you how many of your files were accepted and how many were rejected. The Final Validation Report is the only way to know if your data have been accepted.

So I want to talk a little bit about, now about the timing of this whole process. So once you upload your data, the errors check usually occurs pretty quickly soon after, meaning that your Final Validation Report is usually available soon after you attempt to submit your data. However, in certain circumstances, this errors check can take up to 24 hours after your attempted submission. So all this means is that it may be up to 24 hours before you see a Final Validation Report.

It's very important for you to check and print Final Validation Reports after every attempted data submission. Remember, this is the only way to verify whether the data you have submitted have also been accepted. And even if you have a vendor who's submitting data on your behalf, it's still important for you to log in and look at your Final Validation Report.

So at this point you may be asking yourselves, where do I find the Final Validation Report? How do I read it? What is it going to tell me? So as you can see here on slide 30, we've included a screenshot of a Final Validation Report. So the way to access this report is to log into CASPER, and the Final Validation Report will be auto-generated for you and placed in your CASPER folder. So once that is auto-generated and placed in your CASPER folder, it remains there for 60 days.

So once you log in to CASPER and you see that Final Validation Report – and remember it can take sometimes up to 24 hours to appear – then you want to then review the report and see how many of your records were successfully accepted. So you can see that we have this red circle over a part of the Final Validation Report. And these are really the three most important lines for you to be looking at in the report to determine whether your data were accepted.

So the first line, Number of Records Processed, just tells you how many records you tried to submit. So in this example, the hospice provider attempted to submit one record. The next two lines, Numbers of Records Accepted and Number of Records Rejected, are going to tell you just that, how many of your records were accepted by the system and how many were rejected. So we can see here that we're all set. We attempted to submit one record. We had one record accepted and zero rejected.

If you had, however, had a record that was rejected, what you would need to do is correct whatever the fatal error was that caused the rejection and attempt to resubmit the record. Note that if all of your records were rejected, so say you attempted to submit seven records and for whatever reason all seven had fatal errors and

were rejected, that Final Validation Report is not going to be auto-generated and it will not be placed in you folder automatically. So what this means is, if you go in to CASPER, it's been 24 hours since your attempted submission, and you don't see a Final Validation Report, then that's a problem. It likely means that your entire submission was rejected, and it's something that you should look into to try and resolve the errors and resubmit the data. And for assistance of data submission, record rejections, or help accessing your CASPER reports, you can reach out to the QTSO help desk at the contact information listed on slide 29.

The fifth common reason for non-compliance is untimely HIS data submission. So remember, for HIS we have the Timeliness Compliance Threshold. And for this reporting cycle, at least 80 percent of all of your records must be submitted and accepted within that 30-day timeframe for you to be compliant.

So in general, the only acceptable reason for the purposes of compliance to have a late record is due to one of those extraordinary circumstances. So some sort of natural or man-made disaster for which you've applied for or been granted one of those special extensions or exemptions for extraordinary circumstances. So other reasons, such as those listed on the slide, things like staff turnover or vendor issues, are generally insufficient reasons when thinking about compliance.

On slide 32, we've listed out some specific actions that you can take to make sure that your data are submitted in a timely manner. First, it's important to create policies at your agency and ensure ongoing monitoring of data submission. So the more that you can standardize things and have submissions monitored up at the policy and organizational level, the less likely you are to be impacted by things like staff turnover.

Second, it's important to check your Timeliness Compliance Threshold report in CASPER often. So this report will show you your year-to-date performance on the Timeliness Compliance Threshold. So if you check that report and see you're somewhere around, say, the 80 percent mark for this year, then you want to take extra precautions to make sure that the rest of your records for the rest of the year are submitted well ahead of the deadline.

And that brings us to our third point. It's really important to attempt and submit all of you HIS records early in advance of that 30-day deadline. So in reason number four, we just talked about the case of record rejection; so records getting rejected from QIES due to fatal errors. And if you're submitting records right at the 30-day deadline and you happen to get some that are rejected, that doesn't leave you any buffer for then resolving those errors and attempting to resubmit that data within the 30-day timeframe. So it's really important, again, just to make sure that you're attempting to submit records early so that you leave yourself time to resolve any fatal errors and resubmit your data successfully in advance with that 30-day deadline.

