

Centers for Medicare and Medicaid Services  
Home Health, Hospice and DME/Quality  
Open Door Forum  
Moderator: Jill Darling  
August 9, 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 speaker's remark, 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.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Kim). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications, and thank you for joining us today for the Home Health, Hospice and DME Open Door Forum.

Before we get into our agenda, 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 any inquiries, please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov).

So first up, we had Debra Dean-Whittaker, who has some Hospice CAHPS update.

Debra Dean-Whittaker: Thank you very much, Jill. Today, August 9th is the Hospice CAHPS Data submission deadline for patients who passed away in January, February, or March of 2017, in other words, first quarter of 2107.

We suggest that you check with your vendor to be sure your data is submitted timely. We do not accept late submission. Also, take a look at your vendor report. If you do not have access to this report, please contact technical assistant on the survey website.

Also, for Hospice providers, I would like to announce the reporting Hospice Quality Data Tips for Compliance Conference Call. It will be on September 28th of 2017 from 1:30 to 3:00 Eastern Time. This call is intended to give you information to help you comply with hospice quality reporting requirements.

Topics to be discussed include Hospice item set and CAHPS survey submission requirements, reason for non-compliance and how to address them, resources for success including how to access important websites and help desk. You need to register. In order to register, go to [www.cms.gov](http://www.cms.gov). And in the search box, type MLN event. That's Medicare Learning Network, MLN Events. You will get a list. Choose MLN calls and webcast and then look by date. You should see the dates on 9/20. I looked at this about two hours ago and it was the second one on the list. That is the Reporting Hospice Quality Data Tips for Compliance conference call.

In addition, the 2017 Hospice CAHPS Survey Vendor Training will be conducted on September 27th, 2017. This training session is intended for survey vendor, subcontractors and other organizations involved in the administration of the Hospice CAHPS Survey. However, providers are also welcome. More information is available on the survey website, that [www.hospicecahpsurvey.org](http://www.hospicecahpsurvey.org). That is [www, H-O-S-P-I-C-E-C-A-H-P-S-S-U-R-V-E-Y.org](http://www.H-O-S-P-I-C-E-C-A-H-P-S-S-U-R-V-E-Y.org).

And as a reminder, the Hospice CAHPS Participation Exemption for Size forms for calendar year 2017 is now available on the Hospice CAHPS survey

website I just mentioned. Hospice that serves fewer than 50 survey eligible to sync in the calendar year 2016 can apply for exemption from participation in the CAHPS Hospice survey for calendar year 2017.

The form will be available to complete and submit online until December 31st of 2017, but don't wait, go ahead and get it taking care of. A size exemption is good for one year only. So if you filed last year, but you also qualify for this year, be sure to submit your form again to qualify for calendar year 2017.

Thank you. And Jill, I return it to you.

Jill Darling: Thank you Debra. Up next, we have a few items on the Calendar Year 2018 Home Health Prospective Payment System final rule. So first off we have Elise Barringer who will go over the request for information.

Elise Barringer: CMS is requesting information about improving the health care delivery system how Medicare can contribute to making the delivery system less bureaucratic and complex and how we can reduce burden for clinicians, providers and patients in a way that increases quality of care and decrease this cost, thereby making the healthcare system more effective, simple, and accessible while maintaining program integrity and preventing fraud.

CMS is soliciting ideas for regulatory, sub-regulatory, policy, practice, and procedural changes to better accomplish these goals. Ideas could include recommendations regarding when and how CMS issues regulations and policies, and how CMS can simplify rules and policies for beneficiary clinicians, providers and suppliers.

CMS will not respond to Request for Information, comments submissions in the final rules, but will rather actively consider all input in developing future and regulatory proposed rule to all features on regulatory items.

And next, I'm going to be talking about Payment Policy Provisions for calendar year 2018. The calendar year 2018 Home Health Prospective Payment proposed rule contains payment, updates provisions for calendar year 2018 as well as important payments within changes for calendar year 2019.

The routine payment amount updates provisions for calendar 2018 include an update to the Home Health payment rates of 1 percent as required by section 411 of MACRA. Second, a 0.97 percent reduction of the 60-day episode rate in calendar year '18 to account for nominal case-mix growth from 2012 to 2014 which results in an estimated decrease in payments for calendar year 2018 of points – negative 0.9 percent.

Third, the statutory sunset of rural add-on payments which eliminate the 3 percent payment increase for Home Health Services furnished in rural areas. We estimate that Medicare payments to HHS in calendar year 2018 would be reduced by 0.4 percent or \$80 million based on the payment update provisions for calendar year 2018 in the proposed rule.

And then, turning it over to (Kelly Vontran).

