

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Home Health Quality Reporting Requirements:
Quality Assessments Only (QAO) Measure Review and Historical Performance Reports
Tuesday, June 2, 2015
1:30 p.m. ET
Moderator: Jill Darling

Operator: Good afternoon. My name is (Kyle), 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 Quality Reporting and Requirements, Quality Assessment Only Measure Review and Historical Performance Report Special 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 and the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Ms. Darling, you may begin your conference.

Jill Darling: Thank you (Kyle). Good morning and good afternoon everyone. I'm Jill Darling from the CMS Office of Communications. Thank you for joining us today. For today's Special Open Door Forum, we do appreciate your patience. I know beginning a little later because there were more people dialing in and gathering lots of information, so we appreciate your patience.

Before, we begin just one note. The special open door forum is not intended for the press, so if any press, do have inquiries, please contact Press@cms.hhs.gov. So we will begin the forum today in the middle of the announcement that was sent out there was a link that will included the slide deck for today's call. So I will hand the call over to Dr. Alan Levitt to begin.

Alan Levitt: Thank you, Jill. My name is Alan Levitt, the Medical Officer in the Division of Chronic and Post-Acute Care at CMS, and along with Dr. Eugene Nuccio of the University of Colorado, Anschutz Medical Campus. I want to thank you for joining today's Special Open Door Forum on the QAO or Quality Assessments Only, Measure Review and Historical Performance Report.

At the start of the presentation, like Jill just told you, I just wanted to remind you that today's slides can be found at the Home Health Quality Reporting Requirements web page, and that there is also a link included in the announcements and invitation to today's special open door forum.

Next slide. On the next slide you'll see that the quality assessment only or QAO metric will be used starting next year to assess whether home health agencies have met the quality reporting threshold for the pay for reporting program. We appreciate your participation. Today's session follows up on information previously shared during a special open door forum in November 2014.

As noted on this slide, the presentation today will include a review of the QAO metric including background and how it is computed. In addition, we will present an example of the informational, historical performance report agencies can expect to receive later this month. We will close with an opportunity for questions and comments.

The next slide; slide three, overviews why the QAO metric was developed. The home health quality reporting program was established in the Social Security Act and includes a provision that participating agencies submit oasis data that can be used to calculate quality measures. Compliance with this requirement is tied to the home health market basket percentage increase in Medicare fee for service payment rates that agencies are able to receive annually, known as the annual percentage update, or APU.

Failure to comply with reporting requirements can result in a two percentage decrease in the APU. In 2012 the performance criteria used to determine if agencies were meeting the reporting requirement was deemed to be inadequate by the Department of Health and Human Services Office of

Inspector General. As a result, CMS has developed the QAO metric to measure compliance and articulated new compliance threshold.

Slide four describes CMS's communication to date with stakeholders about the QAO metric and the new compliance threshold. The metric was first announced in the calendar year 2015 rule and was further described in a special open door forum on November 12, 2014 as previously noted. Today is the second special open door forum on the topic. And information on the QAO metric will be further updated in the calendar 2016 rule. I will now turn it over to Dr. Nuccio to further describe the QAO metric.

Eugene Nuccio: Thank you, Dr. Levitt. Slide five reiterates the background information on the QAO metric. This metric will first be effective for the OASIS assessments completed during the performance period July 1, 2015 through June 30, 2016. The QAO metric is a proportion that compares the number of submitted assessments that can be used for quality measurement with the total number that should be usable. Ideally, these two numbers should be the same. A quality OASIS assessment is one that can be combined with another assessment during a reporting period to form a quality of care episode. A quality assessment could also be one that could reasonably be expected to be combined with an assessment completed just prior to or immediately after the reporting period to form a quality of care episode. We should note that the Quality Assessments Only metric calculation does not include any follow-up assessments.

On the next slide, slide six lists examples of OASIS assessments that meet the quality assessment definition. The first type of quality assessment is when a start or resumption of care, an SOCROC assessment can be matched with an end of care or EOC assessment to form a quality of episode of care. As you know, End of Care assessments are conducted at transfer to an in-patient facility, death or discharge to the community. In this case, both the SOC and ROC and the EOC assessments count as quality assessments.

