

Centers for Medicare and Medicaid Services  
Questions and Answers:  
Home Health, Hospice and DME Open Door Forum  
Wednesday, November 6, 2024

1. Question: I have a question regarding the November refresh and how that will apply to the list that's under the [Hospice] Special Focus Program. Do you have a target date as to when that list will be published, and then from what I understand, uploaded onto the website?
  - a. Answer: The SFP selection process will occur after data is available from the November 2024 refresh. Selected hospices will be notified before the Status List is published. We expect to publish the list in early 2025.
2. Question: My question is about the transition from Hospice Item Set (HIS) to HOPE. And it may be that I need to send this into the help desk, but I'll ask in case it's something you can assist with. In the final HOPE Manual, it states that for all patient admissions prior to October 1, 2025, that completion of a HIS admission and discharge is required, or I'm sorry, after October 1. In the quarter three Q&A, it states that only HOPE data will be accepted for patients admitted or discharged on or after October 1, 2025. So, my question is for patients who are admitted prior to October 1 and then discharged after October 1, whether they should have a HIS discharge or a HOPE discharge?
  - a. Answer: Per the Hospice Outcomes and Patient Evaluation (HOPE) Guidance Manual - v1.00, **HOPE will be implemented and effective on October 1, 2025.**
    - i. As per the Q3 Q&A: ONLY HOPE data will be accepted for patients admitted or discharged on or after October 1, 2025.
    - ii. For hospice patients who are admitted to hospice prior to 10/01/2025 but discharged on or after 10/01/2025, providers will complete the HIS admission item set and submit to QIES (status quo). For these already-admitted patients, providers will not be required to administer the HUV assessment.
    - iii. Upon discharge, patients receive the HOPE Discharge assessment, which is submitted to iQIES.
3. Question: My question pertains to the section that Mary presented on, the new CoP requirement that pertain to agency ability to accept new referrals, staffing, and things of that nature. Have the actual processes and requirements for agencies to post or provide information about their different staffing and skill levels been worked out yet? Or is that still in the development stage? [the guidance]
  - a. Answer: I know it's been drafted, but it has to go through the clearance process at CMS.
4. Question: I actually have a two-part question. Both relate to the new Condition of Participation for the HHA acceptance-to-service policy. Will CMS be putting out a template that we can utilize when adding some of these new intricacies to the mix?

*This Q and A document was current at the time it was published or uploaded onto the web. CMS policy changes frequently, so links to the source documents have been provided within the document for your reference. This Q and A document was prepared as a service to the public and is not intended to grant rights or impose obligations. This Q and A document may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

- a. Answer: There's no plans for us to put out any type of template. For us to be able to do that, that has to go through, you know, the federal approval process. Our survey guidelines should have a little more detail that gets to what our surveyors are looking for, which would help you create that. I don't know if the industry, or industry leads, will be developing anything, like NHPCO (National Hospice and Palliative Care Organization), whether they will move forward. Sometimes they do that. I will tell you to take a look at the preamble of the regulation and where we try to give additional information to spell out options for you to be able to do, but an actual template, there's no plans at this point for that.
  - i. Question: When do you think the guidance to surveyors will be out?
    - 1. Answer: My colleagues are diligently working on getting that cleared.
      - a. Question: If we post on our company website with, like, a link to the CMS Care Compare, does that suffice, or does there need to be more than that?
        - i. Answer: We do talk about Care Compare in there. That is certainly an option, but again, you would need to be able to update Care Compare in a timely manner if your service is changed or something changed. And so, it's looking through that process that it is something that may be a viable option for folks.
- 5. Question: Can you review one last time what the recalculation request timeline is for those claim-based measures in the APR is?
  - a. Answer: It's just like our normal appeals process. So, when the final APR which is being posted this week gets posted, you have 15 days to submit a recalculation request for those two measures.
    - i. Question back to CMS: And that's calendar days, correct?
      - 1. Answer: Yes. But we did take into consideration the federal holiday in there, so you get an extra day.
- 6. Question: Could tell us the detail again around the HOPE technical informational training for vendors. How are you able to register for that?
  - a. Answer: They're having it on the 21st and they tell me where you could submit questions. So, I'll put the QTSO website in the chat again because I presume that's where you can go to get further information about how to register for that call. Does that work?
- 7. Question: This is regarding the anti-fraud social media campaign for hospice enrollment and beneficiaries. Thomas, I just did not hear if you stated when this campaign would begin or how we would access those materials.
  - a. Answer: It actually kicked off the latter part of the summer, July into August. Those materials were put out. There was a toolkit, if you will, made available for entities like some of our SMPs (Senior Medicare Patrol), and some of our other

