

Centers for Medicare and Medicaid Services
Home Health, Hospice & DME
Open Door Forum
Moderator: Jill Darling
July 11, 2018
1:00 pm CT

Coordinator: Welcome and thank you for standing by. Your lines are in listen-only mode until today's Question and Answer session. At that time, if you would like to ask a question, you may do so by pressing star and then 1.

Today's conference is being recorded. If you have any objection, you may disconnect at this time.

I would now like to turn the call over to Jill Darling, you may begin.

Jill Darling: Hi, thank you, (Kate). Good morning and good afternoon everyone. Thanks for joining us today for the Home Health Hospice and DME Open Door Forum.

We have a pretty packed agenda, so as always, I have one brief 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'll hand the call off to our chair, Hillary Loeffler.

Hillary Loeffler: Thanks, Jill. So good afternoon to everyone and good morning to those joining from the West Coast. As you know, with the calendar year 2019, Home Health Prospective Payment System proposed rule went on display at the Office of the Federal Register on Monday, July 2 with a 60-day public comment period.

The proposed rule contains several significant proposals. As such, most of the agenda today will be devoted to providing high-level summaries of those key proposals.

But first, there will be a few quick announcements that pertain to HHPPS fill-in and claims processing for HHPPS Quality Reporting Program and the Hospice and Home Health CAHPS Surveys.

So without further ado, I'm going to hand the call over to (Wil Gehne) in CMS's provider billing group to make an announcement regarding improvements in hospice billing and claims processing. (Wil)?

(Wil Gehne): Thanks Hillary. On June 7 we issued MLN Matters Special Edition Article SE18007 which was entitled, "Recent and Upcoming Improvements in Hospice Billing and Claims Processing." By now, all these improvements are recent. The article reminds hospice is about some changes we made in January. They began to accept submission of Notices of Election prior electronic data imaging. We also allowed corrections to election and verification dates using Occurrence Code 56 and Condition Code D0.

The article provides more details about how to make these corrections than our original manual instruction, so I encourage providers to review it carefully.

Particularly helpful, may be the ability to remove a revocation that was submitted in error. For instance when a beneficiary actually transferred to another hospice but a revocation was sent accidentally.

A hospice can now remove the revocation if the final claim was not processed by submitting another NOTR with zeros in the through date. The hospice must also submit the original incorrect revocation date using Occurrence Code 56 and added Condition Code D0.

The really recent changes are changes that were implemented in Medicare systems last Monday, July 2, and a new screen that became available this Monday, July 9.

In the past, a variety of processing problems stem from Medicare using a single file in our (Cedar BEOT) system that contained both election and benefit period information.

We've now redesigned our systems to ensure that hospice election revocation information are separate from benefit periods so the two can be changed independently.

A new separate hospice election period now carries only election related information. The hospice benefit period screens will continue to look the same but election related fields on those screens will no longer be used.

Each period can be viewed on separate screens by your Mac, though HETS inquiries still combine them.

To the greatest extent possible, we've tried to separate which submissions affect which data. Generally speaking, Notices of Election and Revocation

will create and change the new election period; benefit periods will be created and changed by claims.

This redesign is intended to have a number of immediate benefits for hospices. First, it will reduce any timely filing exception requests because cancelling a benefit period will no longer remove the Notice of Elections receipt date.

It will allow NOTR's to be submitted at any time whether there's a benefit period present or not and it will reduce reprocessing workload by automatically removing benefit periods when all claims in the period are cancelled. There used to be an additional step where the provider had to submit an extra cancellation notice, a (type ability to XD) to remove the periods and we've automated that process for hospices.

The article provides more details about these benefits, but I want to emphasize two important points. One is that now that there's no system barrier to NOTR submissions, consistent submission of revocations within five days of the revocation date as required by regulation is very important. Later elections will not be accepted if the revocation is not posted.

And when submitting the NOTR, be sure to use the correct from date. In the past, hospice has used the current benefit period start date, now they should use the election date or the transfer start date instead.

The hospice chapter of the Medicare Claims Processing Manual will be updated in the future to reflect instructions that were included in this article.

Next (unintelligible) comes from (Cindy Massuda).

(Cindy Massuda): Thank you very much. So for the Hospice Quality Reporting Program, we have two exciting upcoming trainings. The first one's going to be on August 15 and it's going to be a webinar entitled, "From Data to Measure" and it focuses on how CMS takes raw HIS data and calculates hospice's performance on the HIS quality measures.

So, and the other upcoming training is going to be on August 30 and that's in Hospice Quality Reporting Program primer. Registration will be opening soon for both of these trainings and we would like you to look and check for these on our Hospice Quality Reporting spotlight page for more information.

Next we have the hospice assessment tools, our factual efforts are currently underway to develop a comprehensive assessment tool in hospice and towards the goal, CMS has convened a technical expert panel and we also started our pilot testing on an early version of the Hospice Evaluation and Assessment Reporting tool.

And so to address concerns raised during Pilot A testing, we're going to be the further testing phases are being delayed at this time and we're working diligently to retool HEART following the lessons learned from pilot A.

