

Centers for Medicare and Medicaid Services
Home Health, Hospice and DME
Open Door Forum
Moderator: Jill Darling
Wednesday, August 22, 2018
2:00 p.m. ET

OPERATOR: Good afternoon. My name is (Julie) and I will be conference facilitator today. At this time, I would like to welcome everyone to The Centers for Medicare and Medicaid Services Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your custom keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

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

Before we dive in to today's agenda, as always, I have my one brief announcement for you all. This open door forum is not intended for the press, and the remarks are not considered on the record. 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.

So, we'll get right into our first topic. We have (Wil Gehne), who will – who has an update on the Home Health and Hospice claims processing.

(Wil Gehne): Thanks, Jill. I have three hospice updates today. First, I want to remind everyone that starting October 1st, hospice claims can report a monthly charge for all drugs given during the billing period. (It's in) Revenue Code 250. Hospices have the option to continue reporting drugs using line item detail but it's no longer required. Hospices can take advantages of this reduction and reporting when best suits their needs. Recently, there's a question about the line item date for the monthly charge line. Medicare has no instructions regarding that date. So Hospices can develop their own reporting practice.

On our last open forum, I talked about MLN Matters Special Edition Article SE18007 that described changes and hospices data in Medicare system. Yesterday, we reissued that article with the correction. If the revocation date was submitted entirely in error, for instance, the beneficiary actually transferred rather than revoking their benefit, the original article recommended that hospices submit an NOTR with zeroes and the through date. Further testing has shown that, that process is not working yet.

So instead hospices can remove the revocation date in one of two ways. If the revocation date was originally submitted on discharge claim, the hospice can submit an adjustment to that discharge claim changing the patient's status code to indicate the transfer with status code 50 or 51. If the revocation date was originally submitted on an NOTR, hospice will need to cancel any claims processed from the benefit period, remove the election period with the Type of Bill 8XD to remove that revocation date and then resubmit corrected information.

Our last hospice update, last week, we added user instructions to the Hospice PC Pricer webpage. The instructions provide field by field guidance on entering claims into the program. We hope that users of the PC Pricer find the new document helpful.

And regarding Home Health, I just wanted to note that the change request on the 2019 changes to the Home Health rural item will not be issued until immediately following the publication of the Home Health final rule. The Home Health agency should be aware that the National Uniform Billing

Committee has created the new value code, Value Code 85, to report FIPS state and county codes on Home Health claims starting January 1st, 2019.

That's all I have, and I'll turn it over to (Amanda Barnes).

(Amanda Barnes): Thank you, (Wil). I will be providing an update on the fiscal year 2019 Hospice Wage Index and Payment Rate Update for the hospice wage index and also the regulation text changes for physician assistants as finalized in August 1st, 2018 and published on August 6th, 2018. Hospices will see a 1.8 percent or a \$349 million increase in their payments for fiscal year 2019. The 1.8 percent hospice payment update percentage for fiscal year in 2019 is based on a 2.9 percent inpatient hospital market basket update, reduced by a 0.8 percentage point multifactor productivity adjustment and reduced by 0.3 percentage point adjustment required by law.

Hospices that fail to meet quality reporting requirement receive 2 percentage point reduction to their payments. The hospice payment system includes the statutory aggregate cap, and the cap limits the overall payments made through hospice annually. The cap amount for fiscal year '19 is \$29,205.44.

There were hospice regulations text changes due to the Bipartisan Budget Act of 2018. This Budget Act of 2018 amended Section 1861 (d)(d)(3)(B) of the Social Security Act such that, effective January 1st, 2019, physician's assistants will be recognized as attending physicians for Medicare hospice beneficiaries. The statutory change (expands) the definition of hospice attending physician to include the physician's assistant in addition to physician and nurse practitioners. Further information about the final rule can be found on the hospice provider webpage on cms.gov.

I will now turn this call to Cindy Massuda.

