Centers for Medicare & Medicaid Services
Home Health, Hospice and DME Open Door Forum
Tuesday, July 9, 2024
2:00 – 3:00 p.m. ET

Webinar recording:
https://cms.zoomgov.com/rec/share/3iMRUEVIQnOQpugXSW1TD2oDDePEDLsZvJQM6D_CMsHSaNN9iAcWz3a2DKfxBTxW.Aen6TFxd8GzCNW4A
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Jill Darling: Great. Thanks, everyone, for waiting. We got more folks into the webinar. Good morning and good afternoon. My name is Jill Darling, and I'm in the CMS Office of Communications. Welcome to today's Home Health, Hospice and DME (Durable Medical Equipment) Open Door Forum. Before we begin with our agenda, I have a few announcements. For those who need closed captioning, a link was provided in the chat function of the webinar, and I will provide it again. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage. That link is included on the agenda. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For today's webinar we have the agenda slide you see on the screen, and during the Q&A portion of the call, I will share a resource slide.

We will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda today. We ask that any live questions relate to the topics presented during today's call. If you have questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox, and we'll try to get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call you when it's time for Q&A. Please introduce yourself and what organization or business you are calling from. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question, and we'll do our best to get to your questions. And now we will begin our agenda with Kelly.

Kelly Vontran: Thanks, Jill. Good afternoon and good morning to those of you calling in from the West Coast, and thank you for joining us on today's Home Health, Hospice, and DME Open Door Forum. My name is Kelly Vontran, and I work in the Division of Home Health and Hospice here at CMS. Just as a general announcement, there are presenters on today's call that will be giving updates on calendar year 2025 proposed rules. So please know that because we are in the comment period, there may be some questions we may not be able to answer. We do have a full agenda today, so I will jump in on the first agenda item, which is an update on the CY 2025 Home Health Prospective Payment System (HH PPS) proposed rule, which was issued on June

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26, 2024. This proposed rule would update Medicare payment policies and rates for Home Health Agencies, and I will be summarizing these proposed payment policies with 2025.

So, the first proposal is the proposed permanent payment adjustment to the calendar year 2025, 30-day payment rate. As required by the Bipartisan Budget Act of 2018, this rule proposes a permanent perspective adjustment to the CY 2025 home health payment rate of minus 4.067%. This adjustment accounts for differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures due to the CY 2020 implementation of the Patient-Driven Groupings Model, or what we call the PDGM, and the change to a 30-day unit of payment. For CY 2023 and 2024, CMS previously applied a 3.925% reduction and a 2.890% reduction, respectively, which were half of the estimated required permanent adjustments for those years. The law also requires CMS to apply temporary adjustments to account for retroactive open payments. We have not applied any temporary adjustments in previous years, but we have stated that any temporary adjustments will be proposed in future rulemaking. While we are not proposing to implement a temporary adjustment in CY 2025, the proposed rule does provide the calculated temporary adjustment based on analysis of calendar years 2020 through 2023 claims, and that amount is approximately $4.5 billion. The law provides CMS the discretion to make any future permanent or temporary adjustments in a time and manner determined appropriate through analysis of estimated aggregate expenditures through calendar year 2026.

The next proposed rule is the proposed crosswalk for mapping OASIS (Outcome and Assessment Information Set) data elements to the equivalent OASIS-E data elements. The Outcome and Assessment Information Set, or OASIS, fee was the home health assessment instrument used under the prior 153 group system and also the first three years. That is the calendar years 2020 through 2022 of the current PDGM. However, the Office of Management and Budget approved an updated version of the OASIS instrument, OASIS-E, on November 30, 2022, with an effective date of January 1, 2023. As part of the finalized repricing methodology to examine behavior change and to accurately determine payments under the 153 group system, we use the October 2019 3M Home Health Grouper to assign a health insurance prospective payment system code to each simulated 60-day episode of care. This older version of the Home Health Grouper requires responses from OASIS-D. Therefore, to continue with the repricing methodology, CMS will need to impute responses for the three items from OASIS-D that have changed in OASIS-E.