So with that, we're going to be having significant interaction with our stakeholders and that means we will be holding special open door forums and they will begin on the quarterly basis, the first one being in Sept – is expected to be in September this year, September 2018 and along with that, those special open door forums.

We've also added a HEART Web page to our HQRP Web site, so please look at our spotlight page for upcoming information about the special open door forums.

The next topic is related to public reporting for Hospice Compare. The next Hospice Compare refresh will happen in August of 2018. The August 2018 refresh will include the HIS data from Quarter 4, 2016 to Quarter 3, 2017 and CAHPS data from Quarter 4, 2015 to Quarter 3, 2017.

The HIS freeze dates for this refresh has already passed, and the 30-day preview report period has closed for the August 28 refresh. However, the HIS freeze date for the following compare which will happen in November of 2018, that freeze date is August 15. The preview reports for this refresh will be released in September. Please ensure that you submit any necessary modifications or inactivation records for HIS data for Quarter 1, 2017 to Quarter 4, 2017 before the freeze date of August 15.

And then finally we have the reconsideration process is going on at this time. And for non-compliance hospices that are – they're being notified by their MACs and also in your CASPER folder, as of July 9, all non-compliant hospices have information in their CASPER folders. They will also be receiving it from their MACs. So we encourage you, highly, to check your CASPER folder to see if there's a non-compliant letter.

If you are found non-compliant and want to send a Reconsideration Request, that 30-day window ends on August 7 of 2018 and so we encourage you to visit the Reconsideration Request Web page on our HQRW Web site for more information. Thank you very much and with that I'll turn it to (Lori Teichman).

(Lori Teichman): Thank you, (Cindy). These are some announcements about Home Health CAHPS Survey. The Home Health CAHPS preview reports for the period of 2017, the entire year, January through December, are available on the Home

Health CAHPS website in the agenda and home health agencies may access their reports from the “For HHAs” portal on our Home Health CAHPS website on the agenda.

We posted the Home Health CAHPS newsletter dated July 2018 on the Web site and in this issue we have easy-to-follow guidance for reaching and surveying or to reach patients who are living in care institutions.

Home health agencies are responsible for monitoring their data submissions by their respective vendors by checking the data submission reports in the “For HHAs” portal on the Home Health CAHPS Web site. These data submission reports for Home Health CAHPS.

All the health agencies are responsible for giving their monthly lists of home health patients on time to their respective Home Health CAHPS Survey vendors so that sampling and data collection can occur according to schedule.

The Home Health CAHPS Survey is available in many languages -- English, Spanish, Chinese in both traditional and simplified forms -- Russian and now Armenian.

Home health agencies are welcome to suggest other languages by emailing – the HHCAHPS email address, that’s also on the agenda, which is hhcahps@rti.org.

HHCAHPS vendors need CMS approval to display a home health agency’s name and logo on their Outgoing Mail Survey envelopes. Vendors need to complete the Home Health CAHPS Exceptions Request form and confirm that the home health agency and vendor have discussed HIPAA protections and

risks and that the home health agency has approved the display of their name and logo on the Home Health CAHPS Mail Survey envelopes.

Data submissions for Home Health Test Data Warehouse always occur on the 3rd Thursday in the month of January, April, July and October. So the next deadline is next week, July 19.

If a home health agency has recently contracted with a new home health CAHPS vendor then the home health agency should verify the vendor's authorization for them by emailing Home Health CAHPS at rti.org or calling RTI.

In addition, we have instructed all of the home health CAHPS vendors to make sure that they check their Vendor Authorization Report.

So any questions about Home Health CAHPS, please email Home Health CAHPS at rti.org or the CMS email which is Home Health CAHPS spelled out (<https://homehealthcahps.org>) and we always welcome your feedback about the Home Health CAHPS service.

And now I'd like to introduce (Kelly Vontran) who will speak to us about the proposed home health rules.

(Kelly Vontran): Hi. Good afternoon everyone. During this portion of this call, I will be focusing on Home Health Payment proposals. As Hillary mentioned at the top of this call, on July 2, 2018, CMS issued a proposed rule which contains several payment update provisions for calendar year 2019 as well as important payment system changes for calendar year 2020.

So the Routine Payment Update Provision for calendar year 2019 include an update to the home health payment rates of to 2.1%. There is also a decrease to the fixed dollar loss ratio so that outlier payments as a percentage of total home health payment would be closer to 2.5%. This would result in a 0.1% or \$20 million increase in payments to HHA.

The Routine Payment Update Provision for calendar year 2019 also include implementation of Section 50208 of the Bipartisan Budget Act of 2018 which extends rural home health add-on payments through calendar year 2022.

The amount of the add-on payments to HHAs depends on whether a particular rural county is considered an area of high home health utilization, low population density or all other rural counties.

So in summary, we estimate that overall Medicare payments to HHAs in calendar year 2019 would be increased by 2.1% or \$400 million based on these Payment Update Provisions. This update results in a national standardized 60-day payment amount of \$3151.22 in calendar year 2019.