*This Q and A document was current at the time it was published or uploaded onto the web. CMS policy changes frequently, so links to the source documents have been provided within the document for your reference. This Q and A document was prepared as a service to the public and is not intended to grant rights or impose obligations. This Q and A document may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

state advocacy group advocates have utilized that to help spread that word. So can certainly get that to you if you would like a link to it.

8. Question: My question is not related to one of the items that was discussed today. It's related to the hospice PEPPER (Program for Evaluating Payment Patterns Electronic Reports). Do you have an estimation of when the next hospice PEPPER will be released and also if there are any deleted or added measures? I'm not sure if you've gotten that far along the process.
  - a. Answer: The email for any PEPPER inquiries is [cbrpepperinquiries@cms.hhs.gov](mailto:cbrpepperinquiries@cms.hhs.gov)
9. Question: I'm just asking for further clarification about the calculation errors on the APR. So, the final report you said is going to come out later this week, and you guys have held the October IPR due to the delay in that. Is there concern that the October report has errors as well?
  - a. Answer: No, we are not concerned because normally we don't send the final APR out until the end of November. But because we did find this error, we wanted to send it out earlier and give you guys a chance to digest and see if it, not that we anticipate, getting a lot of recalculation requests because really what it is down is you have the true north on it. It had something to do with the risk adjustment on those. There were a couple pieces of data that didn't get counted in the risk adjustment. So, we just didn't want you to get two reports at the same time and not know which one to focus on and do the first, the recalculation request first.
    - i. Question: So, will it be an additional final after that then? So, is it not really the final and there'll be another final after the recalculation period?
      1. Answer: For the APR? Only if during the appeals process that one of you guys found something that we didn't find and that it affects everybody. So we've never given an opportunity to do the final APR in the original model in the past, but we just wanted to, you know, because, you know, this one thing affected the, you know, the waiting and the risk adjustment on those two claims measure, we wanted to give, you know, be transparent and give everybody the opportunity to see what it looked like.
        - a. Question: Can you give any further clarification about the risk adjustment error? Because I know people want to know which part of the risk adjustment or what it was that was missing or an error and is that affecting PPH (potentially preventable hospitalization) as well?
          - i. Answer: PPH? No, this is just for the two claims-based measures in the ACH and the ED that are in the current measure set.
  10. Question: I was just wondering in the Home Health Quality Reporting Program, do we have a timeline as to when that final OASIS-E Guidance Manual will be published?
    - a. Answer: I don't have the final date for you, but I can tell you that we are trying to do one last thing, I believe, with it on our side and then it should be ready.

*This Q and A document was current at the time it was published or uploaded onto the web. CMS policy changes frequently, so links to the source documents have been provided within the document for your reference. This Q and A document was prepared as a service to the public and is not intended to grant rights or impose obligations. This Q and A document may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

