

Centers for Medicare & Medicaid Services
Home Health, Hospice & DME Open Door Forum
February 8, 2017
2:00 p.m. ET
Moderator: Jill Darling

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

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

I would now like to turn the call over to Ms. Jill Darling. You may begin.

Jill Darling: Thank you, (Amy). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. Before we begin, in our agenda today I just have a couple brief announcements. This Open Door Forum is not intended for the press and the remarks are not considered on the record.

If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquires, please contact CMS at press@cms.hhs.gov.

And for those who are new to the call, we do have -- our -- sorry, our podcast and transcript webpage, that is on the agenda. So for after the call, you'll be able to review the transcript and the audio to get further details.

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

Hillary Loeffler: Thanks, Jill and thank you everyone for joining us this afternoon for the Home Health, Hospice & DME Open Door Forum. I just wanted to mention and give some apologies for last-minute agenda -- agenda item changes.

So for the agenda today, we're going to start off with an update on the home health conditions of participation final rule, followed by a claims processing announcement. And then, we're going to follow that with some updates for the Home Health & Hospice Quality Reporting programs, including Home Health caps and Hospice caps.

And then, to round out the call, there's going to be a short announcement on the Medicare Care Choices Model. That will be the agenda for today's call; I apologize for the last-minute changes. And with that, I'll hand it back over to Jill.

Jill Darling: Thanks, Hillary. And up first, like she said, we have the Home Health Conditions of Participations final rule with Danielle Shearer.

(Multiple Speakers)

Danielle Shearer: Thanks. On January 12th, 2017, CMS published a final rule that updates the conditions of participation for Medicare and Medicaid participating Home Health agencies. The new conditions address current practices within Home Health agencies, to ensure the health and safety of Medicare and Medicaid beneficiaries.

The final rule is person-centered and outcome-oriented. We believe that these changes are an integral part of CMS's overall effort to achieve broad-based, measurable improvement in the quality of care that's furnished, through both the Medicare and Medicaid program. And while at the same time, we are attempting to streamline the requirements for providers.

Some major provisions of the final rule focus on expanding the current patient rights requirement to clearly enumerate the rights of each patient and to clarify the process for conducting investigations of patient rights, violations and

address -- and addressing any verified violations. We've also expanded the patient assessment requirements to assure that Home Health agencies gather information regarding patient goals and care preferences, as well as some key information about patient caregiver availability and the caregiver's ability to provide care to the beneficiary.

We are also requiring HHA to provide, in writing, some specific information that we believe will improve patient understanding of the care that's being provided, and the patient and caregiver's role within that care. This information includes things such as a upcoming visit schedule and information about the medications that the patient is taking. We've added a requirement to improve communication between HHAs physicians by permitting HHAs to accept orders directly from multiple physicians; things don't have to run through a single physician anymore.

And this is completely an option. If HHAs choose to accept orders directly from multiple physicians, the HHA is required to communicate with all relevant physicians when there's a change in patient condition or there's a need to update the plan of care or for the purposes of discharge planning. We've also incorporated a new requirement for quality assessment and performance improvement, also known as QAPI, or QAPI.

The QAPI requirement mirrors activity that's already taking place within the HHA industry. And it's based on data that's already collected through the (OASIS) process, through CMS provided patient outcome reports and numerous other industry efforts that are currently underway. The QAPI condition also provides flexibility for new data collection and quality measurement work in the future, both on the part of CMS and on the part of the HHA industry.

The final rule includes a new infection prevention and control requirement for the first time, and it permits therapists to repair Home Health aide patient care instructions and supervise Home Health aids. We think that this is going to give HHAs more flexibility to assure appropriate, high-quality Home Health aide care.

The new COPs are available on the Federal Register Web Site. There is a link in the agenda for today's open door forum. I will also give it to you now, if you want to jot it down. It is <https://www.federalregister.gov/documents/2017/01/13/2017-00283/Medicare-and-Medicaid-program-conditions-of-participation-4-home-help-agencies>.