Also in this rule, we have proposed and to define remote patient monitoring and regulation and to include the costs of remote patient monitoring as allowable cost on the Medicare Home Health Agency Cost Report in order to encourage more home health agencies to adopt the use of such technology.

Studies note that remote patient monitoring has a positive impact on patients as it allows patients to share real-time data with their providers which can lead to more expedient and tailored care as well as better patient outcomes.

Next, CMS is proposing to eliminate the requirement that the certifying physician estimate how much longer skilled services are required when recertifying the need for continued home health care.

This proposal is responsive to industry concerns about regulatory burden reduction and could reduce claims denials that solely result from an estimation missing from the Recertification Statement.

And finally for calendar 2019, we are proposing to amend current regulations to align them with current sub-regulatory guidance to allow medical record documentation from the HHA to be used to support the basis for certification of home health eligibility consistent with the Bipartisan Budget Act of 2018.

This rule also includes important payment proposals for implementation in calendar year 2020.

First, this rule proposes case mix adjustment methodology refinements called the Patient-Driven Groupings Model or PDGM that removes the use of therapy thresholds in determining payments under the Home Health Respective Payment System as required by Section 51001 of the Bipartisan Budget Act of 2018.

The proposed PDGM is designed to reflect our focus on relying more heavily on clinical characteristics and other patient information to place 30-day periods of care into meaningful payment categories which more accurately correspond to patient care needs.

Specifically, the PDGM includes changes that account for whether a 30-day period of care is the first 30-day period of care or the second or later 30-day

period of care or in other words, whether it is an early versus late period of care.

The PDGM also accounts for whether the patient was referred to home health from the community or from an acute or post-acute care referral source. It also accounts for the primary reason that the patient requires home care represented by six clinical groups. And those are neuro-rehab, musculoskeletal rehab, behavior health, complex nursing interventions, wound or medication management, teaching and assessment or what we call MMTA.

The PDGM also accounts for the patient's level of functional impairment based on corresponding OASIS items for activities of daily living and risk of hospitalization. And it also accounts for whether or not the patient has certain co-morbid conditions that are present.

We believe that using a patient-driven approach is more consistent with how home health clinicians differentiate between home health patients in order to provide needed services.

We note that the methodology proposed this year under the PDGM is the same case mix adjustment methodology proposed last year except that we include a second co-morbidity category for instances where there are interactions between two or more co-morbid conditions that result in higher resource use.

This results in 216 different case mix groups under the PDGM compared to the 144 groups proposed in last year's rule and the 153 groups under the current HHPPS system.

Second, this rule proposes to change the unit of payment from 60-day episodes of care to 30-day periods of care as required by the Bipartisan Budget Act of 2018. However, this rule does not propose to change any requirements regarding the frequency of home health recertification, the completion of OASIS assessments or updates to the home health plan of care which would still occur on a 60-day basis.

Third, CMS is proposing to not allow newly enrolled HHAs, that is, those HHAs certified for participation in Medicare effective on or after January 1, 2019, to receive requests for anticipated payments beginning in calendar year 2020. This would require newly enrolled HHAs to structure their operations without becoming dependent on partial advance payment and to take advantage of receiving full payment for every 30-day period of care.

We are not proposing a change to the split percentage approach in this proposed rule for existing HHAs meaning those HHAs certified for participation in Medicare prior to January 1, 2019. However, we are soliciting comments on a phase-out of this split percentage approach in the future.

Finally, in conjunction with the proposed PDGM we are also proposing to change the Low Utilization Payment Adjustment or LUPA threshold from four or fewer visits per 60-day episode of care to thresholds that varied based on the tenth percentile of visits in a 30-day period of care for each case mix group in the PDGM.

The improved structure of this proposed case mix system would move Medicare towards a more value-based payment system that puts the unique care needs of the patient first.

Overall we estimate that there would be no payment impact due to the proposed refinements for calendar year 2020 as CMS is required to implement these changes in a budget-neutral manner.

Additionally, the law requires CMS to make assumptions about behavior changes that could occur as a result of a proposed case mix changes and the change in the unit of payments from 60 to 30 days and to adjust the 30-day payment amount to take these behavior changes into account.

These behavioral assumptions are described in this proposed rule. We estimate that 30-day payment amount is implemented in calendar year 2019 with behavioral assumptions applied would need to be \$1753.68 to maintain overall budget neutrality. We would update this payment amount for calendar year 2020 implementation with the most recent data available.

So to support HHAs in evaluating the effects of the proposed PDGM, CMS will provide upon request, a Home Health Claims OASIS Limited Data Set file to accompany the calendar year 2019 Home Health PPS proposed and final rules. This limited data set file can be requested by following the instructions on the cms.gov Web site and there is a link to these instructions on the HHA Center Web page.

Additionally, CMS has posted agency-level impacts, a report to Congressional committees regarding a technical expert panel's insights on the proposed PDGM and an interactive grouper tool that will allow HHA's to determine case mix weights for their patient population.