Finally, another thing to keep in mind that we haven't yet talked about today is, knowing when QIES ASAP has downtime. So like any electronic system, the QIES ASAP system has regularly scheduled system maintenance. This system maintenance occurs monthly, and it usually occurs over a weekend to minimize the impact on providers over a span of 3 days. So during the scheduled downtime, QIES ASAP will be unavailable, and you will not be able to submit any data to the QIES system.

Importantly, CMS does not make allowances for late submissions due to regularly scheduled QIES downtime. So this means you should know when the downtimes are and submit any data that are due right around that

timeframe well in advance of the QIES scheduled downtime. There are three remaining downtimes in 2017, and you can see them listed here on slide 32.

Now I'll spend a little bit of time walking us through exactly how the Timeliness Compliance Threshold is calculated so that you can better understand how CMS is using your HIS data to determine compliance. And the basic algorithm used by CMS or the basic formula is listed here on slide 33. And what this algorithm is telling us is that to determine your compliance, CMS is going to start out with all of the new records that you submitted during any given reporting year. And then what they're going to do is they're going to see how many of those records were submitted and accepted on time.

So that's the basic formula. But as with any good rule, there's always an exception to the rule. And you can see those listed here on slide 34. So CMS has made allowances for two circumstances. First, CMS realizes that sometimes you may find an error in an HIS record that's already been submitted and accepted by QIES. CMS wants providers to correct any errors in submitted data using the proper process, so whether that be a modification request or an inactivation request. And CMS does not want those modification or inactivation requests to count against you unfairly if you have to make them outside of the 30-day time frame. So for this reason CMS only considers whether new records were submitted timely. Modified and inactivated records don't go into the Timeliness Compliance Threshold algorithm to ensure that making corrections to erroneous data does not count against you.

Second, as mentioned previously, CMS wants to accommodate providers who are victim of an extraordinary circumstance. So if you're granted an exemption or extension for extraordinary circumstances, any late or missing data during this time of the exemption or extension won't count against you for the HIS Timeliness Compliance Threshold.

So I know reason five, in particular, talking about the Timeliness Compliance Threshold, was a lot of information to digest. So we have here on slide 35 our second polling exercise or quiz question. And this question is about the Timeliness Compliance Threshold for HIS. It's a pretty long question so I'm not going to read it to you, so please read the question on the slide and take a few minutes to select your answer.

Okay. Hopefully, you've had enough time to read through the question. So I'll go over the correct answer now. So for this polling exercise the correct answer was B. And the situation that we were dealing with here is a situation where a hospice provider had submitted 85 records already to the HIS – submit to the QIES system. They had submitted 85 records on time out of the 100. So that means their current performance on the Timeliness Compliance Threshold would be 85 percent. However, the hospice realized that some of their records that they had already submitted in that bunch of a 100 had errors. So they knew that they had to go back and either complete a modification or inactivation request to correct the data, and they're wondering how those corrections will impact their performance on the Timeliness Compliance Threshold seeing that it's been more than 30 days since they'd submitted the original new record.

So the answer to this question is that correcting the errors will maintain their score at 85 percent, and that's because, remember, CMS makes allowances for modifications and inactivations so that those corrections that they're making don't end up counting against them for the purposes of the Timeliness Compliance Threshold.

Here, on slide 36, we've arrived at our last example that relates to HIS only. And this reason is pretty basic, and it's not submitting any HIS data at all. So as noted on the slide, remember, HIS data submission is required for all Medicare certified hospices. There are no size or newness exemptions. And what we often see happening is that sometimes providers will erroneously assume that because they were exempt for CAHPS that they're also exempt for HIS. And that is not the case. Remember there are no exemptions for HIS. In addition, HIS data submission is required for all patient admissions regardless of the patient's payer source, the patient's age, their length of stay, or where they receive services.

So the action to take for this reason is listed here on slide 37. And again, we've gone over this a lot already, but the most important thing you can do is understand the requirements for HIS and ensure that you're taking action to submit your data appropriately. I'd also like to point out here that failure to submit data can impact more than just your compliance.

So at the beginning of the presentation, I'd noted that CMS uses your data for two things. They're using it for compliance, and they're now using your HIS data to calculate performance on quality measure scores and they're now live on Hospice Compare. So if you're not submitting all of you required data, not only can it impact your compliance but it can now also impact the quality measure scores that are publicly displayed for your hospice on the Hospice Compare site. So in addition to making sure that you're submitting your HIS data for the purposes of compliance, it's also important to make sure that you're submitting it for the purposes of Hospice Compare.

