

Centers for Medicare and Medicaid Service
Home Health, Hospice and DME/Quality
Open Door Forum
Moderator: Jill Darling
February 28, 2018
2:00 p.m. ET

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 and Medicaid Service Home Health, Hospice and DME/Quality Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, you may press the pound key. I will now turn the call over to Mrs. 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 Communication and thanks for your patience. We were trying to get many, many folks in so as always, we greatly appreciate you hanging tight.

So before we get into today's lengthy agenda, I have one announcement this Open Door Forum is not intended for the press and the remarks are not considered on the record.

If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov. And now, I hand the call over to our chair Hillary Loeffler.

Hillary Loeffler: Thanks, Jill. Thank you everyone for joining us today for the February Home Health, Hospice and DME ODF.

Just to give you guys, a heads up, our colleagues in the medical review areas in CMS and those responsible for the conditions of participation weren't able to join us on the call today. So if you join with the intent of asking questions related to medical review or the conditions of participation, I'm afraid we won't be able to answer your question.

But as always, feel free to e-mail the ODF mailbox, that's on your agenda. And we can make sure to triage those inquiries to the appropriate folks. So with that, we can jump right into the agenda and I'll hand it off to Charles Nixon.

Charles Nixon: Thank you. When we last spoke, we inform you that notice of election submission, via electronic data interchange had encountered a couple of issues that will possibly requiring work around, in order to allow them the process.

We are happy to report that affix to this issue was implemented as of February 5th, and we have heard of the no issues since that (VIX) took place. If they have not yet done so, hospices may now submit NOEs through EDI, (will follow them) returning to a provider.

We believe the process of NOE submission will be much quicker and more accurate now that edits have been resolved. And we're pleased to provide you a better service. And with hospice up coming training and education events, we have (Cindy Massuda).

(Cindy Massuda): Thank you very much. Good afternoon. So for the Hospice Quality Reporting Program, hospices are in their calendar year 2018 reporting the Hospice Item Set and CAHPS data.

To asses hospice, hospices and maximize the number of hospices meeting their hospice quality reporting requirements, we're offering training and education as we've talk on prior cause.

We've been doing – we're doing that on a better quarterly basis this year throughout this year. So we're excited to announce that we are in producing two series of educational models – modules that would be released in March.

The first series will focused on helping providers navigate the websites for the Hospice Quality Reporting Program. This includes the CMS-HQRP website, the CAHPS survey website, and the (KEPSA) website.

CMS has recently made updates to the organization of the Hospice Quality Reporting website to improve flow in the organization. This first series with include information on navigating the newly redesigned CMS-HQRP website.

The second series will focus on coding guidance for the Hospice Item Set. Based on questions frequently ask on a hospice quality help desk, CMS has produced, refine coding guidance for specific HIS items. This series will cover refine guidance and will include examples for each section of the Hospice Item Set. Those series will be released as short self-directed video statements.

To launch the release of the video segment series, CMS will host a live webinar events were select modules will be featured. This webinar event will also have a Q&A session. We will be holding this webinar in March, on March 27th, 2018 from 1:00 to 3:00 p.m. Eastern Standard Time.

So please check the training announcement and registration page of the CMS Hospice Quality Reporting website for the launch of data educational modules so that you can register for this exciting training. Additionally, we want to mention about HIS modifications after you preview reports.

So prior to each quarterly released of data Hospice Compare. Hospice providers are given the opportunity to preview their HIS quality measure results using the HIS provider preview report. CMS has noticed an increase in the number of HIS modifications and inactivation after release of the HIS provider preview reports.

We encourage providers to review their HIS quality measure early and often using their CASPER QM report. Please do not wait until the provider preview reports are released to review and modify HIS data, as the updated data will not be reflected on the corresponding Hospice Compare refresh.

It takes a little longer until – is on Hospice Compare. So as reminders, the responsibility of the hospice provider to ensure that records are complete and accurate before submission to the QIES ASAP System.

Modifications and inactivation of HIS records should only occur in case whether HIS record does not accurately reflect the patient's clinical record. We also encourage hospice providers to review their final validation report after record submission to the QIES ASAP to ensure that HIS records are accepted by the system.

For more information about hospice – about how hospice providers can use CASPER QM reports to review data. Please see the hospice quality reporting program requirement and best practices tab on the CMS HQRP webpage. And now I will turn it over to Amanda Barnes.

Amanda Barnes: Thank you, Cindy. On February 28th, 2018 CMS launched to the publication of the CAHPS Hospice Survey results on the Hospice Compare website.

The Hospice Compare tool is a friendly website found on medicare.gov and it provides information to help patients and their families and caregiver provider, and – sorry, providers make more informed decision about choosing a hospice.