(Kelly Vontran): Hi everyone. As Elise mentioned, the calendar year 2018 Home Health PPS proposed rule also includes important payment rules for implementation in calendar year 2019. Specifically, this rule proposed as case-mix adjustment methodology refinement including a change in the unit of payments from 60-day episodes of care to 30-day periods of care, to be implemented January 1st, 2019.

We are proposing implementation for calendar year 2019 rather than calendar year 2018 in order to allow for more provider education and trainings updating and revising relevant manuals, and time for agencies and vendors to make necessary software changes to submit 30-day rather than 60-day claims and to understand the case-mix adjustment changes well in advance of implementation.

CMS is proposing to change the unit of payments from a 60-day episode of care to a 30-day period of care in order to better align payment with the cost of providing care. Costs are much higher earlier in the 60-day episode and lesser later on, so therefore, dividing a single 60-day episode into two 30-day periods more accurately apportions payment.

CMS is not proposing a change to the split percentage payment approach in this proposed rule, most commonly referred to as the Request for Anticipated Payments or RAPs but rather we are soliciting comments on a phase-out of the split percentage payment approach in the future.

The proposed case-mix methodology refinement, what we call the Home Health Groupings Model or HHGM includes changes that account for whether a 30-day period is the first 30-day period of care or the second or later 30-day period of care, or in other words, early versus late periods of care, whether the patient was referred to Home Health from the community or an acute/post-acute care referral source.

Also accounts for the primary reason that the patient requires home care which is represented by six clinical groups. Also, the patient's functional level based on corresponding OASIS items for activities of daily living, and finally whether the patient has certain comorbid conditions present.

So in total, there are 144 different case-mix groups that a 30-day period of care can be placed into under the proposed HHGM. This is less than 153 case-mix groups under the current payment system. The Home Health Groupings Model relies more heavily on clinical characteristics and other patient information to place 30-day periods of care into meaningful payment categories and eliminate the therapy thresholds that are used in the current system to case-mix adjust payments under the HHPPS.

Both MedPAC and the Senate Finance Committee have criticized our use of therapy thresholds in the current system which encourages unnecessary therapy utilization to reach various thresholds and increase payments.

Finally, under the current Home Health Payments System, 60-day episodes with four, or fewer visits during the 60-day episode are reimbursed per visit rather than receiving the full 60-day episode amount. In conjunction with the proposed case-mix methodology refinements, we are also proposing to change the Low Utilization Payment Adjustment, the LUPA, threshold; from four or fewer visits per 60-day episode of care to thresholds that vary based on the 10

percentile of visits in a 30-day period of care for each case-mix groups under the HHGM.

We estimate that the impact of the proposed refinement for calendar year 2019, in particular, the proposed change in the unit of payment from 60-days to 30-days would be a decrease in payments by 4.3 percent or \$950 million, if implemented in a non-budget neutral manner in calendar year 2019, or a decrease in payments by 2.2 percent or \$480 million if implemented in a partially budget neutral manner in calendar year 2019.

The estimated impact of the proposed refinements for calendar year 2019 results from the fact that approximately 25 percent of all 60-day episodes or 30-days or less in length, and thus would receive one 30-day payment under the HHGM. CMS is soliciting comments on this proposed payment methodology refinement. The public comment period for this proposed rule closes on September 25th, and final rules for Home Health are normally issued by November 1st.

So thank you and we look forward to your comments. And I'm now going to turn over to Joan Proctor to talk about the Home Health Quality Reporting Program.

Joan Proctor: Thank you, (Kelly). Section 2A of the Improving Medicare Post-Acute Transformation Act of 2014, the IMPACT Act as we've all so many often heard referred to, requires Home Health Agencies along with other post-acute facilities to report standardize patient assessment data, data on quality measures and data on resource use and other measures.

The data must be standardized in interoperable so it's allowed for the exchanges of such data among providers. It also requires the modification of the post-acute care assessment instruments to provide for the submission and comparison of such standardized patient assessment data. These requirements are intended to enable interoperability as well as improve quality in discharge planning among other purposes.

In this year's rule, CMS is proposing to adapt for their calendar year 2020 payment determination. Three measures to further meet the requirements of the IMPACT Act. These three measures are assessment based on a calculated using OASIS data. The proposed measures are the change in skin integrity post-acute care for pressure ulcer/injury. The second is the application of percent of residents experiencing one or more falls with major injury, NQF number 674. And the third is the application of percent of long term care hospital patients with an admission and discharge functional assessment of care plan that addresses function NQF number 2631.

To meet the requirements for reporting of standardized of patients assessment data required under 1899(b)(1) of the act, CMS is proposing the data elements used to calculate the existing and proposed replacement pressure ulcer measures to meet the definition of standardized patient assessment data for medical conditions and comorbidities.

