Centers for Medicare and Medicaid Services
Home Health, Hospice and DME/Quality
Open Door Forum
Moderator: Jill Darling
November 15, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Megan) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, Home Health, Hospice and DME/Quality Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there'll 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 telephone keypad. If you'd like to withdraw your question, please press the pound key.

Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you, Megan. Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications and welcome to the Home Health, Hospice and DME Open Door Forum.

Before, we get into today's agenda, one brief announcement from me. 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 question during the Q&A portion of the call. If you have any inquiries, please contact us at press@cms.hhs.gov.

So, now, I will hand the call up to our chair, Hillary Loeffler.

Hillary Loeffler: Thanks, Jill. Hi, everyone. I'm Hillary Loeffler, the Director of the Division of Home Health and Hospice here in the Center for Medicare. Unfortunately,

there was a personal emergency that ended up propping up for somebody in the claims processing area. So, we aren't going to be providing an update on home health claims or hospice claims during this ODF. We're going to have to carry those over until after the New Year. So, my apologies for the late cancellation and change in the agenda.

And I just wanted to also thank all of the home health providers that commented on our calendar year 18 prospective payment and proposed rule. This year, we received over 1,300 public comments. We received a lot of really great feedback, detailed comments that were really thoughtful from the public. So, I wanted to extend my thanks on that.

I will now turn it over to (Susan Bauhaus), who's going to provide a summary on the policies finalized in the final rule.

(Susan Bauhaus): Thanks, Hillary. On November 1st, CMS issued the final rule updating the calendar year 2018 Medicare payment rates and wage index for home health agencies. Overall, CMS projects that Medicare payment to home health agencies in 2018 will be reduced by 0.4 percent or $80 million based on the payment updates provision on the final rule.

These provisions include a 0.97 percent reduction to the 60-day episode rate in calendar year 2018 to account for nominal case mix growth from 2012 to 2014. Nominal case mix growth is case mix growth unrelated to changes in patient's severity.

This reduction results in an estimated decrease in payments of 0.9 percent or $170 million for calendar year 2018. It also includes an update to the home health payment rates of 1 percent or $190 million for calendar year 2018, as required by section 411 of MACRA. The home health update is decreased by 2 percentage points for those HHAs that do not submit quality data as required by the secretary.

And finally, the sunset of the rural add-on provision at the end of 2017 eliminates the 3 percent payment increase for home health services furnished in rural areas to episodes and visits ending before January 1, 2018. We

estimate that the sunset of the rural add-on payments will result in a decrease in payments for calendar year 2018 of 0.5 percent or $100 million.

The calendar year 2018 Home Health proposed rule included proposed case-mix methodology refinements through the implementation of the Home Health Groupings Model or HHGM. CMS is not finalizing the Home Health Groupings Model and will take additional time to consider public comments submitted on the proposed rule and to further engage with stakeholders to move toward a system that shifts the focus from volume of services to a more patient-centered model.

I'm going to turn it over to Ed, who's going to discuss the Home Health Value-Based Purchasing Final Rule Provisions.

Edward Lilley: Thank you, Susan. Hello, everyone. This is Edward Lilley. Effective January 1, 2016, we implemented the Home Health Value-Based Purchasing Model, HHVBP, in nine states representing each geographic area in the nation. All Medicare certified Home Health Agencies or HHA that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington are competing on value in the HHVBP model, where payment adjustments will be based on each HHA's total performance score on a set of measures already reported via the Outcome and Assessment Information Set, OASIS, and Home Health Care Consumers Assessments of Healthcare Providers and Systems, HHCAHPS for all patients serviced by the HHA, or determined by claims data plus three new measures where points are achieved for reporting data.

As of November 1, 2017, the final rule was published and could be found at federalregister.gov, search for CMS-1672-F. In the calendar year 2018 Home Health Prospective Payment System final rule, CMS finalized the following changes and improvements related to the HHVBP model. We revised the definition of applicable measure to specify that the HHA will have to submit a minimum of 40 completed HHCAHPS surveys for purposes of receiving performance scores for any of the HHCAHPS Measures.

We removed the OASIS-based measure, drug education on all medications provided to patient/caregiver during all episodes of care from the set of applicable measures. And we also summarized the public comments received on the composite quality measures for future consideration.