All of these materials are available on the HHA Center Web page. CMS encourages comments, questions or thoughts on this proposed rule and will accept comments until August 31, 2018. As you know the proposed rule can

be downloaded from the Federal Register Web site or also from the HHA Center Web page.

Thank you for your time and I will now turn the phone over to (Heidi Magladry) from the Center for Clinical Standards and Quality to talk about proposed changes to the Home Health Quality Reporting Program.

(Heidi Magladry): Thank you. On July 3, CMS published draft versions of the OASIS-D Guidance Manual including the OASIS-D Assessment Instrument. The Guidance Manual details the changes from OASIS-C2 to OASIS-D and includes item-by-item tips for every item included on the Assessment Instrument.

In addition, the manual includes related information about OASIS and the Comprehensive Assessment, data accuracy and recording regulations in quality improvement.

The OASIS-D Guidance Manual and OASIS-D Assessment Instrument are available on the CMS Home Health Quality Reporting Web site on the OASIS User's Manual Page.

The OASIS-D is currently undergoing review by the Office of Management and Budget in accordance with the Paperwork Reduction Act. When this process is complete, an OMB Number will be assigned to the documents which will then be considered final.

The calendar year 2019, Home Health PPS Notice of Proposed Rulemaking was published on July 2. Proposals include removal of seven Home Health Quality Reporting Program measures and an increase in the reporting period

for the Medicare Spending for Beneficiary Measures. Public comments may be submitted through August 31, 2018.

CMS held a Medicare Learning Network call on June 27, 2018, to describe proposed changes to the calculation algorithm for the Quality of Patient Care Star Ratings. Specifically, CMS is proposing to replace the measure Drug Education on All Medications Provided to Patient/Caregiver with the measure; Improvement in the Management of Oral Medications. Materials from this call can be found on the Home Health Star Ratings page in the download section. Public comment on the proposed changes can be sent to Home – HH_QM_Comment@abtassoc.com through July 26.

Some upcoming training opportunities, CMS will be hosting two webinars to introduce home health providers to changes to the Outcome and Information Assessment Set (OASIS)-D, related to the Home Health Quality Reporting Program that are scheduled to become effective on January 1, 2019. The first webinar will occur on Tuesday, August 28 from 2:00 to 4:00 pm and provide a high-level overview of changes to the OASIS-D related to the Home Health QRP.

The second webinar will occur on Wednesday, September 5 from 2:00 to 4:00 pm and focus on new quality measures and data collection items specifically associated with Section GG: Functional Abilities and Goals. Registration is now open and registration is limited to 1500 attendees per event on a first come, first serve basis.

And with that, I will hand it off to (Ed Lilley).

(Ed Lilley): Thank you, (Heidi). Back in January 1, 2016, we implemented the Home Health Value-Based Purchasing Model or HHVBP in nine states representing

each geographic area in the nation. All Medicare certified home health agencies, or HHAs, that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington are competing on value in the HHVBP model, where payment adjustments will be based on each HHAs total performance score on a set of measures already reported by the Outcome and Assessment Information Set, or OASIS, and home health care consumer assessments of health care providers and systems. HH CAHPS surveys for all patients serviced by the HHA are determined by claims data plus three new measures where points are achieved for reporting data.

Regarding the calendar year 2019, Home Health Prospective Payment System proposed rule, CMS proposed the following changes and improvements related to the HHVBP model: remove the OASIS-based measures, influence immunization received for current flu season and pneumococcal polysaccharide vaccine ever received from the set of applicable measures beginning with performance year four or calendar year 2019; replace three individual functional OASIS measures, specifically, improvement in bathing, improvement in bed transferring and improvement in ambulation/locomotion with two proposed composite measures, one on self-care and one on mobility to the set of applicable measures; the proposed total normal as composite change in self-care measure competes the magnitude change by the positive or negative based on normalized amount of possible change on each of six OASIS-based quality outcomes.

These six outcomes are as follows: improvement in grooming; improvement in upper or lower body dressing; improvement in bathing; improvement in toileting hygiene; and improvement in eating.

The proposed total normalized composite change in mobility measure computes the magnitude of change by the positive or negative based on the normalized amount of possible change on each of three OASIS-based quality outcomes. These three outcomes are improvement in toilet transferring, improvement in bed transferring and improvement in ambulation locomotion.

We are also proposing to reweight the OASIS-based measures by 35%; the claims-based measures by 35% and the HHS CAHPS measures by 30% and reduce the maximum improvement points on a measure from 10 points to 9 points.

Finally, while we're not making a specific proposal at this time, we're also providing an update on the progress towards developing public reporting of performance under the HHBVP model and are seeking comment on what information should be publicly available.

If you have other questions about the HHBVP model not related to the proposed rule, please submit them to hhbvpquestions@cms.hhs.gov.

I will now turn the call over the (Susan Bauhaus) for an announcement on the temporary transitional payments for home infusion therapy services in calendar years 2019 and 2020.