The second type of assessment is a Start or Resumption of Care episode that occurs in the last 60 days of the APU performance period. These could be reasonably expected to be linked to the assessment after the performance

period. Similarly, an EOC assessment that occurs in the first 60 days of the APU period is also considered to be a quality assessment because this assessment could be potentially linked to a Start or Resumption of Care assessment from the prior APU period.

The next two examples describe SOC ROC or EOC assessments at the beginning or end of a performance period that can be linked to a follow-up assessment and thus represent an ongoing episode of care. The final example is a Start or Resumption of Care assessment that is considered a one assessment only (One visit only) episode based on claims information and is therefore not expected to be paired with any other assessment.

On slide seven the criteria that determine if an assessment does not need a quality assessment definition or non-quality assessment are displayed. Non-quality assessments at the Start or Resumption of Care are ones that cannot be linked to an End of Care assessment during the APU period or do not occur in the last 60 days of the performance period, or do not have a follow-up assessment in the last 60 days of the performance period, or are not a one assessment only episode.

EOC assessments that are considered non-quality are assessments that cannot be linked with a Start or Resumption of Care that occurred during the performance period, or do not occur in the first 60 days of the performance period or cannot be linked to a follow-up assessment that occurred in the first 60 days during the performance period.

The next slide, slide eight, describes how the QAO metric is calculated. The QAO metric is the number of quality assessments divided by the sum of quality and non-quality assessments. The resulting proportion is multiplied by one hundred to represent the quality value as a percentage. This slide also lists the proposed performance standards for the next three upcoming performance periods. For the period from July 1, 2015 to July 30, 2016 the QAO threshold is 70 percent. As noted in the calendar year 2015 rule, CMS proposes to raise this to at least 80 percent for 2016 through 2017 and to 90 percent in the 2017-2018 APU performance period. Further detail will be provided in the calendar year 2016 rule. To place these thresholds into

context, the average home health agency QAO score based on data from 2013-2014 APU performance period was 91.1 percent. During this same period, more than 86 percent of home health agencies had a QAO score of 90 percent or higher.

Slide nine provides information about historical performance report that agencies will received later this month. The 2013-2014 QAO Historical Performance Report is intended to show how the QAO metric is computed and to show each agency how their historical performance during this time period compares with the threshold for July 1, 2015 through June 30, 2016 APU period. This report is based on historical data and the results may or may not reflect the agency's current performance. The results from this report will not be used to evaluate APU performance for the period that ends June 30, 2015. This historical report is for informational purposes only. An individualized historical performance report will be available in each agency's CASPER folder at the end of this month. A generic example is also available on the CMS website.

Turing to slide 10, slide 10 lists the components of the 2013-2014 QAO Historical Performance Report. This report includes background sections describing the statutory authority for the home health quality reporting program, how the QAO scores are calculated and some guidance to agencies on improving their QAO score if their historical performance does not meet the threshold for the upcoming 2015-2016 reporting period.

Slide 11 is a sample of the information included in the header of the historical performance report for a fictitious home health agency. The header includes the home health agency's name and its CMS certification number or CCN, a description of the date range for the assessments, the agency's QAO score for 2013 through 2014, and an indication whether this level of performance would meet the 2015 through 2016 performance criteria. In the example shown here, the agency's QAO score is 34.4 percent, a score that is below the 2015-2016 threshold of 70 percent.

Turing to slide 12, slide 12 describes the four computational components included on the historical performance report. The first section identifies the

home health agency and its total number of submitted assessments. The second details; the Start or Resumption of Care assessments, that are quality assessments, and those that are non-quality assessments. The third section provides the same information for the End of Care assessments. Finally, the fourth section shows the computation of the QAO score based on the information from sections two and three.

Slide 13 shows the Start and Resumption of Care assessments that meet each of the quality assessment criteria and those that do not. Lines 1A through 4A align with the quality assessment criteria described previously on slides six and seven. Line 5A is a sum of those lines and indicates the total number of quality assessments. Line 6A identifies the number of non-quality assessments, that is, those that do not meet the quality assessment criteria.

Turning to slide 14, slide 14 shows the same information for the End of Care assessments. Lines 1B through 4B align with the criteria for the quality assessments described in slides six and seven. Line 5B is the sum of those lines and indicates the total number of end of care quality assessments. Line 6B is the number of non-quality End of Care assessments, that; is those that do not meet the quality assessment criteria.