I'd also like to remind that the HHA in the nine states that your final annual total performance score and payment adjustment reports have been published. And in the final calendar year 2018 HHPPS rule, the final annual report reflects HHCAHPS quality measures scores calculated using a minimum of 40 completed surveys.

To view your final annual report on the HHVBP secure portal, select August 2017 from the dropdown menu found under the reports tab. Final will display in the current status bar. A fact sheet for the report is available on HHVBP Connect. If you have any other questions about the HHVBP model not related to the final rule, please submit them to HHVBPquestions@cms.hhs.gov.

I will now turn the call over to Joan Proctor for an update on the Quality Reporting Program Provision.

Joan Proctor: Thanks, Ed. Hi, this is Joan Proctor. I'm the Coordinator for the Home Health Quality Reporting Program. And I'm going to provide for you a brief update on what we finalized in the Home Health PPS rule this year for the quality reporting program.

We finalized the replacement of the current pressure ulcer measure, percent of residents of patients with pressure ulcers that are new or worse and short stay with the new modified version of the measure titled, Changes in Skin Integrity Prosecute Care Pressure Ulcer/Injury.

We also adopted two new quality measures. The application of percent of residents experiencing one or more falls with major injury, long stay, and application of percentage long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function.

We also adopted data submission requirements and also exception and extension requirements and reconsideration appeals procedures. Many of you all know that we -- some of these policies have been around. We were formalizing them into her actual rule to align with the other settings, their post-acute setting.

Finally, we removed 235 data elements from 33 current OASIS items, effective January 1 of 2019. And we're not -- one of the things that was proposed was the standardized patient assessment data elements. So, we're not finalizing the standardized data -- standardized patient assessment data elements that we propose to adopt for three of the five categories under section 1891 -- 1899B --1B of the act in the categories of cognitive function and mental status special services treatments and interventions and impairment.

And at this point, I think, I'm going to turn it over to Peggy, who's going to do a presentation on conditions of participation. Thank you.

Peggye Wilkerson: Good afternoon, everybody. It's Peggye Wilkerson with Survey Certification. I was asked today to do a little brief presentation on the section of the new HHA conditions of participation dealing with subunits or the elimination of subunits. We've been working pretty hard back here to get all of this together, not only from the survey side but on the enrollment side.

We have a pretty comprehensive instruction memorandum that is being released Friday and will go up on our website at that time. It goes through a lot of the technical things that the state agencies in ROs will have to do in order to just to get these actions cleaned up. But I just want today to go over with you just briefly how this memorandum is going to lay out all these actions.

So, as most of you know because you're very familiar with the new COPs, the elimination of the definition subunit means that the previous subunits will have to make a choice by January 13th as whether they want to be a freestanding HHA or they want to convert to a branch. That choice is theirs. But if the state agency does not get any notification or the MAC does not get

any notification, it is the assumed as of January 13 that the entity, the previous subunit, wishes to be a freestanding HHA (visit) as such.

But let's go through each of the choices. The first choice is be a freestanding HHA. So, during the process of everybody getting ready for this, the provider enrollment folks are the MACs, as you -- are the people you work, have already set up individual enrollment records for all the subunits. So, they're already out there. The records are already out there showing them as an individual freestanding HHA. And so, that's if, you know, everybody didn't change, everybody be already set up.

But if you do have to do a couple of things, that the easiest route, of course, because everything is pretty much set up, but you do have to do a couple of things. You should -- you are going to have to submit a revised 855A to your MAC. And -- excuse me -- there's a section 2 in your 855A and it's going to say currently home health agency inference subunit. Your revision will show that you are not an HHA subunit. You are an HHA.

So you will need, if you want to remain as a freestanding HHA, to submit that to your MAC. Now the MAC all know all the subunits and I know to expect these revisions that they're coming in. Nothing actually will change with your state survey agency. If you do not notify them in any way that you -- whether you want to be a branch or a subunit as I said, they're going to assume you're going to be a subunit. You're already as a subunit set up for surveys. So they don't need to set you up on a special survey schedule. You're already set-up because they're surveyed separately.

You already have a CCN, a Medicare identification number, so you don't need to have that added and the subunits already have provider agreements separate from the parent. So there's no need for them to do that. So really, if you choose to be a freestanding HHA after January 13th, mostly what you need to do is to send your revision to the MAC on section 2 of the 855A and you'll be set up for anything else.

