

Centers for Medicare and Medicaid Services  
Home Health, Hospice and DME Quality  
Open Door Forum  
Moderator: Jill Darling  
March 22, 2017  
2:00 p.m. ET

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

All lines have been placed on mute to prevent any background noise. After the 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, press the pound key. Thank you.

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Kim). Good morning and good afternoon, everyone. Thank you for joining us today for the Home Health, Hospice and DME Open Door Forum. I'm Jill Darling in the CMS Office of Communications. One brief announcement from me, this Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have inquiries, please contact [cms@press@cms.hhs.gov](mailto:cms@press@cms.hhs.gov).

We will dive right into the agenda. First, we have Joel Kaiser who has announcement about the March 23rd Stakeholder Call.

Joel Kaiser: Hi. This is Joel Kaiser. I'm the director of the Division of DMEPOS Policy here in Center for Medicare. I just want to announce and remind folks that we are holding a stakeholder call tomorrow beginning at 2 o'clock, and this in reference to Section 16008 of the 21st Century Cures Act, which mandates that we take into – that we solicit and take into account stakeholder input regarding fee schedule adjustments for items and services furnished on or after January 1, 2019. The fee schedules are adjusted per the statute based on information from Competitive Bidding Program.

So, this will be a call for stakeholders who are furnishing durable medical equipment, enteral nutrition in the non-competitive bidding areas to call and provide comments to us to provide feedback to us for the purpose of implementing this Cures Provision. There's information that was provided for the call today that gives you the Web site where you can go to register for this meeting, and there's also detailed – more details on our Web site regarding the call. And I just wanted to make sure that as many people were aware of it as possible so that they could have the opportunity to call in and listen and perhaps give comments if they want. We also had a date for submitting written comments, April 6, and we have a mailbox, [dmeupos@cms.hhs.gov](mailto:dmeupos@cms.hhs.gov) where you can send your written comments. Thank you.

Jill Darling: Thank you, Joel. Next we have (Wil Gehne) who has a home Health claims announcement.

(Wil Gehne): Thanks, Jill. Over the last few calls, I've reminded home health agencies that effective April 1, 2017, all home health PPS claims will be subject to a two-step check for the presence of a supporting OASIS assessment. If the OASIS is not found and that OASIS is past due, the claim will be denied.

So, a few reminders about some frequently asked questions. This change only affects home health claims. It has no effect on the processing (reps). The process does not create denial simply because an OASIS assessment was late. For a denial to occur, the OASIS must be missing and past due.

Medicare systems will look for the OASIS assessment that produced the HIPPS code for the claim. So, it may be a start of care or assumption of care

or recertification assessment that our systems will be checking for. And the change is effective based on date of service. So, any claim with a through date after April 1st will be effective.

This time, I'm also going to provide some tips on how home health agencies might avoid denials. But before submitting a claim to your MAC, home health agencies may want to ensure that the OASIS assessment was successfully accepted into the (keys) national database. You can verify this by reviewing your OASIS validation report for submissions with – for submission that included the assessment. The validation report will provide all the information that's needed in order to prevent claims denials or to understand why a denial occurred. That is confirmation of an assessment receipt, the date of that receipt, and any fatal or warning errors that were encountered on the transmission.

So, there's no need for a home health agency to call the QTSO Help Desk with the MAC for this information. That should already be available to you in those validation reports. In the next few days, an MLN Matters Special Edition Article will come out with additional information about this process.

Thanks, Jill.

Jill Darling: Thank you, (Wil). Next, we have Charles Nixon for the Hospice Claims announcement.

Charles Nixon: Thank you. On the last forum, we said that CMS believe all system issues with counting high and low routine home care days were resolved and that adjustments could be made the claims with a routine home care days had been counted incorrectly. We've since learned that in some cases, Medicare systems (were assumed) miscounting some RHC days. These cases are limited to situations where there's (prior) hospice benefit period. They must be included in the count.