Additionally, CMS is proposing new standardized data elements in four other categories, functional status, cognitive function and mental status, special services treatments and intervention, and impairment. Unless otherwise specified, these data would be collected at start of resumption of care and discharge. More information about the specifications for standardized measures and standardized data elements can be found on our Home Health Quality Initiative website.

In addition, CMS has also reviewed our OASIS-C item set to identify candidate items for removal. Based on our analysis, we're proposing to remove our modified 35 current OASIS items beginning on January 1st of 2019. These data – oh this OASIS items or data elements within OASIS items are not used in the calculation of quality measures. Already adapted on their Home Health Quality Reporting Program, nor they're used for previously established purposes unrelated to the Home Health Quality Reporting including payment, survey, the home health value-based payment model or care planning. Because they will no longer be used in any manner, we are proposing to no longer collect them. A list of these changes can be also found at our Home Health Quality Initiative website.

CMS is proposing to formalize these processes for requesting reconsideration, determinations regarding compliance with the Home Health Quality Reporting program as well as its policy for reporting exceptions and extensions of reporting time frames. We should be formalizing this last policy. We've had the policy in place but we're putting it through the record to or just to further align with the other PAC settings.

And now, I'm going to turn it over to (Ed Lilley) for Home Health value-based purchasing. Thank you.

(Ed Lilley):

Thank you Joan. Effective January 1, 2016, we implemented the Home Health Value-Based Purchasing Model 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 HHVBP model, where payment adjustment will be based on HHA's total performance score on the seven measures already reported by OASIS and HHCAHPS for all patients serviced by the HHA or determined by claims data plus three new measures for points achieved for reporting that data.

In the calendar year 2018, Home Health Perspective Payment System proposed rule, CMS is proposing the following changes and improvements related to the HHVBP model. We propose to revise the definition of applicable measure to specify that the HHA would have to submit a minimum of 40 completed Home Health Care Consumer Assessment on Health Care Providers and Systems (or HHCAHPS) surveys for purposes of receiving a performance score for any of the HHCAHPS measures.

We've also proposed to remove the Outcome and Assessment Information Set, (or OASIS), based measure, drug education on all medications provided to patient/caregiver during all episodes of care, from the set of applicable measures. And we're also soliciting public comments on composite quality measures for future consideration.

I'd also like to remind the HHAs in the nine states that your first preview annual total performance score and payment adjustment report will be published at the end of this month. We posted the fact sheet for the reports on the HHVBP Connect and we'll be holding a webinar on the annual report on Thursday, August 31st, 2017.

If you have other questions about the HHVBP model not related to the proposed rule please submit them to [hhvbpquestions@cms.hhs.gov](mailto:hhvbpquestions@cms.hhs.gov). I'll now turn the call over to Carol Schwartz.

Carol Schwartz: Thank you. Based on feedback from Home Health stakeholders and to better align with assessment practices in other post-acute care settings, we have modified the current home care guidance related to the one clinician convention. As required by the commissions of participations, the comprehensive assessment will continue to be the responsibility of one clinician.

However, effective January 1, 2018, the assessing clinician will be allowed to elicit feedback from other agency staff or orders to complete any or all OASIS items integrated within the comprehensive assessment. Again, this new guidance will go into effect January 1, 2018.

Additional clarifications will be available in chapter one of the 2018 OASIS guidance manual that is scheduled for posting this month. If providers have questions after reviewing the guidance manual instruction, questions maybe submitted to the home health quality help desk at one word, [HomeHealthQualityquestions@cms.hhs.gov](mailto:HomeHealthQualityquestions@cms.hhs.gov).

And now, I'll return the conversation over to Joan Proctor.

Joan Proctor: Thanks, Carol. For this refresh only, measures – and we're talking refresh for the October 2017 refresh of the Home Health Compare. We want to note for providers that measures – that for these refresh only measures based on OASIS data. We'll have the same reporting as of July 2007 refresh. And we'll reflect any late submissions or corrections made as of August 25th, 2017. This will impact only the OASIS space measures.

The reporting period for the Home Health CAHPS and claims-based measures will be updated in October. This change was made to accommodate the new and review in correction processes.

As a result of this change, the reporting period for all OASIS in plane space measures in the Home Health Quality Reporting Program will be aligned moving forward. In the January 2018 refresh, the reporting period for the OASIS Home Health CAHPS and claims-based measures will all be updated. Thank you.

I'm going to now turn this over I believe to Carol Schwartz.

(Susan Bauhaus): Actually, this is (Susan Bauhaus). Thanks, Joan.

On August 1st, the Centers for Medicare and Medicaid Services issued the final rule that updates the fiscal year 2018 Medicare hospice wage index, payment rates and cap amount.