(Susan Bauhaus): Thanks, (Ed). For calendar years 2019 and 2020 as required by Section 50401 of the Bipartisan Budget Act of 2018, CMS proposed the implementation of a temporary transitional payment for eligible home infusion suppliers for certain items and services furnished in coordination with the administration of transitional home infusion drugs.

The temporary transitional payment would begin on January 1, 2019 and end the day before the full implementation of the new home infusion therapy benefit.

The payment covers the cost of the professional services including nursing services, training and education not otherwise paid for under the durable medical benefit and monitoring and remote monitoring services furnished in accordance with the Home Infusion Plan of Care for Transitional Home Infusion Drugs.

These drugs are defined as drugs or biologicals administered intravenously or subcutaneously for an administration period of 15 minutes or more in the home of an individual through an external infusion pump that is an item of DME.

Home infusion suppliers that are eligible for the temporary transitional payment are those suppliers that are enrolled in Medicare as pharmacies that provide external infusion pumps and external infusion pump supplies and that maintain all pharmacy licensure requirements in the state in which the applicable infusion drugs are administered. This means that existing DME suppliers that are enrolled as pharmacies are considered eligible home infusion suppliers as are potential DME pharmacy suppliers that enroll and comply with the Medicare program's supplier and quality standards.

In anticipation of future rulemaking, this rule also solicits comments on elements of home infusion for the full implementation of the home infusion therapy benefit.

Section 5012 of the 21st Century Cures Act creates a new separate Medicare benefit category for coverage of home infusion therapy services including

associated professional services for administering certain drugs and biologicals through a DME pump; training and education; and remote monitoring and monitoring services effective January 1, 2021.

In addition, this rule also proposes health and safety standards for home infusion therapy beginning in 2021 which will be discussed next by (Jacqueline Leach).

(Jacqueline Leach): Okay, thank you. I'm (Jacqueline Leach) and I'm an analyst in the Clinical Standards Group in CCSQ and I'll be covering a brief description of the home infusion therapy new benefit and the summary of the proposed Home Infusion Therapy Health and Safety Standards included with the proposed Home Health Payment Rule.

On December 13, 2016, the 21st Century Cures Act became Public Law Number 114-255. The Cures Act established a new Medicare benefit and payment system for home infusion therapy which allows infusion services to be provided in a patient's home.

As part of the law, CMS is responsible for establishing Health and Safety Standards for the new benefit. To minimize burden on providers while maximizing patient safety, the proposed rule will include only those health and safety requirements stated in the statute.

The proposed Health and Safety Standards will require the following: a physician must establish and maintain a plan of care for the patient; the patient must be under the care of a provider which is a physician, a nurse practitioner or a physician's assistant; the home infusion therapy provider must provide training and education of the patient regarding the services provided and the

provider must maintain remote monitoring of the patient on a 24-hour, 7 days per week basis with the access to professional and nursing services.

As required by statute, the proposed rule allows the home infusion therapy services to be provided by a pharmacy, a physician, a home health agency or hospice provider. The provider will need to meet or exceed CMS standards and be accredited by an approved national accreditation organization -- NAO.

The law requires accreditation agencies to be designated by January 1, 2021. This will require a final rule for the Health and Safety Standards to be published by mid-2019 to permit adequate time for the accreditation process which has statutory timeframes for each part of the approval process.

Home infusion therapy providers are already meeting the proposed requirements as part of their AO accreditation for private insurers.

And I'm going to turn it over now to (Caroline Gallaher) who is also an analyst in the Centers for Clinical Standards of Quality in our Survey Division.

(Caroline Gallaher): Thank you, (Jackie), this is (Caroline Gallaher) and I'm going to talk to you about the proposed approval and oversight process for accrediting organizations that accredit home infusion therapy suppliers.

I'm going to use the acronym AO for accrediting organizations of HIT or home infusion therapy for ease of this discussion. Just to tell you a little bit about the – some of the related regulations and statutes, Section 1861 (iii)(3)(d), Roman numeral three, of the Social Security Act or the Act defines qualified home infusion therapy suppliers as being accredited by a CMS approved AO and requires home infusion therapy or HIT suppliers to be

accredited by an AO designated by the Secretary of the Department of Health and Human Services in accordance with Section 1834(u)(5) of the Social Security Act.

Section 1834(u)(5)(a) of the Act identifies factors for designating AOs and modifying the list of designated AOs. Section 1834(u)(5)(b) of the Act requires the Secretary to designate AOs to accredit HIT suppliers by not later than January 1st of 2021.

CMS is proposing to establish regulation in a new Subpart L in 42 CFR Part 488 for the approval and oversight of AOs that accredit at HIT suppliers and these regulations would address the required components to be included in an HIT AOs initial or renewal application for CMS approval of the AOs HIT Accreditation Program, and the procedure for CMS's review and approval of the HIT AOs application for CMS approval of its HIT Accreditation Program and CMS's ongoing monitoring and oversight of CMS approved HIT AOs.

At this time, there are six AOs that are providing accreditation to HIT suppliers. These six AOs are providing accreditation as part of the deeming accreditation programs for home health agencies. However, these six AOs have not been separately approved by Medicare for accreditation of HIT services. This means that these AOs have not submitted an application to CMS for approval of a separate Home Infusion Therapy Accreditation Program.