So the short of it is Medicare and Medicaid conditions of participation for home health agencies, you put a dash in between each of those words, it's going to get you there.

And because you send in such interesting questions that often cut across various groups within CMS, we've also established an e-mail box that's just for questions related to the new COPs.

The e-mail box address is also included in today's agenda. For those who don't have the agenda, the e-mail box is newhhacops, that is s plural, [@cms.hhs.gov](mailto:newhhacops@cms.hhs.gov). Again that's newhhacops@cms.hhs.gov.

That is the best e-mail box to send your questions to and we are happy to answer as best we can. Thanks and that's all I have.

Jill Darling: Thank you Danielle. Up next we have (Wil Gehne) who has a claims processing announcement.

(Wil Gehne): Hi. I have a bit of a mixed bag of claims related announcement so. First I wanted to remind home health agencies that, effective April 1st 2017 all home health claims will be subject to a two step check for the presence of a supporting OASIS assessment.

When a home health claim is received, Medicare system will query the national OASIS database to see if an OASIS assessment has been received. If corresponding assessment is found, that claim will process normally. If no OASIS is found, then our systems will compare the OASIS completion date, reported on the claim, to the claims receipt date, to determine whether the OASIS should have been received.

If the OASIS is not found and that OASIS is past due, the claim will be denied. Note that this change only affects home health claims, it has no effect on the processing of (RATS), doesn't create denial simply because an OASIS assessment was late.

For a denial to occur the OASIS must be missing and past due. And this process applies to all episodes. So the OASIS assessment that's involved may be a start of care, a resumption of care or a recertification assessment.

Next, I've been receiving some questions about change request 9782, which is the annual update to therapy procedure codes. That instruction created some new therapy evaluation codes. It (fixed) 97161 through 97168.

I want to clarify that when billing for the home health benefit, using type of bill 32X, or for the hospice benefits on types of bill 81X and 82X, these new therapy codes would not be used.

The current instructions to use therapy G codes remain in place for those claims. The only time a home health agency would use the new codes is if they're separately billing part B therapies that are not under a home health plan of care; that is when they're using type of bill 34X. In that case they would use the new code in the same situation that they had been using the retired codes, 97001 through 97004.

Finally, a hospice item. Last year we debut the first hospice PC Pricer program, which allows users to key claims data on a personal computer and run the same Pricer software that is used by the Macs.

The annual update to that program, which calculates payments for fiscal year 2017, was posted to the CMS Web Site last Thursday, February 2nd. So if you wanted to get the new version just enter hospice PC Price in the search feature on the CMS home page, first result will take you to the download page and you can get the new version of the PC Pricer. Thanks Jill.

Jill Darling: Thank you (Will). Next we have Carol Schwartz who will have an update on the quality of patient care star rating.

Carol Schwartz: For home health.

Jill Darling: For home health, excuse me.

Carol Schwartz: That's quite all right. OK. CMS is considering two changes to the quality of patient care star rating for home health based on stakeholder and technical expert panel feedback.

We're talking about potentially removing the OASIS based measure influenza immunization received for current flu season. We would continue to report this measure on home health compare to encourage vaccination but would no longer include it in the star ratings calculation.

The rationale to remove this measure is that it can be influenced by factors outside of the home health agencies control that may vary state by state. Second, we are talking about adding the claims based measure, emergency department ED used without hospitalization.

This measure is risk adjusted and (computed) using Medicare fee for service claims. The rationale to add this measure is to reward agencies that are successful in lowering ED use among their patients and to provide a more comprehensive quality rating.

CMS conducted a simulation of the impact of these two action on the star ratings and found that the average star rating was the same, about 3.24 stars. Under this simulation, replacing the flu measure with the ED one resulted in 67 percent of home health agencies receiving the same rating, 17.5 to increase by a half star and 15.8 percent to decrease by a half star.

