

Centers for Medicare & Medicaid Services
Home Health, Hospice & DME/Quality
Open Door Forum
Moderator: Jill Darling
November 14, 2018
2:00 p.m. ET

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

All lines had been place on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Cheryl). 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.

We did extend today's call until 3:30 Eastern Time just because of today's large agenda. So before we get in, 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. So now I will hand the call up to our chair, Hillary Loeffler.

Hillary Loeffler: Thanks, Jill. As Jill mentioned, we do have a pretty packed agenda today and I apologize to all my DME suppliers because the very first agenda item today is actually a DME update and I don't think it made it on the agenda before it was sent to the public.

So, hopefully my DME suppliers still called in. And with that, I'm going to turn it over to Joel Kaiser, who's going to provide an update on DME before we launch into hospice and then wrap up with home health. Joel?

Joel Kaiser: Thanks, Hillary. I'm here to run through the 2019 DME payment rule changes. We went through notes and comment, (rulemaking) this year and made some changes to DME payment rules both under competitor bidding program and understand the payment rules.

Starting with the competitive bidding program, we're making two changes, significant changes to the competitive bidding program that will be implemented with the next round of bidding.

We're implementing lead item pricing and payment based on maximum winning bids. Currently under competitive bidding, suppliers submit bids for product categories which are multiple items that they bid for, furnishing in a competitive bidding area. Suppliers submit bids for every item in the product category.

Then after selecting the winning range of bidders, the payment amounts for each item in the product category is based on the median of the winning bid submitted by the suppliers and the winning range for each item.

Beginning with the next round of competitive bidding, we'll be changing that. Now when a supplier submits a bid for a product category, they will submit one bid for each product category.

That one bid will be submitted for the lead item in each product category. The lead item will be identified as the item with the largest allowed charge total for the nation of the items in the category. The supplier will submit that bid

for that lead item and that bid will be used to set the payment amounts for the lead item and all other items in the product category.

So the lead items, the payment amount will be based on the maximum winning bid. So once all the winning bids are selected, the supplier with the highest winning bid for that lead item, that bid will be used to set the payment amount for that item for all contract suppliers.

For the remaining items in the product category, the payment amounts will also be based on the bid for the lead item. But, it will be based on a ratio that is made up of the difference between the historic fee schedule amounts to the lead item and the historic fee schedule amount for the non-lead item.

So for example, if historically a manual hospital bed is – fee is 72 percent of the fee for a semi-electric hospital bed. Semi-electric hospital bed is the lead item, then the payment amount for the manual bed will be based on 72 percent of the bid for the lead items to semi-electric hospital bed.

So when a supplier submitting bids, obviously they will – for the lead item they will be wanting to factor in what they think they need to be paid for furnishing all the items in the product category.

So, one way to look at it is if you submit a bid for the lead item that's 40 percent below the bid limit, then you're essentially submitting a bid, a 40 percent reduction for all the items in the product category.

So, supplier is (about) to take into account what they think they need to be paid for furnishing all the items when they submit their bid for the lead item that's used to establish the payment amount as I explained.

Also related to competitive bidding, contracts in the 130 competitive bidding areas will expire on December 31st and on January 1, we will not have contracts in place.

We're expecting that there will be a two-year gap in the competitive bidding program, beginning on January 2019. At that time, we'll be reverting to the standard payment rules in these areas.

We'll be paying based on fee schedule amount and any enrolled supplier will be able to furnish the items and services during the gap. All the standard rules will apply. We've developed a temporary gap period fact sheet which is available on CMS' DMEPOS toolkit on [cms.gov](https://www.cms.gov).

Also related to competitive bidding, for the next round which again we expected to be a gap of two years. So, beginning in 2021 we'll have or plan to have new product categories phase-in. Those product categories will be ventilators, off-the-shelf back braces and off-the-shelf knee braces.

We are soliciting comments on these product categories on [cms.gov](https://www.cms.gov). We have listed the product categories and all the HCPCS codes that would fall under these product categories. And any comments on these product categories can be sent to our DMEPOS mailbox, dmeupos@cms.hhs.gov.

So, quickly I'll run down some of the other DME rule changes for 2019. Statute mandates for DME that in areas where we don't implement competitive bidding, we adjust the fees based on the payment determined in competitive bidding.

Twenty-first Century Cures Act, Section 16008, mandated then making these fee schedule adjustments that we take certain things into account. We consider stakeholder input which generally addressed concerns about access in remote rural areas.

We looked at travel distance and cost, volume of items furnished and a number of suppliers in the areas that are competitive bidding areas compared to the areas that are not competitive bidding areas.

So, we proposed the rules and got comments on the rule. And so for our final rule we're mandating fee schedule adjustment methodologies for two years, for two-year periods, 2019 and 2020.

The fee schedule adjustment for non-rural areas or areas that are metropolitan statistical areas will be based on the current fee schedule adjustment methodologies in the regulations.

For areas that are rural or non-contiguous areas, for 2019 and 2020 will be paying based on a 50/50 blend. Fifty percent of the fee schedule amount will be the historic, unadjusted fees and 50 percent of the fee schedule amount be based on the adjusted fee schedule amount. Again, this is for a two-year period.

And finally, since we're going to have a gap in the competitive bidding program, all the current competitive bidding areas will become non-competitive bidding areas effective January 1.

For these areas, we'll be adjusting the fee schedule amount based on the current single payment amount in those areas, increased by an inflation update factor which will be the projected change, 12-month change in the Consumer Price Index for Urban Consumers for the 12-month period ending January 1, 2019.

And then the same thing will happen, January 1, 2020, we'll provide another update just based on the percentage change in the CPI-U for the 12-month period ending January 1, 2020.

For oxygen and oxygen equipment, we're establishing two new payment classes. One is to break out liquid portable equipment which is an add-on payment to our monthly payment amount.