This tool also allows users to select up to three hospices at a time to compare the clinical quality of care provided to patient experiences with these hospices. This February refresh of the data on hospice compared, the first time CAHPS Hospice Survey data has been published.

The initial roll out includes eight quarters of data for CAHPS covering debts occurring between April 1st, 2015 and March 31, 2017. Hospices with at least 30 completed surveys over the course of the reporting period will be reported

on hospice compare, and those with fewer than 30 completed questionnaires will not be reported due to (conservative staff), the reliability of small sample (guidance).

Their current version of this survey includes 47 questions and hospices diversity preview report from their CAHPS survey results through CASPER prior to the publication of the Hospice Compare.

More information can be found on the hospicecahpssurvey.org website as well as the hospice quality reporting – public reporting background and announcement webpage.

Also on February 20th, we – on hospice compare release at the refresh for the HIS measures for patients discharges from quarter 2, 2016 to quarter 1, 2017. You can visit the Hospice Compare website to view the data. And more information again is available on the public reporting background in announcements web page. And now, I turn it over to (Wil Gehne).

(Wil Gehne): Thanks. As most of you know, the recent Bipartisan Budget Act extended the 3 percent rural add-on payments for home health to episodes calendar 2018.

But since that law wasn't in place yet when we implemented our calendar 2018 payment software in January, the roll out on payments are not currently being made in Medicare systems. So I just wanted to give folks a little bit of information about what to expect regarding our retroactive implementation of that provision.

On April 2nd, revised pricing software will be implemented at (MACs) and all things with through dates or home health claims with due dates in – 2018 that are received on and after April 2nd will begin to receive the 3 percent rural add-on correctly.

Shortly after that providers payment software is implemented, the (MACs) will begin to adjust claims for episodes in 2018 that were received during that first quarter and those adjustment will cause the 3 percent rural add-on to be paid.

What I do know at this time is that (MACs) – adjusting all of those claims based on CMS instruction. Providers won't need to contact the (MACs) or take any other actions in order to receive this adjustment just to look for them to be coming, after that time on their remittance advices.

What I don't know yet is the timeframe in which those adjustments will occur. And we had a variety of provision in (MACs) that are requiring us to adjust claims and under a variety of other benefits.

And so, we're still trying to figure out the timeframe to make of those adjustments. Hopefully by the next call, I'll have an update on when you look for those adjustments to be happening. With that, back to Hillary.

Hillary Loeffler: Thank (Wil).

So, just a quick update from me, CMS's contractor, Apps Associates, recently convene the technical expert panel on February 1st, 2018 to collect perspective feedback and recommendations from industry experts and representatives regarding the public comments that we receive on the Home Health Groupings Model, which was describe in the calendar year 2018, Home Health Prospective Payment System proposed rule.

So, CMS recently made the technical expert panel materials available for download on the HHA center page via the cms.gov website.

The easiest way to get to the HHA center page for me and is just to simply Google Home Health Agency Center along with CMS, and that will usually pop up as the first thing returned in your search engine.

So, we encourage everyone to review those materials, if you haven't already. And if you have any questions or comments, there is a e-mail address for Apps Associates and you can submit any questions or comments that you have to that e-mail box.

And with that, I will turn it over to (Joan Procter) who will speak to a calculation clarification for quality reporting.

(Joan Proctor): Thanks, Hillary. This is (Joan) again and I actually have three announcements that pertain to Home Health Quality Reporting Program that I wanted to make today.

For the calculation of the cross setting measure, percent of residents or patients with pressure ulcers that are new or worsened. We were contacted by a provider and we determined that the denominator counts for the outcome measure percent of residents or patients with pressure ulcers that are new or worsened on the home health reviewing correct reports, we're incorrect. So, specifically, they did not include episodes where M1313 was coded as a valid skip when the response to M1306 was a zero). The numerator counts from our reports were calculated correctly.

The confidential feedback reports for this measure, the home health on demand risk adjusted outcome report that was available starting February 2nd, as well as public reporting on Home Health Compares starting in 2019, were both incorrectly incorporating episodes with valid skips and a denominator.

As a result, HHAs can expect to see much lower rates for the measure relative to the values when they're reviewing report – review and correct reports today. The review and correct reports going forward will also include this update. As a result measure calculations will be standardized across post-acute care settings. That was my first announcement.

The second announcement is, we wanted to announce changes to the on-demand CASPER reports. The QTSO, which is the QIES Technical Support Office, recently released a memo containing a summary of updates that were being made to the OASIS Quality Improvement Reports available on-demand in the CASPER system.

The updates that are being made is, one of them is, to rename several reports so that they more accurately describe what their content is so that people are more apt to understand their purpose and select them and make use of the reports.