Cindy Massuda: Thank you. Good afternoon, everybody, and good morning to others on the call. My name is Cindy Massuda. I'm the Hospice Quality Reporting Program coordinator, and I'll provide an update to the fiscal year 2019 hospice final rule as it relates to the Hospice Quality Reporting Program.

So for the highlights of the rule, we revised the data review on correction timeframe for data submitted to Hospice Compare using the hospice item set. For the CAHPS hospice survey participation (requirements), we did it through FY 2023 of subsequent years. We added the quality measures the publicly reported about the website and provided the procedures to determine quality measure readiness for public reporting. Quality measures to be displayed on Hospice Compare in fiscal year 2019 updates for the display of the HIS measures on public Hospice Compare and display of the Public Use File data and their other publicly available CMS data on the Hospice Compare website information.

So to provide some detail about the revised data review and correction timeframe for data submitted to Hospice Compare using the Hospice Item Set, in order to ensure that the data reported on Hospice Compare is accurate and to align with other quality reporting programs, hospices will now have four and a half months after the end of each quarter to review and correct data that is to be publicly reported. This policy goes into effect January 1st, 2019. So, for example, patient admission on January 3rd, 2019, hospices have four and a half months after the end of the calendar year quarter in which that HIS record was submitted, which it means they have until August 15th of 2019 to review and correct the record.

After this date, any data corrections will not be incorporated into measure calculation for the purposes of public reporting on Hospice Compare. Hospices will have until August 15th, 2019 to correct any HIS records with target dates before January 1st, 2019, for the purposes of public reporting. This update does not impact the current 36-month timeframe providers have to correct records, modification, and inactivation request.

To provide some detail about adding quality measures to publicly available websites, we follow a standard consistent process in determining the readiness for a quality measure to be publicly reported, and perform the necessary analysis to determine and demonstrate that our measures meet the NQF Measure Evaluation criteria for your liability, validity, and reportability prior to publicly reporting provider performance on this quality measures. Since all

measures follow the same analysis, CMS will announce results of the analysis and publicly report timeliness for measures via standard subregulatory communication channels.

And then for the measures to be displayed on Hospice Compare in fiscal year 2019, we will be bringing on the Hospice Item Set base Hospice Comprehensive Assessment Measure which is the composite measure known as NQF number 32 and 35, and also the Hospice Visits When Death is Imminent measure cap.

And then the update to display of the HIS measures. So for that update, in order to enable more efficient use of Hospice Compare data, we will no longer directly display the seven component measures on Hospice Compare once the Hospice Comprehensive Assessment Measure that NQF 3235 is displayed. We will still survive the public, the availability to use these seven component measures in a manner that avoids confusion on Hospice Compare. We'll be using a dropdown box. This update only impacts on measure results are displayed on Hospice Compare.

And then another detail about the display for Public Use File data or other publicly available CMS data on Hospice Compare website for information, we will begin displaying this data as shown from the CMS Public Use File or other public available CMS data to the Hospice Compare website, and present that data after additional calculations to help consumers make an informed decision and a selection of a hospice.

For example, we are planning to be using three years' worth of Public Use File data and trend it to provide the percent of data, the hospice provided routine homecare to patient's percentage of primary diagnosis of patients that a patient's served by the hospice to the provider sense of the hospice providing services for cancer, dementia, stroke, respiratory disease, and the like. And also sharing locations for the hospices served patients.

The calculations are performed on the data from the source file like the Public Use File or other publicly available CMS data. The information includes data that is based on the adjudicated claim, and it'll have three years' worth of

(status) claim data. This will become a new section on the Hospice Compare website and will be developed to display information in a consumer friendly format.

For Hospice Compare, the website we have the August quarterly refresh was done on August 16th of 2018; that is now live. The Hospice Compare update reflect the Hospice Item Set quality measures result based on data collected in Q4 of 2016 to Q3 of 2016, and the CAHPS Hospice Survey results reported from Q4 2015 to Q3 2017. We invite you to visit the Hospice Compare website to view this data.