Slide 15 shows the final calculation of the QAO metric. Line 7 is a sum of all quality Start or Resumption of Care and End of Care assessments. That is lines 5A and 5B on the previous slides. Line 8 is the sum of non-quality Start or Resumption of Care and End of Care assessments, or line 6A plus 6B from the previous slides. The total number of assessments, both quality and non-quality is shown on line 9. As described previously, the QAO metric is the number of quality assessments, in this case 72, divided by the total number of assessments, 209 in this example, multiplied by 100 to arrive at the final QAO score of 34.4. This is shown on line 10. And now I will turn the presentation back to Dr. Levitt who will describe the next steps in the process.

Alan Levitt: Thank you, Dr. Nuccio. Slide 16 reiterates the next steps for the QAO metric rollout. The agency specific 2013-2014 QAO Historical Performance Report will be distributed by CASPER folders by the end of June. The QAO metric will first be used to evaluate performance for the APU period that includes

assessments completed between July 1, 2015 and June 30, 2016. The results of this evaluation will be used to adjust payment rates in calendar year 2017. Agencies that do not meet the 70 percent score during the 2015-2016 reporting period will have their market basket update reduced by two percentage points in calendar year 2016.

Slide 17 shows the link to the quality reporting requirements page on cms.gov. On this page you will find a copy of the QAO methodology report, a sample 2013-2014 QAO Historical Performance Report and as I already mentioned, the slides from today's presentation. As needed, frequently asked question information will be posted here as well. We will now open the lines for questions and comments. Thank you for your attention.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, press star and the number one on your telephone keypad. If you would like to withdraw your question, 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. Your first question comes from the line of (Janice Druss) from (Stauton) public health. Your line is now open.

(Janice Druess): Hi, I'm just curious. When they're looking at these, are they going to recognize the open assessments, or the open episodes or just the completed episodes? Like would an open start of care be qualified as a non-quality assessment?

Eugene Nuccio: This is Dr. Nuccio. If you go back to the definitions of quality assessments, slide six, you will see that a Start of Care assessment that occurs in the last 60 days of an APU period that does not have an end of care would be considered a quality assessment because the patient could still be on care.

(Janice Druess): So if we're in the middle of an episode, it's not going to be counted as a non-quality?

Eugene Nuccio: This is Dr. Nuccio. No, that is considered a quality assessment provided you have a Start of Care or Resumption of Care in the last 60 days, or let's say you have a Start of Care in December. As long as you have a follow-up

assessment in the last 60 days, then we know that the patient is on care, and that would also be counted as a quality assessment.

(Janice Druess): Terrific. Thank you.

Operator: Your next question comes from the line of (Tamika Wheeler) from Generation Home Care. Your line is open.

(Tamika Wheeler): I think my question has been answered, but I do have a bit of confusion about the reporting of it. What happens when the initial episode of care is a little bit prior to the 60 days or after, so those assessments are just knocked out, or we're just looking at total assessments from I think it was 2015 to 2016? So this is something new that's being implemented, but we're not dealing with 2014 and 2015 assessments?

Eugene Nuccio: Again, hello, this is Dr. Nuccio. If you turn back to slide number six, I believe you will find the information you need.

(Tamika Wheeler): I'm on it.

Eugene Nuccio: Let's say you have a patient who begins care in August 2015. And your, the patient remains on care, and you have an end of care in August 2016. That would be in the next reporting period. Your SOC/ROC assessment in 2015 would be counted if you have a follow-up assessment in the last 60 days of the reporting period, End of Care assessment would be considered a quality assessment for that next period, because it occurred in the first 60 days of a reporting period.

(Tamika Wheeler): OK.

Eugene Nuccio: So it's the third bullet down. EOC assessment that occurs, in the first 60 days of an APU period is considered a quality assessment. Or if it occurs later in the reporting period but there is a follow-up assessment because the length of care is more than 60 days that occurred in that first 60 days, then that also would be a quality assessment.

(Tamika Wheeler): OK. Thank you.

Eugene Nuccio: Certainly.

Operator: Your next question comes from the line of Linda Johnson from Health Care Systems. Your line is open.