Hospices that are on the – hospices that are aware of routine home care counting errors related the prior benefit period should withhold adjustments until further notice. We are unsure when a fix will be scheduled for these

ongoing issues. And we recognize some of these points may be approaching already beyond the timely limit filing day for adjustments to take place. And we will instruct the MACs to override timely filing once adjustments can be made. So we want to thank you for your patience while we work on a solution.

Jill Darling: Thank you, Charles. The next we have Amanda Barnes who has a Hospice and Home Health Quality Reporting Program announcement.

Amanda Barnes: Thanks so much, Jill. Yes, so the Hospice Quality Reporting Program, we wanted to remind providers that you need to rerun your quality measure reports. So, in the Quality Measure reports that were disseminated and implemented December 18, 2016 through February 26, 2017 for the Hospice-Level Quality Measure Report as well as the Hospice Patient Stay-Level Quality Measure Report, there is an issue identified and also corrected, though, with the calculation and we just need to make sure that you guys rerun the reports during this date range. You can visit the HIS Technical Information Web page for more information.

And then in regards to the Home Health Quality Reporting Program, CMS is hosting a two-day in-person provider training in Baltimore on May 3rd and 4th, 2017. And the focus of this train-the-trainer event will be to provide Home Health Agencies (HHAs) with assessment-based data collection instructions and updates associated with the changes in the release of the Outcome and Assessment Information Set (OASIS) C2 which became effective on January 1, 2017, and other reporting requirements of the Home Health Quality Reporting Program.

We're going to cover information that was presented back in the November training, and also there's going to be additional topics that was also presented in November. There's questions that were generated and we are going to address those as well. Please visit the Home Health Quality Reporting Training Web page on CMS.gov for more information and to register.

And then one other update for the Home Health Quality Reporting Program is that there is update from changes under consideration to the Quality of Patient

Care Star Rating. And (there's two things) under consideration and the calculations that were described during a January 19th National Provider Call in February. And we wanted to just thank the providers that sent in their comments during that public comment period. We're still reviewing them and going through their public stakeholder input and we really value that.

We're going to provide more information about any changes to the ratings calculation later this year once we've completed the review. And in the interim, there will be no changes to the way that Quality of Patient Care Star Rating. They are computed for the July 2017 refresh of home health compare, but the preview reports for July showing star rating results will be available in your CASPER mailboxes by April 6 and then the suppression request will be due by April 21st.

That's all I have. So, Jill, back to you.

Jill Darling: Thanks, Amanda. And last, we have Lori Teichman who has Home Health CAHPS review.

Lori Teichman: Thank you, Jill. Hello, everyone. I would just like to go over some – a lot of things you've probably heard before but there are quick reminders that if you've not yet – if you're a home health agency not yet participating in Home Health CAHPS and you are receiving a 2 percent reduction in your annual payment update because you're not in HHCAHPS, this is a great time to consider joining and participating in the Home Health CAHPS survey because all participation periods run from April 1st through the following March 31st. So, you have a couple of months (yet) because typically if you signed up with one of the Home Health CAHPS Survey vendors, you submit a list of your patients for April, some time in mid-May through the beginning of June.

And we encourage you if you're thinking about this, rather you can go on our Web site, which is in the agenda or you could just e-mail RTI, their federal contractor for Home Health CAHPS because that's the fastest way and they will walk you through all the steps to get on board quickly and that e-mail is [hhcahps@rti.org](mailto:hhcahps@rti.org) and that's also on the agenda.

And another thing that you should know is that right now on our Web site, we have the participation exemption form for the calendar year 2018 annual payment update period and that form is going to be up on the Web site through March 31st. So, if you're not right now in HHCAHPS and you are an agency with 59 or fewer patients that were in the reference period, (the patient count) period, then you should be filling out this form as soon as possible. It's going to be up on the Web site another nine, 10 days. And then on April 1st, we replace that form with a new form for the following APU period.