So this brings us to our reasons for non-compliance that are specific to CAHPS. So at this point I'll turn it over to the CAHPS team.

Reasons for Non-Compliance Specific to CAHPS

Dr. Debra Dean-Whittaker: Hello, everyone. My name is Debra Dean-Whittaker, and I am on the CAHPS team. I'm here with my colleague Lori Teichman. And I'd like to talk to you about some problems we have seen with non-compliance with CAHPS to give you some tips about how to become compliant.

Example 7 here is failure to file the CAHPS size exemption form on an annual basis. Now, CAHPS does have size exemption. It is only for the CAHPS survey, it has nothing to do with HIS. But in order to achieve this exemption, it is not enough to be small. In other words, yes, you may have fewer than 50 survey-eligible patients in the prior year, which would make you eligible to apply for the exemption but you also need to apply for the exemption. And not only that, you have to do it annually. There is no automatic renewal, and this is where many people fall down. They apply for 1 year and think it continues. It does not. There is no automatic renewal. You must be small enough for the exemption, but you must also file it every year. After all, hospices change in size, they get bigger, they get littler, so we ask you to file every year.

If you will look at slide 39 – excuse me, I'm having a cold here. The action for you to take here is to get that size exemption form filed each year. If you think you qualify, fill it out and submit it. It's available on the survey website. I will show you that website. And we also have it listed in the slides further down.

If you think you qualify, go to the website. Submit the form prior to the deadline. The deadline for this year is December 31st, 2017. This covers the data collection year of 2017. And if you are not certain whether or not you qualify, I would say go ahead and file the form.

You will receive a confirmation email. That is not the same thing as saying you're going to get it. But it does mean that we have received your form. Save that for your records. We will determine whether or not you get the exemption based upon our accounts. And let me say that we do check.

Now, for the data collection year of 2018, which is next year, the annual payment update that is impacted is 2020. You will have until December 31st, 2018 to file the size exemption form, and the new form will go up after the New Year. So be sure to keep this mind. You need to file the form every year.

Slide 40 shows you a screenshot of the CAHPS Hospice Survey website. And that is www.hospicecahpssurvey.org. And as I said, we list it on a later slide. And you can see the form can be obtained from the menu on the left. You can print this form out and fill it out if you want, and then transfer it and just submit it.

Okay. Polling exercise number 3 on number 41 here asks the following question. In 2015, my hospice had fewer than 50 survey-eligible decedents for CAHPS. I used the data to apply for the size exemption and was granted an exemption from CAHPS for 2016. It's currently 2017. What would I need to do to maintain my eligibility for the size exemption?

Let me give you just a few seconds here and let you think about that.

Okay. Let's look at answer A. That is incorrect. You don't want to do nothing. That assumes you're going to get an automatic renewal. You're not. So you don't want to say A. And because A is wrong, C obviously is wrong. The only possible answer is B. You want to make sure to go through. Do I have fewer than 50 survey-eligible decedents? And then apply for the 2017 by the deadline.

Okay. Next issue, slide 42, failure to collect CAHPS data for all 12 months of the year. You are required to collect data for all 12 months of the year, unless you have an exemption for size, for newness, or because of special circumstances. Now newness means if you got your CCN after the first of this year, you're going to be automatically granted a newness exemption. But if you are not exempted and you don't have 12 months of data, you fall into the third category. That is non-compliant. You do not want to be there. So, what should you do?

On slide 43, I make the following suggestions. One, prepare in advance. This is not something you want to do haphazardly. Select – first you want to select an approved vendor. The approved vendors are listed on our survey website. Approved means the vendors have met our minimum business requirements, such as how much experience do they have; what about their technology, especially if they're doing telephone surveys; what about their security precautions.

But vendors vary also in quality. And minimum business requirements don't address that. We suggest that you interview several vendors before making a decision. You may ask around to others you may know. See what people have to say. Why? Because your vendor must successively submit your data to the CAHPS data

warehouse. This is how we know that you have complied with the CAHPS requirements. Your vendor successfully submits your data to the warehouse. Another way to put this is, your vendor's actions can impact your compliance and, therefore, whether or not you get a 2 percent reduction.

So this is one of the reasons I say prepare in advance. Spend some time figuring out which vendor you want to choose. Once you select a vendor, you need to authorize that vendor. The form is on the website. The reason you want to do that is you're telling the data warehouse, this is who's going to send the data for me. Okay?