The second is the removal of measures to align with the provisions of the calendar year 2017 Home Health PPS Rule. And the third is the retirement of several on-demand reports including the agency patient related characteristics summary report.

The agency patient related characteristics report, the outcome risk-adjustment two report in text version potentially avoidable event risk adjusted two report, and the process measure two report in quality improvement two reports.

So, those are changes where we have sort of caught up with our program, keeping our reports only those that will provide you with accurate and useful data.

And the last one is we have been contacted regarding the timely initiation of care and the recent changes that were made in the conditions of participation.

The industry did reach out to us and notified us that based upon the revisions to the conditions of participation. There were some changes potentially necessary.

We look into the issue and determined that to allow for physician order, the resumption of care and alternative to the fixed 48-hour timeframe for a post-hospital reassessment that we would have to make some changes ourselves.

So, this change allows physicians to specify a resumption of care date that is tailored to the particular needs and preferences of each patient. The new COPs became effective January 13, 2018.

We have modified the calculation of the quality measure, time initiation of care to align with these guidelines. And post and updated specifications to the quality measure stage of the Home Health Quality QI website.

Use of this new calculation logic will be effective for quality episodes that again, on or after January 13th, 2018. This change will be reflected in the quality of patient care star rating and Home Health Compare with preview

reports available in September of 2018, for January 2019 Home Health Compare update.

Also on September, CMS will retroactively apply these specifications to the – confidential feedback and reviewing direct reports that are available through CASPER. And I think that's all of my announcements that I have to make. So, I'm going to turn it over now the lead to (Lori Teichman).

(Lori Teichman): Thanks, Joan. I would like to make a couple of announcements about postings that are on the Home Health CAHPS website which is referenced in the agenda. And that's homehealthcahps.org.

Right now on the website through April 2nd, we have posted the participation exemption request form for the calendar year 2019. We first posted this form April 2017.

Home Health CAHPS participation for the calendar 2019 APU concludes on March 31, 2018. So, if your agency has not participated in HHCAHPS in the period of April 2017 to March 2018 because your agency served too few patients in the patient count period, which is the previous April through March period, then you or your Home Health CAHPS coordinator in your agency should complete the participation exemption request form for the calendar year 2019 APU. And that form, again, is going to be on our website through April 2nd.

The exemption form is a short form that is completed online. It has drop down menus and a couple of places where you fill in numbers.

The agency completes this form and the agency must state the number of patients served for the time period that is listed on the form. So, for the calendar year 2019, exemptions form, agencies state the number of patients served in the period of April 2016 through March 2017.

So, for the next participation exemption form for the calendar year 2020, , agencies will state patient counts for the period of April 2017 through March

2018. And beginning on 4/13/18, we will post the participation exemption request form for the calendar year 2020 APU.

For small agencies, it is very important that every year, they should count their patients served in the period of April through the following March, and they should complete the Participation Exemption Form, if they served less than 60 patients.

You may have had an exemption that was valid for the CY 2018 APU, but we don't know if you are eligible for the exemption for the CY 2019 APU and for the CY 2020 APU. If you do not tell us your patient counts. It's very important for you to complete the participation exemption request form for every CY APU.

You could also be participating in Home Health CAHPS right now but, for instance, your patient's census may have dropped dramatically so you should complete the Participation Exemption Form for the CY 2020 APU.

We get phone calls sometimes from agencies that ask, should they continue to participate in HHCAHPS because they hardly have any patients now or, you know, for the remainder of the period going through March. And I say yes, you should because your patient count was more than 59 last year.

So, you have to continue HHCAHPS for the remainder of the participation period through March 31, 2018. However, your agency is likely to qualify for the exemption for CY 2020 (data collection April 2018 through March 2019) if you had less than 60 patients in the period of April 2017 through March 2018. Then, you should complete the Participation Exemption Form for the CY 2020 APU when it is posted beginning April 3, 2018. Again, the form is on our website, <https://homehealthcahps.org>.

Also happening on the first week of April 2018, we post our Home Health CAHPS Quarterly Newsletter. We started doing these newsletters a few years ago and we post a new newsletter in the months of January, April, July, and October.

Also in January, April, July, and October, HHCAHPS survey vendors submit HHCAHPS survey data on the third Thursdays in those months.

The next data submission deadline for HHCAHPS survey data is April 19, 2018. About six or seven vendors have started data submission and if there are any vendors on the phone, we encourage you to submit your data as soon as possible just in case, rather than waiting for the last minute.

Home health agencies are reminded to check their HHCAHPS data submission reports on the website, homehealthcahps.org in the secure data portal called “For HHAs”. In that portal, home health agencies use a unique I.D. and password that they established with RTI. HHAs should be checking the portal regularly, and keep in touch with their vendors about what they are viewing about their data in their submission reports.