This Friday, March 24th, we are going to post Home Health CAHPS preview reports in the Home Health Agencies sections of our Web site that home health agencies that have registered on our Web site can access with their ID and passwords. It is a secure portal. So, you can look at what is going to be publicly reported on Home Health Compare beginning April – I think it's April 12 is the date for the refresh. But you can check out the HHCAHPS data for your agency this Friday with the preview report. And if you see anything that you have questions about, you can contact RTI also on our Web site. And it's easily accessible by choosing this option. You can look at all of your data submission reports including current ones. So you can make sure that your vendor is submitting all of your data for Home Health CAHPS on time.

If you ever have problems as the home health agency submitting your monthly list of Home Health CAHPS eligible patients to your respective Home Health CAHPS vendors, you should always immediately contact your vendor because that vendor will fill out – will document your issue and will fill out a discrepancy report, discrepancy notification report it's called, and CMS sees all of these reports. So, it's better to report these problems than to just be silent on them because we like to document and see what's going on that may be the reason for missed months in Home Health CAHPS.

As always, if you have any questions about anything related to the Home Health CAHPS survey, again, please e-mail [hhcahps@rti.org](mailto:hhcahps@rti.org). And also we have a CMS mailbox which is [homehealthcahps@cms.hhs.gov](mailto:homehealthcahps@cms.hhs.gov). Thank you so much.

Jill Darling: Thanks, Lori, and thank you to all of our speakers today. And, (Kim), we'll go into our Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

And your first question comes from the line of (Jennifer Handle) with Hospice of Michigan. Your line is open.

(Jennifer Handle): Hi. This is a question about the hospice billing in routine home care rates and ongoing issues. My first thing is a comment and then I have the question. The comment is, you know, when there was a proposed rule for this – the hospice payment reform, our hospice, along with many others, suggested that CMS tests some of this so we could avoid the very thing that we're experiencing now and CMS insisted on proceeding without testing. And then, you know, here it is, this much later and we still have these problems.

My question is, if CMS, in meeting with the MACs, if there's ever a discussion about how the status of these things is communicated to the providers. And the reason I'm saying that is because I have it up on my computer screen right now the last time NGS reported what the current status was and the last thing that Palmetto communicated. And NGS states that the RHC payment correction was installed in 01/03, and providers are advised they can now adjust the claims that impacted by this issue.

Now, we adjusted dozens and dozens and dozens and dozens and dozens based on that alert that was on February 21st, and Palmetto says on February 9th, the (fixed edition) has been created and is scheduled to be released in production, April 3rd. And Palmetto is waiting for the direction to correct

previously process claim with incorrect payment amount. No provider action is required.

So you know, my frustration is that, you know, two different things by two different MACs. Now we're being told not to adjust certain claims. But I don't know precisely which claims we're not supposed to adjust. So, some of them were OK to adjust, others are not OK to adjust. You know, it'd be really helpful if one analyst could write in detail for hospice billers what they're supposed to be adjusting, what they're not supposed to be adjusting, what's been corrected on 01/03, what's going to be corrected on 04/03, and what remains to be corrected. Can somebody comment on that, please?

(Wil Gehne): Yes, this is (Wil Gehne). You're absolutely right to be frustrated; I am, too. (I want) to accept the characterization that we implemented this without testing. We did test a lot of scenarios and identified some problems before we implement it and we fix them. There are always scenarios with a situation, (a policy of conflict) as this one that, you know, we were unable to – we were unable to identify or regret those – just getting the quibble out of the way (is we're) not implemented on testing. But you're right to be frustrated with the results. I'm very frustrated with the results.

In terms of the point about lack of coordination or the communication, I think that's really well taken. I think we have not coordinated this – the messaging from the provider education departments of the MACs and CMS as well as we ought to. And right now, we don't have enough information about the exact nature of the problems that are ongoing to write the article that you just described. When we do, I think it's a good idea that we do that and do exactly what you said and get all three MACs together with myself and Charles about, you know, what are the consistent message across the country should be. And when we know exactly what we need to say, we will say it. Thank you.