Additionally, 13 items on the OASIS-E are no longer required to be asked at a follow-up visit. For these items, we can use the most recent start of care or resumption of care assessment to determine a response which would not require imputation. We are proposing a methodology to address this issue by mapping OASIS-E items in this proposed rule. Other proposed routine payment updates include the proposals to recalibrate with PDGM case mix rates, update the fixed dollar loss for outlier payments, update the low utilization payment adjustment, or what we

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call LUPA thresholds, as well as the functional impairment levels and the comorbidity adjustment subgroups for CY 2025.

The next proposal is the proposed OT (occupational therapy) LUPA add-on factor and LUPA add-on factor updates. With sufficient recent claims data available and to establish equitable compensation for all home health services, CMS is now proposing to establish a definitive, occupational therapy specific LUPA add-on factor and discontinue the temporary use of the physical therapy LUPA add-on factor as a proxy. We proposed using the same methodology to establish the skilled nursing, physical therapy, and speech-language pathology LUPA add-on factors as described in the CY 2014 HH PPS final rule. The proposed OT LUPA add-on factor of 1.7266 will be updated based on the complete calendar with 2023 claims data in the final rule. Additionally, we are proposing updating LUPA add-on factors to more accurately reflect current health care practices and costs by proposing to use recent claims from 2023 to update the skilled nursing, physical therapy, and speech-language pathology LUPA add-on factors.

Next, this rule proposes to update the home health wage index and adopt the new labor market delineations from the July 21, 2023, OMB bulletin number 23-01 based on data collected from the 2020 decennial census. This OMB bulletin contains several significant changes. It is standard practice to adopt the latest OMB update when available, as using the most recent OMB statistical area delineations results in a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. For example, there are new CBSAs (core-based statistical area), urban counties that have become rural counties that have become urban, and existing CBSAs that have been split. We note that existing Home Health PPS regulations limit one-year wage decreases to 5%, which may help mitigate the impact of CBSA changes on payment.

Additionally, this rule includes a proposed rate update for the CY 2025 intravenous immune globulin, or IVIG, items and services payment under the IVIG benefit. The proposed calendar year 2025 IVIG items and services payments…payment rate would be $430.99, which is the 2024 IVIG items and service payment rate updated by the proposed home health payment update percentage of 2.5%. Additionally, this proposed rule includes a discussion on the disposable and negative pressure wound therapy proposed payment rate update. For CY 2025, we are proposing that the separate payment amount for the disposable negative pressure wound therapy device would be set equal to the CY 2024 payment amount of $270.09 updated by the CPI-U (Consumer Price Index for All Urban Consumers) for June 2024, minus the productivity adjustment as mandated by the Consolidated Appropriations Act of 2023. We note that the CPI-U for the 12-month period ending in June of 2024 is not available at the time of this proposed rule. Therefore, the calendar 2025 payment amount, as well as the CPI-U for the 12-month period ending in June of 2024 and the corresponding productivity adjustment, will be updated in the final rule. The overall economic impact related to the changes in payment under the HHPPS for calendar 2025 was estimated to be a decrease of 1.7%, or $280 million. The $280 million decrease in estimated payments for calendar 2025 reflects the effects of the CY 2025 proposed

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home health update percentage of 2.5%, which is a $450 million increase, an estimated 3.6% decrease that reflects the effects of the permanent behavior change adjustment or a $595 million decrease and an estimated 0.6% decrease that reflects the effects of the updated fixed dollars loss by $100 million decrease. The proposed rule can be found in the Federal Register as well as on the Home Health Agency (HHA) Center webpage, and the 60-day comment for this proposed rule closes on August 26, 2024. Comments can be submitted electronically via regulations.gov. We have also provided the direct link on the slide that accompanies this ODF, and I will also put those notes in the chat. So, that concludes the proposed payment updates in the CY 2025 Prospective Payment System Rule. I will now turn the call to Molly Anderson. Thank you.

