

Centers for Medicare & Medicaid Services
Home Health, Hospice & DME Open Door Forum
Wednesday, November 6, 2024
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Jill Darling: All right, great. Thanks—thanks—everyone. Good morning and good afternoon. My name is Jill Darling, and I am in the CMS Office of Communications, and welcome to today's Home Health Hospice and DME (Durable Medical Equipment) Open Door Forum (ODF). Before we begin our agenda, I have a few announcements. For those who need closed captioning, I provided a link in the chat function of the webinar, and I will provide it again for you. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum transcript web page, and that link was on the agenda, and I will share that as well. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For today's webinar, I have the agenda slide for you, and then we will be taking questions at the end of the agenda today.

We note that we will be presenting and answering questions on the topics listed on the agenda. We ask that any live questions relate to the topics presented during today's call. If you have any questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox that I will provide, and we will get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it's time for Q&A. Please introduce yourself with your organization or business you're calling from. And when the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question, and we will do our best to get to all of your questions today. And to start off, we have Danny Tsoi, who will speak on the calendar year 2025 Home Health PPS (Prospective Payment System) final rule payment rate update.

Danny Tsoi: The final rule for calendar year 2025 Home Health Prospective Payment System updated the Medicare payment policies and rates for home health agencies (HHAs). This rule also updated the IVIG (intravenous immune globulin) items and services' payment rate for calendar year 2025 for Durable Medical Equipment, DME, suppliers. The rule finalized the permanent prospective adjustment of -1.975% to the calendar year 2025 home health payment rate to account for the impact of implementing PDGM (Patient-Driven Groupings Model). For the calendar year 2025 Home Health Prospective Payment System final rule using—we use the calendar year 2023 claims and the methodology finalized in calendar year 2023 final rule. We determined that Medicare is still paying more under the new system than it would have under the old system. We determined a total permanent behavior adjustment of -3.95% is needed to be applied to the 30-day base payment rate to account for overpayments in calendar year 2023, as

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well as the remaining adjustment of 2.89% that CMS delayed finalizing in calendar year 2024 final rule. However, in response to commenter concerns that this would impose too large a reduction in a single year, we are finalizing only half of the adjustments, which is 1.975% to the calendar year 2025 payment rate. This adjustment will continue to satisfy the statutory requirements as section 1895(b)(3)(D) of the Social Security Act to offset any increases or decreases resulting from the impact of differences between assumed behavior and actual behavior changes on estimated aggregate expenditures. The application of a permanent behavior adjustment will reduce the need for any future large permanent behavior adjustments and help slow the accrual of the permanent—of the temporary payment adjustment amount. The final permanent behavior adjustment is also anticipated to lessen any potential temporary adjustments in future years. While we did not propose to implement a temporary behavior adjustment in calendar year 2025, the final rule provided the calculated temporary behavior adjustment dollar amount, which is approximated to be about \$971 million based on analysis of the calendar year 2023 claims.

The law provides CMS the discretion to make any future permanent or temporary behavior adjustments in a time and manner determined appropriate through analysis of estimated aggregate expenditures through calendar year 2026. In addition, we finalized a crosswalk for mapping responses on the current OASIS-E (Outcome and Assessment Information Set) to the prior OASIS-D responses for use in the methodology to analyze differences between the assumed and actual behavior changes on estimated aggregate expenditures. Therefore, to continue with the methodology, CMS will need to impute the responses to the three items from OASIS-D that have changed in OASIS-E. In addition, 13 items on OASIS-E are no longer required to be asked at follow-up visits. For these items, we use a most recent Start of Care or Resumption of Care assessment (SOC/ROC) date to determine a response which would—which would—not require amputation. We finalize a crosswalk to address this issue by mapping the OASIS-E items back to OASIS-D in this final rule.