11. Question: This is regarding the Home Health CAHPS, and my particular vendor did not get enough responses in order for us to qualify for stars on the 40 requirements—required responses. How many of us get quality surveys every day? From a vendor, from anybody, from the car dealership. They're always being asked to answer responses and usually those responses are five, six, seven, eight, nine, tops, five questions. If I got one with 34 questions, I would rip it up if I was a customer. And you know, has there been any thought to because the CAHPS survey summary on the Care Compare website is five questions, and those questions seem really good and seem to give anybody, if they saw those five answers, will give anybody the confidence to use that particular agency. So, my question is: Has there been any thought or you can consider reducing the number of questions in the survey to make it easier for our elderly population to answer and respond to the survey?
- a. Answer: It was announced in the new rule, in the final rule that just came out, the final rule payment rate update rule that came out last week. And in it, we had a couple of sentences that we do have a shortened survey, but it has to go through a long review process. Right now, it is with the CMS pre-rulemaking review process. And once it goes through that, then we will be set to move forward to the next stage, which will be prepare a package for OMB and with the revised rule. And then we will announce in a future, hopefully in a year, but I'm just going to say a future proposed rule, we will announce the revised survey, we will put it in the rule, and we will have a 60-day comment period to assess it, and we'll take everybody's reviews of the survey.
- i. Question: The survey was tested in a very large field test a couple of years ago, and we also tested a web mode with it. We don't know if we're going to start with the web mode because, because of the population, a lot of the people who are respondents don't have email addresses unless it belongs, like, to a relative of theirs, usually a child. So right now, it seems like we're going to stick with those three modes, and I want to thank you for liking the five measures that we have. I also wanted to tell you that three of those measures, the care of patients, the communications, and the special issues measures, they are combinations. They're like multi-survey items. So, the special issues is seven questions that are averaged together. The care of patients are five questions averaged together. Offhand, I don't know if the communications is four or five questions averaged together. That's how that is determined.
1. Answer: This is a problem a lot of agencies have because truthfully, only 60% of our home health agencies have had star ratings. And sometimes, if there is four quarters, we do the star ratings based on the most recent four quarters of data, which is the most recent year. So, if you had less than 40 patients in those four quarters, we can't do a star rating because the statistics aren't accurate. So, what we have to do is wait until the agency has more patients, and sometimes it varies. It does vary. Sometimes an

*This Q and A document was current at the time it was published or uploaded onto the web. CMS policy changes frequently, so links to the source documents have been provided within the document for your reference. This Q and A document was prepared as a service to the public and is not intended to grant rights or impose obligations. This Q and A document may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

agency will have a year with a lot of patients and then they're going to have star ratings and sometimes not. It's just it's not like you never will have them, it's just that we need the 40 patients to prepare star ratings because of the way it's calculated.

a. Question: I was talking to my vendor, and I was going through my patient census and looking at those who will potentially have a difficult time answering those questions. And I was wondering if I could give him the proxies or identify the proxy for them and they said no.

i. Answer: Because the patients are supposed to identify the proxy.

12. Question: My question is related to the new home health CoPs related to the public-facing acceptance service policy. My agency, we obviously have a public-facing website, I'm curious of how the agency plans to enforce this new requirement. How are you defining "public facing," and what will be the actions by the agency to enforce non-compliance with either one, not updating the public-facing information and two, not having the material on a public-facing platform?

a. Answer: So, I'm going to point you back to the Home Health PPS rule to take a look at the preamble language that talks about what we're looking for, for that public-facing information. As for the CoPs in general, they are what our surveyors—whether you go through an accrediting organization or it's the state survey agency, our surveyors would have this new requirement added to the list of CoPs and standards that are surveyed on survey and that guidance would be coming out from CMS as well and what they will be surveying against. So, on routine survey, it would be looked at, and it would be handled like just like any other standard that if it's found out of compliance.

i. Question: I'm pretty clear on what the content is on the, you know, what the content is. What I'm curious about is the definition of "public facing."

1. Answer: So public facing, again, if you take a look at the preamble, I think we do talk about that. It's not in a definition that we're using. So how you define as an agency, public facing, meaning, you know, making sure that information is out there and available to the public, will be up to each agency on how they do that. So, some people may use Care Compare, some may choose just to update their website. There's many different ways that we can be public facing. And so, surveyors would be looking for how you define it and how you have that out available for the public. The goal here, remember, the goal behind this whole policy was to make sure that patients that are looking for home health and referring entities know exactly what you're providing, right? Because on Care Compare, sometimes we have a list of what agencies are providing, but it isn't necessarily accurate. And so, it may say that they're providing the service and they're not. And so,

we are trying to make the connection for people looking for home health and home health services that it's easier for them and easier for the referring agencies to be able to connect the right people with the right resources.

- a. Question: My question was just around, the definition of “public facing.”
  - i. Answer: Correct. So, we don't define it. We do give examples in the preambles and talk to them. They are not in any way, shape, or form the only way. But our surveyors always look to what your own agency's policies state and whether or not you're following your own policies.