Section 411 of the Medicare Access and CHIP Reauthorization Act amends the Social Security Act to set the market basket percentage increase at 1 percent for hospices in fiscal year 2018. Therefore hospices will generally see a 1 percent or 180 million aggregate increase in their payments for fiscal year 2018.

The hospice payment system also includes the statutory aggregate cap. The aggregate cap limits the overall payments made to a hospice annually. As mandated by the IMPACT Act, the cap amount for accounting years that end after September 30th, 2016 and before October 1st, 2025 must be updated by the hospice payment update percentage rather than the consumer price index.

Therefore, the cap amount for fiscal year 2018 will be 28,689.04 which is the 2017 cap amount of \$28,404.99 increased by 1 percent. Now, Carol Schwartz is going to go over the Hospice Quality Reporting Program updates and Hospice Compare.

Carol Schwartz: Thank you. In this final rule, CMS provided updates the Hospice Quality Reporting requirement. The final will make changes to the Hospice Quality Reporting Program, HQRP that will continue to ensure a high quality accessible care without any burdens.

The rule finalized these eight measures from the CAHPS Hospice Survey data that are already submitted by hospice. Further the, rule finalizes the extension or exception for quality reporting purposes from 30 calendar days to 90 calendar days after they've got an extraordinary circumstance occurred. The rule describe plans publicly display quality measures, measure data via hospice compare in August 2017. Additionally, this will outlines policies and procedure associated with the public reporting of the quality measures use in a hospice program.

Finally, the rule also discusses the public comments received on two claims-based measures under consideration in the Hospice Evaluation and Assessment Reporting Tool or HEART, a patient assessment tool.

Moving on, I will briefly discuss about hospice annual payment update reconsideration. If your hospice has received a 2 percent reduction letter and plans to ask for reconsideration. August 17th, 2017 is the deadline for CMS to receive your reconsideration. That's one week from tomorrow. Your 2 percent reduction letter includes instruction, instructions on how to file for reconsideration.

If you don't have the letter or want more information, go to [www.cms.gov](http://www.cms.gov) and search for HQRP. Report that HQRP requirements and best practices page. When we get to that page, look at the manual on the left and choose "Reconsideration Request". Please make sure that you do not send us personal health information as part of your reconsideration. We cannot accept this data and it will delay your case.

You should have – you would have received a letter in the mail and also there is a letter in your file in the key system. If you did not receive a letter, you are a complaint and this is not an issue. If you want to know if you are complaint with a Hospice Quality Reporting Program, go to the HQRP requirements and

best practices page. At the bottom of the page is PDF listing all the complaint hospices. You can download it or just review it. Thank you.

Jill Darling: Thank you, Carol, and to all of our speakers. (Kim), we'll go on to our Q&A, please.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question please press star then the number 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, 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 (Cathy Nieberding) with Saint Joseph Alliance, your line is open.

(Cathy Nieberding): Hello. My question is on HIS and using opioid for indications other pain. And within our EHR we have a warning that's associated with that. And I wanted to know if that was going to be corrected not within our EHR but would CMS recognize opioids other than pain?

Jill Darling: Hi. Can you please send your question into the Home Health Hospice ODF inbox? It's on today's agenda.

(Cathy Nieberding): OK.

Jill Darling: Thank you.

(Cathy Nieberding): Thank you.

Operator: And your next question comes from the line of (Christine Dravic) with the Regional Medical Health. Your line is open.

(Christine Dravic): Hi. Can you tell us what the proposed rule to change from a 60-day episode to 30-day period? Would that include completing OASIS every 30 days?

Hillary Loeffler: Hi there, this is Hillary Loeffler. I'm the Director of the Division of Home Health and Hospice. And the rule outlines that we would still collect the OASIS every 60-days. So we would not require more frequent OASIS reporting.

(Off-Mic)

(Christine Dravic): OK. Thank you.

Jill Darling: Hi, real quick. This is Jill Darling. For the question earlier, we have the Quality Health desk e-mail. It's [hospicequalityquestion@cms.hhs.gov](mailto:hospicequalityquestion@cms.hhs.gov). That's [hospicequalityquestions@cms.hhs.gov](mailto:hospicequalityquestions@cms.hhs.gov).

Operator: Thank you. And your next question comes from the line of (Kathleen Watson) with Interim, your line is open.

(Kathleen Watson): Oh hi. Elise mentioned the CMS requesting the feedback for increasing quality and decreasing cost and ideas, but sorry if I missed it how to respond to that. How to get the information?

Hillary Loeffler: Hello, this is Hillary again. So if you can just provide a public comment in [regulation.gov](http://regulation.gov) just like you normally would on any proposed rule, we'll review them through that process.

(Kathleen Watson): OK. Thank you very much.