We also finalized recalibrated PDGM case-mix weights, updated the LUPA (low-utilization payment adjustment) thresholds, the functional impairment levels, and comorbidity adjustment subgroups. We finalized and adopted the most recent OMB (Office of Management and Budget) CBSA (Core-Based Statistical Area) delineations for the home health wage index. We also finalized an occupational therapy LUPA add-on factor and updated the physical therapy, speech pathology, and skilled nursing LUPA add-on factors. The updated fixed dollar loss for calendar year 2025 final rule is an estimated 0.4% decrease. We estimate that Medicare payments to HHAs in 2025 would increase in aggregate by 0.5% or approximately \$85 million compared to calendar year 2024. The finalized calendar year 2025 national standardized 30-day period payment rate for a home health agency is \$2,000.50—\$2,057.35. For HHAs that do not submit quality data, the payment rate will be \$2,017.28. The finalized calendar year 2025 home IVIG items and services payment rate is \$431.83. The final home IVIG items and services will be posted in the billing and rate session of the CMS Home Infusion Therapy web page and will be updated using the Home Health Prospective Payment System rate update change request or technical direction letter and posted on the CMS HIT (Home Infusion Therapy)/Home IVIG Services web page. That concludes my section, and I'll be passing it now to Lori.

Lori Luria: Thank you, Danny. I'm going to present on the—I'm going to present on the Home Health CAHPS (Consumer Assessment of Healthcare Providers & Systems) Survey updates, and I missed—oh my! OK. I'm sorry, I had misplaced something. The Home Health CAHPS Survey is going to have its annual training in January 2025. It's several different parts. There's an intro training that is self—you—you take it yourself. It's like—and we—we—send you a link, and you take it on your own at your own pace, and then in mid-February after you complete it, we post a—it's not an exam. It's kind of like, just like, you know, just a—a—test sort of, to see if you've got the—the—main points of the training. The other training that we have is the training that we conduct by webinar, and it is on the last Thursday in January, that's January 30, and it's going to be 12 noon Eastern time to 2:00 p.m. Eastern, and it never goes past that. It's just an update training on what happened with HHCAHPS since the last training. And all of the slides for the intro training and the update training will be posted on the Home Health CAHPS website as well as the agendas for the training and the new materials, which is an updated protocols and guidelines manual and an updated data submission manual. We also want to note that if you have not completed your Participation Exemption form for the calendar 2026 reporting, you are welcome to do that. It's on our website right now, and we're going to leave that up until the end of March. This is for agencies that would otherwise be participating in Home Health CAHPS now, but they had 59 or fewer unique patients in the previous year, last year, so they don't have to participate this year because we have a size exemption. The other—this is just a reminder that we have a lot of things on the Home Health CAHPS website and one of them is a quarterly newsletter that is prepared by the Home Health CAHPS Coordination team. It's a one-pager and it's really great, and we just put one up for October and the next one will come out in early January. The registration for the trainings will begin December—it's December 2. It's—December 1 is a Sunday, so we'll begin December 2. You go on the website and sign up. It's—it's—rather straightforward. And as always, if you have any questions about Home Health CAHPS, please email hhcahps@rti.org with any questions. Thank you so much.

Jill Darling: Thank you, Lori. Next up, we have Mary.

Mary Rossi-Coajou: Thanks, Jill. So hello, everybody. I'm going to be—I'm going over changes to the home health Conditions of Participation (CoP) that were made in the Home Health PPS rule that displayed last week. We finalized updates to the home health Conditions of Participation to reduce avoidable care delays by helping, ensuring, that referring entities and prospective patients can select the most appropriate home health agency based on their care needs. We finalized this new standard that requires home health agencies to develop and implement and maintain through an annual review, a patient's acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care. We're finalizing a requirement that the policy must address at a minimum, criteria related to the home health agency's capacity to provide patient care. This criteria includes anticipated needs of the referred prospective patient, the home health agency's case load and case mix, the home health agency's staffing level, and the skills and competencies of the home health agency staff. This final rule does not prevent home health agencies from maintaining their existence—except—maintaining an—their existing acceptance-to-service policy, but rather is intended to complement them. And then lastly, we're finalizing that home health agencies must make available to the public accurate information regarding the services offered by the HHA and any service limitations related to the types of specialty services, service duration, or service frequency. The HHAs must review this

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information as frequently as the services are changed, but no less often than annually. And now, I'm going to hand this over to Annese.

