

Centers for Medicare and Medicaid Services
Home Health, Hospice & DME Open Door Forum
Moderator: Jill Darling
November 16, 2016
2:00 p.m. ET

Operator: Good afternoon. My name is (Jack) 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 remarks there will be a question-and-answer session. If you'd like to ask a question during this time, simply press star then the number one on your telephone keypad. If you'd like to withdraw your question press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Jack). Good morning and good afternoon everyone. My name is Jill Darling in the CMS Office of Communication. Thanks for joining us today for the Home Health Hospice and DME Open Door Forum. We do have a really good agenda, I just have two brief announcements. This open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have inquiries, please contact CMS at press@cms.hhs.gov. Now, a new update, if you've notice on the agenda we now will be – have podcast available for all of our Open Door Forums. So that will be available in about a week or so after each Open Door Forum if you are unable to make any of the calls and we will still have the encore presentation for two days at – available two days after the open door forum. This is just another way to catch you – catch up if you and other colleagues were unable to join the call.

So that link is on the agenda. So now, I'll hand the call up to our Chair, Hillary Loeffler.

Hillary Loeffler: Thanks, Jill. Hi, I'm Hillary Loeffler, I'm the Director of the Division of Home Health and Hospice here at CMS. I just want to say, good afternoon and good morning to those joining from the west coast and I want to thank all the presenters here in the room for taking time out of your day to participate in this call.

And as Jill mentioned, there's a pretty packed agenda. So I'm going to go ahead and hand it over to (Kelly Vontran) who's going to work through the payment provision in the 2017 Home Health final rule.

(Kelly Vontran): OK. Hi. I'm (Kelly Vontran). I'm a nurse consultant in the Division of Home Health and Hospice in the Chronic Care Policy group here at CMS. And as Hillary mentioned, I'm going to briefly summarize the payment provisions in the calendar year 2017 Home Health prospective payment system final rule. So for calendar year, 2017, CMS will complete the final year of a four-year face in of the rebasing adjustments to the Home Health payment rates as required by the Affordable Care Act.

The overall impact due to the rebate – rebasing adjustment is an estimated 2.3 percent decrease in payment for calendar year 2017. This decrease is all set by the Home Health payment update percentage, up 2.5 percent for calendar year 2017. We will also implement a 0.97 percent reduction to the 60-day episode payment rate in calendar year 2017 to account for nominal case mix growth from 2012 to 2014 prior to rebasing.

So calendar year 2017 will be the second year of the three-year face in, in the production to account for nominal case mix growth. Nominal case mix growth is a portion of case mix growth unrelated to increases in patient severity often referred to as upcoding. The 0.97 percent reduction in the 60-day episode payment rate results in an estimated decrease in overall payment for calendar year 2017 of 0.90 percent.

We are also finalizing our proposal to change the methodology used to calculate outlier payments moving from a cost for visit approach to a cost per

unit approach or one unit equal 15 minutes. This approach would more accurately calculate the cost of an outlier episode of care and that's with better align outlier payments with episode cost than the cost for visit approach.

In addition, CMS will increase the \$6 loss ratio from 0.45 to 0.55 in order to ensure outlier payments do not need to 2.5 percent of total payments for calendar year 2017. So in summary, we estimate that Medicare payment to Home Health agencies in calendar year 2017 will be reduced by 0.70 percent or \$130 million. This is less than the estimated impact in the proposed rule of a 1 percent payment reduction or \$180 million decrease in payment for calendar year 2017.

And finally, the Consolidated Appropriations Act of 2016 requires a separate payment to be made to Home Health agencies for disposable negative pressure wound therapy devices when furnished on or after January 1st 2017 to an individual who receives Home Health services for which payment is made under the Medicare Home Health benefit. As described in the Consolidated Appropriations Act of 2016, a separate payment amount for furnishing negative pressure wound therapy using a disposable device will be set to the amount of the payment that would otherwise be made under the Medicare hospital outpatient prospective payment system.

So now, we will turn the call over to Michelle Brazil from the Center for Clinical Standards and Quality to discuss the Home Health Quality Reporting Program Provision in the calendar year 2017 Home Health final rule.

Michelle Brazil: Thank you, (Kelly). Hello everyone. In this year's 2017 Home Health PPS final rule, the Home Health Quality Reporting Program finalized to report in the areas that we would like to talk to everyone about. The first is the impact at quality measures. First is, we won't use the standardize assessment based data and this measures title drug regimen review conducted with follow-up for identified issues. We also finalized three impact at clean space cross setting measures, these are discharged to community, Medicare spending for a beneficiary and potentially preventable 30-day post discharge readmission measure.