And then the free date for the Hospice Item Set that's going to be included in quality measures calculations for the November Hospice Compare Refresh was August 15th of 2018. That refresh will include the Hospice Item Set data for Q1 to Q4 of 2017, so all of calendar year 2017 from January through December. This HIS record includes modifications, corrections, and inactivation needed to submitted and accepted by the Quality Improvement and Evaluation System, the QIES system. And they are reflected in your provider (preview) report that will be available on September 4th of 2018. We encourage providers to be looking at their (preview) reports in the CASPER system for the November 2018 Hospice Compare Refresh.

The November 2018 Hospice Compare Refresh will include the new Quality Hospice Comprehensive Assessment Measure NQF 3235. Providers will have an opportunity to preview their score on this measure in conjunction with the currently reported seven HIS measures during the preview period from September 4th to October 4th of 2018. We encourage providers to become familiar with the Hospice Comprehensive Assessment Measures specifications and their measures score using the HQRP Quality Measure User Manual Version 2 and their CASPER QM reports.

CMS has noticed an increase in a number of modifications, corrections, and inactivations after the release of the provider preview report. As a friendly reminder, it's the provider's responsibility to ensure that records are complete and accurate prior the submission to the QIES ASAP system. CMS

encourages providers to review quality measure data often using their CASPER QM reports and not waiting for the freeze date or when the provider preview report to release to submit any necessary HIS corrections. For more information on how providers can use their CASPER QM reports to review data, please see the CASPER QM report stock sheet, which is located on the HQRP Requirements and Best Practices webpage.

And then in addition to that, we are having upcoming training on August 30th of 2018. That training will be are HQRP primer. We've just completed training on how the measure goes from data to measure that was on August 16th of 2018, that information from that great webinar is now going to be available on our website at HQRP website. And our upcoming training on August 30th with the HQRP primer, that has the benefit of following the HIS manual to help providers for the HIS portion of HQRP to follow along with the manual.

We also are doing our special open door forum on September 26th of 2018 on HEART, and that we encourage people to be looking for the – for that on our spotlight page along with the open door forum page.

And with that, I'll turn it over to Jill.

Jill Darling: All right, thanks, Cindy. Next, we have Emily Calvert, who will give an update to the required prior authorization list of DMEPOS Items that require prior auth as a condition of payment.

Emily Calvert: Hi, everyone. This is Emily from the Center for Program Integrity. I'll be giving the update on the updated of required prior authorization list for durable medical equipment. CMS has selected 31 items of durable medical equipment to be subject to require prior authorization beginning nationwide on September 1st, 2018. The HCPCS codes added to the required prior authorization list are currently included in the prior authorization of Power Mobility Devices demonstration also known as the PMD demonstration, which will be ending on August 31st, 2018.

All new rental series for the 31 PMDs with the date of delivery on or after September 1st, 2018 must be associated with a prior authorization request as a condition of payment. Therefore, a lack of a provisionally affirmed prior authorization request will result any claim denial. And the state currently participating in the PMD demonstration, the DME MACs map will continue accepting prior authorization for class for the PMDs without interruption. Prior authorization decisions received prior to September 1st will continue to be valid and will satisfy the condition of payment requirement.

The DME MACs stop accepting prior authorization request for items under the PMD demonstration that are not being added to the required prior authorization list on August 18th, 2018. And in the state that are not currently participating in the PMD demonstration, the DME MACs began accepting prior authorization request for those PMDs on August 18th, 2018.

HCPCS codes K0856 and K0861 were added to the required prior authorization list in 2017, and these will continue to be subject to the requirements of prior authorization. The updated operational guide frequently have questions and also the complete required prior authorization list can be found in the download section of the DME Prior Auth webpage.

And I will turn it over to (Heidi).

(Heidi): Hi, this is Heidi with the Home Health QRP Program with just one small update. An OASIS D Guidance Manual Errata, which was updated on 8/6/2018, is available in the download section of the OASIS Users Manuals webpage. And with that, I'll hand it to Debra Dean-Whitaker.