Molly Anderson: Thanks, Kelly. Today, I'll be going over the updates to the Home Health Conditions of Participation (COP). CMS is proposing changes to the Home Health COPs to reduce avoidable care delays by helping ensure that referring entities and prospective patients can select the most appropriate Home Health Agency based on their care needs. These changes can support timely admission to home health services, which has demonstrated improvements for patient outcomes and reducing risk of hospital readmissions. CMS proposes adding a new standard that would require Home Health Agencies to develop, implement, and maintain, through an annual review, a patient acceptance to service policy that is applied consistently to each prospective patient referred for home health care. We are proposing that the policy must address specific criteria related to the Home Health Agency's capacity to provide patient care. At a minimum, this criteria includes the anticipated needs of the referred prospective patient, the Home Health Agency's caseload and case-mix, the HHA's staffing levels, and the skills and competencies of the HHA staff.

This proposed rule would not prevent HHAs from maintaining their existing acceptance to service policies, rather it is intended to complement them. Additionally, we are proposing that Home Health Agencies make available to the public accurate information regarding the services offered by the Home Health Agency and any service limitations related to the types of specialty services, service duration, or service frequency. Home Health Agencies would be required to review this information annually or sooner, as necessary. We are also seeking public comment on two RFIs (requests for information). First, we are seeking information regarding the feasibility of rehabilitative therapists conducting the comprehensive assessment for cases that have both therapy and nursing services ordered as part of the plan of care. Second, we are seeking information regarding the Home Health Agency's scope of services and how these services interact with Home Health Agency operations. We're soliciting comment on the communications that occur between patients, physicians, and the allowed practitioners in establishing and reviewing the plan of care. We are also seeking information on how the physician and allowed practitioners ensure patients receive the right mix, duration, and frequency of services to meet measurable outcomes and goals identified by the Home Health Agency and the patient. I'll now pass it over to Abby Ryan to cover the 2025 ESRD (End-Stage Renal Disease) proposed rule. Thank you.

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Abby Ryan: Good afternoon and good morning to those on the West Coast. I am going to go ahead and give you just a real brief blurb on the ESRD PPS calendar year 25 proposed rule. On June 27, CMS issued the proposed rule for updates on payment rate policies that included a request for information under ESRD PPS for renal dialysis services furnished to Medicare beneficiaries on or after January 1, 2025. And in this rule, CMS proposed a new end-stage renal disease prospective payment system-specific wage index that would be used to adjust only the ESRD PPS payment for geographic differences in area wages. This proposed methodology would combine our data from the Bureau of Labor Statistics occupation employment wage and statistics in addition to the freestanding ESRD facility cost reports. In combining these, we would produce an ESRD PPS-specific wage index for use instead of what we're currently using, which is the hospital wage index values for each geographic area, which are derived from hospital cost report data. You may view this rule in the Federal Register, and comments are due on August 26, 2024, and everyone is encouraged to comment your views and comments on this ESRD PPS-specific wage index with regard to any potential applicability to other payment systems and to our own payment system's ESRD PPS.

There are two other analysts that are the subject matter experts with this on the call—Nicholas Brock and Russell Bailey—and we will all be available for questions at the end of this ODF. Thank you so much. Appreciate it. And I'll pass this on to Lori Luria. Thank you.

Lori Luria: Thank you so much, Abby. I just want to give a couple of updates on the Home Health CAHPS (Consumer Assessment of Healthcare Providers & Systems) Survey. First, we posted on July 1 our quarterly newsletter for the Home Health CAHPS Survey, and this newsletter is a one-page update on key feature items. We featured response rates in this newsletter, which is very important all the time to the survey, and we posted how response rates have changed and what seems to be successful ways to improve response rates. One way to improve response rates is to use the Home Health CAHPS fact sheet, which we introduced in the spring of 2024, and we have seen immediate results with using this. This is a fact sheet that is for Home Health Agencies to put into the welcome packages that they give to home health patients. This way, new patients for home health services will see the survey and understand that if they receive it, this is a legitimate survey. So, it's very useful because it gives them an overview of the survey and what the purpose is to us, and why it's very useful to other home health patients as well. Next week on July 18, is our next data submission deadline for Home Health CAHPS Survey data, and we urge all Home Health Agencies to check to see if their data have been submitted. The best way to do this, rather than check directly with your vendor, is to go into the portal on the Home Health CAHPS Survey website. It's labeled for HHAs, and you go in with your respective ID and password, and you can see if your vendor has started to submit your data.