Linda Johnson: Actually I have two questions, and the first one may be a naive, but what exactly is the APU period? Is that a timeframe on a calendar or is that a quality period?

Eugene Nuccio: The APU period is from July first of one calendar year to June 30 of the next calendar year.

Linda Johnson: Great. My other question is how is this in any way, does this in any way interact with the Five Star system that was just rolled out? I mean will this impact the Five Star, or is it totally separate?

Eugene Nuccio: Alan or Dr. Levitt? Do you want to talk about that?

Alan Levitt: Yes, this is Dr. Levitt. This is totally separate from that. The OASIS data that is collected through this will be used for the Five Star, the measures that are used in Five Star.

Linda Johnson: Then it's going to be used?

Alan Levitt: Yes. The information that comes to us will be used for those measures, but it is totally different.

Eugene Nuccio: To maybe clarify a bit more, the QAO metric is not part of the star rating computation. The QAO metric simply identifies whether or not assessments can be created or made into episodes of care. Based on those quality episodes of care, your star rating is computed for the identified outcome and process measures.

Linda Johnson: Thank you. I know I said two, but I actually have three questions. The last one is you mentioned the criteria that you're going to use. Is that in the slide deck, or is that going to be in the June release of the CASPER report?

Eugene Nuccio: I'm not sure what you mean by criteria. For the first performance period the criteria for the QAO metric is that you need 70 percent on that quality measure. So that's a criterion. For what constitutes a quality assessment, I refer you back to slide six.

Linda Johnson: Exactly. OK. I apologize. Thank you for your help.

Eugene Nuccio: Certainly.

Operator: Your next question comes from the line of (Joyce Rackers) from Department of Health. Your line is open.

(Joyce Rackers): Hi. I just have a question. When providers have questions, where do they need to go?

Alan Levitt: This is Dr. Levitt. If providers have further questions about this, they can send emails to, and I'll spell out the website. It's, hhapureconsiderations, R, E, C, O, N, S, I, D, E, R, A, T, I, O, N, S at cma.hhs.gov.

(Joyce Rackers): OK. So any questions that they have regarding this whole thing, they can write their question to this email address. Not necessarily talking about their reports, but if they have questions in general; this is where they would need to go.

Alan Levitt: Correct. Any questions regarding this, they can email there and we will monitor that email.

(Joyce Rackers): OK. All right. And then they can expect an answer back directly then from you guys?

Alan Levitt: Yes. They should expect an answer back. Now we may take some of the email questions and end up using them in a frequency answered question document just to help agencies if these questions are asked frequently.

(Joyce Rackers): OK. Thank you.

Operator: Your next question comes from the line of (Annalyn Kurdin) from (Hayeswood) Home Health. Your line is open.

(Annalyn Kurdin): Hi, yes, thank you. I have two questions. The first one is if our assessments get sent in backwards, like say we turn in a resumption of care, and for whatever reason, like another nurse didn't get the transfer put in, or somebody forgot to the transfer and we do it later, do we still get credit for it, or do we get (deemed) for that?

Eugene Nuccio: The order that you turn the assessments in doesn't matter. The analysis is done at the end of the reporting period, so that everyone has sufficient time according to the Conditions of Participation to turn in their assessments. So the order does not matter.

(Annalyn Kurdin): OK. And secondly, will this information be on CASPER report so that any given date I can go to CASPER and run my reports and kind of see where we're at on our preparing, or will it just be put out there specific times?

Eugene Nuccio: Dr. Levitt, would you like to handle that one?

Alan Levitt: Can you repeat the question for me please?

(Annalyn Kurdin): Will the information that we need to calculate our percentage, will that be on the CASPER reports, or is it like, because you said that this report will come out at the end of June. Will it just be put out by you all at specific times, or is there a way we can go calculate at any given time what our percentage is?

Alan Levitt: This is Dr. Levitt. We are in the process of determining our plans for providing you this performance information in the future. So please look out for further announcements from us on this.

(Annalyn Kurdin): OK. Thank you.

Operator: Your next question comes from the line of Raymond (Thisall) from Lifelink Health (Provential) Care. Your line is open.