We first described this change on a national provider call on January 19, 2017. We are accepting public comment on the changes under consideration from now through February 20th at HH_QM_Comment@ABTASSOC.com.

Moving on we're going to – about Home Health Compare January refresh. The first 2017 update for the Home Health Compare was released on January 26th, 2017. This update includes the quality of patient care star rating and

quality measure (values) shown in the previous reports, distributed in early October via CASPER.

This release is the first that reflected the measure removals finalized in the C.Y. 2017 rule. As a reminder, these measures were removed from the public facing site, but will still appear on the preview reports for another few refresh cycles because of production processes.

Some providers may have noted that the downloadable files that accompanied this refresh contained duplicate values for the patient survey ratings the quality of patient care star ratings. This has been corrected and revised files are now available on Home Health Compare. Thank you.

Jill Darling: Thank you, Carol. Next we have (Lori Teichman) who's and update on the Home Health CAHPS.

(Lori Teichman): Thank you, Jill. This is just a few reminders. It is not too late to participate in Home Health CAHPS.

(AUDIO GAP)

(Lori Teichman): ... (just need) interested HHAs need to register now for Home Health CAHPS if they are not yet doing the survey. And the Home Health CAHPS Web Site is noted in the agenda. If you start soon, then you can participate in the required survey period or the calendar year 2019 annual payment update period which runs from April 2017 through March 2018. That is April 2017 through March 2018.

Please e-mail RTI at HHCAHPS@RTI.org if you are an HHA that is not yet participating in Home Health CAHPS and you need help registering for the survey and you also would like some assistance in choosing your Home Health CAHPS survey vendor. If you are a home health agency with 59 or fewer patients in the period of April 2015 through March 2016, please make sure that you file a Home Health CAHPS participation exemption request for the CY 2018 APU that is now on our Web Site.

We are posting the CY 2018 form on our Web Site up through 11:59pm on March 31st, 2017. Beginning on April 1st, 2017, we remove the 2018 form and we replace it with the same form, but it is for the calendar year 2019 payment period.

All home health agencies that are currently in Home Health CAHPS and may have data problems should always immediately notify their respective Home Health CAHPS survey vendors. If home health agencies are unable to submit a monthly file to their survey vendor, then their survey vendors will note this and document the problems and the reasons for the inability to provide a file. The HHCAHPS survey vendor will fill out a discrepancy notification report about the HHA's reasons and sent the report to CMS.

Again, if you are a home health agency and you are planning to switch your survey vendor, please contact RTI. Again, at HHCAHPS@RTI.org, or telephone RTI at (866) 354-0985. It is very important that agencies switch their survey vendors in the correct way. And also, please do not hesitate to call or e-mail RTI with any questions at all about HHCAHPS participation. Thank you.

Jill Darling: Thank you, (Lori). Next, we have (Deborah Dean-Whittaker) who has an update on the Hospice CAHPS.

(Deborah Dean-Whittaker): Hello everyone, the next deadline to submit Hospice CAHPS survey data to the Hospice CAHPS data warehouse is today; February 8, 2017. Survey vendors are responsible for successfully submitting files to the data warehouse by 11:59pm Eastern Time on February 8th; today.

Hospice (users are) you having trouble logging into your CAHPS data warehouse to retrieve your reports? If you have a problem, go to the button labeled, quote, "Need Help With Signing-In" – I'll say that again, "Need Help With Signing-In." This will lead you through a process to create a new password. The warehouse has upgraded their software and it is possible that your old password will not work.

By the way, you can always call or e-mail the Hospice CAHPS technical assistance team. Their phone number and e-mail are on the agenda.

Technical correction and clarifications to the CAHPS Hospice survey quality assurance guidelines manual, version 3.0, have been release. And they are available on our Web Site, which is listed on the agenda;

www.HospiceCAHPSuvey.org.