Jennifer Handel: Thank you.

Operator: And your next question comes from the line of (Jan Lara) with (Banner). Your line is open.



(Jan Lara): Thank you. And (shifting) back to the home health claims that will go into effect in April, the two-step check for OASIS to clarify that past due components or criteria for claims to be denied is defined as end of the 60-day episode or date of discharge on the claim?

(Wil Gehne): I'm sorry, which criteria are you talking about, like how we're going to discharge past due?

(Crosstalk)

(Jan Lara): Correct.

(Wil Gehne): We're going to compare the receipt date of the claim to what the claim tells us was the OASIS completion date. And if the claim was received after the – more than 30 days past the scheduled completion date, which is when that OASIS should have been transmitted, then we're going to see if the – if it's past that date and missing, then the claim would be denied.

(Jan Lara): OK, thank you.

Operator: And your next question comes from the line of Mary Jo McGraw of Community Hospice. Your line is open.

Mary Jo McGraw: Hi, this is Mary Jo. I was just going to ask if there was going to be any mass adjustments anytime soon for the claims that did not pay last year for the SIA payments and you know when they didn't go back to look at the previous month's claim and pay SIA. We saw some balances that are hanging way out, you know, from last year.

(Wil Gehne): Yes, this is (Wil) again. We have been trying our best to identify mass adjustment criteria that could work for those. But today we have not been successful; I mean I think when we have (assured) that none of these issues with counting (RHC) days from the prior period could affect a claim that, you know, that wasn't identified properly to pay an SIA. That will be part of the message that we've talked about with the earlier hospice to tell the providers that they can adjust those to get those payments corrected. I don't believe

we're going to be able to mass adjust them. But at the moment it's possible that you could adjust that claim, get your SIA payment correct and then potentially have the ...

(Crosstalk)

Mary Jo McGraw: How we would adjust the claim? I mean that's something Medicare is supposed to be calculating. When we adjust the claim, we had to put like a reason code on the claim for why we're adjusting it, and I don't think there's anything that would match for SIA. Does – I mean why are providers being told to adjust claims when these issues are things that (happened) by the Medicare systems.

(Wil Gehne): Because you can't tell from the face of the claim sitting in the (paid) claims history at the MAC which claims need to be adjusted and which don't. They all need to be – they would all need to be processed back to the common working file in order to identify the SIA adjustments that we missed the first time. And the alternative – yes, we could mass adjust these. But we would end up mass adjusting thousands of claims that didn't need to be touched in order to identify the ones that we're – the ones that needed to be. And we think that will be more disruptive to provider's accounts receivables and, you know, processes in general than having provider submit adjustments for the claims that they know and exactly adjust those claims that they know are incorrect.

(Crosstalk)

(Wil Gehne): I agree with you that there's not a – one of those (the) condition codes that identifies the change reasons that's applicable, but they're not required in all cases. Hospice could submit an 817 or 827 type of bill adjustment and not making ...

(Crosstalk)

Mary Jo McGraw: Without any ...

(Crosstalk)

(Wil Gehne): ... any other changes and ...

(Crosstalk)

(Wil Gehne): ... at the point where all of the other problems are out of the way that would succeed in giving the SIA payment triggered.

Mary Jo McGraw: OK. All right.

Operator: And, again, if you would like to ask a question, please press star then the number one on your telephone keypad. Your next question comes from the line of Stephanie Fishkin with Kaiser Permanente. Your line is open.

Stephanie Fishkin: Good afternoon. This was just a clarification when you said that the Hospice CAHPS reports were available on April 6. Are you referring to the reports, like the data submission reports? Or were you talking about public reporting preview reports?

Amanda Barnes: Yes, this is Amanda Barnes. It's actually Home Health preview report.