Operator: And your next question comes from the line of (Deidre Almoite) with Eco Home Health. Your line is open.

(Deidre Almoite): Good afternoon. I have a question. I didn't quite get the location where we can review the removal of the 30 – of the proposed removal of the 35 items for the OASIS under quality initiative. Where would I find that?

Joan Proctor: Under our – if you Google – I mean if you do in a search engine for the CMS website Home Health Quality Reporting Program, there's a link there for quality initiatives and it's there. We've linked it there.

(Deidre Almoite): OK. Thank you.

Joan Proctor: If you want, you can give us your e-mail address and I can e-mail it to you, the link.

(Deidre Almoite): OK. I will – so I give it to you, it's [ecohomehealth@gmail.com](mailto:ecohomehealth@gmail.com).

Joan Proctor: OK. I'll send it to you.

(Deidre Almoite): OK. Thank you.

Operator: And your next question comes from the line of (Karen Mikula) with VITAS, your line is open.

(Karen Mikula): Yes, hello. I just have a couple of question. If you could repeat the location where that PDF is of a hospices that were compliant with the HQRP and also regarding the hospice compare launch. I know that that is supposed to be launched this – sometime this month. Do you have any further information about that?

Debra Dean-Whittaker: This is Debra Dean-Whittaker. The PDF that Carol referenced refers to 2017. That is my fault. The current status of 2018 is that we are in the process of determining whether or not people are compliant. If you have not received a letter that says you are noncompliant, then you should assume you are compliance and we will when we finish our process, I think we are planning to add that time put up this 2018.

I apologize for that, but what's up there now is last year's compliant list.

(Karen Mikula): OK.

Amanda Barnes: Sorry. And in reference to hospice compare launch, this is Amanda Barnes. It is to launch in August of 2017. Again, that's all we can say at this time. Thank you.

Operator: And your next question comes from the line of Richard MacMillan with LHC group, your line is open.

Richard MacMillan: Hi, in table 55, the IMPACT table of the proposed rule, there was a note that stated, this analysis included assumptions on behavioral responses as a result of the new case-mix adjustment methodology. Could you please explain these behavioral responses to which you refer? And whether they increase or decrease the impacts on the magnitude of that change please.

Hillary Loeffler: Hey, Richard, this is Hillary Loeffler. So because this rule is in a public comment period you're going to have to submit a comment via regulations.gov and we'll respond your comments in the final rule.

Richard MacMillan: All right, thank you.

Operator: And your next question comes from the line (Halley Sony Elise) with Herbert Healthcare, your line is open.

(Halley Sony Elise): Hi, I just need the last part of the hospice quality questions piece at CMS.HHS that I wasn't catching the G, it sounded like you said G-M-E as an elephant?

Hillary Loeffler: G-O-V, for gov.

(Halley Sony Elise): Oh gov.

Hillary Loeffler: Yes.

(Halley Sony Elise): OK, thank you.

Hillary Loeffler: No problem.

Operator: Thank you. And your next question comes from the (Diane Siegel) with Tri-County in Montgomery, your line is open.

(Diane Siegel): Hi. We're a DME Company and I was wondering you can have any information about the competitive bid program for 2019?

Hillary Loeffler: Hi (Diane), I'm sorry we don't have any information on competitive bidding at this time?

(Diane Siegel): All right, thank you.

Operator: And again, if you would like to ask question please press star then the number one on your telephone keypad. Your next question comes from the line of (Angela Anderson) with Permanent Health, your line is open.

(Angela), if your line is on mute, please unmute, your line is open.

(Angela Anderson): I apologize. So I was just wondering if you could clarify the OASIS would only be required still every 60-days, but the RAP is only paying for 30 days. So we would be doing the second part of the episode. We do the first episode 30 days and then the next 30 days really wouldn't be paid for because the RAP was only submitted for the first 30 days, is that right?

Hillary Loeffler: So what we're proposing is for the RAP to be submitted for each 30-day period. So you would still get a RAP just like you did for 60-day at the beginning and then we'll reconcile with the final, (but) in a 30-day basis for each 30-day claims.

(Angela Anderson): Without an OASIS?

Hillary Loeffler: So you would have an OASIS done at the start of care that we could use for two 30-day periods.

(Angela Anderson): OK, OK.

Operator: And your next question comes from the line of (Jacky Ever) with Wellmont Hospice, your line is open.

(Jacky Ever): Thank you. I'd like to ask, if there somewhere we can go to view the proposed standardized hospice assessment?

Carol Schwartz: Hello, this is Carol Schwartz. We do not have it publicly available at this time because it really is truly under development. But we anticipate down the road,

it will be, you know, it will be publically available for review, but not at this time.

(Jacky Ever): Thank you.