This align with the LTAC, IRF and SNF programs whose rules were finalized in August of this year. We also identifies stakeholders in this – that 28 quality measures would no longer be included in the Home Health quality initiative effective January 1st 2017. In additional, we finalize our proposal term at six measures from the Home Health Quality Reporting Program in public reporting on Home Health Compare. In accordance with their statutory authority and further recommendations and request from the stakeholder community, we will continue to provide Home Health agencies their data on all 34 of these removed measures for youth by agency for internal quality improvement effort and to support excuse me CMS's survey processes.

We provide quality measures data to Home Health agencies via cast for report which are available to the Quality Improvement Evaluation System or QIES eval system. These includes the potentially avoidable events reports, outcome quality measure report and process quality measure report. The first 2017 update for Home Health Compare is scheduled for January 25th 2017. This update will include the quality of patient care star rating value shown in the preview report which will be – which will – excuse me, were distributed in early October via CASPER.

As a reminder, prior to each quarterly refresh of the quality of patient care star rating on Home Health Compare, agencies receive a quality of patient care start provider preview report in their which folders on the case system. The quality of patient care star provider preview report are available approximately three months prior to the refresh Star Ratings on Home Health Compare. This update will also include the quality measure value shown in the preview report distributed in CASPER in early October.

Please note that six measures will be brought from Home Health Compare beginning with the January 2017 refresh but will still appear on the new preview report for another few refresh cycles. The six process measures that will be removed are pain assessment conducted, pain interventions implemented during all episodes of care, pressure of the risk assessment conducted, pressure of the prevention and plan of care, pressure of the prevention implemented during all episodes of care and heart failure symptoms addressed during all episodes of care.

Thank you. That concludes my update and now, I'm going to turn the call over to (Ed).

(Ed Lilley): Good afternoon. Effective January 1st 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 the HHA's model where payment adjustments will be based on each HHA's total performance score on a set of measures already reported via OASIS and HH CAHPS for all patient service by the HHA or determined by claims that – plus three new measures were points are achieved for reporting data.

In last year's rule, we finalize that the HHAs in these nine states will have their payments adjusted in the following manner. The maximum payment adjustment of 3 percent upward or downward in calendar year 2018, 5 percent upward or downward in 2019, 6 percent upward or downward in 2020, 7 percent upward or downward in 2021 and 8 percent upward or downward in calendar year 2022. On November 3rd 2016, the final rule calendar year 2017 Home Health prospective payment system final rule was published and could be found at federalregister.gov.

In the rule, CMS is finalizing the following changes and improvements related to the to the HHA model. We finalized calculating benchmarks and achievement threshold at the state-level rather than the level besides cohort and revising the definition for benchmark to state that the benchmark refers to the meaning of the top decile of Medicare certified HHA performance on the specified quality measure during the baseline period calculated for each state. The finalize requiring a minimum of eight HHAs in any size cohort.

We finalized increasing the timeframe for submitting new measures data from seven calendar days to 15 calendar days following the end of each reporting period to account for weekends and holidays. We have finalized removing four measures, care management, types and sources of assistance, fire

functioning activities of daily living or ADL, instrument radio, influenza vaccine data collection group period and recent pneumococcal vaccine not received from a set of applicable measures.

We've finalize adjustment in the reporting period in the submission date for the implicit vaccination coverage for Home Health personnel measure from a quarterly submission to an annual submission. We finalized the implementation of the recalculation and reconsideration process and we provide an update on a progress towards developing public reporting of performance under the HHA model. I'd also like to remind the HHA and the United States that your first and second interim performance reports as imposed here in the HHA secure portal.

So please, if you haven't already done so, take the steps needed to request access to the secure portal. If you have other questions about the model not related to the final rule, please submit them to hhvpquestions@cms.hhs.gov. And I'm turning it back to Jill.

Jill Darling: Thanks, (Ed). Up next we have (Kim Rehor) from the TMS Health Quality Institute and she'll go over the Home Health and Hospice PEPPER.

(Kim Rehor): Thank you, Jill. Again, I'm (Kim Rehor) with TMS Health Quality Institute. We are contracted with CMS through the center for program integrity provider compliance group. And we prepare and distribute provider level comparative data report called, PEPPER. PEPPER is acronym that stands for Program for Evaluating Payment Pattern Electronic Report. The PEPPER is a data report that summarizes Medicare billing statistic for one provider so that would be one Home Health Agency or one hospice and it compares that providers statistics to aggregate data for all providers in the nation in the Mac jurisdiction and in the state.