Annese Abdullah-McLaughlin: Thanks, Mary. Good afternoon, everyone, and thank you for joining the Open Door Forum today. I'm going to provide a few updates on the Home Health Quality Reporting Program (HHQRP), and then I'm going to provide some updates for the Hospice Quality Reporting Program (HQRP). So first, for HHQRP, I wanted to give a few updates about public reporting. So, the October 2024 refresh is on Care Compare, of course, now. This quarterly refresh includes the annual refresh for claims-based measures, and this is the very first refresh without the ACH, which is the Acute Care Hospitalization During the First 60 Days of Home Health measure. And it's also without the ED (Emergency Department) Use without Hospitalization During the First 60 Days of Home Health measure. This refresh also contains an update to the Patient Care Star Ratings for home health quality.

Secondly, I wanted to talk about the distribution of the Health Equity Confidential Feedback Reports. You will receive those mid-October. The January 2025 public reporting refresh will have the addition of the TOH (Transfer of Health) Provider and Patient measure as well as the DC Function (Discharge Function Score) measures. Next for rulemaking, as you can see on the agenda, it says about the comment period that ended on August 26 when the rule was actually finalized and posted as of 11/1/2024. So, I will put the links to the Federal Register in the chat if you haven't had a chance to take a look at that. I also wanted to talk about a few new resources that we have available for your review, and that is the October 2024 quarterly OASIS Q&As. It's posted on the QTSO (QIES Technical Support Office) site under "References and Manuals." And I'll also put that link in the chat.

Now, there is one final update that I wanted to provide that didn't make it onto the agenda, and that is about the non-compliance notifications. So, we are providing notifications to home health agencies determined to be out of compliance with requirements for HHQRP for calendar year 2025, the annual payment update. So, the notifications will be distributed by the MACs (Medicare Administrative Contractors), and they'll be placed in the home health agency My Report folders in IQIES (Internet Quality Improvement and Evaluation System) on October 21, 2024, so they should have already been in there. Let me know if there are any issues with that. Home health agencies that do receive a letter may submit a request for consideration to CMS via email no later than 11:59 p.m. on November 27, 2024. So, if you do receive one of these notices for non-compliance and want to request a reconsideration, please look at the instructions in your notification and on our Reconsideration Extension and Exception web page, which I will also put in the chat.

So next I'm going to go on down to talk about updates for hospice. So, it's a few public reporting announcements about the HQRP program. The next refresh of the hospice data on Care Compare will happen on November 2024, and that will include the annual refresh for claims-based measures. As far as the Care Compare refresh schedule and preview periods, it's been updated to remove August 2024 and include August 2025 and is available on the HQRP Public Reporting Key Dates for Providers web page. So now I want to talk a little bit about the HOPE (Hospice Outcomes and Patient Evaluation) technical specifications. CMS is planning to host a hospice technical informational call for software vendors and developers on Thursday, November the

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21st, 2024. And the topics that will be covered in this call is HOPE—the HOPE Guidance Manual. They'll also talk about the HOPE data submission specifications effective October 1, 2025, the IQIES system and validity—Validation Utility Tool (VUT) updates, and submitted Q&As. So, vendors can submit questions prior to the call to the IQIES email address and I'll put that in the—the—chat as well, But it's iqies@cms.hhs.gov. Pretty easy to remember. And make sure to include “hospice vendor call” in the subject line so we can easily find your question. They can be emailed prior to 6:00 p.m. Eastern Standard Time on Friday, November the 15th. So please go to the QTSO website for more details on that. And CMS will also be hosting an upcoming Hospice Quality Reporting Program forum on the HOPE tool in the coming weeks. So please just stay tuned and—and—follow the HQRP spotlight announcement pages for more details on that.