We also want to remind home health agencies that you are responsible for getting your monthly patient lists to your respective HHCAHPS survey vendors in a timely manner. Your vendor will set a deadline for the monthly patients’ lists with you.

The Home Health CAHPS team just completed their annual HHCAHPS survey vendor training and we had it on January 30th and 31st in the afternoon. And then on February second, we had update training from 12:00 noon to 2:00 p.m.

On the HHCAHPS websites, we posted the slides, the new materials, and new Manual that we used in the January-February vendor training. Again, on the website, the secure portals for the survey vendors, to survey data to the warehouse, and then a portal for the home health agencies where they can view everything their HHCAHPS data.

And if you have any questions about Home Health CAHPS, we advise you to, first, e-mail, H-H-C-A-H-P-S, hhcahps@rti.org or CMS has a mailbox, homehealthcahps@cms.hhs.gov. Thank you. And, Jill, I'll turn it back to you.

Jill Darling: Thanks, (Lori). Last on the agenda, this – it was an added topic. We have Ronke Fabayo who has an announcement about the low volume appeals opportunity.

Ronke Fabayo: Thank you, Jill. Good afternoon. My name is Ronke Fabayo and I'm the Deputy Director for the Division of Medicare Debt Resolution in the Office of Financial Management.

As part of the department's broader efforts to improve the appeals process, CMS made available the low volume appeals settlement option on February the 5th, 2018.

The LVA is limited to providers and suppliers, or appellants with the low volume of appeals pending at the Office of Medicare Hearings and Appeals and the Medicare Appeals Council at the Departments Appeal Board.

Specifically appellants with fewer than 500 Medicare part A or part B claim appeals pending at OMHA and the DAV combined as of November 3rd, 2017 with the total billed amount of \$9,000 or less per appeal could potentially be eligible if certain other conditions are met. CMS will settle eligible appeals at 62 percent of the net approved amount.

CMS will host a Medicare learning network provider calls on March 13th to discuss the process and detail. Registration for this call can be found on our website at, go.cms.gov/LVA. Linked for the written transcript and audio recordings for the January and February Medicare Learning Network Provider Calls that we held are also available on the LVA website.

We encourage those who are interested in learning more about this new opportunity to visit our LVA website where you find a wealth of information regarding the settlement including settlement process documents and frequently asked question. Interested appellant should also attend our March 13th Medicare Learning Network Call for additional information.

As a reminder, that website again is, go.cms.gov/LVA. If you have any questions related to this process, please contact us at Medicare settlement F-

A-Q-S, again, it's Medicare Settlement F-A-Q-S at cms.hhs.gov. Thank you, Jill.

Jill Darling: Thank you, Ronke, and thank you to all of our speakers. And, (Amy), we'll go into our Q&A, please.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, please go ahead and press star then the number one on your telephone keypad. If you would like to withdraw your question, you may press the pound key.

Please limit your questions to one question and one follow-up to allow other participants time for question. If you require any further follow-up, you may again press star one to rejoin the queue. Your first question today comes from the line of (Susan Vanesen) of Kaiser Permanente. Your line is open.

(Susan Vanesen): Thank you and good morning to you there back n the east coast. I'm calling clarifying, you may not have answer this. But in the budget deal that was passed on 2/9/18, there are elements in there about the Home Health face to face and I'm curious as to when CMS might be able to provide more details on implementation of this new ruling.

Hillary Loeffler: Hey there, (Susan). Hi, this is Hillary Loeffler, the Director of the Division of Home Health and Hospice. So we're still currently digesting the Bipartisan Budget Act of 2018. If we had any more information to provide on certification and recertified eligibility for Home Health, it would be in our proposed rule for 2019. And our ...

(Susan Vanesen): OK.

Hillary Loeffler: ... proposed are usually issued at the end of June.

(Susan Vanesen): Excellent, thank you very much.

Hillary Loeffler: Thank you.

Operator: Your next question comes from the line of Nancy Chang of Asian Network Hospice. Your line is open.

Nancy Chang: Hi, thank you. My question pertains to the written CPI, and I want to find out, is it required that there will be two CPIs. One for the current attending and one for the hospice position or can the attending physician which is often outside physician, cosign a written CPIs with the hospice division.

Kelly Vontran: When you say – this is Kelly Vontran in the Division of Home Health and Hospice. When you say cosign the written CPI, you're talking about a single document?

Nancy Chang: Yes, yes.

Kelly Vontran: Yes, we do, we have stated in previous rules that when there is this certificate of terminal – certification terminal illness in which post physician sign. Only one of the physicians needs to develop and write the narrative for the certification.