You should also get access to the data warehouse reporting system because we have reports available to you that tell you what your vendor's been doing. Make sure that more than one person has the information to access your reports. You'll need a user I.D. and a password. You can contact our technical assistance team for more information on how to get access. But again, the survey website will tell you. Make sure more than one person have access to that. We've had in other programs situations where the only person who knew how to get in quit. Don't put yourself in that position.

Now, this was mentioned previously, but it's important, so let me mention this again. The deadlines for submitting hospice CAHPS data are the second Wednesday of February, May, August, and November. That means that on the second Wednesday, by the second Wednesday of these months, your vendor must have submitted data to the CAHPS data warehouse. Perhaps you would like to give your vendor a call beforehand and see if they're ready to submit and when they're going to do it. Perhaps then you could check your reporting from the data warehouse to see if they did do it. In any event, we cannot accept late submissions. So plan and be careful to get all of your data in.

Now, let me talk about slide 44. This is the unsuccessful switch between CAHPS vendors. This is actually dangerous territory, and we didn't realize it. But now we do, and we want to tell you about it. We have found that switching vendors can become an occasion for non-compliance. So before you start moving to switch vendors, contact the technical assistance team. The next slide is going to have their contact information. They will help you make the move safely.

For example, here's the kind of a problem you can face. You choose to – you – if you choose to switch from one survey vendor to another, you could only do so at the beginning of a quarter – only at the beginning. Why? Well, remember, we've authorized a vendor. Okay. You've got your authorized vendor, he has 2 months of data. He uploads it to the web, to the data warehouse, that's fine. Your new vendor isn't authorized. He has 1 month of your data. He can't upload it. Bingo! Non-compliant.

We often see the hospices that were in compliance lose it because they switched vendors and didn't talk to us. So if you will please look at slide 45. E-mail or call our technical assistance team. This will help you greatly. They are there to help you with this process. And you have every right to switch vendors when you want to, but let them help you do it successfully. Don't hesitate to call. Please don't. They like to do this.

Now, let's go to slide 46. This is our last CAHPS non-compliance problem. Sometimes non-compliance is a result of a failure to stay in touch with your CAHPS vendor, including not reading the reports produced by the data warehouse for data submission. It's important to stay in touch with your vendor. If you know when data's being submitted, you can check with your vendor and also monitor your reports. If your vendor fails to submit your data on time, you can be declared non-compliant. This can cost you money.

We have had the situation, not necessarily in this program but in another program, where a vendor did not successfully submit the data, but they didn't realize it. The hospice didn't check, and they didn't realize it either. And everybody was surprised when they got hit with the 2-percent reduction. Therefore, we would suggest, and you can see this on page 47, slide 47, that you – we do repeat some of the things I said earlier about interviewing multiple vendors, but I would also suggest you make an effort to get to know your vendor. Some vendors will assign you a project managers or sales rep. See if you can get a name, somebody you can get in touch with, and stay in touch with them. Sometimes your vendor can be helpful to you, and just be in touch. Make sure you know what's going on.

Remember the data submission deadlines for the vendor are the second Wednesday in February, May, August, and November. So maybe the first Wednesday, you give them a call and say, so, how's it going? Am I going to be okay? When are you going to submit my data? And then you check up on them.

Get access to the reports from the CAHPS data warehouse. It's free, and use them to monitor what your vendor is doing.

And finally, I would like to mention this. CMS has zero authority to regulate your vendor. Your relationship with your vendor is between two private businesses. We do not have anything to say about it. So please, think carefully, not only about cost, sure that's relevant, but also about quality and who you are comfortable with when you are selecting your vendor.

That's all I have to say for CAHPS. Thank you.

Further Actions To Take for Fiscal Year 2019 Reporting

Alexis Kirk: Thank you, Debra. So now we can conclude with our final two portions of this presentation. So on the third section of our presentation, which starts here on slide 48, we're going to go over action that you need to take for the current reporting year, which remember, is the fiscal year '19 reporting cycle.

On slide 49 we list some actions of things that you should be doing now. So it's currently September 2017, that means we're already three quarters of the way through this reporting cycle. So you have just one quarter left to take action and help ensure you're compliant with the fiscal year 2019 requirements.

First, you should ensure that you're on track for any exemptions. Again, I know we've talked about this a lot today, but just remember, there are no exemptions for HIS. If you're eligible for the CAHPS newness exemption, it will be automatically granted to you. This means that your one action item as far exemptions go is to submit your CAHPS size exemption form by December 31st if you had fewer than 50 eligible decedents in 2016.