The CAHPS Hospice survey participation exemption (for size) form is now available on the survey Web Site. This is the form for hospices that believe themselves to qualify for a size exemption. The form will be up until December 31, 2017 but we encourage anyone who feels they are exempt to go ahead and fill out the form now.

It's available on the Web Site and can be submitted on the Web Site. Finally, the CAHPS hospice survey fact sheet is now also available on the Web Site. It provides general background information on the survey. Thank you.

Female: Thanks, (Deborah). Next we have (Stacy Payne) who has an update on the hospice QRP.

(Stacy Payne): Hello, everyone. Today I have one update regarding the hospice quality reporting program provider training that was held in Baltimore on January 18, 2017. Presentations with answers to practice activities discussed during the hospice QRP provider training are available and have been posted in the download section of the hospice QRP Web Site on the hospice quality reporting training page.

Also included in the folder for each presentation are the pre-training materials without answers included and any documents necessary to facilitate exercises used during the training. We hope these will be helpful to you and your staff. This Spring, we are planning a web-based training on new available reports, particularly the QM reports and how to access and utilize them.

We will be sending out announcements and posting to the hospice QRP spotlight and announcements page when the date is set and registration is open. Thank you.

Jill Darling: Thank you, (Stacy). And last, we have (Shannon Landefeld) who has an announcement on the Medicare Care Choices Model.

(Shannon Landefeld): Hi, this is (Shannon Landefeld). As you may know, the Medicare Care Choices Model tests whether beneficiaries quality of care and satisfaction at the end of life could be improved by allowing the beneficiaries to simultaneously receive curative care services while receiving select hospice support services. It's completing its first year of implementation.

Due to the lower than expected enrollment in the model and stakeholder feedback, four of the more restrictive eligibility criteria have been relaxed. In April of 2016, the requirements were two hospitalization admissions were reduced to one encounter of any type including an emergency room visit, observation stay, or admission. Also, the model is no longer required participation in Medicare Part D and instead gathers data on beneficiaries various drug coverages – drug coverage types as a means to further understand the impact of the model.

Effective January 1, 2017, we've reduced the 24 month enrollment of Medicare requirements to 12 months of enrollment and the requirement of three offices at the same physician practice for the eligible diagnosis will change to three office visits with any physician practice for any condition. We determined that the 12 months of data for both Medicare Parts A and B would be sufficient for evaluation and create additional opportunities for enrollment.

Thank you.

Female: Thank you, (Shannon), and to all of our speakers for today. (Amy), we'll go to our Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press "star" then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the "pound" key. Please limit

your questions to one question and one follow up to allow other participants time for questions.

If you require any further follow-up, you may again press “star” 1 to rejoin the queue. Your first question for today comes from the line of (Don Clayback) of (N cart). Your line is open.

(Don Clayback): Thank you. My question was on actually one of the items that was removed from the agenda and that’s regarding the prior authorization for two conflicts. (We have) wheelchair codes and I was just curious as to why it was removed and then more importantly when providers will be receiving information given the – at least the last implementation date was March 20.

Hillary Loeffler: Hi, (Don). This is Hillary Loeffler. Unfortunately, there’s nobody here from our (DME) area to speak to that or from our center for program integrity. If you want, you can e-mail the home health hospice and (DME) mailbox that’s on the agenda and I can go ahead and forward that and see if somebody can get a response on when you can expect an update.

(Don Clayback): OK. That’d be great, Hillary. And is it normal for things – because I know there’s a few people, maybe more than a few, that were on the call for that topic. Are the last minute changes – is that a normal occurrence or was there something particular about this issue?

Hillary Loeffler: I’m not sure there’s anything particular about the issues. There’s just a few things that the administration would like to review before we go forward with any decisions or commitments to the public.

(Don Clayback): Great, thank you.

Operator: Your next question comes from the line of (Andrew Kosky) of Home Care Association. Your line is open.

(Andrew Kosky): Yes, thank you. Do you have any idea when CMS plans to issue the interpretive guidelines to the states for the Medicare home health (COPs)?