Nancy Chang: OK. Thank you for your clarification.

Operator: Your next question comes from the line of Justin Hunter of Encompass Health.

Justin Hunter: Thanks operator, this question is for Hillary. Hillary, thanks for the update earlier on the (TAP) that was held earlier this month. First question there is, will you all be releasing any information of et cetera that reports on the developments of the (TAP) in term of what was discussed, reviewed, analyzed, recommended all of that.

First and secondly in light of the BBA '18 and the (TAP) provision that was included in that new law under some of the Home Health provisions, will you all be planning to host another (TAP) or (TAPs), plural, later this year.

Hillary Loeffler: Thanks, Justine. So, for your first question, as summary of the (TAP) proceedings and the feedback and recommendation we received. We're currently working to put that summary together and I don't actually have an (ECN), when we're going to make that public. But it's obviously our intent to make a summary of those proceedings public.

With regard to the second question on the BBA of '18, the requirements to have a technical expert panel, CMS is still internally considering our next steps with regards to that.

Justin Hunter: Got it, thank you.

Operator: Your next question today comes from the line of (Andrea Vadrain) of LHC group. Your line is open.

(Andrea Vadrain): Thank you and good afternoon, everyone. My question pertains to the timely initiation of care process measure specification revision.

I appreciate that we will make in that revision shortly and it sounded like that the revision had already been made but when I look on the website, the tables have not been revised. Can you let us know when we can expect to see that?

(Joan Proctor): We're looking at September of 2018 for us to be updating out logic. However, when you receive your actual full start, that's just us going back retroactively doing the review and correct adjustments that we need to do. So, when you look back at your own demand report, so you're reviewing correct, they will reflect the correct information. However ...

(Andrea Vadrain): My question is – I'm sorry. Our question pertains to the measure specification, the table's definition revision.

(Joan Proctor): And those table definitions we are working with (intelligently) support contractor for the QIES system to make those changes.

So, the announcement I made was the fact that we were going to have to, for a period of time, which you look at in the on demand reports and stuff like that are not going to reflect that logic change.

But we did, put the logic out there so folks knew that we were making it. And we also made available for you, a data which you'll be able to see the changes which is up – we're looking at September 2018.

(Andrea Vadrain): OK, yes. I understood that I guess our software vendors will not make the change to their logic until the specifications tables, the outcome and process measure tables are updated on, you know, the website saying what the definitions are.

And usually those are updated like about this time, this year and I was just wondering if we could expect to see that in the near future.

(Joan Proctor): You will see that in the near future. We did release to the folks who do the web posting for them to provide the update and specifications. If you want to follow up with me ...

(Andrea Vadrain): OK, thanks. Thank you very much.

(Joan Proctor): You're welcome.

Operator: Your next question is from (Jacob Myer) of Healthy Living. Your line is open.

(Jacob Myer): Hey, just a quick question for you. So, I wanted to seem when will it OASIS did take effect and when will the guidance be released for the training?

(Joan Proctor): In terms of the (OASIS-D), we're working on the training – the revising of Oasis instrument to accommodate all the changes. And we plan to post it in July and address format and, of course, finalize it, probably, like November. We have to go through the PRA approval process with (OMD).

(Jacob Myer): OK, thank you.

(Joan Proctor): Yes, you're welcome.

Operator: Your next question is from (Kathy Ward) of Central Montana Medical. Your line is open.

(Kathy Ward): Hi. We were just wondering when will you guys – the module training for the March 27th from 1:00 to 3:00 Eastern Time, will those be archived so the people can access them at a later date if they can't attend that?

(Cindy Massuda): Yes. They are archived. And also the trainings are actually web-based trainings that are going to be sitting on our website and then, we're going to have a live, at least, a live webinars to walk through key aspects or to make people aware of these different websites, web trainings that are on and that also will be archived.

So, it's a host – it's a wealth of information and look forward to having people register and join us on March 27th, 2018 from 1:00 to 3:00 p.m.

(Kathy Ward): Thank you. You guys have good afternoon.

Operator: your next question is (Marianne Maginnis). Your line is open.

(Marianne Maginnis): Hi. Thank you. I'm just calling to – I was just wanted to ask about the rural add-on updates. Are you going to be publishing the rural add-on group of payments amounts and the outlier factors that are in the final rule for 2018?

(Wil Gehne): Yes, there should be a change request coming up about that in the next few weeks.

(Marianne Maginnis): Next few weeks, OK, great. Thank you.

Operator: Your next question comes from the line of (Diane Segal) of (QNES). Your line is open.

(Diane Siegel): Thank you. I wanted to find out if you have any information regarding the DMEPOS Competitive Bidding for the new round of bidding.