Lastly, I just want to remind everybody that if they have any questions at all, excuse me, about the Home Health CAHPS Survey, they are to email RTI (Research Triangle Institute), which is our national survey contractor, at hhcahps@rti.org or call RTI's team at 1-866-354-0985 with any questions at all about the survey, whether you are a current participant, current Home Health

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Agency, or you would like to start participating. And now, it's my pleasure to pass this on to Jermama Keys, who will present on both the Home Health Quality Reporting Programs and the Hospice Quality Reporting Programs. Thank you.

Jermama Keys: Thank you so much, Lori. Good afternoon, everyone. Today, I will be providing several announcements about the Home Health Quality Reporting Program, or HHQRP, and the Home Health Value-Based Purchasing Program, or HHVBP. First, we would like to share an update about the public reporting. The Next Care Compare refresh will take place this month, in July of 2024. The preview reports related to the July refresh of the home health data on Care Compare was released to providers in May. In reference to rulemaking, the calendar year 2025 Home Health Prospective Payment System notice of proposed rulemaking was published on June 26. Public comments can be submitted electronically through regulations.gov, and the comment period is open for 60 days after the rule is published. We do have several resources currently available on the HHQRP webpage. In addition to a quick reference guide, which is now available in the download section of the Home Health Quality Reporting webpage. That guide provides a high-level overview or information related to the quality reporting program, including some frequently asked questions and helpful links.

In reference to Home Health VBP, I am joining you today in place of Marcy O'Reilly, who is the coordinator for that program, and I'll be updating you in reference to some information provided in the calendar year 2025 proposed rule. The HHVBP program did not make any proposals to modify the model in this proposal rule, but they did include a request for information based on future performance and measure concepts, and they also provided an update on health equity just to let stakeholders know that they're committed to developing approaches and meaningfully incorporating the advancement of health equity in the HHVBP model. As they move forward in the work, they encourage home health stakeholders to monitor those equity policies and CMS initiatives. In reference to providing comments, that also can be submitted through regulations.gov.

There is a reminder for the HHVBP program. Those preliminary July interim performance reports, or IPRs, will be in the HHAs' folders on iQIES before the end of the month. We want you to remember that IPRs are using the most current 12 months of data available, and the final IPRs will override the preliminary IPRs. We encourage Home Health Agencies that have not been accessing their IPRs to do so, and all Home Health Agencies to at least access each quarterly report as soon as they are released. The July IPR will include an extra tab that will have benchmarks and achievement thresholds for the revised applicable measures. Those measures would start in the calendar year 2025. A web-based training that will review the new measures will be available this August, and the first annual performance report, or APR, will be posted this August. That report will include your annual total performance score for the calendar year 2023 and the associated payment adjustment that will be applied to all Medicare fee-for-service claims submitted for home health services with through dates in 2025. That information will also be publicly reported.

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In addition, on August 13, the HHVBP program will be providing a webinar that discusses the APRs. HHVBP newsletters and updated FAQs will be posted quarterly, and if you didn't see a June newsletter, you should be able to find it on the expanded Home Health VBP model webpage. Finally, if you're receiving email announcements or if you're not receiving announcements from CMS about the expanded HHVBP model, please go to our webpage and join the listserv. The link should be at the bottom of the model's web page. If you have any questions about the information that was presented today, please send those questions to the HHVBP help desk at hhvbpquestions@cms.hhs.gov.

Thank you. Now, I will provide updates for the Hospice QRP. We have a couple of updates regarding the HQRP, or Hospice Quality Reporting Program. The next refresh of hospice data on Care Compare will take place in August 2024. Provider preview reports for the upcoming August refresh were actually released in May. The fiscal year 2025 hospice notice of proposed rulemaking public comment period has closed, and CMS is currently reviewing the comments received. We will take them into consideration as we're drafting the fiscal year 2025 final rule. That rule is expected to be released this August.

Finally, we have several updates or resources available on the HQRP website. We have posted an updated fact sheet and updated information about data correction deadlines on the HQRP "Public Reporting: Key Dates for Public Providers" webpage. The HQRP Q&A is based on recently received help desk questions, and that will be posted to the HQRP website later this month. Please also look for training resources that should be available in the coming months, after the fiscal year 2025 rule is posted in reference to the HOPE (Hospice Outcomes and Patient Evaluation) data set. And that concludes my updates for today. I will pass it back to Jill.