Hillary Loeffler: So, I apologize, I don't see anybody here from our survey and certification area that could speak to that. If you want to go ahead e-mail the mailbox, I can go ahead and triage that for you.

(Andrew Kosky): OK, thank you because obviously if the rule goes to effect July 13, it would be nice to have the guidelines out next month or whatever, very soon.

Hillary Loeffler: Sure, yes, go ahead and e-mail the mailbox and my division personally monitors that e-mail and we'll go ahead and forward it over to survey and cert and see if they can get you a response.

(Andrew Kosky): OK. Thank you.

Operator: Your next question comes from the line of (Freda Chuckfuller) of North Bay Healthcare. Your line is open.

(Freda Chuckfuller): Hi my question is about plan processing and OASIS edits. So was it that the receipt date would be considered if the OASIS let's say is later than 30 days since the start of care? Or it would not be considered? That's one question. The second one -- I think I heard that all kinds of OASIS's will be considered a resumption of care -- start of care and recertification. I don't understand how the resumption of care would be considered for the payment of claims. Thank you.

Wil Gehne: Thank you. So I understand the first part of your question, right, it's your -- I think you were asking if there would be denial entirely based on the receipt date of the claim based on how long -- based on the timeliness of the assessment itself, is that what you were asking?

(Freda Chuckfuller): Correct.

Wil Gehne: No it would not. The -- we're only looking at editing at this point to see, is an OASIS missing and based on the time frame that the claim is received and should we have one. Is one due or past due at that point? So there's no enforcement being built around the OASIS timeliness itself.

The second part is that the start of care resumption or recertification assessments can all produce (IP's) codes that are reported on claims today and generally it starts of care and recerts, but in cases of transfers or intervening hospital stays, resumptions of care can be used. So we're looking for all three before we deny a claim.

(Freda Chuckfuller): Can you elaborate on the resumption of care and how it would affect the payment? How would it -- how would the edit work?

Wil Gehne: I don't know -- edit doesn't work differently based on what type of assessment it is. But if we're just making sure that we're looking for all of the possible assessments. So when a claim comes in we're looking for an assessment of one of those three types that would correspond to the claim dates and if one is present of any of those three types, then the claim would be processed and paid normally.

Operator: Your next question comes from the line of (Pat Mingle) of Home Healthcare. Your line is open.

(Pat Mingle): I have further clarification on the claims and in -- I understand that the edits were supposed to be different starting in April. That if the OASIS is not submitted and in the system within thirty days at the (moon 90 date), that it could be denied. Could you clarify that please?

Wil Gehne: That is correct. That's what the change that we're implementing would be doing. If we -- if a claim is received and we find no corresponding assessment, then we'll be comparing that (M0090 date) to the claim received date and if the reporting requirement current is that it should be submitted within 30 days, if that assessment is not found then the claim could be denied.

(Pat Mingle): Thank you.

Operator: Your next question comes from the line of (Jenny Sadler) of Mercy. Your line is open.

(Jenny Sadler): My question is in regards to the Medicare (care choices) model. And I'm just wondering, is there any place I can go to find the updated eligibility requirements for the model -- we -- our organization is phase 2 and we're beginning preparations for preparing our system.

(Shannon Landefeld): That -- this is (Shannon). We are actually -- well we're in the process of updating the information on the Web Site. Also we will start -- we've actually started conversations with our contractor and we will start with the education process in the summer and the first -- one of the first things on the list is to talk about the interoperability between the portal and the software system.

(Jenny Sadler): If I send an e-mail from the Web Site, could somebody possibly just give me an overview of some of those changes you highlighted? Is that feasible?

(Shannon Landefeld): You mean the eligibility criterion?

(Jenny Sadler): Yes, right. I could definitely speak to the team and you can go ahead and send an e-mail and then we can -- you know I can follow up that way. Thank you.