We currently pay one amount for both portable gaseous and portable liquid. Beginning in January 2019, we'll have a separate category for portable liquid that pays a higher amount than portable gaseous. This is to incentivize the use of this more costly modality.

We're also going to be paying a higher payment amount for delivery of liquid oxygen contents after the cap on the equipment for patients with high flow needs.

So once the 36-month payment cap for the portable liquid equipment ends, we pay for the delivery of portable liquid contents. Beginning in 2019, that content payment will be higher for patients with high flow needs.

If you're a patient who is using more than 4 liters per minute, you used up a lot of oxygen if you're going to leave the house. You won't be able to be out away from the house for very long unless you're using a liquid oxygen system. So to accommodate that need, we'll be paying a higher amount in those situations.

And then finally, we have a new payment rule for a new type of DME. It's a multi-function ventilator. It functions as a ventilator, this one piece of equipment, but it also serves the purpose of other types of DME.

For example, it provides concentrated oxygen, it also operates as a nebulizer, cough stimulator and a suction (pump). So, these are five different items of DME right now with five different payment rules under the statute.

In order to accommodate this situation, we established a rule where we would treat this item as a ventilator. Pay for it based on the ventilator rules but that the payment would be higher than what we pay for ventilators alone and we're adding an additional monthly amount to pay for the additional functions of the equipment. And that's a rundown on DME rules. Thank you.

Hillary Loeffler: Thank you, Joel. Next we have Cindy Massuda.

Cindy Massuda: Thank you and good afternoon everybody. So for the Hospice Quality Reporting Program, the updates are for Hospice Compare, the refresh will occur later in November 2018.

With that refresh, the NQF number 3235, the Hospice and Palliative Care Composite Measure, the Comprehensive Assessment and Admission Measure,

which is known as the Hospice Comprehensive Assessment Measure and some people referred to it as the composite measure.

It appeared for the first time in the provider preview reports that were released in September 2018. This is in preparation for the Hospice Compare measure, comprehensive measure going live on Hospice Compare in November 2018 refresh.

Hospice providers should check their preview reports as well as Hospice Compare following the November 2018 refresh to view their Hospice Comprehensive Assessment Measure Scores.

More information about the hospice comprehensive assessment measures including measure specifications can be found in the quality measure user's manual available for download on the HQRP current measures page.

Additionally, CMS recently posted the Hospice Item Set, the Hospice Comprehensive Assessment Measure fact sheet on the HQRP current measures web page, the details, what the measure captures, how it's calculated and frequently asked questions about this measure.

The four and a half months data correction deadline for public reporting, this is also in our fiscal year '19 final rules to improve the freeze date policy and ensure that Hospice Compare is accurate and consistent representation of hospice quality.

CMS instituted a four and a half month data correction deadline for public reporting in the FY 2019 hospice wage index and payment rate update and hospice quality reporting requirements.

Under this new policy, beginning January 1st of 2019, providers will have approximately four and a half months following the end of each calendar year quarter to review and correct their Hospice Item Set record with target date in that quarter for public reporting.

After this four and a half months data correction deadline has passed, the Hospice Item Set data for that calendar year quarter will be permanently frozen for the purposes of public reporting.

Updates made after the correction deadline will not appear in any subsequent Hospice Compare refresh. For more information about this policy, we will be having information on the – with the fact sheet posted to the download section under key dates for provider's web page.

And then for upcoming training, on December 13th from 1:00 to 2:30 p.m. Eastern Standard Time we will be doing updates to the public reporting and fiscal year 2019 will be specifically focused on the Hospice Comprehensive Assessment Measure and data correction deadline.

So in addition to – so please look out for this webinar where we'll be taking a deeper dive into how the Hospice Comprehensive Assessment Measure is calculated and how the four and a half months data correction deadline for public reporting will impact providers.

It's recommended that providers review the two previously referenced fact sheets prior to this training. And then, we have an upcoming freeze date which is tomorrow, November 15th. The freeze date for the December Hospice Item Set preview report is November 15th, 2018.

All Hospice Item Set records for patients date of discharge between quarter two 2017 and quarter one 2018 including modifications, corrections and inactivation need to be submitted and accepted by the Quality Improvement and Evaluation System, the QIES system – the QIES ASAP system by 11:59 p.m. Eastern Standard Time.

To be reflected in the hospice provider preview report that will be available on December 3rd, 2018. Other updates for public reporting, hospice providers can begin keeping an eye out for the next round of hospice preview reports which will be posted in the beginning of December of 2018. This version of the preview reports will be related to the February 2019 Hospice Compare refresh.

As a reminder, the 2019 Hospice Quality Reporting requirements to the Hospice Item Set and the CAHPS Hospice Survey starts January 1st of 2019. To assist providers with that, we also have posted getting started with the Hospice Quality Reporting Program under our best practices page on the Hospice Quality Reporting Program web page.

Also a reminder that one of our contractors, CORMAC, provides quarterly newsletters to providers, giving you updates about the Hospice Quality Reporting Program.

Interested in receiving those quarterly newsletters, please e-mail to the grphealth@cormac-corp.com and include your facility name, CMS certification number and any – and with that – and provide any of your e-mail updates.

As a reminder for natural disasters, CMS allow – follows the FEMA and to check our website, that website along with the Hospice Quality Reporting Program exemption/exception web page for updates about natural disasters.

And finally, our QTSO web page address, web address has been updated to qtso.com – qtso.cms.gov which is Q-T-S-O.cms.gov. And the previous web address will temporarily – will redirect providers to this new web address.

And this automate – as this automated redirect to the new address is time limited, we recommend that you update your QTSO website bookmark as soon as possible and the – but the e-mail address for the QTSO technical help desk will remain help@qtso.com and that has not changed. And with that, I will turn this open door forum over to Debra Dean-Whitaker for her updates.

Debra Dean-Whitaker: Thank you very much, Cindy. The next Hospice Compare refresh is as Cindy said scheduled for this month and we do intend to display the scores for the Hospice CAHPS Survey at that time.