Now, the one point that I would add is that in the past as you know subunits were allowed to share administrator and governing body. Everything else,

they had to meet on their own but they were allowed to share those with the parent. They can no longer share those once they become the freestanding.

So, we are instructing in our memo that's going out that the surveyors do not have to go out immediately to check to see that the subunits now have this on their own, they're compliance of those two requirements on their own. But you're -- the surveys schedule for the previous subunits, now freestanding HHA, will be moved up. And most will be reviewed within the next year to 18 months to make sure that they have achieved compliance with those two requirements on their own and are no longer sharing with the previous parent. So that's if you choose to be freestanding.

Now, the other option that the regulations have given is that a previous subunit may elect to be a branch of the parent -- to convert to a branch of the parent. This will take a little bit more work, but not -- is not insurmountable and a couple of things that had to be done. One, is that -- remember I said that they, that the MACs have already set up these records, these enrollment records. So, now you're going to become a branch and no longer have provider agreement and CCN that kind of thing.

You're going to have to send in a revised 855A to the MAC terminating your current enrollment which is as a subunit -- as a freestanding because they set you up with an enrollment of the freestanding. So, you have to send in a revised 855, terminating your enrollment. Simultaneously with that -- and they want to be done at the same time so there's no billing issue.

Simultaneously, the parent, which were becoming a branch underneath, must submit also a revised 855 to the MAC indicating that they now have a branch. But before they did not, they have a branch now. Also, before it said you have a subunit so they said yes before, now they would say no. And now they would add the branch at the -- as part of their enrollment record. That's the MAC side.

For us, these are new branches and they are going to have to be evaluated by the state agency and the RO as far as meeting the requirements of a branch. I

think somebody talked about a little earlier that the regulation did make some changes in the language as regards requirements for branches.

Before, we had a lot of geographic requirements. It had to be within service area, this sort of thing. Those requirements are gone now because things have really changed with the ability for parents to supervise at much long -- greater distances and in you know some things have those mountains in between or whatever. But supervision, you know, has certainly changed. It was the technology of today. So, it's not base anymore at all on distance or whether there's a mountain between you and the branch.

The reg did say that they have to be able to show that there is daily supervision of that branch because they very much want the branch just simply be an extension of the parent. And for the branch to exist, they require the parent. So, they cannot exist on their own. It's one operation and the parent is in charge of both, so the region and the state.

What happens when you submit your change on your 855A? That triggers a note to the state survey agency that says, "We've reviewed the 855. It's OK for you to evaluate the branch to see if they meet the requirements to that. When they get that note, they will review the information to see if your previous subunit that now wants to be a branch meets the requirements for a branch as far as supervision.

And so, they may ask you to submit on -- they'll probably will, I shouldn't say may -- they will ask you to submit some documentation to them to indicate how you will do this daily supervision of this branch. So, it's not a matter of deciding, "Hey, flip me over to a branch", it's a matter of "I'm taking on this branch. I'm going to be in-charge of daily supervision and here's how I will do that daily supervision".

And that information the state RO will use to decide whether or not the new branch meets the requirements for branch. Once they've done that and they recommend, "Yes, this does meet the requirement," they'll send a note back to the MAC and it will be set up. Now, there's also a CMS form that the surveyors use that they will ask you to change of update as well the form that

you all get usually at the beginning of your survey and they will likely send that to you as well and ask you to fill that out.

There's a lot of background stuff that will be going on as far as our system technical certification stuff which you don't have to worry about. But I've just tried today to let you know what you're -- what will be your burden if that's what you have to do in the transition of these. I think it's going to be fairly easy for -- certainly, for those people remaining as a freestanding.

For the branch, we'll certainly we'll make it as easy as we can. We will expedite these reviews as much as we can. Again, we do have to wait for that -- for that all clear from the MAC. But as soon as we get that, we can -- we will expedite them as much as we can to get it -- to get it all resolved.

So, that is about a 7,000 to 10,000 feet overview. Hillary, I don't know do ask the question now or do you wait. I haven't done one of these before.

Hillary Loeffler: Thanks, Peggy. We're going to wait and take questions at the end, if that's OK.

Peggye Wilkerson: OK. Thank you.