Operator: Your next question today comes from the line of (Josh Lambkin) of Medic. Your line is open.

(Josh Lambkin): Hi there, what would be the effects on CMS regulations -- especially the coming effective dates of Florida pre claim review and home health (COP's) update of the executive orders and White House memorandums of January 20th, 24th and 30th which call for such things as delaying effective dates at least 60 days, a general regulatory freeze and the elimination of at least two regulations for every new regulation issued.

Hillary Loeffler: Hey, (Josh), it's -- (Josh), it's Hillary.

(Josh): Hey, Hillary

Hillary Loeffler: We're really not able to comment at this time. We're still waiting further guidance from the administration on those executive orders but any updates we have will be announced through our regular channels.

(Josh): Thank you very much.

Operator: Your next question comes from the line of (Kay Smith) of Ohio Home Healthcare. Your line is open.

(Kay Smith): Thank you. My question is regarding the new conditions of participation. As I review the 484.55 condition of participation regarding the assessment of patients, I'm seeing that in A2, it is stating that – and I will read (each) PT or OT, if they're the only service ordered, the initial assessment can be completed by that one needed discipline. And then in B3, I'm reading when PT speech OT is the only service ordered by the physician. Any of these disciplines may also complete the comprehensive assessment. My clarification that I'm asking for is are you therefore saying that occupational therapists can do the start of care now?

Danielle Shearer: I'm going to first say that we have not changed any of the program eligibility requirements or Medicare coverage of the home health benefit. So when it comes to Medicare patients, the answer is going to be that nothing has changed. When it comes to non-Medicare patients, if that service is what establishes eligibility and if it is the only one ordered, then it is permitted for the therapist to complete the assessment.

(Kay Smith): When you say assessment, does that mean the start of care assessment?

Danielle Shearer: What we mean – the initial assessment and the comprehensive assessment.

(Kay Smith): OK and I interpret that as potentially being a start of care assessment to include that initial comprehensive (by) the physician ordered discipline, which may be OT. That's what I'm confused about and I was seeking clarification on.

Danielle Shearer: Well, we don't use the term start of care assessment, so I can only answer you based within the regulation.

(Kay Smith): I understand ...

Danielle Shearer: ...an initial and a comprehensive assessment. So whether that applies to what you're specific start of care assessment is or not, I don't know.

Hillary Loeffler: This is Hillary. For payment, OT cannot be a qualifying service under the Medicare home health benefit. Any time that an RN/PT/SLP or OT completes the start of care assessment, HHAs can't bill that visit unless a service was actually furnished. Because the OT isn't a qualifying service, even if other skilled services are ordered, you wouldn't be able to count a visit done by an OT to complete the start of care assessment. Does that answer your question?

(Kay Smith): OK. So just to make sure I do understand, so OT can never be the only qualifying service. We still need one of the other (inaudible) or PT to be the qualifying discipline.

Hillary Loeffler: You do for the initial episode. If you had PT and OT in the first 60 day period and only OT is carrying over for the second 60 period, the OT can do the recertification assessment and they continue on as the qualifying service. For the very first episode of care, OT cannot be the only service. There has to be another skilled service need.

(Kay Smith): OK. So therefore, the physician cannot order – have a referral order for occupational therapy under the Medicare benefits.

Hillary Loeffler: As the sole service.

(Kay Smith): OK.

Hillary Loeffler: Initially. Yes.

Operator: Your next question come from the line of (Brenda Cartrove) of Mercy Home Health. Your line is open.

(Brenda Cartrove): Thank you. I'm following up on a question from one of my other colleagues prior, regarding the Medicare Care Choice model. We're actually in (Cohort2), which is to begin in January of 2018. And my last correspondence with my contact person there was last June. And it said that webinars would begin in summer and early fall for (Cohort2) and I haven't

received any further notification for that. I've tried to e-mail the (MCCM) group but I haven't gotten a response back.