Let me remind you that the only official Hospice CAHPS Survey scores are calculated by CMS. Results provided by your vendor are not the official

scores. The results provided by your vendor may in fact not match the official scores.

One common reason for this is that vendors do not adjust their CAHPS Hospice Survey scores. This is not necessarily a problem. You can use the unadjusted scores for your quality improvement efforts.

The reason CMS adjust CAHPS Hospice Survey scores is to ensure that publicly reported scores can be fairly compared across hospices. So, we're leveling the playing field across hospice.

Survey vendors and the hospices may closely replicate the score calculated by CMS by following CMS guidance. Guidance is available on the CAHPS Hospice Survey website under the scoring and analysis tab and it is summarized in a podcast on the information for hospices tab. But to be clear, unadjusted scores can be used for quality improvement. You do not need to replicate the official scores.

Today is the second Wednesday of the month of November, that means that today is a deadline date for date of submission for the CAHPS Hospice Survey. Specifically, the deadline is 11:59 p.m. Eastern Time on Wednesday, 11/14/18.

Has your survey vendor successfully submitted your data? Check your report at the CAHPS Hospice Survey data warehouse to see if your vendor has successfully submitted your data. Remember that we cannot accept any late submission.

Now, I would like to speak briefly about the next CAHPS Hospice Survey data collection year. The CAHPS hospice survey data collection year begins with January death. That means the calendar year 2019 data collection year begins with patients who died in January of 2019.

We recommend that you get ready to participate in the CAHPS Hospice Survey as of January 1st, 2019. You will need to provide your vendor with list of deceased who died in 2019 as well as other relevant information. Now

it's a good time to finalize your plan, so you can be ready to participate when the new data collection year start.

I'm now going to switch from the next data collection year to the current data collection year, in other words the 2018 data collection year. Do you qualify for size exemption for the 2018 data collection year?

The deadline for submitting the size exemption form is December 31st, 2018. So if you qualify for the size exemption, submit your form before the deadline. The form can be found on the survey website which is shown on the agenda.

Here are the requirements for the size exemption they applied to the 2018 data collection year. If your hospice had fewer than 50 survey eligible patient and caregiver (peers) in the period from January 1 to December 31 of 2017, you can file a form asking for a size exemption for the 2018 data collection year.

The form asked to the (counts) the number of survey eligible patients in the reference year and the reference year is January 1 to December 31, 2017. The exemption applies to the 2018 data collection year.

And something that I hope will be clear for everyone, we are right now in the 2018 CAHPS data collection year. It ends on December 31st, 2018. The reference year for the 2018 data collection year is 2017, in other words the year before.

And the next data collection year is 2019, that will start January 1st, 2019. It starts with death that occurs in January of 2019. That is all I have and I would like to turn everything over now to Home Health CAHPS and Lori Teichman.

Lori Teichman: Thank you, Debra. I appreciate that, thank you. I just have a few announcements, the Home Health CAHPS. First, a short reminder to all home health agencies that they are responsible for checking the date of submissions, date of submission history by their vendors by checking the – home health agency portal on the Home Health CAHPS' website.

So when you go to homehealthcahps.org right on the home page, there is a tab that says for HHAs. That is a tab that is the secured portal. You'll need an ID and password in order to enter it and when you look up, your information, nobody else can look it up except yourself and maybe another designated person in your agency.

What is suggested is that you check with your home health CAHPS survey vendor about their schedule when they typically submit data for you, whether it be quarterly or monthly. And when you have that information in hand, you will know when you check the portal whether or not the information has been submitted because you know your vendor schedule.

Now I'm going to turn over – just to focus on our upcoming training. We have – annually we have introductory training and we have update training. The training is primarily focused to survey vendors that implement the Home Health CAHPS survey.

However, interested home health agencies and others may attend the training but they should register for the trainings on the Home Health CAHPS' website. It's on the home page. It's very easy, you can register for one of the three of the trainings.

Two of the trainings are introductory trainings. They – it is a one-time session, in other words we don't repeat them. The first one like part A is going to be on the afternoon of January 29.

I think the time is 12:30 to 4:30 and it will be the same time on January 30th. So, introductory training part 1 or part A is going to be on 29th of January and the second part, the part B will be on the 30th of January.

There is no training on January 30th but on Friday, February 1st is a very important training for all currently approved Home Health CAHPS survey vendors. It is mandatory for those vendors.

It is called update training and every year we have this training and it always focuses on brand new information about Home Health CAHPS and we do not repeat the information year to year.

This is new information. It might be related to issues that have come up during the year or survey results that we had, also an update on the demographics on who's completing the survey, who's participating in it and so forth. So, we also go over some issues that are covered in intro training.

But, that we have chosen to focus on such as sampling issues or any type of issue that is very important for the implementation of the survey and has been found on site visits or (through) other ways there needs to be a reminder or sort of reeducation on certain points to the process.

The day training again will be Friday, February 1st. It's only two hours from 12:00 p.m. to 2:00 p.m. in the afternoon. And again, it's required for currently approved vendors.

We are going to post the training slides for all the training sessions on the homehealthcahps.org website about a week prior to the trainings, so I would say some time after January 21st to 22nd.

The slides for all the trainings will be up as well as the updated version of the protocols and guidelines manual which is a very big manual that basically gives everything from A to Z, how to implement the survey.

It also includes the survey and its many language translations. And also what – we will also post the updated Home Health CAHPS data submission manual which is a much smaller manual but it's a – it's very useful for the Home Health CAHPS vendors on site because it is just a simple way of looking at all the steps to submit data and it also has a section in there for home health agencies if they want to quickly refresh what is their role in data submission. That's all I have for today and thank you, Jill. We appreciate it, thanks.

Jill Darling: Thanks, Lori. Next, we have Jennifer McMullen, who will go over the review choice demonstration for home health services.