Operator: And your next question comes from the line Brenda McClanahan, with Smoky Mountain Home, your line is open.

Brenda McClanahan: Yes, I would just to ask to repeat the information. You said about the LUPA changes from the four or fewer visits and how would that be effective?

(Kelly Vontran): Hi this is (Kelly). We basically have a LUPA threshold for each of the clinical groups. It's a minimum of two visits, or the 10 percentile of visits whichever is higher. We do have in the proposed rule a full list of all of the various groups and the establishment for thresholds.

Brenda McClanahan: Thank you.

Operator: And your next question comes from the line of (Emmy Narkow) with (MDC), your line is open.

(Emmy Narkow): Hi, thank you. I have a question regarding the grouper tool that posted on the CMS website, the grouper tool related to the 2019 regulations. It looks like – maybe it's excluding points related to question M1033. Has anyone reported this?

Hillary Loeffler: Hi there. So this is Hillary. Yes, we've had several e-mails from folks and we did posts an updated version. So I'm glad you asked that question. We should have announced that in the call.

(Emmy Narkow): OK.

Hillary Loeffler: So, on the HHA Center page that we're responsible for, we posted an updated grouper tool that fixes the M1033 responses. And just of note, there is a footnote in the proposed rule that I wanted to point out just so folks don't miss it. I think its response eight and nine do not count for points of their check.

(Emmy Narkow): All right. And I'm sorry, where did you say that we can get the updated grouper tool from?

Hillary Loeffler: Sure. If that – the easiest thing for me to do because I find the HHAs – the CMS website a nightmare is just to Google HHA Center and then CMS and then it will take you to the HHA center page. And the first items on the spotlight is our proposed rule and it has all the downloads underneath there and the tools for those downloads.

(Emmy Narkow): OK. OK. So, if I go, where we grab that the first time that you're saying it will be updated there now?

Hillary Loeffler: Yes. Yes.

(Emmy Narkow): OK.

Hillary Loeffler: So, just replaced with the updated files.

(Emmy Narkow): OK. And that was written, so we just download it yesterday. So, it was correct that between yesterday and today?

Hillary Loeffler: Yes. We fixed it yesterday and it refreshes over night. So it should be fixed today.

(Emmy Narkow): Perfect. OK. Thank you very much.

Hillary Loeffler: No problem.

Operator: And your next question comes from the line with (Judilynn Ferguson) with NHPCO. Your line is open.

(Judilynn Ferguson): Hi. I am having additional question about Hospice Compare. And I know in previous discussions, we've heard from CMS that there'd some training to providers or a heads up before the launch date. Do you have any additional information about that?

Hillary Loeffler: Unfortunately, we can't really say much this coming August 2017. Thank you.

(Judilynn Ferguson): OK.

Operator: And your next question comes from the line of (Sue Dustin) with Center Healthcare. Your line is open.

(Sue Dustin): Hi. My question goes back to the once OASIS with the two 30-day period. So you're saying that we're going to submit two RAPs and one final for that each 60-day period?

Hillary Loeffler: So for each 30-day period you're going to submit a RAP and a final. So, where – for a 60-day period, if you have one RAP and one final you're now going to have two RAPs and two finals. So each 30-day period is just treated on its own and it will have its own RAP and final claims.

(Sue Dustin): OK. Thank you for clarifying.

Hillary Loeffler: No problem.

Operator: And again to ask your question, please press star and the number one on your telephone keypad. Your next question comes from the line of (Christine Dravic) with regional medical. Your line is open.

(Christine Dravic): Hi. With the 60-day episodes put in the 30-day episodes, will the LUPA (array) apply to both 30-day episode or will it apply to the 60 day?

Hillary Loeffler: It will apply to the 30-day period. It's a little ...

(Crosstalk)

(Christine Dravic): It will apply to the 30-day period.

Hillary Loeffler: Yes. Yes. So the ones that are printed in the rule, I think we have it for each of that 144 case-mix group. There's a LUPA threshold that applies on the 30-day basis, so for each 30-day period.

(Christine Dravic): So the first 30-days you'll have to meet the LUPA threshold and then the second 30-days you'll have to meet the LUPA threshold?

Hillary Loeffler: Exactly.

(Christine Dravic): OK. Thank you.

Operator: And your next question comes from the line of (Lynn Brown) with the (Institute). Your line is open.

(Lynn Brown): Yes. I have a question regarding the surveys with the H CAHPS, the 40 that is needed. Is that in a monthly, quarterly, yearly? Where does the 40 surveys come in?

Hillary Loeffler: Well, you are not required to produce any particular number of surveys. Your respondents ...

(Lynn Brown): OK.