(Shannon Landefeld): This is Shannon. As I mentioned previously, we are just now ramping up our education for (Cohort2) to start this summer. I'm sorry if you were given misinformation. Probably the (year's) – or I'm not going to make excuses but when they were speaking about the summer, they probably meant this summer, 2017 is when we're going to start the education process for (Cohort2) and then that will just roll right into the face-to-face training that we're planning for the fall and you'll be ready to implement the model as of January 2018.

Does that answer you question?

(Brenda Cartrove): Pretty much so. I'll keep an eye on the Web Site as you update it and I'll go from there. My other comment was on the gentlemen that asked about the interpretive guidelines that we're anxiously awaiting. I think that's -- I'm guessing that we're all going to get noticed when those interpretive guidelines are released. I don't want his e-mail to be the only e-mail that's answered.

Female: Are you speaking about the eligibility criteria?

Female: No, I'm talking about the new, sorry, Medicare conditions and participation that go into effect this summer.

Hillary Loeffler: Yes, hi. This is Hillary, I can go ahead and pass on that information to the director of the survey and certification area and just make sure that she makes a broad general announcement on the (list serv), the Web Site, or next ODF on when those will be available.

Female: Perfect. Thank you.

Hillary Loeffler: Sure.

Operator: Your next question comes from the line of (Annette Kaiser) of Carolina Center, your line is open.

(Annette Kaiser): Thank you. I just wanted to see if I could get some insight into the ongoing problems with implementation of the two tiered routine homecare rates for hospice. There have been issues since these new rates were effective and each time one issue is fixed, another one seems to occur. As we understand it, the problems are due something with the fifth, which I'm assuming in the responsibility of the fifth maintainer.

So insight into when there's going to be complete resolution of these problems and then also kind of what quality measures were in place for the fifth maintainer to produce a good product that works and that we don't keep having problems with.

(Wil Gehne): Hi, it's (Wil Gehne):

(Annette Kaiser): Hey, (Will).

(Will Gehne): As far as I know the last -- the last few tiered payments related issues that I was aware of in the system, it should have been corrected with our January release. I'm not aware of any that are -- that are still ongoing, in terms of responsibility. The latest ones were -- the system issues were in -- not in the fifth system but in the common (recon) file system.

And they were in that system because CMS, particularly myself, directed them to do the wrong thing and had to do another issuance to direct them to do the right thing. So no all the fifth maintainers fault, I've got some. I apologize for the delays and the complications that have come with that. But the bottom line is that -- as far as I know, the high and low payments should be being made correctly as of today. And we're looking at -- we've already performed some adjustments to correct payment errors that occurred last year, we're looking at which claims still need to be adjusted to take care of that.

Because of the multiple issues on the multiple faces of adjustments that we've done, that's a little bit tricky. So we're trying to make sure we get the criteria right and don't adjust claims that we don't need to adjust and complicate hospices and accounts receivables more than we need to. If you're aware of claims that still haven't been paid correctly and want to submit adjustments

now to take care of that -- before CMS in the next -- and collaboration figure it out, please do that so that they can get your payments corrected.

As for the last piece of quality standards for the system maintainers, they are on the issues that happened in implementation are reflected in the (ward b) portion of those maintainers contracts. So they -- if you think they don't feel, then they can.

(Annette Kaiser): OK. That is very helpful (Will). And one follow up question. In regard to the adjustments, I just want to be sure, you said hospices could make adjustments, so if they file an adjusted claim and then the (mac) is instructed to adjust, there will be some way for the system to know that the hospice has already filed an adjusted claim and they won't have money recouped a second time?

(Wil Gehne): That's -- you're getting right at the competition of what we need to figure out, but what that's certainly what we intend to avoid.

(Annette Kaiser): OK. OK. All right. Thank you. Could I ask...

Operator: Sorry, your line is open again.