And we use these comparisons to identify when the provider might be at a higher risk for improper Medicare payment. The PEPPER is available to Home Health Agency and hospices as an educational tool to support efforts to identify and prevent improper Medicare payment and so it supports CMS's effort to protect the Medicare trust fund. The goal is for providers to use

pepper so that they can then review their statistics and conduct self-audit or review their operation to determine if any correct – any concerns exist in which case they would want to take corrective measures as necessary.

So if you – the high points about PEPPER, it does summarize three years of fee-for-service Medicare claims data for the areas that have been identified as at higher risk, and it presents these statistics as graph that show changes over time and we also include tabular data for those who want to review the actual statistics. It's important to remember that the PEPPER cannot identify the presence of improper payment. Those can only be identified by reviewing the medical record and the billing documentation and we produce the PEPPER annually in April for hospices and in July for Home Health Agency.

I do want to review the types of risk areas that are summarized and included in each of these types of PEPPER so you have an idea what the statistic pertained to and I'll start off with the Hospice PEPPER which we've been producing since 2012. The Hospice PEPPER include a total of 10 risk areas. Now, there has been a recent focus on life discharges as an indicator of potential abuse at the Medicare hospice benefit and so we include three reports related to life discharges.

The first one calculates the percent of hospice episode discharged alive as no longer terminally ill. The second, calculates the percent of hospice episode discharged alive where the beneficiary revoked the Medicare hospice benefit, and the third focuses on the percent of hospice episode discharged alive with a length of stay of 61 to 179 days.

The PEPPER also includes a report calculating the percent of episodes that have long length of stay which would be longer than 180 days. It also include four reports that are related to hospice services provided to beneficiaries residing in a number of different settings. We added these reports last year as a result of an OIG report released in January 2015 that identified incentive for hospices to provide care to beneficiaries residing in an assisted living facility.

So we do calculate the percentage episode where the beneficiary resides in an assisted living facility where the beneficiary received at least eight hours of

continuous home care. There's another report that calculates the percent of routine homecare days that are provided to beneficiaries residing in an assisted living facility. We also calculate the percent of routine homecare days provided to beneficiaries residing in a nursing facility and the percent of routine homecare days provided to beneficiaries residing in a SNF.

The last two target areas in the PEPPER, the Hospice PEPPER calculate the percent of claims where there's only one diagnosis coded on the claim. And the last, the episode – the percent of episodes where the beneficiary did not receive any GIP or the CHC that would be general inpatient care or continuous homecare during their entire episode.

Moving on to the Home Health Agency PEPPER which has been available since 2015. This PEPPER summarizes statistics for six risk areas. The first is average case mix for all episode excluding the Lupus and the (PEPs). The second is the average number of episodes per beneficiary. The third at the percent of episodes with five or six visits. Number four, percent of episodes that do not have a (LUPA) payment. Number five, is the percent of episodes with 20 or more therapy visit and the sixth is the percent of Medicare reimbursement that is composed of outlier payment.

So I would like to encourage all Home Health Agencies and hospices to obtain their PEPPER if they have not already done so. As of today, 24 percent of the Home Health Agency PEPPER have been accessed and 58, that 58, 58 percent at the Hospice PEPPER have been accessed. I would encourage you to visit our website, pepperresources.org, that's pepperresources.org to access your PEPPER and we also have available on the website, our pepper users' guide. There's a sample pepper out there if you would like to check out what the PEPPER looks like. We have recorded training session and also a helpdesk if you have questions or you need assistance obtaining your report.

I'll turn the session back over to Jill.

Jill Darling: Thank you, (Kim). Up next we have (Djanira Rivera) who will go over the Round One 2017 Contract Suppliers for Medicare DMEPOS Competitive Bidding Program.

(Djanira Rivera): Thanks so much, Jill, and good afternoon or good morning everyone. Again, my name is (Djanira Rivera) and I am with CMS in the Division of DMEPOS competitive bidding. And this afternoon, I wanted to inform you that on November 1st, CMS announced the round one 2017 contractor suppliers for the DMEPOS competitive bidding program.