Stephanie Fishkin: I'm sorry, can you say that again, please? It's just I'm having a hard time hearing you, the what reports?

Amanda Barnes: It's the Home Health preview reports.

(Crosstalk)

Stephanie Fishkin: Right, but somebody said – somebody else was talking about Hospice preview reports I thought?

Amanda Barnes: No, there's ...

Stephanie Fishkin: OK.

Amanda Barnes: No.

Stephanie Fishkin: OK, thank you. Sorry about that.

Amanda Barnes: It's OK.

Operator: And your next question comes from the line of (Walter Elar) with (Bay Area Home Health). Your line is open.

(Lorna): Hi, this is (Lorna) and I have a question for (Will) regarding – when we submit our OASIS and we get a warning like there's some kind of a warning and then we fixed that and resubmit the OASIS, then our OASIS are coming back at their past timely filings or, you know, their past due. Can you – do have to fix those warnings?

(Wil Gehne): I'm not sure I know what – I'm not sure I know what you mean. You're getting warning messages on your validation reports for OASIS that are accepted?

(Lorna): Correct, correct.

(Wil Gehne): OK, I think we need to learn more about what the particular warning message was to know what the resolution is.

(Lorna): OK, like for instance, like the client has a middle initial and it's correct as we submit it, but it was incorrect when somebody else submitted it. So, we get a warning and we go in and correct that and resend it and then we get the (190) is past due.

(Wil Gehne): OK, I'm looking at some OASIS colleagues for whether those corrections are necessary. What I do know is that, that's not a circumstance that would create a claim denial on this case. We would find the original assessment that was accepted with the warning, and we would find the second assessment that was corrected and get back another warning message said it was late. There's no chance that, that claim is going to be denied for that reason. But as far as the ...

(Crosstalk)

(Off-Mic)

(Wil Gehne): Right.

(Lorna): OK, that sounds good.

Operator: And your next question comes from the line of (Stephanie Hansbury) with (Hospice). Your line is open.

(Stephanie Hansbury): Good afternoon. Regarding the new hospice (item set) data collection which goes into effect April 1st, can you explain the intent for collecting payer information outside, beyond hospice services? Or did I misinterpret the intent of that data collection field?

Jill Darling: Amanda?

Amanda Barnes: Yes, I'm sorry, can you repeat that one more time?

(Stephanie Hansbury): Sure. Regarding the new hospice items at data collection which goes into effect April 1st, can you explain the intent for collecting payer information outside of hospice services? I believe its A1400 is the field.

Amanda Barnes: Yes, unfortunately, we don't have anyone on the line to help you to answer that question today. Would you be able to submit that to the resource box that was (inaudible) in the agenda and we can get that address, please?

(Stephanie Hansbury): Sure. You say it's in the agenda here?

Amanda Barnes: Jill, it's in the agenda, is that correct?

Hillary Loeffler: Yes, the mailbox should be on the agenda. It's [homehealth\\_hospice\\_dmeodf-l@cms.hhs.gov](mailto:homehealth_hospice_dmeodf-l@cms.hhs.gov) ...

(Crosstalk)

(Stephanie Hansbury): OK, I see it.

Hillary Loeffler: It's pretty lengthy – OK, great.

(Stephanie Hansbury): I see it there. Thank you.

Operator: And again to ask a question, please press star then the number one on your telephone keypad.

And there are no further questions at this time.

Jill Darling: Thank you to all of our speakers today and thank you for all of our participants for dialing in. Our next Home Health, Hospice and DME Open Door Forum is scheduled for May 3rd, but note that the date is always subject to change as well as the agenda items. So, we appreciate your time today. Thank you, everyone. Have a great.

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, March 22nd at 5:00 p.m. 2017 through March 24th, 2017 at midnight. The conference ID number for the replay is 57590512. The number to dial for the replay is 855-859-2056.

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

END