And then lastly, we have some updates on some resources that are available on the HQRP website. We actually have a new web page. So, the HOPE Technical Information web page was created on the first of October and the initial draft of the HOPE data submission specifications were posted on that web page. A new web-based training titled “Introducing the Hospice Outcomes and Patient Evaluation of the HOPE Tool” was posted to the HQRP Training and Education Library web page also on October 1, 2024. A new chapter was added to the Hospice Quality Reporting Programs QM (quality measures) User Manual chapter for HOPE quality measures. And that chapter was also posted on the web page on October 1, 2024. So now I want to turn it over to Marcie O'Reilly to provide updates on HHVBP. [HHVBP]

Marcie O'Reilly: Thank you, Annese. And good afternoon, everyone, or morning, depending on where you might be. I have a pretty brief update, but it's an important one. First, I just wanted to summarize what was in the—this year's final rule. We had not proposed any changes to the model. However, we did include a Request for Information on future measure concepts for the expanded model, and we've summarized the comments we received and summarized responses related to those comments and included those in the rule. This information will be shared with the HHVBP (Home Health Value-Based Purchasing Model) implementation monitoring TEP (Technical Expert Panel), which will next meet on—in early—in early—December. We also included an update on health equity, continuing to affirm our commitment to meaningfully advanced health equity in the expanded model. We summarized related comments that interested parties wanted to share with us about including health equity work in the model, and we will also share them with next month's TEP. On to another important topic is the first Annual Performance Report, or APR, was posted in August. The APR includes your annual Total Performance Score (TPS) for calendar year 2023 and the associated Adjusted Payment Percentage (APP) that will be applied to all Medicare fee-for-service claims submitted for home health services with three dates in 2025. And the—the—data on this report will also be publicly reported starting in January on the CMS Provider Data Catalog.

The recalculation request period for the preview report ended on September 7. The preliminary APRs were posted on the 27th, and the next phase of the appeals process was the reconsideration request. And we have completed both of those steps, and the next step is posting the final APRs. However, during the reconsideration period for the preliminary APRs, CMS identified some coding errors related to the calculation of the two claims-based measures used in the expanded HHVBP model. By resolving the errors, this could result in an HHA's adjusted payment

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percentage remaining the same. It could move up or down from what was posted in the preliminary APR. And these issues are fixed in the final APRs. And I want to note specifically that these coding errors did not affect the OASIS-based and the HHCAHPS survey-based measure performance. So, although—although—the correction was applied to all HHAs in the same manner and provides the actual APP for all HHAs for the 2023 performance year and would not impact the calculation of any one HHA, we are providing all home health agencies that receive a final APR this week the opportunity to submit a recalculation request within 15 days. And again, only requests that pertain to the performance on the corrected claims-based measures are eligible for recalculation as I—because like I said, the OASIS-based and HHCAHPS measures were not affected by this coding error.

Also, I wanted people have been asking when the preliminary October 2024 Interim Performance Reports (IPR) will be available, and they will be uploaded into your IQIES folder the week after next. We wanted to give you time to digest the—the—final IPR before putting that report out also. Finally, like I say every ODF, if you're not receiving email announcements from CMS about the expanded model, please go to our web page and join our listserv. The link is near the bottom of the model's web page. And I will add the web page URL and the HHVBP help desk email address to the chat here in a second so that you can copy them and have them handy. Thank you, and have a great rest of your day, and I will now hand it over to Thomas Pryor.

Thomas Pryor: Thanks, Marcie. Can you hear me OK?

Jill Darling: Yes, we can.