Raymond (Thisall): Hi. My name is related to the payment adjustment. Just want to make sure I clarify this matter. So if an agency does not reach the 70 percent or lower than 70 percent threshold, so (inaudible) would be 2 percent reduction. Is this related to per-patient reimbursement?

Alan Levitt: This is Dr. Levitt. The answer is yes.

Raymond (Thisall): That will be all.

Operator: Your next question comes from the line of (Jenny Curtain) from St. Joseph's (inaudible) Healthcare. Your line is open.

(Jenny Curtain): Thank you. I have a question regarding the slides from today. I'm receiving an error message that says that there's a problem reading the document. Is there another way to access these slides?

Female: We're checking right now. Hold on just a second.

Alan Levitt: We'll check it again ourselves, but if you're having problems downloading the slides, either send an email to the email address I gave you before, or send an email to the help desk and they'll be able to help you.

(Jenny Curtain): Thank you.

Operator: Your next question comes from the line of Bill Sinclair from Capitol Health Services. Your line is open.

Bill Sinclair: Yes. I just had a question about the reporting time period. What if the assessment does not get submitted within the 30 days that it's required to be submitted? Will it still be counted?

Eugene Nuccio: As you know, the Conditions of Participation say the assessment should be submitted within 30 days of the assessment date. We do take that into consideration when we download the data, so that we give you an additional 30 days after the end of the reporting period to submit those assessments. So while the reporting period for APU performance period ends of June 30, we actually wait and collect assessments through the end of July to ensure that you have that 30 days to turn in your assessments.

Bill Sinclair: OK. But say, I'm not even talking about the end of the reporting period. I'm talking about, say, it was back in January and it was supposed to be submitted January 1, but it wasn't submitted until January 15, which was 45 days past, will it still be counted?

Eugene Nuccio: Currently the methodology does allow us to count that.

Bill Sinclair: OK. Thank you.

Operator: Your next question comes from the line of Mary Carr from NAHC. Your line is open.

Mary Carr: Yes, hi everyone. I just want clarification on the statement follow-up assessments not counted in the calculation. Does this apply for those patients who may have (inaudible) follow-up assessments throughout the reporting year to accommodate for the long-term care patients?

Eugene Nuccio: If a patient only has follow-up assessments for the entire 12-month period of the APU performance period, then those assessments would not be counted.

Mary Carr: OK. Thank you.

Operator: Your next question comes from the line of (Darlene Literal). Your line is open.

(Darlene Literal): Hello? Could you clarify the two percent reduction question that was asked earlier about whether or not the two percent reduction is applied to the market basket or whether it's applied by HRG or extrapolated across the universe? Hello?

Alan Levitt: The explanation of it, this is Dr. Levitt. The explanation of it is in the payment rule that comes out every year.

(Darlene Literal): So the 2 percent reduction is a market basket decrease in the initial base rate?

Alan Levitt: That is correct.

(Darlene Literal): OK thank you.

Operator: Your next question comes from the line of (Maryanne Laverde) from Option Home Healthcare. Your line is open.

(Maryanne Laverde): Yes, I had a timing question about recert being done at the end of the reporting period, but I believe you answered my question. Those assessments where the actual recert would be due on the last few days of the reporting period but because there is a window of 30 to 35 days, how would they be calculated? So you did answer my question by saying that you do give an extra 30 days to look at those assessments. Is that correct?

Eugene Nuccio: That is correct.

(Maryanne Laverde): OK. Thank you.

Operator: Your next question comes from the line of (Joyce Rackers) from Department of Health. Your line is open.

(Joyce Rackers): Hi. I just needed just a little more clarification for myself. When we're looking at that formula, the QAO, I'm trying to understand not the point of all this, because I understand the point is agencies are to transmit their OASIS, but I'm trying to understand how this is catching that. So if I got this right, the number of non-quality assessments? If an agency is just transmitting sporadically and not like they are supposed to based on the regulations, then that number of non-quality assessments is going to be much higher, right? Which; is then going to cause their percentage to be lower. Is that how they're catching those agencies?