The round one re-compete contract period expires on December 31st 2016 and round one 2017 contract will become effective on January 1st 2017 through December 31st 2018. CMS is conducting the round one 2017 competition for eight product category in the same nine Metropolitan – I can't – excuse me, statistical areas also known as MSAs including in the round one re-compete. Competitive bidding areas or CBAs and multistate MSAs have been defined so that there are no multistate CBA. And as a result, 13 CBAs are in round one 2017.

For a list of specific items in each product category or for a list of the areas included in round one 2017, please visit the Competitive Bidding Implementation Contractor or also known as the CBIC their website at www.dmecompetitivebid.com and to locate a contract supplier, please visit the supplier locator tool which is located at www.medicare.gov/supplier.

The media fact sheet that was published on November 1st is also attached to your agenda and that contains more information and more detail. I also wanted to let you know that we are reaching out to beneficiaries during this time by the way of a beneficiary brochure will be printed and will also be made available online on cms.gov along with messages and beneficiary Medicare summary notices or MSN. And beneficiary messages which are posted in the message center on mymedicare.gov. So they are being informed.

That concludes my update on round one 2017 and I would now like to introduce my colleague (Julia Howard) who will be giving an update on

DMEPOS competitive bidding rules that have recently been published.
(Julia).

(Julia Howard): Thanks, (Djanira). Hello everyone. The Medicare Access and Chip Reauthorization Act also known as MACRA was signed into by the president on April 16th 2015. Among the numerous provisions included in this legislation was an amendment 1847 of the Social Security Act that affects the DMEPOS competitive bidding program, specifically Section 522 of MACRA implements bid surety bond requirements and requires bidding entities to be in compliance with state licensure requirements.

With the issuance of our final rule we've implemented the MACRA requirements and regulation. Also in this rulemaking we finalized the revision to our appeals process for breach of DMEPOS competitive bidding contract. Prior regulations only outlined in appeals process for one breach of contract action, a contract termination instead of all breach of contract actions and regulation. In the final rule we've extended the appeals process to all of the breach of contract actions and not just termination. This expanded appeals process ensures that any supplier that is in breach of the terms of their competitive bidding contract will have an appeal right.

I'm going to go into a little more depth on our three different provision starting first with the bid surety bond requirement. This was specified in MACRA and required us to make a revision to 42 CFR 414.412 submission of bids under our competitive bidding program. With issuance of the final rule bidders now must obtain and submit proof of a bid surety bond for each competitive bidding area also known as the CBA in the amount of \$50,000. This was a small revision from our proposed rule which said that bid surety bond at \$100,000.

The bid surety bond must be maintained until it is collected upon our return for not meeting bond forfeiture specifications. Bid surety bonds must be obtained from an authorized surety on the Department of Treasury's listing of certified companies. Bearers will attest at the time of bid submission that the bid surety bond has been obtained and will provide a hard copy of the bond to CMS. Bidders offered a contract where its composite bid is at or below the

medium composite bit rate for all bidding entities included in the calculation of the single payment amount for the competition which is the CBA/product category combination, must accept all applicable offers specific to CBA or the bidder will forfeit their bid surety bond for that CBA.

We contemplated that suppliers may accept the contract offer with no intention of fulfilling the terms of their agreement in order to avoid bond forfeiture. You therefore finalize the rule with language that a breach of contract under the circumstantial result in a contract termination. Our second provision concerned the state licensure requirement also contained in Section 522 of MACRA which stated that a contract will not be awarded to a bidding entity unless an entity meets applicable state licensure requirements.

We finalized the rule by revising our existing regulation at 42 CFR 414.414 conditions for awarding contract to reflect this change. The revision to the regulation make it explicit the contract will only be awarded to suppliers that meet all applicable state and local licensure requirement. We do note that this revision does not reflect the change of policy of CMS has always had a regulation – this regulation in place and operationalize the requirement that suppliers meet applicable state and local licensure requirement.

Finally, I'd like to touch on our expanded appeals process for breach of contract action at 42 CFR 414.423. The final rule revises the appeals process doing include appeal for any breach of contract action that CMS may take. Under the prior regulation of the all – appeals process only apply to contract termination. However, pursuant to 414.422 G2 there any number of actions that CMS may take a result of a breach of contract. Our revisions leave in place the existing appeals process for termination but extend the process to any breach of contract action.

The final rule outlines the effective contract action by expanding on the effective termination and adding the effects of contract suspension and preclusion from the competitive bidding program. We also removed certified mail as the only method to communicate the breach of contract notification to our suppliers and that concludes our rule that will take effect January 1st 2017. Thank you.