Debra Dean-Whitaker: Hello. This is Debra Dean Whitaker. I am filling in for Lori Teichman today about Home Health CAHPS. We have some reminders for you. First, home health agencies are responsible for monitoring data submissions by their vendors. Check your data submission report in the four HHA's portal on the HHCAPHS website. It is listed on the agenda. Data submission deadline for HHCAPHS data always occur on the third Thursday in the month of January, April, July, and October. The next deadline is October 18th, 2018. Please check your data prior to that time and note that we

do not accept late file. Also, home health agencies are responsible for giving their monthly list of home health patients to their vendors on time so that vendors can sample and data collection can occur according to the schedule.

If you are home health agency, as recently switched vendors, please contact our contractor RTI by e-mailing them at HHCAHPS@RTL.org to be sure that your current vendor is authorized to submit your HHCAHPS data. You must drop your former vendor and add your current vendor to the authorization form. We highly recommend that you do this as soon as you contract with your new vendor. You do not want to miss a date of submission deadline because the wrong vendor was authorized to submit your data.

The Home Health CAHPS Survey is available in many languages, English, Spanish, Chinese, Russian, and Armenian. We are asking you to please feel free to suggest other language. You can e-mail us with your suggestions. Please let us know why you'd like to have it so we get an idea of your need. And finally, Home Health CAHPS vendors need CMS approval to display a home health agency's name and/or logo on outgoing mail survey envelopes. Vendors need to complete the HHCAHPS exceptions request form and confirm that the home health agency and vendor have discussed (HIPAA) risks and that the home health agency has approved the display of their name and logo.

Thank you very much.

Jill Darling: All right. Well, thank you, Debra, and thank you to all of our other speakers today. (Julie), we'll go into our Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for question. If you require any other further follow-up, you may press star one again to rejoin the queue.

Your first question comes from the line of (Shannon Home) with Quality First Home Choice. Your line is open.

Your next question comes from (Kathleen Warsen) with (Interim Healthcare).

(Kathleen Warsen): Hi. Thanks for taking my question. I was wondering if Mr. (Gainey) could repeat the information on the rural add-on with the new value code please.

(Wil Gehne): Sure. The new value code will be 85 and I use that to report FIPS state and county code on the claim.

(Kathleen Warsen): So that'll be a requirement on ...

(Wil Gehne): Yes.

(Kathleen Warsen): ... this claim, January 1st?

(Wil Gehne): Yes.

(Kathleen Warsen): OK. Thank you.

Operator: Your next question comes from (Carrie Vandelheimel) with Good Samaritan Society. Please go ahead. Your line open.

(Carrie Vandelheimel): Hello there, good afternoon. Could you please repeat the date of the special open door forum in September?

Cindy Massuda: Sure. The special open door forum for the hospice evaluation and assessment reporting tool is September 26 of 2018 from 2:00 to 3:00 p.m. Eastern Standard Time.

(Carrie Vandelheimel): Thank you.

Operator: So our next question comes from (Robin Strauss) with Fairview Health Services. Please go ahead. Your line is open.

(Robin Strauss): Hi. I'm just wondering, where did you say we could find the 31 items that'll be subject to the prior authorization?

Emily Calvert: Hi. This is Emily. The 31 codes are listed on the durable medical equipment, DMEPOS prior authorization page on the CMS website.

(Robin Strauss): On the prior authorization page, all right. Thank you.

Emily Calvert: You're welcome.

Operator: Your next question comes from (Ronda Oaks) with (Netsmart). Your line is open.

(Ronda Oaks): Hi. I'm sorry. I need (Will) to please repeat the number for the FIPS code. It did not come across clear.

(Wil Gehne): Eighty-five, 8-5.

(Ronda Oaks): Eight-five. Thank you so much.

(Wil Gehne): Sure.

Operator: As a reminder, if you would like to ask a question please press star one on your telephone keypad.

There are no further questions at this time.

You have another question from (Kathleen Warsen) with (Interim Healthcare). Your line is open.