Jill Darling: Great. Thanks, Jermama, and to all of our speakers. We will go into our Q&A. So, a reminder to use the raise hand feature at the bottom of the screen. One question and one follow-up question, please. We'll give it a moment.

Marvelyn Davis: Sarah Simmons, your line is unmuted.

Sarah Simmons: Thank you. This is Sarah Simmons from NHPCO (National Hospice and Palliative Care Organization). My question is about the non-compliance notification letters that were recently released. The quality reporting program email that CMS distributed on July 3 and the announcements and spotlights webpage indicate that providers that receive a non-compliance letter may submit a reconsideration request no later than 11:59 p.m. on August 14. However, the reconsideration request webpage as well as the PAC (post-acute care) hospice outreach email clearly state that the reconsideration period is 30 days from the date documented on the non-compliance letter distributed electronically to the provider's CASPER (Certification and Survey Provider Enhanced Reports) folder. Those time frames are inconsistent. Could you clarify the correct time frame for hospice providers to submit reconsideration requests?

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Jermama Keys: I can see how that is confusing, Sarah. Normally the reconsideration period starts when letters are dropped into the folders. But the reconsideration time frame that you see listed for the August 14 at 11:59 date is correct.

Sarah Simmons: Thank you very much.

Jermama Keys: No problem.

Marvelyn Davis: Tracy, your line is unmuted.

Tracy Wodatch: I'm sorry. It's Tracy. I didn't mean to raise my hand. I don't have a question. I apologize.

Marvelyn Davis: No worries. Thank you. Sarah Simmons, your line is unmuted.

Sarah Simmons: I'm sorry. I already asked my question.

Marvelyn Davis: Thank you.

Sarah Simmons: Thanks.

Marvelyn Davis: Kate, your line is unmuted.

Katie Wehri: Thank you. This is Katie Wehri with the National Association for Home Care and Hospice, and I was asking questions about the Home Health Value-Based Purchasing Interim Performance Reports. We understand there's a difference and there could be some recalculations between the interim and final reports, but we notice that there were some pretty significant changes according to the providers who reviewed the reports so far—differences between the final and the interim. And I wondered if you could provide any additional detail on why that might be.

Jermama Keys: Thanks, Katie. I am not able to provide any additional detail. I know that there were some changes between the interim and the final, and that's probably the most that I know. But what I would love for you to do is to direct those questions to the HHVBP model help desk. They should be able to give you a better explanation of what the changes were, if there were discrepancies, specifically why they may have been, and what the specifics were for that.

Katie Wehri: OK. Thank you. I think some have submitted questions and the response was just the generic differences between interim and final sometimes do occur, but since there were some significant ones this past time, we just were looking for a little bit more detail. If the help desk

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could be given—I'm not sure whether it's permission, authority, whatever it happens to be to share some of that additional detail, that would be appreciated. Thank you.

Jermama Keys: No. That's helpful, Katie. I appreciate the feedback, and I'll run that by Marcy and the team so that we can hopefully get you guys a more detailed explanation.

Katie Wehri: That would be great. Thanks so much.

Jermama Keys: No problem. Thank you.

Marvelyn Davis: Billi St. Clair, your line is unmuted.

Billi St. Clair: Hi, this is Billi St. Clair with Capital Health. I just had a quick question on hospitalization reporting. When will this change, and when will we see that in the Care Compare? When will the 60-day hospitalization be removed?

Jermama Keys: I'm sorry, Billi. Is this for home health?

Billi St. Clair: Yes.

Jermama Keys: And could you repeat that question? I apologize.

Billi St. Clair: That's OK. Can you tell me when the 60-day hospitalization and ER use are going to be removed from Care Compare?

Jermama Keys: OK. Got you—with what refresh. That is probably going to be a question for the help desk, unfortunately, because I don't want to give you guys the wrong quarter or wrong refresh.

Billi St. Clair: So that's a home health quality question?