Eugene Nuccio: That is correct. For example, look at slide, let me think, slide 13. You'll notice on this example on line 6A the agency; this fictitious agency had 131 Start or Resumption of Care assessments that did not meet the quality criteria. That is, they could not be matched with an end of care; they did not occur in the last 60 days of the reporting period, they did not have a follow-up assessment in the last 60 days that we could use to match them. And they were not a one-assessment only episode. So the agency, this hypothetical agency, is producing lots of Start and Resumption of Cares, but are not doing any follow-up assessments, and are not doing any End of Care assessments for their patients, and so this is an example of poor quality because we're not able to create a quality of care episode because we don't have that second assessment to match.

(Joyce Rackers): Ok. I do understand that. Thank you very much.

Eugene Nuccio: Certainly.

Operator: Your next question comes from the line of Doris Hampton from Plus Virginia Healthcare. Your line is open.

Doris Hampton: Yes. If I understand correctly, this information comes from our submitting the OA, so there's nothing we have to sign up for or anything, we're just automatically enrolled with RP10 is that correct?

Eugene Nuccio: This is Dr. Nuccio. Yes that is correct.

Doris Hampton: Thank you so much.

Operator: Your next question comes from the line of Bill Sinclair from Capitol Health Services.

Bill Sinclair: My question would be are the reports that we're going to be getting at the end of June, are they going to be detailed reports, or are they just going to be numbers, so that we can look into maybe improving our quality? How are we going to be able to find out which reports weren't sent to you guys and things like that?

Eugene Nuccio: The historical performance report that you'll be receiving at the end of the month will look pretty much like the information that is displayed on slides 13, 14 and 15. So you will have a detailed breakdown of how many of your assessments, Start of Care, Resumption of Care and End of Care assessments map to each of these quality criteria.

Bill Sinclair: But it's not going to give any individual names so that we can look into maybe what occurred and the organization that we didn't have follow-up or discharge reported?

Eugene Nuccio: No. There will be no PHI information in these reports.

Alan Levitt: And this is Dr. Levitt. Just to remind you that a sample 2013-2014 QAO report is on the link that we gave on the last slide.

Bill Sinclair: OK. Thank you.

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

(Andrew Closky): Yes, two questions. One is could you just repeat that long email address you gave? And then I have one other question

Alan Levitt: This is Dr. Levitt. The email address is hhapureconsiderations@cms.hhs.gov.

(Andrew Closky): Great. Thank you. And then the other question I had was as a follow-up to (Mary Caw's) question. For the so-called long term cases where the person is getting services for more than a year, I thought you said that would count as a non-quality assessment? Is that correct?

Eugene Nuccio: This is Dr. Nuccio. No, I tried not to. I perhaps did. If a patient has only follow-up assessments for the entire 12-month period, then those follow-up assessments are neutral. They're not counted toward or against the QAO metric. If a patient starts care at some point in the 12-month period and is on follow-up for the remainder of the period, then the Start or Resumption of Care is counted as a quality assessment. Conversely, if a patient is on care at the beginning of QAO period, the APU period, then is discharged to the community toward the end of that period, as long as we have a follow-up assessment in the first 60 days of the reporting period, then that End of Care assessment would be counted as a quality assessment.

(Andrew Closky): OK. That's very clear. Thank you. I appreciate that.

Eugene Nuccio: OK.

Operator: Your next question comes from the line of (Laurie Touchman) from CMS. Your line is open.

(Laurie Touchman): Thank you very much. I just wanted to make a comment and then make a reminder, if I may do so. I'm one of the leads on home health caps. So as a reminder, I just wanted to say that home health caps participation does count along with the OASIS requirements. So, both of them count to the APU

participation requirements. And the second was a comment about the two percent reduction that it's towards your market basket increase. That's what it's for, the market basket. So it's a two percent reduction in the market basket. Thank you.

Alan Levitt: Thank you Lori. Thank you for that reminder as well.

(Laurie Touchman): Thank you.

Operator: Your next question comes from the line of Estelle Maciello from Visiting Nurses of New York. Your line is open.

Estelle Maciello: It's sort of a two-part question. I just want to clarify on slide number six the last bullet is talking about one assessment only. That they; are counted in quality assessment. I want to be clear about how you're defining that and how quality is being measured when you don't have another assessment to compare it to?