Second, you should be checking to make sure that your data are both being submitted and accepted. For HIS, you should do this by reviewing your final validation report. And for CAHPS, you can do this by reviewing reports from the CAHPS data warehouse and reaching out to your vendor.

Third, it's critical to ensure the timeliness of your data. For CAHPS, ensure that your vendor is submitting complete data by each of the quarterly deadlines. And for HIS, ensure that your records are being submitted within 30 days by reviewing the Timeliness Compliance Threshold Report in CASPER. And remember, we're already three quarters of the way through the year. So if you log in to CASPER and see that your current performance is somewhere around the 80 percent mark or below, it's going to be critical for you to make sure that every single one of your HIS records from here on out is submitted on time and accepted on time so that you can increase or boost your performance on the timeliness compliance threshold.

Finally, if you encounter an extraordinary circumstance, apply for an exemption or extension for extraordinary circumstances, as appropriate. And as I mentioned, CMS has already started to grant some region-wide exemptions and extensions due to recent hurricanes. So monitor the Spotlight & Announcements page of the HQRP website for updates on that.

Slide 50 has a graphic that we've seen already today. So as 2017 draws to a close, we're going to move into 2018. And remember that's when CMS is going to move into the compliance determination phase of the fiscal year '19 cycle. So in 2018, CMS is going to review your 2017 data and determine whether or not you are compliant. And it will then send out those determinations, initial determinations of compliance some time in summer 2018. These letters are sent out by the MACs in the mail, and they're also made available in your CASPER folders.

So next summer, if you do receive a letter of non-compliance and you believe that that non-compliance determination was made in error – so you have evidence that you were actually compliant – then you can apply for what's called reconsideration. CMS will review requests for reconsideration next summer and make a decision about whether to reverse or uphold that initial non-compliance determination. If that determination is upheld, your payment reduction will go into effect in fiscal year 2019, which starts October 1st, 2018.

So on slide 51, to recap, if next summer you receive a letter of non-compliance, review both your HIS and CAHPS data submissions to determine if that non-compliance ruling was made in error. If you think it was, you should apply for reconsideration by the due date noted in the letter.

Slide 52 shows a screenshot of the Reconsiderations webpage. You can visit this webpage for detailed instructions on how you submit a reconsideration request and what information you need to include in that request. And note that you can only initiate a reconsideration request after you receive a letter of non-compliance. So even if you know right now that you have failed to take action on some front, say, your vendor missed one of the CAHPS quarterly deadlines, there is not any action that you can take right now as far as reconsideration goes. You're going to have to wait until next summer once the letters are sent out and you can apply for reconsideration at that time.

So on slide 53, we've talked a lot throughout this presentation about valid and invalid reasons for not complying with the HQRP requirements. Listed here are some reasons that are invalid for applying for reconsideration. And really what this slide underscores is the importance of taking action to insure compliance now using the steps that we've outlined throughout the presentation today.

Where To Go for Additional Information

So the final portion of this presentation begins on slide 54. And here we're going to go over some of the resources that are available to you to assist you in compliance.

As shown on slide 55, there are really three main websites that you should be accessing on a regular basis in order to stay up to date with requirements and be in compliance. And those are the CMS HQRP website, the CAHPS Survey website, and the QTSO.com website. CMS recommends that hospice providers bookmark these pages and visit them often for updates. In addition, you can also stay informed by signing up for the PAC QRP listserv using the link on this slide.

So let's go over some of the details for each of those three websites and what you can find on each one. On slide 56 is the CMS HQRP webpage, and this webpage contains resources for the HQRP overall and is the home for all HIS content. So this is where you'll find links to important HQR policy pages, so things like the Reconsiderations page and that exemption or extension for extraordinary circumstances. And it's also where you can find all of the information pertinent to the HIS.

The Hospice Quality Help Desk is available at the email address listed on this slide to answer questions about most of the content on this webpage, including general policy questions about the HQRP overall and HIS-specific questions, whether it'd be questions about quality measures specifications, HIS coding, or public reporting of your HIS data.

The second website is shown on slide 57, and that's the CAHPS webpage. This CAHPS Survey webpage contains CAHPS resources for providers and vendors. So this is where you can go to find all of the forms that we've mentioned today; so the CAHPS size exemption form and the vendor authorization form. It's also where you can go to find information on CAHPS deadlines. The CAHPS team, as we've mentioned, has two help desks available to you, and their contact info is listed on this slide.