Jill Darling: Thanks, (Julia). Next we have (Stacey Payne) who will go over the Hospice Quality Reporting Program.

(Stacey Payne): Hello, everyone. This is (Stacey Payne) and I'm the program coordinator for the Hospice Quality Reporting Program. I have three updates for you today. The first about the upcoming hospice quality measures report. The Hospice Quality Measure or Q.M. report are scheduled to be available in mid to late December. These new report will allow providers to view their quality data both at the facility level as well as the patient level prior to the implementation of public reporting which is scheduled for summer of 2017.

Providers will be able to access these report to the (CAFRA) application in the keys (ASAP) system. We will provide notification to our ListServ as well as on the Hospice QRP website Spotlights and Announcements page when Hospice Q.M. reports are available.

The second update today is regarding public used files. Public used files are scheduled to be posted on data.medicare.gov in December. These files will show national averages of the seven NQF endorsed quality measures from the hospice items that – as well as data obtained from the hospice kept survey.

This is not provider level data but an opportunity to view how states compare on a national level. Again, we will provide notification to our (list serves) as well as on the Hospice QRP website by Spotlights and Announcements page when the public used files are available. My third and final update today is to let you know the regional office and state coordinator list has been updated on the hospice data directory page located at data.medicare.gov. This is the contact list for updating information in the CMS automated survey processing environment or ASPEN.

If your hospice's information on the Hospice data directory is incorrect, contact the regional office or state coordinator listed for your area. This list is only updated quarterly so when the updated information is able to be seen on the hospice data directory will depend on when the regional office or state coordinator is able to input the request to change in ASPEN.

This completes my update today. And now I will turn the call over to Lori Teichman.

Lori Teichman: Thank you so much, (Stacey). I just have a couple of (inaudible) Home Health CAHPS and some are ones you've heard before. It's never too late to participate in Home Health CAHPS. You may email RTI which is the federal contractor for Home Health CAHPS at Home Health – HHCAHPS@RTI.org. You may also go on the website which is <https://homehealthcahps.org> and that is the official website. You may sign up there all the information also is on the homepage about how you get assistance with home health CAHPS with any issue.

On the homepage there is a tab on the top that says for Home Health Agency only and that is one of the secure sections of the website. The website is both a public and a secure website. For entry into the Home Health Agency section you need to have an ID and password but it's very important that every Home Health Agency obtain that so they may view all of their home health CAHPS report including most importantly the data submission report.

Because the data submission reports will tell them whether or not the data has been successfully submitted to the Home Health CAHPS website and if it is not successfully submitted then their annual payment update is going to be compromised. So it's important to check data submission report. Also, through that same portal, Home Health Agencies may see their preview report, these are preview reports about what data will be provided on Home Health Compare.

So every quarter there is a new preview report that will show the updated data going on Home Health Compare. The preview report that generally posted in the month of December, March, June and September. For Home Health Agency that are participating in Home Health CAHPS and never have any problems regarding submission of their patient file to their respective Home Health Center. The patient files of first the first step in the whole process of implementing the survey.

If they cannot get patient file to their Home Health Centers then they should immediately notify their inventors about the problems because then the vendors will notify RTI, the federal contractor for Home Health CAHPS that there was a problem and they file these problems in discrepancy notification reports. We remind all Home Health CAHP vendors that they should always fill out discrepancy notification report for any and all missed month of survey data collection. So CMS is aware of the reason for missed month by their client's Home Health Agencies.

Again, if your Home Health Agency had 59 or fewer unduplicated patients in the period of April 2015 to March 2016, then your agency must file a calendar year, 2018 Home Health CAHPS exemption form so that you do not have to do the Home Health CAHPS Survey now which is in the period of April 2016 to March 2017. If you fill out your exemption form on the website before March 31 and in fact you do have 59 fewer patients you will most likely be exempt from the survey. Every year an agency must complete an exemption form because the count year has changes as it moves up in time.

CMS had a due date of midnight, November 7th to submit a request for reconsideration of the calendar year 2017 annual payment update decisions for the Home Health Quality Reporting Program and I just wanted to mention that, that of course, in concludes Home Health CAPHS and when no longer accepting request for reconsideration of noncompliant decisions for Home Health CAHPS reason for the calendar year 2017 annual payment update.

If you have any questions about Home Health CAHPS, please email hhcahps@rti.org the CMS mailbox at Home Health CAHPS, so Home Health, the two words put together and then CAHPS@CMS.HHS.gov. You may also telephone RTI the federal contractor at 866-354-0985.