Jermama Keys: At cms.hhs.gov, yes. And I could put it in the chat if you need me to.

Billi St. Clair: I see it up on the screen. Thank you.

Jermama Keys: Great.

Marvelyn Davis: Pamela Morgan, your line is unmuted.

Pamela Morgan: OK. Thank you. Hi, I wanted to address Katie's question with the experience that we had, because our rehospitalization changed a lot between the preliminary and the final and we asked some very specific questions to the help desk, and we were told that they had

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included Medicare Advantage in their hospitalization rate when they were only supposed to be including Medicare when we asked that question. So, what we learned from that exercise was that we have a much better rehospitalization rate when you include our Medicare Advantage, but I wanted to just pipe in with that.

Jill Darling: Pamela, it seems that we don't have someone on the line regarding your question. Could you please send your question to the Home Health Hospice and DME Open Door Forum email? I'll put it in the chat for you.

Pamela Morgan: I was just responding to something Katie said.

Jill Darling: OK. Thank you.

Pamela Morgan: Uh-huh. Thank you.

Jill Darling: We'll just give it one more moment if anyone has any questions. I see one hand raised. Irina.

Irina Gorovaya: Yes. Hello. Question regarding proposal, you know, for all payer sources for home health for agencies needing to complete the OASIS assessment. I was wondering if all the payer sources are going to be included in the OASIS assessment—how it's going to impact their quality measures for home health agencies.

Jermama Keys: I mean, I could be missing the question. Could you repeat the question?

Irina Gorovaya: Yes. So, if the proposed rule indicates that the all payer sources for home health agencies or patients with various payer sources will have to have releases, one, completed as of January, voluntarily, and mandatory as of July of 2025, with incorporating all payer sources into OASIS assessment, how it's going to impact the quality measures, quality indicators, for Home Health Agencies, because right now we only include managed care, Medicare, and Medicare fee-for-service or Medicaid and Medicaid HMO, but with including other payer sources, how it's going to impact the calculation of the quality measures and the various process measures, you know, all of those?

Jermama Keys: I totally got you. Because we're in, within rulemaking and taking public comments, delineation of how measures will be affected and what would be expected and actually finalizing the time frames for the collection is all going to be addressed in the final rule, but if you do have a specific question, which is still a very good question, we appreciate any questions and comments to be put into the rule via rulemaking with going on the regulations.gov and adding that comment to the workflow so that we at CMS can take that comment into consideration along with others.

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Irina Gorovaya: Thank you.

Jermama Keys: No problem.

Marvelyn Davis: Casey, your line is unmuted.

Casey Byman: I heard earlier about the Home Health CAHPS and the flyer they can put into packets for their patients. Is there a hospice flyer about the CAHPS Survey, or is it just going to stay with home health?

Lauren Fuentes: Hi, this is Lauren Fuentes with the Hospice CAHPS Survey. We have received that feedback from previous calls that that's something that the hospice community is interested in. We have been looking at it, as I'm sure everyone understands home health population is very different from the hospice population as far as who is being surveyed, you know, when they're being surveyed, but we are discussing it and thinking that it could be something that hospices might be able to include in the bereavement packet, something that is sent to the caregivers, you know, not necessarily something that would be used, you know, for an intake with a hospice patient. So, it's something we're discussing—that's sort of where we landed on in terms of our thoughts on it, but we'll keep everyone posted on, you know, kind of the final decision and any materials that we end up producing for hospices to use.

Marvelyn Davis: Lisa Bivens, your line is unmuted.

Lisa Bivens: Yes, ma'am. I just had a quick question, and really, it's in response to, I believe it was Pamela Morgan's response to Katie's question about the final interim performance reports and the variants. I was wondering, I just want to make sure I understand, did you say that the CMS was saying that Medicare Advantage plans were supposed to be included and they're not? Like, what was the variant there? I didn't catch all of what you meant by that difference. We also saw a significant change from the—to the final report and our scores were a lot worse. So that's my question.

Jermama Keys: Not sure if Pam would…

Pamela Morgan: I'm here if I'm unmuted.

Lisa Bivens: Yes, you are.

Pamela Morgan: They said that Medicare Advantage was not supposed to be included in the initial report, and it was. When they released the final report, it only had Medicare, which was the correct number.