The third website is the QTSO.com page. And this is the home for things related to QIES ASAP, the HART system, as well as CASPER reports. So this is where you can go to get help accessing those Final Validation and the Timeliness Compliance Threshold reports. And the screenshot that's shown here on slide 58, shows how you can navigate this website to get to the trainings and manuals that are available to you.

So you'll click over on the left-hand side bar on the link for Hospice, and then once you're there, go up to the top of that page and you'll see a link for Hospice User Guides & Training. And this is where you can get to the Submission Users Guide, which will help you with QIES ASAP, and the CASPER Users Guide, which will help you with accessing those reports. The QTSO.com help desk is also available to you via phone or email, and you can ask them questions about submitting data, any fatal error messages, or questions about accessing your CASPER reports.

Finally, as Cindy mentioned earlier in the call today, today's call is going to be the first in a series of education and outreach activities that CMS will be hosting. CMS is going to host additional educational events that will be announced on the HQRP webpage, the PAC listserv, and through the MLN Connects newsletter. So be sure that you're checking those outlets for updates on upcoming education and outreach activities.

And with that, I believe we will now initiate our question-and-answer session.

Question & Answer Session

Leah Nguyen: Thank you, Alexis. We will now take your questions. As a reminder, this event is being recorded and transcribed. All right, Dorothy, we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press star one to get back into the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Leah Ozment.

Leah Ozment: I have a question. On slide 11, it notes that the HIS records should be submitted within 30 days of the target date, which is the patient's admission or discharge. With the new HIS updates on April the 1st, we have the admission date plus 30 days or the discharge plus 30 to submit. So I want to clarify that, if this is saying it's within 30 days including the admission or discharge date?

Cindy Massuda: Alexis will answer that question.

Leah Ozment: Okay.

Alexis Kirk: Yes. So you can find the answer to that question. The best place that I like to go is in the HIS manual. So if you look in here at the Timing and Sequence policies, which are in Section 1-7, then you can see exactly how we have defined the submission deadline. And as you'll notice in here, it is the admission date plus 30 calendar days and the discharge date plus 30 calendar days.

Leah Ozment: Right. I just wanted to clarify that for sure.

Alexis Kirk: Yes.

Leah Nguyen: Thank you.

Alexis Kirk: Thanks for that clarification.

Operator: Your next question comes from the line of Nicole Strauss.

Nicole Strauss: Hi. I just was wanting to clarify in terms of slides 33 and 34, if we are – am I understanding correctly, if we are past the 30 – we submitted but we got fatal errors or information that was rejected, are we

able to apply for the modification to go back and still correct that data even if we're after the 30 days, as long as we submitted timely? I want to make sure I'm understanding it correctly.

Cindy Massuda: And Alexis will be answering that question.

Alexis Kirk: Yes. Thanks. So you can always use the modification and inactivation request at any time. So regardless of whether that original new record was submitted timely or not, you can always go back and correct any erroneous data. And it's really important to do that, especially now with Hospice Compare. It's important to go back and correct any errors in your data so that your quality measure will be displayed correctly.

So for the purposes of compliance, if you submitted the original record within that 30-day timeframe and it was accepted before the deadline, then if you go back to modify or inactivate the record say, you know, another 30 days past that – so it's now, say, 60 days from the target date – that does not "count" against you for the purposes of the Timeliness Compliance Threshold, because we do not include modifications and inactivations in the calculation of that algorithm.

Does that answer your question?

Nicole Strauss: It does, but you said that if it was submitted and accepted. If it's submitted and there are fatal errors, it's rejected. So I'm talking about correcting things that were rejected past that 30-day mark.

Alexis Kirk: I see.

Nicole Strauss: Sorry.

Alexis Kirk: I see. So if it was submitted and the submission was rejected, and you're not able to correct the errors and resubmit until past the 30 days, that counts as late. It has to be accepted within the 30-day timeframe for it to be considered on time.

So that's why it's really important, I mentioned in the presentation, it's important to try and attempt that first submission early so that you build yourself a buffer.

Leah Nguyen: Thank you.

Nicole Strauss: Perfect.

Operator: Your next question comes from the line of Kenya Eindole.