Thomas Pryor: Great. Well, again, thank you for all of you in attendance today. I'm just going to give a quick little update on behalf of the Centers of Program Integrity, or CPI, that for those of you in the hospital certainly may have heard or know that there's been a lot written about some of the issues, concerns regarding fraud and abuse nationally in different publications, what have you. And one of the areas that we're working with right now is to enhance education, beneficiary education specifically, and this has to do with those situations, but where we have often, benefits—beneficiaries that are unfortunately fraudulently signed up for the benefits. These kind of what we call “door knocker scams” unfortunately, are entities that are out there reaching out to beneficiaries, offering free TVs, recliners, groceries, services, whatnot. And then when they get the MBI (Medicare Beneficiary Identifiers) from the beneficiary, ultimately in many of these cases, find out that they've been inadvertently signed up for the hospice benefit, that therein creates other issues for them regarding getting their normal Medicare coverage.

So, with all that being said, we've been collaborating with Office of Communications who has, in addition to their overarching media campaign for fraud, has worked with us to kind of create some hospice-specific social media campaign materials as well as insert documents to put into national publications. Again, helping to enhance the education of the beneficiary to inform them to not necessarily accept these kind of open invitations or marketing schemes to get these free benefits that were, you know, reported or presented to them as, you know, being provided by Medicare in the attempt to mitigate or to compromise their MBIs and ultimately sign them up on a hospice—fraudulently elected statement for hospice services. So again, when these activities started late June into early August of this last year, and we continue to enhance our educational

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beneficiary activities with more collaboration with our Office of Communications on this particular fraud scheme. And again, we'll have more to follow in the future, but just wanted to share that what we started with now. Thank you. Send that back to you, Jill.

Jill Darling: Great. Thank you, Thomas. And thank you to all of our speakers today. We will be going into our Q&A portion, so reminder to please use the raise hand feature at the bottom of your screen if you have a question. And we will do our best to get to all of our questions today. So, Tony, you may—you're unmuted. Tony Christopherson?

Tony Christopherson: Hi, this is Tony. I didn't have a question at this time. I'm not sure if I must have clicked something inadvertently. I apologize.

Jill Darling: OK, thank you. Laura Smitley. Please—please—unmute yourself. Laura Smitley. All right, we'll try her in a little bit. Next, I see Sheila Clark.

Sheila Clark: Hi there. Good morning. Thank you, Jill. I have a question regarding the November refresh and how that will apply to the—the—list that—under the Special Focus Program. Do you have a target date as to when that—that—list will be published, and then from what I understand, uploaded onto the website?

Annese Abdullah-Mclaughlin: And this is for hospice?

Sheila Clark: Yes, yes, I'm sorry for hospice, the hospice special focus. We were under the impression that it's going to be based on the November refresh.

Annese Abdullah-Mclaughlin: OK. So, Sheila, I'm covering for my colleague, who is the program coordinator. So, I'll need you to just send that question to the quality—to the help desk and then we get that answer for you. OK?

Sheila Clark: Wonderful. Thank you so much.

Annese Abdullah-Mclaughlin: You're welcome.

Jill Darling: Laura?

Laura Smitley: Yes, this is Laura. Hello.

Annese Abdullah-Mclaughlin: We can hear you, Laura. Did you have a question for us?

Laura Smitley: I didn't. Something must have clicked on my raise my hand. I heard my name, and I finally found my unmute, but I'm sorry, I don't have a question.

Annese Abdullah-Mclaughlin: No worries.

Jill Darling: Sarah Simmons.

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Sarah Simmons: Hi, good afternoon. 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?

Annese Abdullah-McLaughlin: Oh yeah, that'll be another one for the help desk. I don't want to give you the wrong information. I'm so sorry.

Sarah Simmons: No problem. Thank you

Jill Darling: Ernest Roy, you may ask your question.

Ernest Roy: Thank you. 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?

Mary Rossi-Coajou: Are you referring to the guidance?

Ernest Roy: Correct.