Hillary Loeffler: Thank you.

Jill Darling: All right. Thank you, Peggy. Next we have, (Lori Teichman) who will go over some Home Health CAHPS survey announcement.

(Lori Teichman): Thank you, Jill. I have a couple of announcements. And, the first is a new challenge for Home Health CAHPS and we're very much looking forward to this. We're going to be reviewing the Home Health CAHPS Survey questionnaire. And this is a follow-up to the focus groups and telephone interviews that we conducted with home health patients in 2016. And the interviews and the focus groups were about the topic, what is most important to you about home health care?
CMS is now interested in hearing from home health agencies about whether there are topics they would like to see added to the Home Health CAHPS

survey item in place of the current questions or in addition to the current questions. Right now, we have 25 questions that are based on the topic of home healthcare. The additional nine questions are about you, which is about the survey respondent.

As part of CMS' effort to gather feedback from stakeholders on this topic, the Home Health CAHPS survey coordination team will be conducting telephone interviews with patient advocates, industry representatives, and others over the next few months. The interview will focus on questions and measures that would be useful to patients in helping them choose a home health agency and also to providers for their use of quality improvement effort.

We are asking if you are interested in taking part in a telephone interview to share. We welcome it and to please send an e-mail to RTI, the Home Health CAHPS survey coordination team and the e-mail address is hhcahps@rti.org. And we ask that you include the name of the person that the coordination team should contact and the best way to contact you. We also are going to plan to conduct a limited number of interviews. So, we wanted to express that to you so you know that if we have a lot of interest we would have to select who will participate in this process.

Next, I have an announcement about the Home Health CAHPS survey vendor participation application and also our annual HHCAHPS training. First about the vendor participation forms, annually, we post the Home Health CAHPS survey vendor participation form for new applicants if they are interested in becoming a vendor for the Home Health CAHPS survey.

And right now, we have it posted on our website, which is on the agenda today, that’s the homehealthcahps.org website. You will see on the homepage under the For Vendors tab. And under there, there is the new vendor participation form. And when you complete it, you designate a staff person who will be the Home Health CAHPS survey project manager and you are also required to attend our annual training, which is at the end of January. You ou must attend both sessions one and two of the introduction for Home Health CAHPS survey training and you must also successfully complete an online training certification test after participating in both of the sessions.

The training dates for the Home Health CAHPS training have been announced and they are posted now on our homehealthcahps.org website. They were first posted on November 1st and they will stay up for a couple of months. The registration for the Home Health CAHPS training begins on December 1st.

The training dates are as follows -- so you might want to know this -- the introduction trainings are on the afternoons of Tuesday, January 30th, and also the afternoon of Wednesday, January 31st. Usually, the introduction trainings are about three hours in duration and they usually are scheduled about 1 o'clock through 4 o'clock Eastern Time.

The update training is a training that's mandatory for all currently approved Home Health CAHPS vendors but others may attend it as well. And the update training session is a shorter training session, a little shorter. It's about two to three hours and we're going to have that scheduled about 12 noon to 2:30 Eastern Time on February 2nd, which is a Friday.

Please check our Home Health CAHPS website for the registration announcements and for the exact dates that we're going to decide on for the training sessions. And there will be a link available under the training tab on our website. Also, you should know that we post the slides on the Home Health CAHPS website prior to the training. They're up about a week prior. So, if our training begins January 30th, I would say that you could probably check beginning January 25th. They're probably all going to be up there. The only thing that's not included on the slides are, of course, talking points that the individual trainers will have.

And as always, if you have any questions about Home Health CAHPS, you could e-mail us, again, at RTI. That's our national implementation contractor for the Home Health CAHPS survey. And it's the same e-mail address, which is hhcahps@rti.org or you may call RTI Monday through Friday, 9 am to 5 pm Eastern Time.. The toll-free number is 866-354-0985. Thank you, Jill.

Jill Darling: Thank you, (Lori). And next, we have Cindy Massuda who will -- excuse me -- she has an update on the Hospice Quality Reporting Program.

Cindy Massuda: Thank you. So, good afternoon. I'm Cindy Massuda of the Hospice Quality Reporting Program coordinator. And as I have mentioned on prior calls, the Hospice Quality Reporting team is focusing on education and outreach to assist hospice providers submitting the requirements for the Hospice Quality Reporting Program.