(Kathleen Warsen): Hi. Back to the 85 value code, does that replace the CBSA code?

(Wil Gehne): No, we're not because we still need the CBSA code to (wage-adjust) the claims.

(Kathleen Warsen): OK. And where – is that written in the CR or somewhere, did I miss?

(Wil Gehne): No. The CR can't come out until the final rule is published on the documentation about that. (The value code) so far is that minutes from the National Uniform Billing Committee meeting. So there's no way to middle that it yet. Yes.

(Kathleen Warsen): Got it. So wait for the – got it. Thanks so much.

(Wil Gehne): Sure.

Operator: Your next question comes from (Jennifer Hansel) with Hospice of Michigan. Your line is open.

(Jennifer), your line is open. You may be on mute.

(Jennifer Hansel): Hi. My question is for (Will), I think. If this is not part of the agenda, so if you can't answer it, just let me know or direct me accordingly. So we have – we served the entire state of Michigan and we have physician visits that are performed for four different NPIs throughout the state. So, for physician visits, so, are we able to bill some of them at the 01 locality map and some at the 99? Or do they or have to be at one for one organization?

(Wil Gehne) I'm not sure if some of that build them at the locality. And the locality is generally assigned in the course of claims processing.

(Jennifer Hansel): OK. So we (can though) like – so we have – because there's four counties in Michigan that are 01 and all the rest to the counties are 99. So we can bill them separately. I mean like the ones that are performing in the four counties can build the 01 locality. It's automatically defaulting to the 99 so I just want to make sure we're good to bill the ones that are current in the four counties that have in 01 locality at the 01 locality.

(Wil Gehne): So you're saying that if this different – physicians with different localities that are on the same claim?

(Jennifer Hansel): Not in the same claim, no, no, no. Because they'd be in different NPIs altogether. But is there a documentation somewhere in the CMS website about this type of billing and distinguishing? I mean I printed out the one

page on map localities but it doesn't really get into depth on this. And right now ...

(Wil Gehne): We don't have anything written of that hospice specific, but I think you have my e-mail. Could you (clear up) the details of this? I may need to ...

(Jennifer Hansel): Sure.

(Wil Gehne): ... to research a little bit more.

(Jennifer Hansel): Perfect. Yes, I will.

(Wil Gehne): Thanks.

Jill Darling: Hi. If you have – if you're unable to get your question answered, if you don't mind please send your questions into the Home Health Hospice DME ODF e-mail. That is on the agenda. Thank you.

Operator: Again, if you would like to ask a question, please press star one on your telephone keypad.

Your next question comes from (Renee McCann) with Office of the Inspection. Your line is open.

(Renee McCann): ... changes of being made to the quality measures rating part of hospice? Hello?

Female: Hi. Can you please ask your question again? I'm not sure I heard you.

(Renee McCann): Sure. Sure. I just wanted to – maybe I didn't hear properly but there were some mention of changes to the quality measures component of the rating system for hospice. I just wanted a little clarity on that.

Female: Are you referring to as – bring on the component measure in – OK. So we're going to be bringing on the hospice component measure which is NQF 3235. And that's going to be coming on to Hospice Compare this November of 2018. And that measure is a component of the seven HIS measures.

(Renee McCann): OK.

Female: So, we're not changing anything related to how to we collect our data or anything. It doesn't affect that. It's really the display on Hospice Compare. We're going to be making it so that it's more user friendly display on the Hospice Compare website.

(Renee McCann): OK. OK. Thank you.

Female: Sure.

Operator: There are no further questions at this time.

Jill Darling: All right. Well, thank you, everyone, for joining today's call. You will get some time back. And again, if you have any further questions, please feel free to send them in to the Home Health Hospice DME ODF e-mail that is listed on the agenda. It's always on the agenda for you. So thanks, everyone, have a great day.

Operator: Thank you for participating in today's open door forum conference call. This call will be available for replay beginning 4:30 p.m. Eastern Time. Conference ID number for the replay is 33439872. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

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