Mary Rossi-Coajou: So that's being—I know it's been drafted, but it has to go through, you know, the clearance process at CMS. So, what I'd ask you to do and—is to send your question in and then I can have my colleagues in—in—QSOG (Quality, Safety & Oversight Group) respond back and give you more of a timeline. But I don't have the details of that information unfortunately.

Ernest Roy: Sure. And where would I—where would you like me to send that question specifically to?

Mary Rossi-Coajou: You can send it to the ODF mailbox. Jill, do you have that email box up?

Jill Darling: Yeah, I'll put it in the chat.

Mary Rossi-Coajou: Yeah, so just to the general Open Door Forum mailbox, and then we can get it over to our colleagues in—in—quality and oversight group.

Ernest Roy: Thank you.

Mary Rossi-Coajou: Thank you.

Jill Darling: Victoria Barkin, you may ask your question.

Victoria Barkin: Thank you. I actually have a two-part question. Both relate to the new Condition of Participation for the HHA acceptance-to-service policy. Is there—will CMS be putting out a template that we can utilize when—when—kind of adding some of these new intricacies to the mix?

Mary Rossi-Coajou: No, there won't—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—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.

Victoria Barkin: OK. And when—when—do you think the guidance to surveyors will be out?

Mary Rossi-Coajou: Again, that's the—that the—it'll—that's up to my colleagues, or not up to, but it's my colleagues in QSOG because they are diligently working on getting that cleared. My—I mean the—this goes into effect January 1, so I'm hopeful that they'll have some type of either QSO (Quality, Safety and Oversight) memo that would come out or some type of information. But the more that, you know, hopefully the next open door, we'll have a little more information on that for everybody.

Victoria Barkin: OK. And then the last part to my question relates to, kind of, the part two, make it available to the public with accurate information. So, 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?

Mary Rossi-Coajou: So, take, again, take a look at the preamble. 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—so it's—looking through that process that it is something that may be a viable option for folks.

Victoria Barkin: All right. Thank you.

Jill Darling: Katy Barnett, you may ask your question.

Katy Barnett: Hi, my question is for Marcie. Can you review one last time what the recalculation request timeline is for those claim-based measures in the APR is?

Marcie O'Reilly: Yeah, it's—it's—just like our normal appeals process. So, when you—when the—the—final APR which is being posted this week gets posted, you have 15 days to submit a recalculation request for those two measures.

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Katy Barnett: And that's calendar days, correct?

Marcie O'Reilly: Yes. But we did take into consideration the federal holiday in there, so you get an extra day.

Katy Barnett: Thank you.

Jill Darling: Cheryl Stasa, you may ask your question.

Cheryl Stasa: Hello, this is Cheryl. Are you able to hear me?

Jill Darling: Yes.

Cheryl Stasa: All right, great. This is—wondered if you could tell us the detail again around the HOPE technical informational training—training—for vendors. How are you able to register for that?

Annese Abdullah-Mclaughlin: So, I think I put the thing in the chat, but so 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?

Cheryl Stasa: Yep, I just don't see the link.

Annese Abdullah-Mclaughlin: OK, I'll put—I'll put—it back in.

Cheryl Stasa: Perfect. Thank you.

Jill Darling: Annie, you may ask your question.

Annie: Thank you. This is a question for Thomas Pryor 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, and it might—you might not know yet.

Thomas Pryor: Yeah, so it actually kicked off the late—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 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.

Annie: I would appreciate that. I can copy it right out of the chat if it can go in there. That'd be super.

Thomas Pryor: I don't have that in front of me, unfortunately, but I can certainly make it available, get it to you. Do you want to just put that request into ODF, and so we don't lose track of it and then we'll make sure we get that to you?

Annie: I can do that. Thank you.

Thomas Pryor: Yeah.

Jill Darling: All right. Christy Dorto, you may ask a question.

Christy Dorto: I didn't raise my hand. Sorry.