Thank you so much. Thank you Jill. Thanks you (Stacey) and now I would like to introduce Debra Dean-Whittaker who is going to talk about Hospice CAHPS.

Debra Dean-Whittaker: OK. This is Debra Dean-Whittaker, I have two reminders relating to the Hospice CAHPS Survey. The first it has to do with the exemption for

size. Exemption precise forms will be accepted until December 31st 2016 that is the deadline date after that date, it will be too late to file. You have about six weeks to get your form in. Here's how you know if you should file a form.

If your hospice served fewer than 50 survey eligible/caregiver. In the calendar year 2015, meaning, January 1st through December 31st 2015, you can apply for an exemption for size from doing the Hospice CAHPS survey. The exemption for size applies for only one year. So, if you applied last year and you believe you're still qualified you must apply again this year. So go get your form in. If you apply this year and you think you will probably qualify next year, make your plans to be ready to make a reapplication next year. You will need to fill in and submit an exemption for size form. It is on the survey website. The URL is on the agenda for this form.

Secondly, I want to talk to about the vendor authorization. Have you authorized your CAHPS survey vendor? Your vendor cannot submit data to the Hospice CAPHS data warehouse unless you authorize them to do so. The authorization form is on the survey website. If you have not authorized your vendor, get in touch with the Hospice technical assistance team immediately. Some hospices are in danger of falling out of compliance because their vendor cannot submit their data. Don't let this happen to you make sure that you have authorized your vendor. Thank you.

Jill Darling: Thanks, Debra. Last we have (Will Gehne) who will go over the Change Request 9585.

(Will Gehne): Thanks, Jill. Since our last open door forum, Medicare issued Change Request 9585 which is entitled denial of Home Health payments when a required patient assessment is not received. This instruction creates enforcement in Medicare claims processing system for the Home Health condition of payment requiring submission of a ways to its assessments. So effective April 1st 2017 all Home Health PPS claims will be subject to a two-step check for the presence of a supporting leases assessment.

First Medicare systems will create a national OASIS database to see if an OASIS assessment has been received. If an assessment is found, the claim will process normally. If now OASIS is found, then our systems will compare the OASIS completion date before the treatment authorization code field of the claim, to the claim received to determine whether an OASIS should have been received by that date.

If the OASIS is not found and the OASIS is past due, the claim will be denied. Claims denied for this reason will be identified on the Home Health Agency remittance advice using claim adjustment reason 272, just defined coverage program guidelines were not met. I want to answer a few question that I have received since we issue the change request. First this change only affects Home Health claims and has no effect on the processing of reps. This process does not create denial simply because an OASIS assessment was late.

If the OASIS has found when a claim is received, Medicare systems will not look at the receipt date of that OASIS for a denial to occur, the OASIS must be missing and pass due. This process applies to all episodes so the OASIS assessment involved maybe a start of care, a resumption of care or recertification assessment. And a correction in process to an assessment that's already been received will not affect the process. Medicare systems will recognize the original assessment that's already in the OASIS database.

In addition to CR 9585 Medicare also recently issued Change Request 9736 which includes the claims processing manual revisions and system requirements for the Home Health rule changes that (Kelly) discussed earlier. You may find answers to your questions about the implementation of that rule in the change request which is available on the CMS transfer of page. Thanks, Jill.

Jill Darling: Thank you, (Will) and thank you to our speakers. (Jack), we'll go into our Q&A, please.

Operator: As a reminder, ladies and gentleman, if you'd like to ask a question, please press star one on your telephone keypad. If you'd like to withdraw your question, press the pound key. Please limit your questions to one question and

one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

Your first question comes from the line of Josephine Madden with Accessible Home Health. Your line is open.

Josephine Madden: Hi. I was just wondering if everything that was discussed today will be put on a printout for us to reread as it was quite quick like you couldn't write everything down as you were talking?

Jill Darling: Hi. This is Jill Darling. There is an encore presentation which you can hear the playback for two business days after today's call. And then like I had mentioned earlier in the call, we will be having a transcript and the audio available within – I guess it's about a week or so and it's on – there's a link that's on the agenda. That will take you to where the transcript and the audio will be. So give us a little bit of time to create that.

Josephine Madden: OK. Thank you.

Jill Darling: You're welcome.

Operator: Your next question comes from one of Elizabeth Buckley with Trinity Health At Home. Your line is open.