Jennifer McMullen: Thank you. I'm Jennifer McMullen. I'm going to talk to you today about the review choice demonstration for home health services. Initially, we implemented a pre-claim review demonstration for home health services on August 1st, 2016 in Illinois. We later (post) that demonstration on April 1st, 2017.

We received a lot of feedback from stakeholders on that initial demonstration and we worked to revise the demonstration to make it more flexible, allow for provider choice and include risk-based changes that rewards providers who showed compliance with Medicare Home Health policies.

This revised demonstration does not create any new documentation requirements or alter the Medicare Home Health benefit. The beneficiary access to care will not be delayed. The demonstration will be a five-year demonstration in the states of Illinois, Ohio, North Carolina, Texas and Florida.

At this time, we plan to begin the selection period at Illinois on December 10th. However, we are currently attending our (full) Paperwork Reduction Act approval and will not begin the selection period until we have received that approval.

Initially, home health agencies can choose between three initial review options. These options are 100 percent pre-claim review, 100 percent post-payment review or a minimal review option with the 25 percent payment reduction.

For those home health agencies who choose the 100 percent pre-claim review or 100 percent post-pay review options, their compliance determines their next steps. For those two options, a pre-claim review full affirmation rate or post-payment approval rate will be calculated every six months.

If the home health agency reaches a 90 percent full affirmation or claim approval rate based on the minimal of 10 request or claims being submitted, they can choose between three subsequent review options.

These options are 100 percent pre-claim review, a selected post-payment review or a spot-check review of 5 percent of their claims every six months.

For Illinois providers who participated in the initial pre-claim review demonstration, if they met that 90 percent threshold based on submitting at least 10 pre-claim review requests, they will be able to start with the subsequent review option.

CMS and Palmetto GBA will continue to provide additional details and educational opportunities. Please continue to check the demonstration website listed in the agenda in the Palmetto GBA website for update. Thank you. I will now turn it over to the next presenter.

(Will Gehne): Hi, this is (Will Gehne). I had hope to report today that change request 10782 which would describe the 2019 changes to the home health rural add-on was recently published. But due to a mix up in issuance process, it should be out in the next day or so. I apologize for the delay.

In the meantime, home health agencies should be aware that claims for episodes ending in 2019 must include the new value code 85 and report the FIPS state and county code for the beneficiaries, residents in the associated value amount. Based on the questions I received so far, these are some key points to know.

Value code 85 must be reported on all Home Health PPS claims not just rural claims. This is required by the law. Both value code 61 which reports the CBSA code for the beneficiary and value code 85 are required. Value code 61 will continue to be used to (weight) adjust the home health agency's payment.

Value code 85 will be used to determine the category of rural add-on that applies. When value code 85 is not on the claim for use in rural payment calculations, the claim will be returned to their provider, so they can add the code and resubmit.

If the CBSA code on the claim is for a rural area, that is the code that begins with 999, then the FIPS state and county code must be one of those listed in the rural add-on categories posted in the home health final rule.

If not, the claim will be returned to the provider to resolve the conflict between these two pieces of information. And with that, I'll turn it over to Heidi Magladry.

Heidi Magladry: Hi, this is Heidi Magladry with some updates to the Quality of Patient Care Star Rating. On the Medicare Learning Network call held on June 27th, 2018, CMS described two recommended changes to the Quality of Patient Care Star Rating calculation based on its ongoing monitor and activities.

Those changes were removal of the measure, Drug Education on all Medications provided to Patient/Caregiver from the calculation and addition of the measure, Improvement in Management of Oral Medication.

Following a 30-day public comment period, and additional analysis to address comments, CMS announced on an October 3rd Medicare Learning Network call that these changes would be implemented effective with the April 2019 refresh of Star Rating results on Home Health Compare.

The first preview reports to the home health agencies using the new calculation algorithm will be available in January 2019. For more information including materials from the Medicare Learning Network call is available on the star rating page on the Home Health QRP website.

And now with some OASIS-D training updates, we'd like to share two training announcement and a training opportunity. We anticipate posting the post-training versions of the in-person OASIS provider training and a link to the playlist of the video recording in late November, early December.

Also, CMS is hosting a teleconference on November 29th from 2:00 to 3:00 Eastern Standard Time to address questions from providers related to changes and items collected by the Outcome and Information Assessments at OASIS-D in support of the Home Health Quality Reporting Program.

Questions were solicited from providers during webinars in August and September and a Train the Trainer event which occurred in Baltimore.

The OASIS-D will become effective on January 1st, 2019. Please visit the Home Health QRP training page to register for this event. And with that, I'll hand it off to Amanda Barnes.

Hillary Loeffler: Hi, there, just really quick. This is Hillary Loeffler. We had a DME update, we had a couple of hospice updates, a couple of home health updates. The remainder of this call will focus on the provision in the calendar year 2019 Home Health Prospective Payment System final rule.

So Amanda will kick it off with the routine rate updates for 2019. We'll discuss some of the other policies we finalized for 2019.

We'll also touch on the payment changes that we're finalizing for 2020 and then we'll wrap it up, discussing the home infusion provisions that will also finalize in the 2019 home health rule. So with that, I'll turn over to Amanda and she'll kick it off with what was in our final rules. Amanda?

Amanda Barnes: Thanks Hillary. I'm Amanda Barnes from the division of Home Health and Hospice in the Chronic Care Policy Group here at CMS.

On October 26, 2018, CMS issued the calendar year 2019 Home Health PPS final rule which contains several payment update provisions for calendar year 2019 and also finalizing the important payment system changes for 2020.

The routine payment update provisions for calendar 2019 include an update to the home health payment rates of 2.2 percent or \$420 million increase in payment to home health agencies. A decrease to the \$6.00 loss ratio to that outlier payments as a percentage (of) home health payments would be closed to 2.5 percent.