Jill Darling: OK, no worries. Marty [inaudible]? Marty [inaudible], you may ask your question. Hayley Fink? All right. Kim Baker. Kim Baker, you're off mute. You may ask your question.

Kim Baker: Hi, can you hear me?

Jill Darling: Yes.

Kim Baker: Sorry about that. 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.

Annese Abdullah-McLaughlin: Hi Kim, if you could just submit that question as well to the hospice help desk. I just don't run that program, so I don't want to steer you wrong.

Kim Baker: OK, thank you.

Jill Darling: Michelle Horner, you may ask your question.

Michelle Horner: Hi, 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?

Marcie O'Reilly: No, we are not concerned that the—it—it—we just didn't want—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—to—digest and see if it, you know, not that we anticipate, you know, 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 was 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, like, to focus on and do the first—the recalculation request first.

Michelle Horner: So, will it be an additional final after that then? So, is it, like, not really the final and there'll be another final after the recalculation period?

Marcie O'Reilly: For the APR? Only if during the appeals process that we see something—something came—someone—one of you guys found something that we didn't find and that it affects everybody. So we've never done—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—see—what it looked like.

Michelle Horner: 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?

Marcie O'Reilly: PPH? No, this is just for the two—the two—claims-based measures in the ACH and the ED that are in the current measure set.

Jill Darling: All right. Jennifer Osburn, you may ask your question.

Jennifer Osburn: Thank you. I was just wondering for Annese in the Home Health Quality Reporting Program, do we have a timeline as to when that final OASIS-E Guidance Manual will be published?

Annese Abdullah-Mclaughlin: 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. So let me—can you just send it through the help desk so I can keep track of it or to—to—ODF and then I can answer that question once we get a—I can get a final date from the contractor to let me know. It's one little thing we have to do.

Jennifer Osburn: Thank you, Annese.

Annese Abdullah-Mclaughlin: You're welcome.

Jill Darling: Drake Torrado, you may ask your question. Drake Torrado.

Drake Torrado: Yes, can you hear me?

Jill Darling: Go ahead.

Drake Torrado: OK. Hi. Well, I had sent you an email prior to the—prior to this open door conference, and it was mostly regarding the Home Health CAHPS and we, my particular vendor did not get enough responses in order for us to qualify for stars on the 40 requirements—required responses. But, you know, as you look at it—as I thought about it, you know, how many of us get quality surveys every day? I mean, you know, from our—from a vendor, from, you know, from anybody, from the car dealership. They're always being asked to answer responses and

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usually those responses are five, six, seven, eight, nine, you know, tops, five questions. If I got one with 34 questions, I would rip it up if I was a—if I was a, you know, a—a—customer. And you know, has there been any thought to—because the—the—the—CAHPS survey summary on the Care Compare website is a five—gives you, like, numbers of five questions, and those questions seem really good and seem to give me—will give anybody, if they saw those five questions—five answers, will give anybody the confidence to use that particular agency. So, my thought—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—to—to—answer and respond to the survey?

Lori Luria: Hi. Hi, Drake, this is Lori Luria. I'm the, you know, I'm one of the people who manage the Home Health CAHPS contract, and yes, we, in fact, 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, you know, it is a long review process. It will take a little while. 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—of the—survey.

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, they don't—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. And I wanted—and I also wanted to tell you that three of those measures, the care of patients, the communications, and the special issues measures, it—they are—they are—combinations. They're like multi-survey items. So, like the special—the special—issues is seven questions that are averaged together. The care of patients, I think, are five questions averaged together. Offhand, I don't know if the communications are four or five questions averaged together. So yeah, that's—that's—how that is determined. I hope that was helpful.

Drake Torrado: Yeah. Yeah. And well—well—thank you very much. I appreciate that. My—my—other second part of that question.

Lori Luria: The star rating. If you have a small number. I didn't address that.

Drake Torrado: Right. That and—

Lori Luria: 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, see, we base—we do the star ratings based on the most recent four quarters of data, which is the most recent year. So, if you—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 agency will have a year with a lot of patients and then they're going to have star ratings and sometimes not. It's—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.