Elizabeth Buckley: Hi. I wanted to ask a question about the disposable negative pressure wound treatment that's new in the new rule and the question is, if you have a patient with this – with one of these devices does the co-pay apply – that the patient may be responsible for applied to this visit? The cost of the visit and the cost of the device or just the cost of the device?

Hillary Loeffler: So when the Home Health Agency build for this, this is Hillary, they are going to bill it on the 34 type of bill. And they are only going to bill this to CPT code associated with negative pressure when therapy disposal devices when they are replacing the entire device. And the coinsurance is the only applicable to those two CPT codes when build on the 34X. So not to every visit.

Elizabeth Buckley: So it's the cost of the device or just the cost of that visit whatever our cost is for the visit.

Hillary Loeffler: Well, if you're doing something else separate from negative pressure wound therapy when you're furnishing the entire integrated device say doing a catheter change, the catheter change would be on the 32X and no co-insurance would apply to that. It's just the 34X CPT codes for when you're replacing the entire device. So the co-insurance is just for negative pressure wound therapy.

Elizabeth Buckley: Is that something that we have to be a Part B provider to bill for or is that something that we should already be able to bill for with our current status?

Male: No, that is an institution of claim. So if you can bill it under your current provider number just using a different type of bill code.

Elizabeth Buckley: OK. Thank you.

Operator: Your next question comes from the line of (Caitlin Blink Clorek) with Home Health Care – Home Therapy of Austin. Your line is open.

(Caitlin Blink Clorek): Hi, yes. And you guys mentioned making sure we have access to the secure value-based purchasing portal and I just want to confirm that, that is for agencies within the states that currently has value based purchasing because our agency is located in Texas.

Male: Yes. So Texas would not be included just some agencies within Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington need to be on the HHA secured portal.

(Caitlin Blink Clorek): Thank you, that's all I asked.

Operator: Your next question comes from line of Trish Twombly with DecisionHealth. Your line is open.

Trish Twombly: Thank you. It's my understanding that the OASIS data set query process is no longer going to utilize OASIS answers but instead if agencies have a particular question about an OASIS item they are to contact their state

coordinators. I was wondering if that is correct and if it is, how is that information going to be organized where you would have a quarterly process of publishing those answers?

Michelle Brazil: Hi, this is Michelle Brazil with the Home Health Quality Reporting Program. There is – there are no representatives from the (Inaudible) here today at the open door forum but I ask please that you (make) questions to us detailing what's your asking to HomeHealthQualityQuestions@cms.hhs.gov and we'll point you in the right direction.

Trish Twombly: Thank you.

Michelle Brazil: Thank you.

Operator: Again, if you'd like to ask a question please press star one on your telephone keypad.

Your next question comes from the line of Kathy Cook with Lifetime Care Home. Your line is open.

Kathy Cook: Hi. I had a question about the IMPACT Act quality reporting measures. I didn't hear you say the percentage of patients with new or worsening pressure ulcer is that also one of the quality measures?

Female: It is and it was implemented last year. So you can find on all the details in the federal register which goes over the pressure also measure as well as these four measures that were finalized in the shares rule.

Kathy Cook: OK. Thank you.

Female: If you have additional questions. You can always submit them to the HomeHealthQualityQuestions@cms.hhs.gov.

Kathy Cook: Thanks.

Female: You're welcome. Thank you.

Operator: Your final question comes from the line of (Freda Chatfor) with North Bay Healthcare. Your line is open.

(Freda Chatfor): Hi. I just want to go back to a question two which is regarding the NPWT and I just want to clarify that we're going to bill on type of bill 34X both the visit and the disposable device, correct?

Female: So when the nurse is out there furnishing negative pressure on therapy using the disposable device, the CPT code under OPPS includes like a reimbursement amount for both the service which is assessing the wound, applying the dressing, supplying the device along with the actual device cost like it's all integrated in that OPPS amount so that's going to be reimbursed on the 34X. If you're doing something else during the visit like a catheter change you would still report the time spent for the catheter change as a visit on a 32X.

(Freda Chatfor): OK.

(Crosstalk)

Female: Yes, the OPPS reimbursement is for furnishing the service along with the device.

(Freda Chatfor): OK. So regardless what the survey says.

Female: The service for negative pressure wound therapy. Like if you're in there performing negative pressure wound therapy and you're replacing the entire device that's when you bill the 34X. If you're out there just doing addressing change or maybe changing the canister that collects the exudates, there's different systems out there so I don't want to be specific to anyone system that you may be using, that would still be on the 32X. The 34 is just when you're replacing the entire device including the pump.