To address this issue, we are proposing in this rule to require that these AOs submit an application to CMS for approval of a separate and distinct accreditation program for HIT accreditation.

We are also proposing to publish a solicitation notice in the Federal Register after publication of the final rule in which we would invite national AOs to apply for CMS approval to accredit HIT suppliers for Medicare programs. We will publish the solicitation notice so that we can seek and designate AOs to accredit HIT suppliers by no later than January 1, 2021 as required by Section 1834(u)(5)(b) of the Act.

We have also proposed to establish regulations regarding the oversight – application and oversight of HIT AOs at, as I said, at 42 CFR Part 488 in a new Subpart L – I’m just going to briefly just give you a brief oversight of what’s contained in these regulations.

There are nine sections in this regulation, Section 1 which is 488.1005 just provides definitions of key terms contained in the regulations.

Section 448.1010 is the procedures for application or reapplication for the accrediting organizations for home infusion therapy accrediting organizations.

Section 1010(a) 1-24 contains all the information that’s required in the HIT AOs application –

Section 488.1010(b) would require the HIT AOs to agree to submit any additional information or documentation not previously listed that CMS may deem necessary to make a determination for approval of the application.

And 488.1010(c) would allow the HIT AO to withdraw their initial application before CMS approves it at any time or any time before we publish the notice in the Federal Register.

And 488.1010(d) requires CMS to complete its review of the application within 210 days from receipt of the complete application.

The third section is 488.1020 which is titled Public Notice and Comment requires CMS to publish a notice in the Federal Register upon receipt of the complete application so that the public has notice of the application and we seek public comments.

The fourth section is 488.1025 which is titled Release and Use of Accreditation Surveys. This will require the HIT AO to include an agreement with each of their HIT suppliers, an acknowledgement that the HIT supplier agrees to release a copy of their most current accreditation survey to CMS. However, 1025(b) would prohibit CMS from disclosing any surveys.

The fifth section is 488.1030 which is titled Ongoing Review of Accrediting Organizations and this would allow CMS to perform four different types of reviews of the HIT AOs under certain circumstances. And these reviews would be a performance review, comparability review, standards review and an accreditation program review.

The sixth section is 488.1035 which is titled Ongoing Responsibilities of a CMS Approved Accrediting Organization. This section speaks to the requirements of what the HIT AO must do after they're accredited, certain documents they must provide to CMS to allow CMS to assess the performance of the HIT AO on an ongoing basis.

The seventh section is 488.1040, Onsite Observation of Accrediting Organization Operations. This would allow CMS to conduct onsite inspections of the HIT AOs operations at any time to verify the organization's

representations and to assess the organization's compliance, with their policies and procedures.

The eighth section is 488.1045 which, addresses voluntary and involuntary terminations. A voluntary termination would be if the HIT AO decided it wanted to terminate its CMS approval of its Accreditation Program. An involuntary termination would be if CMS decides that it wants to terminate the CMS approval of an HIT AOs Accreditation Program.

And the final section would be Reconsideration, at 488.1050 which sets forth the appeals process with which an HIT AO, may request reconsideration of an unfavorable decision made by CMS.

We are seeking comments on the proposals made for the proposed regulations and also regarding these proposals regarding submitting applications by the AOs.

And that's all I have. I'll turn it back to Hillary.

Jill Darling: All right. Well this is Jill, thank you Caroline and thank you to all of our speakers today.

(Kate), will you please open the lines for a Q&A please.

Coordinator: If you would like to ask a question at this time, please press star and then 1. You will be prompted to record your name which is used to introduce your question.

Again, that is star and then 1 if you would like to ask a question at this time, one moment while we see if we have any questions.

Our first question is from (Barb Emong), your line is open.

(Barb Emong): Hi, I was just going to ask, what – when you guys said that there was a registration open for an event, where can we find that and what was the name of that again?

Female: If you're talking about the Home Health Provider webinars on the OASIS-D training?

(Barb Emong): Yes.

Female: Those are on – if you go to the Health Home Quality Reporting page, there's a link to training and the registrations are on the Training page place.

(Barb Emong): Okay, thank you.

Female: You're welcome. Next question please.

Coordinator: The next question is from (Robin Savoly), your line is open.

(Robin Savoly): My question's been answered, it was the same one about the webinars, thank you.

Coordinator: The next question is from (Tina Sanchez), your line is open.

(Tina Sanchez): Mine was the same question about registration, thank you.

Coordinator: Next question's from (Darlene Little), your line is open.

(Darlene Little): Hi, thanks for taking my question. In regard to the home infusion transition payment, how is that going to be affected by the states that currently have Certificate of Need processes?

Hillary Loeffler: Hi there, this is Hillary Loeffler, we actually don't have anybody on the line from our Enrollment area, is there any way that you can send your inquiry into the mailbox and I can make sure to get an answer for you?

(Darlene Little): Yes, that would be fine.