Drake Torrado: OK. Can I finish one little question related to that? I was talking to my vendor and my vendor was telling me—I was telling him that I was going through the—through my—through my—patient census and looking at those who will—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—for—them and they said no.

Lori Luria: Yeah, because the—because the—patients are supposed to identify the proxy.

Drake Torrado: But if the patient has Alzheimer's—

Lori Luria: Yeah, the reason for that is because sometimes a patient will ask—this actually happened with my mother because she had skilled home health care and then round the clock, she had home health care that was, you know, for basic needs such as dressing, all kinds of things. You know, everything that's, like, not necessarily—it's not what Medicare covers. It's other type of home health care.

Drake Torrado: Right.

Lori Luria: But that—those people, she got very close with, and she could have asked one of them to complete the survey. And technically, you're supposed to—for a proxy, we only allow proxies that are a caregiver, you know, a spouse or children. It could be grandchildren, but they're not supposed to be a person or people who actually deliver home health care.

Drake Torrado: And that certainly could be pointed out to the—to—to—to the—to the—family and in terms of that—because they can—we would certainly take care of that on our own. We don't want an aide who was working for another agency to answer our HCAHP. [HHCAHPS]

Lori Luria: Yeah.

Drake Torrado: But the daughter, I spoke to one daughter. I said, yeah, no, don't—tell them not to call my mom, but just tell them to call me. I'll answer the questions.

Lori Luria: OK. Well OK, I—I—think maybe we'll communicate about this in another way if that's OK because I'm taking up everybody's time on the call.

Drake Torrado: OK. Thank you very much.

Lori Luria: But thank you for your very good questions.

Drake Torrado: Appreciate your time.

Lori Luria: Thank you. Right back to the mailbox. Thank you.

Jill Darling: Peter Zorc, you may ask your question.

Peter Zorc: Yes, I have a question for Thomas Pryor. I just wanted to know how I could get the—the—toolkit that you said you made available for advocacy groups. I think you had to email somebody about that.

Thomas Pryor: Yeah, I think Jill put that in the chat box.

Jill Darling: I did. I can do it again.

Peter Zorc: OK. Just email, that email asking for it?

Jill Darling: I put it in the chat.

Thomas Pryor: It's a link, yes.

Peter Zorc: Oh, it's a link.

Jill Darling: Yes.

Peter Zorc: OK. Thank you very much. Appreciate it.

Jill Darling: Stacey Smith, you may ask your question.

Stacey Smith: Hi, thank you so much. I appreciate the opportunity to ask a question. So, 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, but my—I'm curious of what the—how the agency plans to enforce this new requirement. You know, how are you defining “public facing,” and what will be the actions by the agency to enforce non-compliance with—with—either one, not updating the public-facing information and two, not having the material on a public-facing platform?

Mary Rossi-Coajou: Sure. Thank you for your question. 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—what—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.

Stacey Smith: OK. Just a quick follow-up question. I think I'm—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.”

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Mary Rossi-Coajou: So public facing, again, if you take a look at the preamble, I think we do talk about that. We did not—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. You know, there's—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? When—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—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.

Stacey Smith: But yeah, I think—and I appreciate that, and I think it's very valuable. My—I guess my question was just around, you know, the definition of “public facing.”

Mary Rossi-Coajou: Correct. So, we don't define it. We do give examples in—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—what your—own agency's policies state and whether or not you're following your own policies.

Stacey Smith: OK. Thank you very much. Appreciate it.

Jill Darling: All right. Well thank you, everyone. That is our time today. If you were unable to get your question in, we apologize, but I will send the Home Health Hospice DME ODF mailbox. Please send it in. And we appreciate you spending your time with us. Again, the email was sent out for any questions or comments. And everyone have a wonderful day and thank you for joining us. This concludes today's call.