This results in a 0.1 percent or \$20 million increase in payments to home health agencies. A 0.1 percent decrease in payment due to the new rural add-

on policy mandated by the Bipartisan Budget Act of 2018 for calendar year 2019 resulting in \$20 million decrease.

And then new rural add-on policy requires that CMS classifies rural counties and equivalent areas into one of three categories based on one, high home health utilization; two, low population density and three all others. Rural add-on payments for calendar year 2019 towards 2020 based – very based on counties or equivalent areas and their classifications.

In summary, we estimate that overall Medicare payments to home health agencies in calendar year 2019 will be increased by 2.2 percent or 420 million based on the final payment update provision for calendar year 2019. I will now hand the call over to (Susan) who will discuss the other provisions of the final rule.

(Susan): Thank you, Amanda. There are few additional policy changes to the Home Health Prospective Payment System for calendar year 2019.

CMS finalized its proposal to define remote patient monitoring in regulation for the Medicare home health benefit as “the collection of physiologic data digitally stored and/or transmitted by the patient or caregiver to the home health agency.”

CMS also finalized the proposal to include the costs of remote patient monitoring as allowable costs on the HHA cost report, if remote patient monitoring is used by the HHA to augment the care planning process.

Studies note that remote patient monitoring has a positive impact on patients as it allows patients to share more live-time data with their providers and their caregivers which will lead to more tailored care and better care outcome.

CMS believes that defining remote patient monitoring and including such costs as allowable costs on the HHA cost report could encourage more HHAs to adopt the technology.

Also for 2019, CMS finalized its proposal 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 policy is responsive to industry concerns and results in an estimated physician cost savings of 14.2 million annually. CMS also finalized the proposed change to align the certification of eligibility regulations with current sub-regulatory guidance which allows medical record documentation from the HHA to be used to support the basis for certification of home health eligibility.

This change is consistent with Section 51002 of the Bipartisan Budget Act of 2018. Now, I'll hand it over to (Kelly Vontran) to discuss changes to the Home Health Prospective Payment System for calendar year 2020.

(Kelly Vontran): Thanks (Susan). So in addition to the calendar year 2019 home health human update and other provisions effective for calendar year 2019 as detailed by (Ms. Susan), the 2019 home health final will also include in important provision for implementation in calendar year 2020.

Specifically, I'm going to talk about the patient driven groupings model or PDGM, the change in the unit of payment from 60 days to 30 days, and requests for anticipated payment or RAPs.

So, first model finalizes (inaudible) methodology refinement which removes the use of a therapy professional in determining payment under the home health prospective payment system as required by Section 51001 Bipartisan Budget Act of 2018.

In order to comply with the requirements of removing therapy professional in the current case adjusted methodology and that's what we finalized to implement the PDGM for calendar year 2020.

The PDGM is very similar to the Home Health Groupings model proposed in last year's rule; however we did make some refinements to the alternate case

adjustment methodology including a change to its name to better reflect the model focus on patient characteristics.

The PDGM relies more heavily on clinical characteristics and other patient information to place 30 day periods of care into a meaningful human category.

The PDGM includes changes that account for whether a 30 day period is the 1st 30 day period of care or the 2nd or later 30 day period of care, so in other words early versus late period care.

The PDGM also accounts for whether the patient was referred to have help in the community or an acute or peracute care referral first. Also accounts for the primary reason the patient requires some health care represented by distinct clinical group.

It also accounts for the patient functional impairment level based on a list of items that attribute the daily living. And finally, it accounts for whether the patient has certain co-morbid conditions present.

I mention that we did make some refinements in the finalized PDGM specifically we finalized it different ways to adjust payments of (inaudible) from last year's proposal and from the technical expert panel held in February of this year.

So instead of a yes or no comorbidity adjustment, the PDGM will have a none, no, or high co-morbidity adjustments to take into account the presence of multiple co-morbidities and interactions between those conditions.

We also will fund a clinical group in response to stakeholder comments suggesting that we fund one clinical group in particular medication management teaching and assessment or what we call MMTA.

The recommendation was to break the MMTA clinical group into subgroups that we analyzed and discussed and proposed and final ruling. Dividing the MMTA clinical group which comprises the majority of home help (inaudible) care which further accounts unique patient characteristics in the PDGM.

So therefore in the calendar year 2019 home health final rule, we finalize the division of the MMTA clinical group into 7 subgroups; MMTA for aftercare, for cardiac circulatory condition, endocrines, gastrointestinal or general urinary condition, infectious disease, neoplasms, blood forming disease respiratory condition and for all others, which results in 12 clinical groups and over all there are 432 different (inaudible) groups under the PDGM.

In conjunction with the implementation of the PDGM we also finalized the change in the low utilization payment adjustment for loop up threshold for four or fewer visits to 60 day thresholds of care to thresholds that vary based on the 10th percentile of visits on a 30 day period of care for each case mix group under the PDGM.

We did not make any changes to the methodology to calculate partial payment for outlier payment except that outlier payment will be calculated on a 30 day basis. Next, this will finalize a change in the unit of payment of 60 day period of care to 30 day period of care are also required by Section 51001 of the Bipartisan Budget act of 2018.

In calculating the 30 day payment amount the law requires to amass make assumptions about behavioral changes that could occur as a result of the case made changes and they change and they enter a payment from 60 to 30 days and to adjust the 30 day payment amount to take these behavioral changes into account.

So in this final rule same (inaudible) assumption about behavior changes that could occur in calendar year 2020 as a result of the implementation of the 30 day method of payment of repose with the finalized PDGM cases suggested methodology.

First we assume that HHA (inaudible) documentation and coding practices and would report the highest paying diagnosis group at the principal diagnosis in order to have a 30 day period be placed into a higher paying clinical group.

Next, we assume that more 30 day period of care will receive a co-morbidity adjustment given the opportunity for HHA to report more co-morbidity on the home health claim compared to what can be reported on the (inaudible).