(Inaudible)

Hillary Loeffler: Hello, yes. This has been an investment to DMEPOS Competitive Bidding. So, CMS will communicate any updates regarding the next steps on the program through its normal communication channels. That is LISTSERV, messages, press release and et cetera. So, be looking out for any information we might have through channels. Thank you.

(Diane Siegel): Thank you.

Operator: Your next question comes from the line of (Marianne La Verde) of Options Home Health. Your line is open.

(Marianne La Verde): Yes, hi. Thank you for taking my call. I just have a quick question about the low volume appeals. We did file for that and we received confirmation back, everything was OK that they were go to begin processing it.

But, then subsequent to that, we receive an e-mail for the password. And we did send them – we responded back by asking what the password is for, where we supposed to do it and we haven't heard anything, it's been several weeks. So, I'm just curious, what is the password for?

Ronke Fabayo: Hi. This is Ronke. Can you do me a favor? Can you send me an e-mail to the medicaresettlementfaqs@cms.hhs.gov e-mail, and with your specific like provider information and I can look into that for you?

(Marianne La Verde): OK. What's the e-mail address again?

Ronke: Sure, sure, it's Medicare, all one word, Medicare Settlement, S-E-T-T-L-E-M-E-N-T, F as in Frank, A as is apple, Q like s – frequently ask questions, faqs@cms.hhs.gov so, medicaresettlementfaqs@cms.hhs.gov.

(Marianne La Verde): And should I address it to you?

Ronke Fabayo: It will – tell me your name again please.

(Marianne La Verde): (Marianne La Verde).

Ronke Fabayo: (Marianne). Yes, you can address it to me. That's fine.

(Marianne La Verde): I'm sorry, what's your name again?

Ronke Fabayo: It's Ronke, R-O-N-K-E. If you just put my first name. It will get to me.

(Marianne La Verde): OK, thank you so much.

Ronke Fabayo: No problem.

(Marianne La Verde): Bye-bye.

Ronke Fabayo: Bye-bye.

Operator: Your next question comes from the line of Nancy Gelle, of Park Nicollet Hospice. Your line is open.

Nancy Gelle: Yes, this is a hospice question. If program had rejection of payments because of the NOE edit problem, what should be our next stop be?

(Wil Gehne): I'm not sure what you mean by rejection of payments.

Nancy Gelle: We submitted bills for January and they were rejected for untimely NOE submission.

(Wil Gehne): OK.

Nancy Gelle: And we submitted them electronically, the bills or the NOEs.

(Wil Gehne): OK. The reason that the NOE was untimely was because of the system problems that we were having that causes ...

Female: Correct, correct.

(Wil Gehne): ... to do returned an error. But you can – bill request and exception for those and we've given guidance to the (MACs) that – for their early days of this year when we're having that problem, that there are approving exceptions in those cases because it's a circumstance beyond hospice's control.

Nancy Gelle: OK. So bill is exception, is that what we do or we just rebill?

(Wil Gehne): You need to – the rebill with the CAC modifier on the claim indicating that an except that you're requesting an exception.

Nancy Gelle: OK. Thank you very much.

Operator: Your next question comes from the line of (Cody River) of FHT. Your line is open.

(Cody River): We already had our question answered. Thank you very much.

Operator: Your next question is from Jennifer Riggs of Grace Hospice. Your line is open.

Jennifer Riggs: Hi, thank you. I just had a question regarding the CAHPS hospice provider preview report. If the provider review the CAHPS hospice provider preview reports for the reporting period of April 1st, 2015 to March 31st, 2017 and identified some type of an issue with submitting CAHPS hospice data and the error was that 10 error the hospice did not submit any required data for this quality reporting period.

So, if the hospice has already worked with their approved survey vendors to submit the CAHPS process TRF, is this situation impacted by the 2 percent APU reduction and what is the timeframe of hospice for how this will take place?

(Lori Teichman): Hi, this is (Lori Teichman) on the answering four Hospice CAHPS. So the question is, you saw something in the Hospice CAHPS preview report that was wrong, right?

Jennifer Riggs: Correct.

(Lori Teichman): OK. And did you follow the directions for reporting that error?

Jennifer Riggs: We did.

(Lori Teichman): And what happened? I misunderstood.

Jennifer Riggs: We haven't received the response yet and I just wondered if the situation will be impacted by the 2 percent APU reduction for not reporting?

(Lori Teichman): OK. Well, two things that I can answer because I have to tell you. One thing a lot of people get mixed up. What is on Hospice Compare and what is on for

instance Home Health Compare with Home Health CAHPS is not necessarily tied to the annual payment update. Because your seeing publicly reported data that's coming in for a time period that's now available.