Our goal is for all providers to be compliant and get their full annual payment updates. So, since we are holding quarterly trainings as one of our efforts and the most recent training was held on September 20th with a focus on common reasons for noncompliance to the Hospice Quality Reporting Program and how to address them.

Those resources are available on the Hospice Quality Reporting Program webpage to assist providers and those materials from the September 20th MLN webinar call are available in the download page. They included the PowerPoint slides, the audio recording, the transcript. They can found on the Hospice Quality Reporting training webpage.

And then to supplement that training, we have also posted three fact sheets along with some checklist to aide providers with the hospice item set and those hospice CAHPS requirements. Those materials are available on the Hospice Quality Reporting requirements and best practices webpage and include getting started with the Hospice Quality Reporting fact sheet, the Hospice Quality Reporting program activities checklist, and Hospice Quality Reporting Programs fiscal year 2019 fact sheet.

We will be having upcoming quarterly education outreach. The first one is to be held in September and we will be holding at least one education opportunity for hospice providers every quarter. The next event will take place in early 2018. The hospice provider should monitor their CMS Hospice Quality Reporting Program webpage for updates and announcements about the upcoming events.

Currently, we're in the final quarter of 2017. So, please ensure you're on track for compliance of the reporting cycles requirement that will affect your

FY 2019 annual payment updates reporting year. So, to be compliant with Hospice Quality Reporting Program requirements and to avoid a 2 percent annual payment update reduction from your FY 2019 reporting year, hospices must be compliant with both the hospice items set and the hospice CAHPS requirement.

So, HIS providers will have to (inaudible). Providers should check their timeliness and compliance threshold report to ensure that their hospice is on track to meet the timeliness threshold requirement of 80 percent for fiscal year 2019. For the fiscal year 2019 reporting year, providers have submitted at least 80 percent of their hospice items set records on time, which means within 30 days of the patient's discharge date to be determined compliant with all hospice items for that requirement. So, please see the timeliness compliance threshold fact sheet on the Hospice Item Set portion of the CMS HQRP webpage for more information.

For CAHPS, the deadline for the fourth and final quarter for the CAHPS data submission is the second Wednesday of November. So, if you think your hospice is available for the site exemption for CAHPS, you must apply by December 31st and see the site extension portion of the Hospice CAHPS for more information.

The Hospice Compare Refresh Schedule for November 21, 2017 has been delayed. CMS will provide -- will inform the provider community when the new refresh date is determined, which will be sometime in December. Please note that this refresh delay will not impact the Hospice Item Set freeze date of November 15, 2017 and the Hospice Item Set Provider Preview Report. They will be available on December 1st, 2017.

Finally, the Hospice Item Set Provider Preview Report must be submitted by 11:59 Pacific Standard Time on 12/30/2017. Thank you very much, Jill.

Jill Darling: Thanks, Cindy. And last, we have Debra Dean-Whitaker who has an update on the Hospice CAHPS.

Debra Dean-Whitaker: Thank very much. I have an announcement, some reminders, that I hope will be useful. First, on December 1, 2017, we will release preview reports for Hospice CAHPS Survey Data. These reports reflect the data that will appear on the hospice compare website for the February 2018 refresh. The Hospice CAHPS data covers deaths that occurred during the period of quarter two 2015 through quarter one 2017.

The preview reports will be available in your CAHPS folders. If you have questions about how to access your CAHPS folders, please contact the QIS technical support office. Their help desk can be reached at help@qtso.com or call them at 1-877-201-4721, and I will repeat that. If you need to ask questions about how to get your CAHPS reports, please e-mail at help@qtso.com or call 1-877-201-4721.

All hospices will have 30 days to review your Hospice CAHPS Preview Report and you will have the right to request at CMS review that report if you believe that one or more of your CAHPS quality measures have been calculated incorrectly. To request for a review, please contact the Hospice Survey Project Team at hospicecahpssurvey@hcqis.org , that is H-O-S-P-I-C-E-C-A-H-P-S-S-U-R-V-E-Y@HCQIS.org; that e-mail address is also on the agenda. You must use this e-mail address for your request. The preview period begins on December 1st and ends on December 30th of 2017. We are unable to accept request for review after December 30th, 2017.