And finally we assume that for one-third of (inaudible) that are 1 to 2 visits away from the 30 day (inaudible) threshold HHA will provide a 1 to 2 threshold visit to a full 30 day payment rather than the per visit payment amount.

Before the application of our behavioral change assumption we estimated that the 30 day payment for calendar year 2019 amount would need to be set at approximately \$1874.00. However with behavioral change assumption applied, we estimated that the 30 day payment amount would need to be lowered to approximately \$1754.00 to maintain raw budget neutrality.

Now remember the change in the unit of payment from 60 days to 30 days in the implementation of the PDGM does not take effect until 2020. So we will propose the calendar year 2020, (inaudible) amount in next year's proposed rule.

While Section 51001 of the Bipartisan Budget Act of 2018 requires the mass to make behavioral changes when calculating the 30 day payment rate same as the mass is also required to analyze the effect on the behavioral change on aggregate payments and make future payment adjustments accordingly to either increase or decrease the 30 day payment.

Overall we estimate that there would be no payment impact due to the change in the unit of payment and the case makes refinement finalize for calendar year 2020 is required to implement these changes in a budget neutral manner.

(Inaudible) to not allow newly enrolled HHA that is HHA certified perpetration and Medicare effective on or after January 1 2019 to receive requests for anticipated payment or RAPs beginning calendar year 2020.

This requires new and old HHA to structure their operation without becoming dependent on a partial advance payment and to take advantage of receiving RAP payment for every 30 day period of care.

We did not suppose they change the percentage of paying the price for existing HHA meaning no certified this patient or Medicare prior to January 1 2019 but rather we solicit a comment on the phase out of percentage payment approach in the future. This means existing home health agencies will continue to receive RAP payments upon implementation of the PDGM.

So that summarizes the important changes to home health care policy provisions for implementation on calendar year 2020. So I will now turn it over to Heidi Magladry from the Center for clinical sense of quality to discuss changes to the home health quality reporting program.

Heidi Magladry: Thank you Kelly. So the calendar year 2019 changes to the Home Health Quality reporting program includes items finalized in the rule. We finalized 8 factors that CMS will use when evaluating previously adopted home health quality reporting measures for potential removal.

These factors are; number one, measure performance among home health agencies is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

Factor two, performance or improvement in a measure does not result in better patient outcomes. Factor three a measure does not align with current clinical guidelines or practice.

Factor four a more broadly applicable measure (across settings, populations or conditions) for the particular topic is available. Factor five a measure that is more proximal in time to desired station outcomes for the particular topic is available.

Factor six a measure that is more strongly associated with desired patient outcomes for this particular topic is available. Factor seven, collection or

public reporting of a measure leads to negative unintended consequences other than patient harm.

And factor eight the costs associated with the measure outweigh the benefit of the continued use of the program. These factors replace the six criteria previously used to evaluate Home Health Quality Reporting Program measures.

This change aligns with the Meaningful Measures Initiative and improves consistency with the factors used by other established quality reporting programs. We are also finalizing the removal of seven Home Health Quality reporting measures. The following measures will be removed beginning with the calendar year 2021 home health quality reporting program.

Those measures are Depression Assessment Conducted, Diabetic Foot Care and Patient/ Caregiver Education Implemented during all Episodes of Care, Multi-Factor Fall Risk Assessment Conducted for All Patients Who Can Ambulate, Pneumococcal Polysaccharide Vaccine Ever Received, Improvement in the Status of Surgical Wounds, Emergency Department Use Without Hospital Readmission during the First 30 Days of Home Health, and Rehospitalization During the First 30 Days of Home Health.

We are also finalizing revisions to our regulations to clarify that not all of OASIS data described in 484.55 (b) and (d) are needed for purposes of complying with the requirements of the Home Health Quality Reporting Program. With that, I'll hand it off to Jen Donovan.

Jen Donovan: Thanks Heidi. I'd like to provide an update on the refinements we made to the home health value based purchasing model in the calendar year 2019 HHPPS final rule. The CMS Innovation Center implemented the HHVBP model January 1, 2016 in nine states that represent each geographic area in the nation. All qualified Medicare certified HHA that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington participate by competing on value.

The HHAs receive payment adjustments that are based on an HHA's performance on a set of existing quality measures from OASIS and HHCAHPS or determined by claims data plus three new measures where points are awarded for reporting data.

The model is being conducted for 5 performance years from calendar year 2016 through calendar year 2020. Calendar year 2019 is performance year four the model; year 4 of data collection.

Payment adjustments began this year in calendar year 2018, January 1st, and the payment adjustments are based on performance year one data, which performance year one was calendar year 2016. Payment adjustments will continue through calendar year 2022.

In the calendar year 2019 final rule, in addition to providing an update on our plans to publicly report performance under the HHVBP model in future years, we finalized, as proposed, four refinements to the model.

These refinements make changes to the applicable measures to incorporate more meaningful measures, rescore maximum improvement points, and reweight measures to increase competition on quality performance.

The following four refinements are effective beginning performance year four, calendar year 2019, and for subsequent performance years of the model. The first refinement removed from the set of measures two OASIS based process measures. These measures are the Influenza Immunization Ever Received for Current Flu Season and the Pneumococcal Polysaccharide Vaccine Ever Received.

The second refinement replaces three OASIS based measures with two composite measures. The three OASIS measures replaced are, Improvements in Ambulation and Locomotion, Improvement in Bed Transferring and Improvement in Bathing.

The two composite measures replacing these outcome measures are Total Normalized Composite Change in Self-Care and Total Normalized Composite

Change in Mobility. The two composite measures will each have a maximum score of 15 points so that their total maximum score of 30 points is the same as the three measures that they are replacing.

The third refinement to the model is how the total performance score is calculated by changing the weighting methodology from equal weight given to individual performance measures.

For HHAs that have data for all measure categories, the OASIS measures and the claim based measures categories each count for 35 percent of the total performance score and the HHCAHPS measures category will count for 30 percent.