Lisa Bivens: Got it. OK. Thank you very much.

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Jermama Keys: Lisa, everybody's situation could be a little different. So, if you all still have specific questions in reference to the difference between those IPRs and the final reports, then it's still a good idea to send those questions, if it's a specific question, to that help desk so they can make sure that they're directing your response based on your specific issue.

Lisa Bivens: Appreciate that, Jermama.

Jermama Keys: No problem.

Marvelyn Davis: Chris, your line is unmuted.

Chris Weigel: Yes. Thank you. I had a question about the CAHPS Survey fact sheet. Where can that be found?

Lori Luria: Chris, it's on the Home Health CAHPS website, and there's a link for it on the home page. It's actually in two places. But one place easily to find it it's in the—there's like a box that says, "For Home Health Agencies," and it's in there.

Chris Weigel: OK. Thank you.

Lori Luria: You're welcome.

Marvelyn Davis: Lisa, your line is unmuted.

Lisa Selman-Holman: Lisa Selman-Holman?

Marvelyn Davis: Yes.

Lisa Selman-Holman: I was going to follow up on the changes to the acute care hospitalization and the [inaudible] numbers. If they said that they mistakenly included Medicare Advantage, that would make sense, why the scores dropped so much after they took them back out. It did lower the percentile ranking, too, so there was good and bad there because the percentile ranking had increased quite a bit. My question, though, is about how you go about adding the new diagnosis codes to the grouper. For example, the new Z51 code for aftercare sepsis, we didn't get a lot of information about that code at all, and it seems like we're supposed to use that instead of using the sepsis code, which is at this point in a grouper. So, how do you go about adding those new codes to the grouper? And make comments about those.

Jermama Keys: Lisa, this is in reference to the specs themselves?

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Lisa Selman-Holman: Yes. The diagnosis codes in the grouper. You did make a comment on the proposed rule about UTI versus bladder inflammation. I was going to make a comment about that one as well in my comments but just a question about how the new diagnosis codes that effective October 1 are actually included in the grouper.

Jermama Keys: No. That's definitely a good question. Some of it we may be able to answer without going through any additional issues because we're in rulemaking, but again, any questions that you have, any comments that you have, make sure that you put it in that comment section when you are replying to the proposed rule. In reference to the additional codes, iQIES may be able to give you an update because it would be across the board. So that iQIES help desk is in—it's on the screen right now, but it would be iQIES@cms.hhs.gov, and they should be able to help you in reference to the specs.

Lisa Selman-Holman: OK.

Wil Gehne: Lisa, this is Bill Gehne. Are you asking about the decision process?

Lisa Selman-Holman: Yeah, and just like that code, for example, just bothers me, the Z51 code for the aftercare sepsis. We really didn't get guidelines to go with it, but it feels like we're supposed to use it instead of the sepsis codes we're using now in the grouper. So, I'm just kind of asking, should we be commenting on codes like that in the comments to the rule?

Jermama Keys: Decisional more so than actually technical.

Lisa Selman-Holman: Yeah. I'm going to comment Z51 needs to be added to the grouper.

Jermama Keys: Got you.

Lisa Selman-Holman: And bladder inflammation also needs to be added to the comorbidity group and why. And I don't know whether to make those comments in these comments or like I have in the past where I just emailed you, Wil, and said "what about these?"

Kelly Vontran: Yes. You can certainly, Lisa, send them in as a comment to the rule itself because that means we will have to consider it as far as the rulemaking process. I'm pretty sure you can also send these types of questions to either the grouper mailbox or home health policy mailbox. But I think since you're referencing, it sounds like, the rule itself, definitely please send me the comment so we can take a look.

Lisa Selman-Holman: OK. Thanks, Kelly.

Jermama Keys: Thanks, Kelly. Thanks, Wil.

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Jill Darling: All right. I don't see any more hands raised, so we can conclude today's webinar. Thank you, everyone, for joining us. We hope that the links sent out in the chat are helpful to everyone. Again, if you have any questions, please e-mail the Home Health Hospice and DME Open Door Forum email listed on the agenda. Thank you for joining us today.

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