(Annette Kaiser): OK. Thank you. I'm sorry. In regard to Medicaid implementation of the two tiered routine homecare rate and the (SIE) payment, Medicaid -- may Medicaid agencies have not implemented these rates? Is CMS doing anything to work with the Medicaid agencies, is there a time line as to when the Medicaid agencies need to implement?

I mean, we're now more than a year into this and still don't have these rates and so to try to do a recoup repay for more than a year's worth of claim is going to be an absolute nightmare and the further this goes, the worse it's going to be.

Hillary Loeffler: Hey (Annette), its Hillary. Do you mind just articulating your concerns in an e-mail and sending it to the mailbox so I can ping the Medicaid folks again and see if can get a response for you?

(Annette Kaiser): I'll be glad to, thank you.

Hillary Loeffler: Thank you so much.

Operator: And your next question today comes from the line of (Susan Vosset) of (Kaiser), your line is open.

(Susan Vosset): Thank you very much. My question has been addressed.

Operator: And your next question comes from (Matthew Hubbard) of Center for Medicare. Your line is open.

(Mathew Hubbard): Hello, good afternoon. I'm wondering if you could -- if you previously went over this earlier, go over the timeline for the pre claim review demonstration. I had trouble getting in on the call on time, had to wait a while to log in. Thank you very much.

Hillary Loeffler: Hey, (Matthew), this is Hillary. I apologize, but that item was removed from the agenda.

(Matthew Hubbard): OK. Thank you very much.

Hillary Loeffler: Yes, no problem.

Operator: And your next question today comes from the line of (Kelsey Kenworthy) of (Murphy). Your line is open.

(Kelsey Kenworthy): Hi. I was wanting to get some more information on the change request 9585 in regards to the drug max to automate the denial of home health (PBF) claim on the condition of payment for submitting patient assessment data have not been met. I wanted to know if the oasis, or information is not received, prior to billing, or for some reason was rejected, or anything along those lines, are those able to be appealed, or is that just no further -- nothing further can be done?

(Wil Gehne): Hi, this is (Wil) again. The denials represent an initial determination by the Medicare program and every initial determination brings with it appeal rights. But mechanically, those claims could be appealed. I don't know what grounds

you would be appealing on if the assessment wasn't received within the timeframe set in the regulation, it wasn't. So I don't know what -- I don't know what argument you would make in your appeal, but the appeal avenue is available to you.

(Kelsey Kenworthy): OK. That helped, thank you.

Operator: And your next question comes from the line of (Elizabeth Wallace) of (LFH). Your line is open.

(Elizabeth Wallace): Hello. My question has to do with hospice quality reporting. I'm needing to know if the seven quality (majors) that we report using hospice item set, will they satisfy the quality reporting requirements under the (MIPS) new quality system?

Dr. Levitt: Hi, this is (inaudible). And the hospice item set and the measures that are under the hospice item set are different than the measures that are under the (MIPS) program. So the answer would be no, we don't have anyone in the (MIPS) program here, so you could send your question specifically to the help desk, but they really are two different types of measures.

(Elizabeth Wallace): So it sounds to me like we need to submit data under both systems.

Dr. Levitt: I'm not sure what your question is regarding. The hospice quality program is a program that's for a facility based, obviously based for hospices. So it is a more general program. The (MIPS) program is a different program.

(Elizabeth Wallace): OK. Thank you very much.

Operator: And there are no further questions today. I turn the call back over to the presenters.

Jill Darling: Thanks, everyone, for joining today's call. We appreciate your time and patience. The next Home Health Hospice and (inaudible) is scheduled for March 22. But just remember the dates are always subject to change as well as the agenda. So thanks, everyone. Have a great day.

Operator: Thank you for participating in today's Home Health Hospice and DME Quality Open Door Forum conference call. This call will be available for replay beginning at 5:00 p.m. Eastern time today, February 8, 2017, through midnight on February 10. The conference ID number for the replay is 56385067. The number to dial for the replay is 855 859 2056. This concludes today's conference call. You may now disconnect.

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