But, for instance, for home health CAHPS – I'm sorry, (UFC) about hospice CAHPS. The hospice CAHPS for risk is right now where in 2018, we're collecting data that's going to affect your calendar year 2020 APU, OK?

So, the period of data is really it's a big period that its – when you're talking about four quarters, it's two years and it's crossing over calendar years.

So I can't really say which calendar year like particular errors would have affected because we do the APU decisions for hospice CAHPS based on calendar year data. It's not really by these quarters that may start like March or February and whenever they first start.

So, it may or may not. I'm not sure. I would have to actually go back and see which year and it may have this and affected your determination of compliance for CAHPS in a previous period. So ...

Jennifer Riggs: OK.

(Lori Teichman): ... I don't know but I'm a little concerned about the lack of getting the reply to you. When did you send in the e-mail?

Jennifer Riggs: Just recently, actually yesterday, so.

(Lori Teichman): Oh OK. Well, I'm sorry didn't mean to laugh. OK.

Hillary Loeffler: So, this is Hillary. Can you resend an e-mail to the Home Health Hospice & DME/ODF mailbox and I'm going to send that to (Lori) just to make sure she got.

(Lori Teichman): That would be great. Thank you.

Hillary Loeffler: Unless she can have a timely response for you.

(Lori Teichman): Yes, I'm sorry. Yes, it could just be that maybe they take some up to 24 or 48 hours to reply because I don't know that – they have a rule for that for how hospice CAHPS and I forgot it could be up to 48 hours. OK, I wouldn't be concern yet about the APU, OK.

Jennifer Riggs: OK. Thank you so much.

Female: Thanks.

Operator: Your next question comes from the line of (Anna Hall) of 3HC. Your line is open.

(Anna Hall): Yes, I have a question about the timely initiation of care. Did I understand you to say that the logic was on a website somewhere that we could go to and look at? The changes in the logic.

Hillary Loeffler: For timely initiation of care?

(Anna Hall): Yes ma'am.

Hillary Loeffler: I said that it will be posted soon. I need to follow-up because I believe that we already forward it to the folks who did the web posting but I will check.

(Anna Hall): OK. And who does the web post team?

Hillary Loeffler: We have a (ton of) staff here who ...

(Anna Hall): OK.

Hillary Loeffler: ... CMS staff who post the material for us.

(Anna Hall): OK. Thank you.

Hillary Loeffler: So hopefully I try to make sure that they try to get it out by the end of this week. I'll posted up there for everyone.

(Anna Hall): Wonderful. Thank you so much.

Hillary Loeffler: Thank you.

Operator: And your next question comes from the line of Christopher Traver of Meadows Home Health. Your line is open

Christopher Traver: Good morning and thanks for taking my question. I have a quick question on the settlement. Is that \$9,000 each claim or is that the total amount of claims total you can appeal?

Ronke Fabayo: It's for appeal. So you can have several – hi, this is Ronke again, sorry. So if you have like three claims filed under your appeal like group together under your appeal, all the total of build amount for all three claims under that one appeal have to be \$9,000 or less, so it's on the appeal level not a claim level.

Christopher Traver: OK. So at the appeal level, correct?

Ronke Fabayo: Yes.

Christopher Traver: OK. And I have one more question, so you can answer me this question. We are audited by the ZPIC and we got our results and we've been asking for the last six months for provider education as to what we've done wrong about the ZPIC company safeguard and our MAC, and no one has gotten back to me about it. Is there anybody we can call or give us education?

Hillary Loeffler: So hey, this is Hillary Loeffler. If you can just send an e-mail to the ODF mailbox we can (write it over) to our program integrity folks and they can get back to you.

Christopher Traver: What was that e-mail address? I'm so sorry.

Hillary Loeffler: Oh it's on the – do you have the agenda for the ODF? It's kind of a long e-mail address it's homehealth, all one word, underscore, hospice, underscore, DMEODF-L@cms.hhs.gov.

Christopher Traver: OK. Because we did call the safeguard and they said it would be NGS that will be doing our intermediary.

Hillary Loeffler: OK, yes. I'm sorry there's nobody from medical review here? But if you e-mail me I can definitely send it over to the right folks and they can write you back and contact you.

Christopher Traver: OK. All right, thank you for your time. I appreciate it.

Hillary Loeffler: Thank you.

Amanda Barnes: Hi, this is Amanda Barnes. Real fast about the timeliness for Home Health specification. They are posted as a download on the Home Health Quality Measures webpage. It's actually the first PDF it says Home Health QRP Timely Care Specification February 2018. Thank you.

Operator: And your next question comes from the line of (Shirley Fass) of Hospice Illinois. Your line is open.