(Freda Chatfor): OK.

(Crosstalk)

Female: ... negative pressure wound therapy.

(Freda Chatfor): And now the – do we go back to – on that exact question. This co-pay, so now the patient has a co-pay that applies here when it is used for wound care. Is that what you said?

Female: Yes, for the Consolidated Appropriations Act, if you're going to bill reimbursement on the 34X for those two CPT codes for disposable devices the beneficiary is required to pay a 20 percent co-insurance amount.

(Freda Chatfor): OK. Very well. Thank you very much.

Female: No problem.

Operator: A few more people have queued up. Your next question comes from the line of Elizabeth Buckley with Trinity Health At Home. Your line is open.

Elizabeth Buckley: Thank you. I had one more follow-up to that of the negative pressure disposable. Is there somewhere where there is a list or something that will tell us how much the payment is for those two CPT codes so we can make sure we inform the patient prior to what amount their co-pay will be?

Female: Yes. It is on the OPPS perspective payment system amount. I can get you a link if you want to email the Home Health Hospice DME ODF mailbox.

Elizabeth Buckley: OK.

Female: You can still send your email there and I'll send you a link directly to what the OPPS reimbursement amounts are for those two CPT codes.

Elizabeth Buckley: Thank you.

Female: Yes.

Operator: Your next question comes from the line of Sharon Hamilton with Brooks Healthcare, your line is open.

Sharon Hamilton: Hi. This is Sharon Hamilton, I'm actually with Brooks Healthcare. I have a question about the OASIS set, do you have any idea when it's going to be finalized?

Michelle Brazil: Hi, the OASIS C2 is currently with OMB right now once we received word from them. We will notify providers through probably a spotlight announcement and with the serve announcement and then the ODF that are scheduled at that time. So stay tuned hopefully, it will be soon.

Sharon Hamilton: OK. I have one other question as far as that dataset go, M1028 you can – it's talking about three different diagnoses that the patient might have and you're supposed to check it off as they do. However, you can also use the dash as a valid response and that dash is used when the information is not available or you weren't able to assess that about the patient. There's no option for patients that do not have these diagnoses.

So you know it's been my experience that you can't leave an item blank. So how does a clinician get around that question if the patient doesn't have the – any of that – anyone of those three diagnoses.

Michelle Brazil: I'm not going to be able to answer that off the top of my head right now. So, can you please send me that exact question to HomeHealthQualityQuestions@cms.hhs.gov and we'll be happy to get you to respond within the next day or so.

Sharon Hamilton: OK. Thank you.

Michelle Brazil: Thank you very much.

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

Operator: Your final question comes from the line of (Barbie Long) with Community Hospital. Your line is open.

(Barbie Long): Yes. I was just wondering if you could – in the state of Nebraska where I am at right now, and I'm a clinical access hospital that has in the Home Health

and Hospice program with it, does that value based purchasing is that happening right now that you would know of for our agency?

Male: Yes. So it started January 1st 2016 and all agencies in Nebraska are expected to participate.

(Barbie Long): OK. I just became the Director of Home Health and Hospice, so I'm trying to get as much information as possible. So when I heard that, I just wanted to make sure and so, with the PEPPER report we should be on that correct? Any agency should be on the PEPPER report, correct?

Female: So the PEPPER report is separate from value based purchasing the PEPPER just provide utilization data that might be of interest to Home Health Agencies and we can ...

(Crosstalk)

(Barbie Long): Right.

Female: And we can get you the email for that. So for value base purchasing are you asking about the portal?

(Barbie Long): Well, yes and that's what I was wondering too. I have this three questions sorry.

Female: Yes, if you want to email the ODF mailbox, it's on the agenda just with everything you're looking for. We can go ahead and just send you everything back in an email.

(Barbie Long): Perfect. Thank you so much.

Female: And include your provider number in the email.

(Barbie Long): OK. All right.

Female: Thank you.

(Barbie Long): Thank you.

Jill Darling: All right. Well, thank you everyone for joining today's call. The next Home Health Hospice CME ODF is scheduled for January 11th 2017 and we hope to hear from you then. Thanks everyone. Have a great day.

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 at 5 PM Eastern Time today, November 16th 2016 through midnight on November 18th. The conference I.D. number for the replay is 851-3026. The number to dial for the replay is 855-859-2056. This concludes today's conference call. Participants may now disconnect.

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