Hillary Loeffler: Okay, and it should be on the agenda, it's the Home Health Hospice DME ODS mailbox.

(Darlene Little): Okay, thank you very much.

Hillary Loeffler: Thank you.

Coordinator: As a reminder, if you would like to ask a question, please press star and then 1. The next question is from (Brenda McClanahan), your line is open.

(Brenda McClanahan): Yes, I'd like to ask you to please elaborate or explain a little more on the home infusion therapy. Are you relating to infusion therapy companies such as we use today to provide pharmaceutical supplies and infusion supplies or does that also include the home health agencies who provide the nursing portion of that to administer that to a patient in their home? Would that be – would they be required to have that accreditation also?

Jill Darling: Caroline and (Jackie), do you want to respond to that?

Hillary Loeffler: So home health agencies could become home infusion therapy suppliers in 2021. They're not eligible for the temporary transitional team, it's effective for 19 and 20. (Jackie) or Caroline do you have any other info you want to add?

Caroline Gallaher: Yes, this is Caroline. Anybody who provides home infusion therapy would have to be accredited.

(Brenda McClanahan): All right, thank you.

Caroline Gallaher: Other, but yes, in 2021, effective 2021. I mean, you could be accredited now under the current rules but the – when the new rules go into effect in 2021, you're going to have to be accredited under the new rules with an accrediting organization under the new Health and Safety Regulations that are being established. And the accrediting organizations will be following the new rules that we're establishing now.

(Brenda McClanahan): And that is only if you're providing the nursing service to administer the medication in the home?

Caroline Gallaher: Yes, that's my understanding. It's the provider, this is supplier – the supplier of the service, the home infusion therapy service.

(Brenda McClanahan): All right, thank you.

Caroline Gallaher: You're welcome.

Coordinator: As a reminder, please press star 1 to ask a question, one moment for our next question.

Our next question is from (Amy Nethertite), your line is open.

(Amy Nethertite): My question has been answered, thank you.

Coordinator: One moment for the next question. (Honor), your line is open.

(Honor): Hi, I have a two-part question on the behavioral adjustments in the proposed rule. One, are these behavioral adjustments reflected in the PDGM impact file by agency? And then secondly, does CMS expect to continue to make behavioral adjustments beyond 2020 or are the adjustments one-time in nature. Thank you.

Hillary Loeffler: The behavioral assumptions are not part of the posted agency-level impact files and for the behavioral assumptions for beyond 2020, so in calculating a 30-day payment amount were to make assumptions about expected behavior change that can occur. And then beyond those years, we go and we look back to see if, indeed, those behavior changes occurred or if additional or different behaviors occurred that result in changes to overall expenditures.

So going forward, 2020 through 2026, for those calendar years with claims, we'll look for behavior changes that occurred even if they weren't originally at let in this rule, and we could make future adjustments, either up or down, to the 30-day payment amount.

Does that answer your question?

(Honor): Yes.

Hillary Loeffler: Great.

Coordinator: And Ken Van Pool, your line is open.

Ken Van Pool: Hi, this Ken Van Pool with National Home Infusion Association. Quick question on the home infusion provisions and, specifically, because the eligibility for the benefit is solely reliable on - relied on a pharmacy license and the pharmacy component of being a DME provider. I have to ask why a pharmacy is – or the pharmacy services are not included in the rule as a professional service?

It appears professional services are solely reliant on the nurse being in the home, the day of an administration, but there doesn't seem to be any indication that pharmacy services, specifically drug preparation, are included as a professional service and I was wondering if you could provide any flavor on that decision?

Hillary Loeffler: Hey, (Ken), its Hillary. So unfortunately because this is open for public comment, I really can't respond to that question on this ODS but we encourage you to submit a public comment on the rule and we will respond to you in the final rule.

Ken Van Pool: Got it, thank you.

Hillary Loeffler: Yes.

Coordinator: Our next question is from (Lisa Rickert), your line is open.

(Lisa Rickert): Hi, my question is regarding the proposed final rule. I had originally heard that part of the Bipartisan Budget had stated that they're going to start alleviating some of the face-to-face requirements, but I haven't heard anything

about that in the proposed Home Health Prospective Payment changes. Has anything come out about that?

Hillary Loeffler: Are you referring to the supporting documentation information?

(Lisa Rickert): Yes.

Hillary Loeffler: Or the (restart) – okay, the supporting documentation – what we’re doing, proposing in this rule is to allow documentation from the home health agency to be used to support the bases of certification so it’s not a face-to-face proposal but it’s to allow home health agency documentation to be used to support the certifying physicians or the acute or post-acute care facility medical records in establishing eligibility for the benefit.

(Lisa Rickert): Okay, thank you.

Hillary Loeffler: Okay.

Coordinator: Our next question is from (Kristen Dravik), your line is open.

(Kristen Dravik): Hi, could you clarify how the payment will be split with a 30-day payment episodes, will it be 50/50 and also if the LUPA rate is applicable to a 30-day payment episode or the 60-day episode?