And as Cindy mentioned, the deadline for submitting hospice CAHPS size exemption, you have to submit the form by December 31, 2017. Late filings cannot be accepted. To file the size exemption form, go to the Hospice CAHPS survey website which is hospicecahpssurvey.org, H-O-S-P-I-C-E-C-A-H-P-S-S-U-R-V-E-Y.org. The size exemption form can be reached from the menu on the left hand side of the screen.

A reminder to you that the size exemption is good only for one year. So if you file for one last year and you still qualify, then file again. Reminder, the deadline December 31, 2017. The next Hospice CAHPS data collection year will start with January 1st, 2018. So if you will be participating in the survey, be ready to start as of January 1st, 2018. Thank you very much.

Jill Darling: Thank you, Debra, and thank you to our other speakers. (Megan), 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 participant's time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

Your first question comes from the line of (Mary Schnowman) with Peterson Hospice. Your line is open.

(Mary Schnowman): Yes, thank you. On the Hospice Compare website I'd been trying for several months now to understand why our hospice is listed as an other instead of a nonprofit and I cannot get anybody that can help me with that, so that it shows that we're nonprofit organization.

Amanda Barnes: Hi, this is Amanda Barnes from CMS. I would suggest contact – have you attempted to contact your ASPEN coordinator?

(Mary Schnowman): Yes, I have contacted everybody you can imagine.

Amanda Barnes: OK. And you've contacted the QTSO Help Desk I'm assuming?

(Mary Schnowman): OK, now which one?

Amanda Barnes: QTSO, Q-T-S-O.

(Mary Schnowman): No.

Amanda Barnes: OK. So, we actually have guidance that's going to be posted on the Hospice Quality Reporting webpage today. That is actually going to give you further guidance on how to update your demographic information including that profit status to, you know, reflect what you're talking about.

So, I would suggest looking at that spotlight page today, if not today by tomorrow and then if you don't see that by this time tomorrow, contact the public reporting help desk. Do you have that e-mail address?

(Mary Schnowman): No. Can you give me that?

Amanda Barnes: Yes. And then just reference that you were on this call today and – that you need to see the demographic instructions because like I said it should be updated by early tomorrow morning at the latest. That e-mail address is hospice PR, so public reporting questions with an S @cms.hhs.gov.

(Mary Schnowman): HS.gov, great, thank you so much.

Amanda Barnes: You're very welcome.

(Mary Schnowman): Thanks.

Operator: Your next question comes from the line of (Cathy Watson) with (Interim). Your line is open.

(Cathy Watson): Hi, I was wondering if – when submitting the 855 for changes for the branch or sub-unit issue, would the fee, enrollment fee apply?

Peggye Wilkerson: Gosh, I didn't – this is Peggye Wilkerson. I did not ask them that question but I believe that it would not. I don't speak for the MACs officially but you know this is all part of a regulatory requirement, so it's my understanding that it would not.

(Cathy Watson): OK, thank you.

Peggye Wilkerson: I can tell you this, if you – if you do get to charge to fee, you should – you should contact the provider enrollment folks here in Baltimore. You can – you can send a note to me and let me know and I'll hook you up with – my e-mail is P-E-G-G-Y-E.Wilkerson@cms.hhs.gov.

(Cathy Watson): Thank you very much.

Peggye Wilkerson: Sure.

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

Our next question comes from (Jess Gecosmoda) with ProHEALTH. Your line is open.

(Jess Gecosmoda): Hi, I just wanted to clarify, I believe I heard that the refresh for Hospice Compare website is going to be delayed until some time in December, was there a date given on that, for when that would be available or why the delay?

Amanda Barnes: The date has not been released and we haven't given any further updates on that. Thank you.

(Jess Gecosmoda): Thanks.

Operator: Your next question comes from the line of (Deb Lockheart) with Five Points Healthcare. Your line is open.

(Deb Lockheart): Thank you. In regards to the Value-Based Purchasing information that Mr. Lilley provided, I did not get the e-mail address to be used for VBP questions, can he repeat that please?

Edward Lilley: Hi, this is Ed. Yes, that e-mail address is hhvbpquestions, Q-U-E-S-T-I-O-N-S@ symbol cms.hhs.gov.

(Deb Lockheart): That's @ T as in Tom, M as in Mary, F as in Frank?