Note that these weights exclude the ten percent of the total perform score that is for the three new measures collected as part of the model.

The fourth and final refinement changes the scoring methodology for improvement points by reducing the maximum amount of points an HHA can earn from 10 points to 9 points.

The CMS is planning a January 2019 learning event focusing on the policies finalized in the calendar year 2019 HHPPS final rule for the HHA's in the nine participating states. In addition, the HHVBP model team can answer any additional questions the HHAs in the nine participating states that they may have.

You may submit your questions to hhvbpquestions@cms.hhs.gov. That is all the updates I have for HHVBP and I will turn over to (Susan) for our next update.

(Susan): Thanks Jen. For calendar years 2019 and 2020 as required by section 50401 of the Bipartisan Budget act of 2018 CMS is implementing a temporary transitional payment for home infusion therapy services for eligible home infusion therapy suppliers.

This payment is for associated professional services furnished to administer certain home infusion drugs and biologicals infused through a durable medical equipment external infusion pump, training and education, and monitoring services, including remote monitoring.

By law, transitional home infusion drugs are assigned to three payment categories for which a single payment amount will be paid for home infusion therapy services furnished on each infusion drug administration calendar day.

Payment category 1 includes antifungals and antivirals, uninterrupted long term infusions, pain management, inotropic drugs for treatment of heart failure and chelation drugs.

Payment category two includes subcutaneous immunotherapy infusions and Payment category three includes certain chemotherapy drugs. By law, the payment amounts for each category are set equal to the physician fee schedule amount for 4 hours of infusion therapy.

Additionally, CMS finalized definition of “infusion drug administration calendar day” to mean the day on which home infusion therapy services are furnished by skilled professionals in the individual’s home on the day of infusion drug administration.

The skilled services provided on such day must be so inherently complex that they can only be safely and effectively performed by, or under the supervision of, professional or technical personnel.

We do plan on closely monitoring for any effects on access to care. Additionally we will continue to seek comments from stakeholders on our interpretation of “infusion drug administration calendar day.”

This comment period will close on December 31st 2018. Finally, in the proposed rule we solicited comments from the public on aspects of the full implementation of the home infusion therapy benefit for calendar years 2021 and beyond.

We received many thoughtful comments and feedback that we plan to review and consider for future rulemaking. Now I'll turn it over to Jacqueline Leach to discuss the Health and Safety Standards for Home Infusion Therapy Suppliers beginning in calendar year 2021.

Jacqueline Leach: Thank you Susan. Hi I'm Jacqueline Leach from the clinical standards group at CMS I will be discussing the health and safety standards for the home infusion therapy suppliers.

So like Susan mentioned regarding payment for the Home infusion therapy services the 21st Century Cures Act requires in addition to the payment benefit that CMS establish home infusion therapy supplier health and safety standards for the new benefit.

At this time the final rule only includes those health and safety requirements that are stated in the Cure's Act specifically those health and safety requirements are, one that we require that a physician must establish and maintain a plan of care for the patient, two the patients must be under the care of a provider though the home infusion therapy provider must provide training and education to the patient.

The provider must ensure a safe and effective provision of home infusion therapy on a continuous basis 24hours a day 7 days per week with access to professional emergency services and finally as a result of suggestions received during the proposed regulation comment period the final rule out of the requirement that services must be provided in accordance with a nationally recognized ways to practice in accordance about applicable state and federal laws and regulations. Really that's all I have and I'm going to turn it to
Caroline Gallaher

Caroline Gallaher: Thank you Jackie. This is Caroline Gallaher and I'm going to tell you about the regulations that were finalized for the approval and oversight of the accrediting organizations that will be accrediting home infusion therapy suppliers.

A little background about the statutory authority that required this is Section 1861(iii) (3) (D) of the Social Security Act (referred to it as the Act) defines qualified home infusion therapy suppliers as being accredited by a CMS-approved Accrediting Organization.

Section 1834 (u)(5)(B) of the Act requires the Secretary to designate Accrediting Organization (from here on out referred to as AOs) to accredit home infusion therapy suppliers or HIT suppliers to furnish HIT services by no later than January 1st of 2021.

So CMS is required to select and approve AOs to accredit HIT suppliers by no later than January 1st 2021. CMS has finalized regulations in the Home Health Final Rule for calendar year 2019.

And the new regulation will go into a new subpart L in 42 CFR Part 488. These rules are for the approval and oversight of AOs that accredit HIT suppliers and they address the following 4 areas. They address the components to be included in the HIT AO initial and renewal application for CMS approval of their HIT accreditation programs.

The second component is the procedure for CMS review and approval of the HIT AOs application for CMS approval of their accreditation program.

Number three is the ongoing CMS monitoring and oversight of CMS-approved HIT Accrediting Organizations or AO's.

And number four the process to be used to seek reconsideration of an adverse decision made by CMS on an application review so that if CMS denied a AOs application there is a process for reconsideration provided for in the regulations.

Section 1834 (u)(5)(A) of the Act identifies factors for designating AO's and modifying the list of designated AOs.

These statutory factors are that CMS must look at the ability of the organization to conduct timely reviews of present applications, the ability of

the organization to take into account the capabilities of suppliers located in rural areas and whether the AOs have established reasonable fees to be charged the HIT suppliers applying for accreditation by that organization and such other factors as a Secretary or CMS determines is appropriate.

Section 1861 (iii)(3)(D) of the Social Security Act as amended by Section 5012 of the 21st Century Care Act requires that the supplier be accredited by and accrediting organizations designated by the Secretary in accordance with Section 1834 (u)(5)(B) of the Act. At this time there are eight Accrediting Organizations that provide HIT accreditation programs that have not been approved by Medicare yet.

These eight accrediting organizations are (1)The Joint Commission, (2)The Accreditation Commission for Health Care, (3)The Compliance Team, (4) Community Health Accreditation Partner, (5) Health Care Quality Association on Accreditations, (6) National Association of Boards of Pharmacy, (7) The Centers for Pharmacy Practice Preservation, and (8) URAC.