(Shirley Fass): Hello. Recently when we've been verifying Medicare benefits, we've seen a lot of occurrences where Medicare is listed as secondary payer and the primary payer is a third-party liability such as Work Comp or auto insurance, which we feel is not related to the Hospice diagnosis, but our claims are being rejected due to different coverage. So is there a reason that we're seeing all of these occurrences and what can we do about them?

Hillary Loeffler: Hey, (Shirley). I apologize I don't have anybody on from our secondary payer area. Do you mind sending me an e-mail and we can definitely look into it and get you a response?

(Shirley Fass): OK. Do I send it to the e-mail that's listed on the e-mail that was sent out?

Hillary Loeffler: That'll be perfect.

(Shirley Fass): All right, thank you.

Hillary Loeffler: Thank you.

Operator: Your next question comes from the line of (Jessica Cosmaca) of ProHealth. Your line is open.

(Jessica Cosmaca): My question as already answered. Thank you.

Operator: Your next question comes from the line of (Liza Johnson) of STRS. Your line is open.

(Liza Johnson): Hi, thank you for taking my call. My question is regarding the low volume appeal. I'm wondering about the dates. I have some information that for NPI numbers and an even number needs to be by March 9th and you said there is another additional webinar on March 13th, and I'm wondering if that timeframe is correct?

Ronke Fabayo: Yes, the timeframe is – sorry this is Ronke again. That timeframe is correct. So the process opened up for providers with an even number on February the 5th and the timeframe for them to – with providers with an even number to submit their expressions of interest to get the process started for settlement within February the 5th until March the 9th.

So we've a provider call. We had a provider call on February to answer, you know, questions for providers with odd NPIs. I'm sorry, even NPIs, so that March 13th MLN provider call, they were having will be – they'll answer the questions of providers with Odd NPI.

Did that makes sense? So we're just doing multiple provider calls while the process is open, but there are two different timeframes to submit expressions of interest. Does that help?

(Liza Johnson): OK. Is there – yes. Is there information to get the – or a place to get the data from the prior call?

Ronke Fabayo: Oh yes. So there's a link on our website. If you go to the website, again, that website – if you're ready I'll go ahead and give it to you again it is go.cms.gov/LVA, and Jill correct me if I'm wrong, I think it may also be on your agenda. On the agenda for those call, but again its [go.cms.gov/ capital L-V-A](http://go.cms.gov/capital-L-V-A).

And we've just added an update a couple of days ago, so you'll see within that the very – like under the, what's new portion of the website, you'll see a link where you can access the audio transcripts and the presentation for the previous calls.

(Liza Johnson): Thank you.

Ronke Fabayo: No problem.

Operator: Your next question comes from the line of (Jacob Myer) of Healthy Living. Your line is open.

(Jacob Myer): Another question for you. So we've submitted questions in the health desk for understanding COPs, so we didn't get a response. We just wanted to know how we can get this clarifications for the new COPs and then when will the final Interpretive Guidelines be published?

Hillary Loeffler: Hey, (Jacob), so I apologize. I announced that in end call that our colleague in the COP area survey, they weren't able to join us today. So we can't answer your question. But if you send an e-mail to the mailbox on the agenda I can make sure that I send that over to these folks.

(Jacob Myer): OK, we'll send an e-mail then.

Hillary Loeffler: Thanks.

Female: And (Amy), we'll take one more question please.

Operator: Your last question for today comes from the line of Nancy Chang of Asian Network Hospice. Your line is open.

Nancy Chang: Hi, thank you for taking my call. I think the previous call answer somewhat one my questions. So this e-mail box is very long e-mail box is where we can send questions about compliance, correct?

Hillary Loeffler: Compliance with the COPs?

Nancy Chang: Yes, and so for example if I can just ask this question? So according to COPs, it really talked about the patient's right to be informed in advance of care to be furnished regarding their visit pattern, who's going to be visiting in.

Is it the – how can that be established when – I mean you have to see that patient at the start of care. So I mean how does CMS want us to address this when they say we need to inform the patient a visit patterns and who is going to see them before care started? How can that be done? That's my question.

Hillary Loeffler: Sure. I mean I apologize there's nobody from the Conditions of Participation or the Interpretive Guidelines here with me in the room are on the line so the best I can do is forward an e-mail to them for response.

Nancy Chang: OK, all right. OK, thank you.

Hillary Loeffler: All right, thanks. Well, thank you everyone for joining us today for the Home Health Hospice & DME open door forum and we will be back in touch in a few weeks for the next call. So thanks everyone, have a great day.

Operator: Thank you for participating in today's Home Health Hospice & DME/Quality open door forum conference call. This call will be available for replay beginning today February 28 2018 at 5:00 p.m. Eastern through March 2nd 2018 at midnight.

The conference ID for the replay is 31630800. 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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