Kenya Eindole: Hi. My question is, and I think it's already been answered, so, but I will just make sure. Can you correct data that has been submitted to CMS and still in the – has not been uploaded yet and is not included in the Hospice Compare and correct that? And I think the answer would be, yes, you can do that. Am I correct?

Leah Nguyen: Can you hold on a moment?

Kenya Eindole: Sure.

Cindy Massuda: Can you please repeat your question?

Kenya Eindole: Sure. My question is, can you correct data that has been submitted to CMS and is still in the QIES ASAP system and is yet – not yet included in the Hospice Compare? We are still allowed to correct data if we notice that there's error in data, but it's not a fatal error?

Charles Padgett: What do you mean by not included in Hospital Compare, do you mean it's not been posted on Hospice Compare yet?

Kenya Eindole: Right. On Hospice Compare. I'm actually asking a question by the person who puts – who is in charge of HIS. She's not here right now. She couldn't be here, so she asked me to ask this question. So I just wanted to make sure that her question is, as long as it's still – she notices the data once it's been – she uploaded it in to HART and it's there, but it has not been submitted yet, she still can correct that data if she noticed that there's an error when she's reviewing data. Am I correct? Or am I making it too confusing?

Charles Padgett: So, I mean just so I understand the scenario correctly. The hospice had submitted the data to CMS, so we now have possession of that data. It has not been posted on Compare. But that doesn't necessarily matter because there's a lag and deadlines that are related to that data being posted. And so there are data submission deadlines or freeze dates by which you need to submit any data or any corrections or modifications to that data in order for those to be included in the data when – once it gets posted on Compare.

Kenya Eindole: Okay.

Charles Padgett: And we do list those out on our website.

Kenya Eindole: Yes. Okay.

Charles Padgett: The hospice public reporting website. So as long you're submitting or correcting or modifying the data prior to one of those freeze dates, that data will be included in the data that gets posted on the Compare website. And each freeze date that we list has a corresponding Compare refresh – Hospice Compare refresh that you'll see. So as long as you're doing that prior to that freeze date, it will…

Kenya Eindole: Yes.

Charles Padgett: …the corrected data will be used to calculate your quality measures.

Kenya Eindole: Okay.

Charles Padgett: Does that help?

Kenya Eindole: Yes, it does. Yes, it does. And sorry about it. I'm reading the question that she wrote down on the piece of paper, so that's why…

Charles Padgett: Oh, no problem.

Leah Nguyen: No problem.

Kenya Eindole: …I apologize.

Leah Nguyen: That's fine, thank you.

Operator: Your next question comes from the line of Kathleen Kozlowsky.

Kathleen Kozlowsky: Hi. At times we have been unable to get a Social Security Number for a patient, and I'm just wondering what our risk is for not having that number.

Leah Nguyen: Could you hold on a moment?

Cindy Massuda : Can you elaborate a little about this – about the need for the Social Security Number?

Kathleen Kozlowsky: Well, there is an area in the HIS to enter the Social Security Number. And is there any risk if we don't have it?

Cindy Massuda: Alexis will be answering that question.

Alexis Kirk: Great. Thank you, Cindy. So, you – in order to help avoid inaccuracies in patient record matching, because the Social Security Number is one of those key patient identifiers, it's best for you to attempt to get the Social Security Number from the patient and include it on the record. But we do realize that sometimes that is not possible.

So in those instances, if the patient either does not have a Social Security Number or if the Social Security Number is unavailable, you can leave that item, A0600, blank. And you can find more guidance on that on page 2A-9 in the HIS manual.

Kathleen Kozlowsky: Thank you.

Leah Nguyen: Thank you. Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Theresa Hipp. Ms. Hipp, your line is open.

Theresa Hipp: Yes. Hi. Thank you very much. Can you tell me where the instructions are to – for modification and inactivation?

Cindy Massuda: Sure. Alexis will be answering that question.

Alexis Kirk: Yes. Now, you can find the instructions for completing the modification and inactivation request in the HIS manual. That manual is available on the HQRP website. There's a tab for Hospice Item Set, HIS. It's

down there in the downloads. It's version 2. And the section that you want to be looking at is Chapter 3, Section 6.

Theresa Hipp: Thank you.

Leah Nguyen: Thank you.

Alexis Kirk: And if you run into any, you know, technical issues as you're going through the process, you can also reach out to the QSTO.com help desk.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on Slide 56. For information on evaluating today's event, see Slide 61.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network Event on the Hospice Quality Reporting Program. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.