Eugene Nuccio: This is Dr. Nuccio. (inaudible) The one assessment only (One Visit Only) episode is based on information from the HHA claims and there is a special code on the claims document that says this assessment is the only assessment expected for this patient. And so we give credit for that Start or Resumption of Care that is a one assessment only (One Visit Only) episode. Clearly we cannot compute a quality episode of care, but we did not want that assessment to be counted negatively for the QAO metric, and so we give them credit for that only if it's documented on the HHA claim that Start or Resumption of Care assessment is a one assessment only assessment.

Estelle Maciello: OK. So really it's you're measuring the compliance with whether or not the assessment is done. We're really not going to measure quality from that in any way, right?

Eugene Nuccio: Yes. We cannot compute a one visit only, if you have a one visit only assessment, then you can't compute a quality episode from that.

Estelle Maciello: OK. Thank you.

Operator: Your next question comes from the line of (Joyce Rackers) from Department of Health. Your line is open.

(Joyce Rackers): Hi, I have another question. What, since you guys do, you wait, if I understood you right, you wait to the end of the APU timeframe and 30 days beyond that before you do all your computations? What keeps an agency from if they have a good quality review going on in their agency from perhaps submitting a start of care assessment and then in their reviews find out five months down the road, six months, that a discharge assessment was never done, so they go back and they delete that start of care assessment. What keeps an agency from doing that so that it's not calculated against them?

Eugene Nuccio: Dr. Levitt, do you want to discuss that?

(Pat Sevast): Hi Joyce, this is (Pat Sevast).

(Joyce Rackers): Hi.

(Pat Sevast): That obviously would be not in compliance with the COPs. The agency could have billing repercussions because they probably submitted their start of care and probably submitted the bill. I don't know that we can prevent that from happening, but they might get caught in the process. That's all I can say.

(Joyce Rackers): OK. All right. Thank you.

Operator: Your next question comes from the line of Sue Brown from Home Care Grand Valet. Your line is open.

Sue Brown: Hello?

Female: We're here.

Female: We're here. Go ahead.

Operator: Sue Brown, your line is open.

Sue Brown: Hello? Can you hear me?

Female: Yes. Please go ahead.

Sue Brown: Our question has to do with when, with the dual eligible for example, and I think this is what Mary Carr was asking, but we're still a little fuzzy about this. If a patient is re-certed, and they become a long term Medicaid patient, then they don't count in the numerator or the denominator is that what you're saying, until they're discharged or go in the hospital and have that episode assessment that compares the end of care to the beginning of care?

Alan Levitt: This is Dr. Levitt. The answer is yes. They will not be counted until –

Sue Brown: OK. And is that the same thing then with a one visit only? Would you explain to us how the software or whatever is doing this, how does it know that this is a one visit assessment only and not just one of those research situations? Or some other situation? Is there something on the claim that's file? Or?

Eugene Nuccio: Yes. This is Dr. Nuccio. On the claims there is a box that needs to be checked that indicates that this is a one visit only assessment. And only if that box is checked will the assessment, the OASIS start of care, resumption of care assessment be classified as a quality assessment.

Mary Pratt: This is Mary Pratt. We will follow-up with that instruction and confirm it so that we're you know absolute about that and make it clear. Thank you for the question. We will take one more question please. I'm sorry go ahead.

Sue Brown: Thank you.

Jill Darling: (Kyle), we'll take one more question please.

Operator: Your final question comes from the line of Tracy Jackson from Care South. Your line is open.

Tracy Jackson: Yes, I have a question about the one visit billing. You have a start care, and they (inaudible) and you do a resumption of care, and they only have one visit on that resumption of care, we do not require to do a discharge OASIS, will that affect your billing if you had six visits at start of care (inaudible), do a

resumption of care and you just do a physical discharge? How do you do that on a bill?

Eugene Nuccio: Are you speaking about your claims statement?

Tracy Jackson: Correct. You're saying one visit like in a resumption of care; you have to document that on the bill. because they've already had six visits, and then they go to (inaudible) and we do a resumption of care, and no further visits are required, you are not required to do a discharge OASIS, so does that –

Eugene Nuccio: And as Mary Pratt just mentioned, these are all the nuances to one visit assessments, and you'll probably see a FAQ on that topic posted.

Tracy Jackson: OK thank you.

Jill Darling: All right well thank you everyone for joining today's special open door forum. We had a lot of great questions. So thank you very much and have a wonderful day.

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

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