Hillary Loeffler: ... voluntarily respond or they don't. Now, for Hospice Compare, we will probably say that if you don't have a certain number of surveys, your data will not be recorded. That is what we do on other compare sites. But you are not responsible for whether or not your potential respondent volunteer to respond. Does that help you at all?

(Lynn Brown): Yes. But I thought ...

Female: The performance...

(Lynn Brown): ... we – it was part of the performance score.

Hillary Loeffler: Oh, I'm sorry. I'm not the right person to answer that. Excuse me. We need to go to ...

(Crosstalk)

(Ed Lilley): Yes. So this is (Ed Lilley). If you are referring to HHVBP, we're switching from having a – an HHA having to have a minimum of 20 completed

HHCAHPS surveys to 40 in order to better align the model with the HHCAHPS, we have a minimum of 40 completed surveys similar to the patient surveys star ratings on home health compare.

(Lynn Brown): Right. So what if we don't have the 40 minimum? Is that going to bother our payments?

(Ed Lilley): So, you wouldn't receive a score if you didn't have the minimum of 40. However, in order to generate a score, you need to have a performance on at least five of the applicable measures. And if this proposal is finalized, there will be 19. So, you have 19 measures be on the – I'm sorry, you'll have 14 measures beyond the five HHCAHPS measures in the model.

(Lynn Brown): OK. So, technically, it should (incur) payments because of the (thought), that 14 measures.

(Ed Lilley): Right. Well, it depends case by case but we can definitely get back to you with more information, just feel free to e-mail the HHVBP health desk. [HHVBPquestions@cms.hhs.gov](mailto:HHVBPquestions@cms.hhs.gov).

(Lynn Brown): OK. Thank you.

(Ed Lilley): Sure.

(Off-Mic)

Operator: And your next question comes from line of (Wet Neil) with (Robert Fierd). Your line is open. (Wet Neil), if your on mute, please unmute. Your line is open.

(Wet Neil): Oh thanks. I'm just wondering why CMS is proposing to implement the group or model changes in a non-budget neutral manner. I've been operating under the assumption that the change is needed to be budget neutral, so if you could just help me understand that it would be helpful.

Hillary Loeffler: Hi there. So, once again, we're in a public comment period. So, feel free to review the rule. There is enough detail and information in the background and

also along with the proposal to kind of show you what the agency was thinking. And why we're proposing to implement the model that's the way that we are. And you can feel free to comments through [regulations.gov](https://www.regulations.gov).

Operator: Thank you. And your next question comes from the line of (Karen Light) with North Country Home Health. Your line is open.

Patricia Brown: Hi. This is Patricia Brown. Actually, I'm the clinical director here and I have a question about the 30-day period. So I'm thinking you do your first 30-day period then you do your second 30-day period and then there'll be no more research, is that correct?

Hillary Loeffler: So, if you only have two 30-day periods, you would just do the start of care OASIS then you would charge them at the end. So you wouldn't have to research them.

Patricia Brown: OK. But what if you continue, like you have your long-term catheter patients?

Hillary Loeffler: Yes.

Patricia Brown: And you're going in there for more than 60-days. Is there going to be a research or will that just continue on what's – how is that going to be handled?

Hillary Loeffler: So that would be the same as you have now. So, every 60 days you're going to be required to update that comprehensive assessment.

Patricia Brown: OK. So then there would still be a research at the end of a 60-day length of time?

Hillary Loeffler: Exactly.

Patricia Brown: OK, great. Thank you.

Hillary Loeffler: No problem.

Operator: And your next question comes from the line of (Deidre Almoite) with Eco Home Health. Your line is open.

(Deidre Almoite): I have a quick question regarding the plan of care in regards to the 30-day episodes. So – plan of care still be of 60-day – covering a 60-day time period? I'm looking at the rule and I can't find it.

Hillary Loeffler: So I'm not sure if we were explicit in the rule.

(Deidre Almoite): OK.

Hillary Loeffler: So definitely feel free to comment if it's not specific enough. But yes, we were envisioning that a plan of care would cover a 60-day period along with the OASIS still being done in a 60-day period.

(Deidre Almoite): OK. So we would do – so if the 30-day is just for a billing purpose, not so much for our data collection?

Hillary Loeffler: That is correct.

(Deidre Almoite): OK. OK. Thank you.

Hillary Loeffler: Yes.

Operator: And your next question comes from the line of Andrea Sullivan with Nizhoni Health. Your line is open.

Andrea Sullivan: Just on that topics of the plan of care. As far as the signature requirement goes, currently, you can do the RAP based on verbal orders and you would the final based on when you have signed orders. So, could you considerably have two RAPs processed at the same at time if it's – if you're not able to get the physician's signature in a timely manner? Or would you only be able to do one at a time?

Hillary Loeffler: No, considerably you could have two RAPs at the same time.