Edward Lilley: No @ C as in Charlie, M as in Mike, S as in Sierra, CMS.

(Deb Lockheart): CMS, I'm sorry, I misunderstood you. Thank you very much.

Edward Lilley: You're welcome.

Operator: Your next question comes from the line of (Justine McKee) with (Amadeus). Your line is open.

(Justine McKee): Yes, my question is related to the Value-Based Purchasing. Do we know what the adjustments will look like on the remits?

Edward Lilley: What the adjustments will look like on – I'm not getting that one.

(Justine McKee): Is it going to be – is it on the remittance advice when we receive payment, the adjustment is – will we know, will it be on the remit and will we know how much for each claim?

(Susan Bauhaus): Hey, there, so unfortunately, the claims processing expert for home health and hospice has an emergency and couldn't make it to the call. Do you mind sending your e-mail or sending an e-mail to the mailbox and then I'm sure …

(Justine McKee): I certainly will.

(Susan Bauhaus): … somebody from that area can provide you a detailed response on what that should look like on the remittance advice.

(Justine McKee): Perfectly, thank you.

(Susan Bauhaus): Thank you.

Operator: Your next question comes from the line of (Eugena Soler) with Bluegrass Care Navigators. Your line is open.

(Eugena Soler): Thank you. I just want to be sure I understood you correctly, so there's no release date for the refresh for the Hospice Compare. The freeze date, which I believe was today, is remaining the same and the preview period is also remaining the same. Did I get those details correct?

Cindy Massuda: Hi, this is Cindy Massuda. So, the refresh date will be some time in December and you do have the dates correct.

(Eugena Soler): So, it's December that the next Hospice Compare refresh date is?

(Cindy Massuda): It will be some time in December and if you are on our Listserv or you are looking on our Hospice Quality Reporting Program spotlight page you will see the – you will see the update when that announcement comes out.

(Eugena Soler): OK, I get both of those. OK, thank you so much.

Cindy Massuda: Thank you.

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

Our next question is from (Jackie Music) with (Inaudible) Home Health Care. Your line is open.

(Jackie Music): My question is related to the elimination of sub-units, so if there is a parent agency within your organization and our other agencies become parents, are you allowed to share administrator and/or director?

Peggye Wilkerson: Share between who?

(Jackie Music): Share between the different agencies if you wanted – they're currently sub-units and if you wanted to switch them to parents, would you be allowed to share administrator and director?

Peggye Wilkerson: No, that's – once they become freestanding, they have to meet those requirements for administrator and governing body on their own. Before we allow them to share …

(Jackie Music): OK, thank you.

Peggye Wilkerson: But now they're distinct and separate providers.

(Jackie Music): Thank you.

Operator: Your next question comes from the line of (Cindy Brinns) with Visiting Nurse. Your line is open.

(Cindy Brinns): Hello. Can you hear me?

Hillary Loeffler: Yes, we can hear you.

(Cindy Brinns): Hello? OK. I apologize I missed the beginning of the call and the Home Health Prospective Payment System final rule, where can I find information on that, what's come out with that because I missed what you talked about?

Hillary Loeffler: OK, you can find the – a link to the final rule on the Home Health Agency center page if you gone there before. If not, I think the easiest thing to do is Google Home Health Agency center and then CMS for the Centers for Medicare & Medicaid Services.

(Susan Bauhaus) has provided an update on that. We did not finalize the Home Health Groupings Model in that rule. So for payment, it was mostly just a routine rate update that we finalized for 2018 and …

(Cindy Brinns): So, they're not going to change the 60-day, the 30-day?

Hillary Loeffler: No, that was not finalized.

(Cindy Brinns): OK. OK, thank you.

Hillary Loeffler: Yes.

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

We have no further questions at this time.

Jill Darling: All right, everyone, this is Jill, so thank you for joining us today and the next Home Health, Hospice & DME Open Door Forum will be next year, so we will talk to you then. Thank you. Have a wonderful day.

Operator: Thank you for participating in today's Home Health, Hospice & DME/Quality Open Door Forum Conference Call. This call will be available for replay beginning today at 5:00 p.m. Eastern through November 20th at midnight.

The conference ID number for the replay is 61718392. The number to dial for the replay is 855-859-2056.

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

END