Hillary Loeffler: So let me address the LUPA question first, so for each of the 216 case mix groups under the proposed Patient-Driven Groupings Model, there’s going to be a case mix groups specific LUPA threshold. So if you have visits at or abouts the 10th percentile, or two visits, whichever is greater, you will get the full 30-day payment.

So take a look at the rule, it'll have the table with all of the thresholds for the different case mix groups so you can get a sense of how many visits need to be done to get that full 30-day payment.

And the 30-day payment amount, in last year's rule, we proposed to somewhat split the payment, the 60-day payment amount, in half and apply those to 30-day periods. For this year's rule, we're required to set the payment in a budget-neutral manner, so although the 2019, 60-day payment amount is about \$3100, the 30-day payment amount would currently be around \$1750, so higher than half.

(Kristen Dravik): Okay, thank you.

Coordinator: Next question is from (Frieda Tetfor), your line is open.

(Frieda Tetfor): This is a face-to-face (unintelligible).

Coordinator: You know we're not able to hear you, could you please unmute your line or pick up your handset.

(Frieda Tetfor): Oh, I'm assuming this is me. My name is (Frieda Tetfor).

Coordinator: Thank you.

(Frieda Tetfor): Can you hear me?

Coordinator: Your line is open.

(Frieda Tetfor): Okay, yes, and my question is regarding the infusion therapy and earlier somebody mentioned something about suppliers and providers, can you

elaborate on that? Does it mean that it is the suppliers that will receive a payment for infusion therapy or is it the providers, by providing the service. Thank you.

Hillary Loeffler: So for the temporary transitional payment is the DME supplier is also the home infusion therapy provider. So for the temporary transitional payment for 2019 and 2020, it's only the DME supplier who is providing the services and receiving the temporary transitional payments. Did that answer your question?

(Frieda Tetfor): And does my – now for providers to receive that payment do they need to apply for an accreditation, is that how it works?

Caroline Gallaher: This is Caroline Gallaher. Yes. When the new rules go into effect, you would have to be accredited. It is required by Section 1851iii, it's (3)(d), Roman numeral three of the Act, that you must be a qualified home infusion therapy supplier in order to receive payments and so you would have to be accredited – seek accreditation out. It doesn't have to be just home health agencies; it could be pharmacies could become accredited if they can meet the requirements for accreditation.

(Frieda Tetfor): Okay, thank you very much.

Coordinator: The next question is...

Caroline Gallaher: You're welcome.

Coordinator: ...from (Amy Nethertite), your line is open.

(Amy Nethertite): Thank you. I have a question about the 30-day wait on Page 151 of the rule, I see that it starts at \$1873.91 before behavioral assumptions. Can you tell me how you got to the \$1873.91?

Hillary Loeffler: Sure. There's actually a very detailed footnote that accompanies, like, either right before or after that table if you want to look for that. So basically what we do is we look at for all of the 60-day periods in our analytic file, how much in payment we would pay out for 2019. And then what we would be to set the 30-day payment amount at to pay out that same amount in aggregate. So I think the footnote describes that we target...

(Amy Nethertite): Okay.

Hillary Loeffler: ...\$16 billion and so it's just a function of plugging in how much we need to set that 30-day payment amount at to make sure that we still pay out in aggregate to home health agencies that same \$16 billion.

(Amy Nethertite): So what should we expect that to be increased by the market basket? So this 2017 data you used would – is that going to be increased by the 2020 market basket or the 2019 market basket or is this the rate?

Hillary Loeffler: Sure. In the table that you're referring to, that's – that would be as if we were to implement this in 2019 and it already includes that 2% market basket increase.

(Amy Nethertite): Okay.

Hillary Loeffler: But this isn't going to go into effect, you know, if it's finalized, it wouldn't go into effect until 2020 so we would, again, update that in 2020 and increase that by the 2020 market baskets.

(Amy Nethertite): Okay, all right, that makes sense. And my second question is, on Page 524 of the rule, Table 60, where you talk about the impacts, those PDGM, you know, we're looking, for example, at proprietary is -1.2%, what's the base, what are you comparing that to? Is that over 2017 or over 2018, 2019, how do you get to that number?

Hillary Loeffler: Sure. So that's comparing payments with the new model, the PDGM, to payments they would've received under the current 60-day system. And what we do is we use 2017 utilization data but then we apply the proposed 2019 payment rates to that.

(Amy Nethertite): Okay, so it's really the, over the 2019 rates?

Hillary Loeffler: Yes, they're both for utilization data that's complete for our purposes is 2017 so we take that utilization and we apply the 2019 payment amounts and then we compare, you know, the 60-day current system to what would pay out under the new PDGM.

(Amy Nethertite): Okay. All right, I think that answers my questions, thank you.

Jill Darling: All right. Well thank you everyone for joining today's call. If you were unable to get a question in, please send it into the Home Health Hospice DME ODF mailbox which is on the agenda and we will talk to you at the next call. Thanks everyone.

Coordinator: This concludes today's conference, thank you for your attendance. You may disconnect at this time.

END