(Andrea Sullivan): You could.

Hillary Loeffler: Yes.

(Andrea Sullivan):OK. Thank you.

Operator: And your next question comes from the line (Marcia Macri) with M.W. home health, your line is open.

(Marcia Macri): The question came up here as to – we just wanted to clarify that the outcomes in would be still be based on the 60-days or the end of discharge as it is now, so the outcome timeframe would not change?

Joan Proctor: This is Joan Proctor.

(Crosstalk)

Hillary Loeffler: Oh go ahead Joan. I'm sorry.

Joan Proctor: Yes. I was just saying, if you're speaking from a quality perspective, no we're not. This doesn't have any impact on how we're determining the outcome for the measures. We're not – we wouldn't be revising our measure outcomes.

(Marcia Macri): Thank you.

Operator: And your next questions comes from the line (Dan McCormick) – sorry (Dan Cormack) with (Seek In-Home) Care, your line is open.

(Dan Cormack): Yes, could you just remind me again if when the comment period is over and when the changes to the home health quality reporting in value-based purchasing would go into effect?

Hillary Loeffler: So the comment period for the rule closes on September 25th and then for quality reporting, you're proposing changes for 2019, Joan?

Joan Proctor: Yes, but we also have some proposals that – because they are collective in their claims-based, they don't use our reporting in 2019 and the outcomes are determined in 2020. So, you really have to look at – read the rule or I think I outlined earlier on in my talking point, various dates. And I'm trying to look

back here as to the three new measures that we're talking about, the skin integrity that we would be collecting, those start getting reported for payment determination, so you begun reporting in 19 and we – the payment determination effects is effective in 2020.

(Dan Cormack): OK. OK, thank you.

(Ed Lilley): This is (Ed Lilley). So there's two different proposals for HHVBP. The first one, to use the minimum of 40 completed HHCAHPS surveys. If that's finalized, CMS would apply the policy to the calculation of the benchmark and achievement threshold and the calculation of performance course for all model years beginning with performance year one which was calendar year 2016. The second proposal to remove the drug education measure from the set of applicable measures that would take place in calendar year 2018. And just a reminder, the payment adjustment also take place in calendar year 2018.

Operator: Thank you. And your next question comes from the line of (Maria Everest) with Stillwater Medical. Your line is open.

(Maria Everest): Yes, hello. Thank you for taking my question. Back to the 30-day payment in the LUPA requirement, it's in the second 30-day period, only one visit was paid, say the patient was hospitalized and transferred out to a higher level of care or passed away. How would that second 30-day period be paid?

Hillary Loeffler: So if you only had one visit in a second 30-day period you would get (approvals) reimbursement. So you'd get got the ...

(Maria Everest): Even though it's one visit and does it meet the LUPA requirements?

Hillary Loeffler: So if it's just a single visit, it will get reimburse due to the skilled nursing rate, the P.T. rates, the special language pathology rate, you'll just get \$150 for whatever professional went out and saw the patient.

(Maria Everest): OK, thank you.

Operator: And your next question comes from the line of (Christine Dravic) with Regional Medical. Your line is open.

(Christine Dravic): My question has to do with the 60-day episode, but currently we get paid – let's say we get paid \$2,400 for our 60-days episode of care. So we're now switching to the 30-day period. Will that be split 50-50? You get like 1,200 for the first 30 days, 1,200 for second 30 days or how will that play out?

Hillary Loeffler: So in the – sorry I'm getting some feedback here, hold on. OK, hopefully that's better. So in the proposed rule, we're proposing to take the 60-day episode rate, add back in the non-routine supplies add-on amount and then divided two to create a 30-day payment amount.

(Christine Dravic): OK, thank you.

Operator: And your final question comes from the line (Sue Dustin) with Center Health Care. Your line is open.

(Sue Dustin): Just one clarification again on the 30-day periods and the LUPAs. Will we still be able to submit no RAPs LUPA claims?

Hillary Loeffler: Yes you will.

(Sue Dustin): Awesome, thanks.

Operator: And there are no further questions at this. We turn the call back over to the presenter for closing remarks.

Jill Darling: All right, well thank you everyone for joining today's call. We had a lot of great questions. So next, Home Health Hospice and DME Open Door Forum is to be announced. And so, as always, you know, the date is subject to change and as well as the agenda item. So we appreciate your time today. Thanks everyone.

Operator: Thank you for participating in today's Home Health Hospice and DME/Quality Open Door Forum conference call. This call will be available for replay beginning today at 5:00 p.m., August 9th, 2017 ending at 11:59 p.m., August 11th, 2017.

The conference I.D. number for the replay is 60574200. The number to dial for the replay is 855-859-2056. This concludes today's conference call and you may now disconnect.

END