Five of these AOs I've just mentioned are home health AOs that accredit home health providers and the HIT accreditation provided is done so as part of their Home Health accreditation programs. However, the other three AOs are pharmacy associations that have not received Medicare approval for the HIT accreditation provided.

What we have proposed to address this situation is that we will publish a solicitation notice in the Federal Register. And that will be done by December 31st of this year.

In this solicitation notice, we would invite all national AOs, any national AOs interested that is, to apply to CMS for approval to accredit HIT suppliers. This would include any AOs, not just the eight that I mentioned, but any national AOs that would like to apply is welcome to as long as they submit an application that meets the requirements of the regulations. We will post a notice in the federal register so that it is seen by these parties.

The purposes of the solicitation notice, like I said, is to put on notice all interested parties such as other AOs but also the existing eight accrediting organizations that are currently not Medicare approved reservation, put them on notice that they need to file an application with CMS to have their HIT accreditation program reviewed by CMS and approved, if they want to provide or continue providing HIT accreditation in the future.

The HIT approval and oversight regulations that were finalized contain several sections. As I said the first component of these regulations govern the initial and renewal application process. Those sections of the regulations that govern the application process and contents to be included in the application are §488.1010(a) and §488.1010(b).

The next section of the regulation is the procedures for CMS in review and approval of the HIT AOs application for CMS approval of their HIT accreditation program. The regulation sections that apply to this component are §488.1010(c); §488.1010(d) and §488.1020, which the Public Notice and Comment.

The next main component of these regulations is the ongoing monitoring and oversight of CMS approved HIT AOs. Part of our duty is to monitor the ongoing business of AOs and make sure that they're doing everything they're supposed to be doing.

The regulations that govern this particular component of the regulations are §488.1025, Use and Misuse of Accreditation Surveys; §488.1030, which is Ongoing Review of HIT Accrediting Organizations; §488.1035 Ongoing Responsibilities of a CMS-Approved HIT Accrediting Organization; §488.1040 Onsite Observations of HIT Accrediting Organization Operations; and, §488.1045, which is a Voluntary and Involuntary Terminations.

And the final section would be the Reconsideration for a adverse decision made by CMS and that would be §488.1050. That's all I have here, so I'll turn it back over to Jill.

Jill Darling: Great. Thanks Caroline and thank you to all of our speakers today. Please open (present) the line for Q and A.

Operator: If you would like to ask a question at this time please press star one on your telephone handset. We will pause briefly to compile the Q and A roster. And again, that is star one to ask a question. And our first question comes from (Cindy Burns), visiting nurse. Please go ahead, your line is open.

(Cindy Burns): Hello, can hear me?

Jill Darling: Yes, go ahead.

(Cindy Burns): OK. My question is about the county code submission for home health claims starting in 2019, the 85 code. You said there was going to be some kind of publication put out about that but it's not out as of yet. So is there -- and where will that come out on the web site?

Male: There will be the transmittal sheet about that in the next hopefully day and it will be on the regular CMS transmittal web page for all the change requests to publish.

(Cindy Burns): OK, and that's going to give all the details as to what the codes are and all that?

Male: (Plus), provide you with a link to the code source, yes.

(Cindy Burns): OK. Thank you.

Hillary Loeffler: I'm sorry, are you asking the HIPPS code of the county code?

(Cindy Burns): Well, whatever goes with the code 85 is now being required.

Hillary Loeffler: OK. So that should be in the (CR) but if you're curious, there is a list of all the HIPPS codes and the crosswalk SSA code for each county on the HHA center page.

So the easiest way to go that is just Google CMS HHA Center and the first item there on the web page is a spotlight about the final rule and there's a download for the county designation. It will tell you each county and would (bucket) as in and then what HIPPS code is. Get that help.

(Cindy Burns): OK, great. Thank you very much.

Operator: Thank you. Our next question comes from (Diane Segal) QMES. Please go ahead.

(Diane Segal): Hi. I wanted to find out is the demi post competitive bid updates that was provided at the beginning of the call, will that be on the CMS.gov web site. I found the gap document but I was trying to make notes as you were speaking but I couldn't type fast enough.

Male: Yes, hi. The final rule actually I think is published on the Federal Register website today. So you could go to the web site for today's date and find the rule there and that would describe all the changes.

(Diane Segal): OK. And that's on the CMS.gov website.

Male: Federal Register.

(Diane Segal): OK. Thank you.

Male: (UPL).

Operator: Thank you. Our next question comes from (Dan Short) SHP. Your line is open.

(Dan Short): So, yes. I have a couple questions about risk adjustment. I was curious with which Home Health Compare report, the recalibrated risk adjustment that we published or utilized. Hello?

Jill Darling: Heidi, are you -- are you on the line?

Heidi Magladry: Yes, this is Heidi. Can you do me a favor and send you question in so I can make sure I get the right response to you to our help desk at Home Health Quality Questions@cms.hhs.gov and I'll be happy to get an answer for you.

(Dan Dhort): Certainly. Thank you.

Heidi Magladry: Thank you.

Operator: And again, that is star one if you would like to ask a question. Our next question comes from (Caroline Dean) (Bright Trees). Your line is open.

(Caroline Dean): Yes, hello. I'm wondering if you can advise as to when the DMA POS calendar year 2019 to be schedule files will be available.

Male: I believe that public use files usually go out early December.

(Caroline Dean): OK. Thank you.

Operator: And we have no further questions in the queue at this time. I'll turn the call back to the presenters.

Jill Darling: All right, well thanks everyone for joining today's call. I know it was extra long today but we appreciate your patience in the beginning. So this is the last Home Health, Hospice & DME Open Door Forum for 2018. So we will talk to you next year. Thanks everyone. Have a great holiday.

Operator: Thank you ladies and gentlemen. This does conclude our call. You may now disconnect.

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