Centers for Medicare and Medicaid Services
Questions and Answers:
Home Health, Hospice and DME Open Door Forum
Tuesday, July 9, 2024

1. Question: 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?
    a. Answer: 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.
2. Question: 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.
    a. Answer: Through our quality control monitoring and processes, it was determined that some Medicare Advantage enrollees were inadvertently included when calculating the HHVBP claims-based measures in the Preliminary April 2024 Interim Performance Reports (IPRs). This affected the rates for the Acute Care Hospitalization (ACH) and Emergency Department (ED) Use measures reported in this report. This issue did not affect any previous IPRs. Consistent with the measure specifications, Medicare Advantage enrollees were excluded from the ACH and ED Use measures reported in the Final April 2024 IPRs that became available in iQIES on June 11, 2024. Note that the values in the April Final IPRs were generally consistent with the January Final IPRs.
3. Question: I have 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?

    a. Answer: The October 2024 refresh will include the removal of two claims-based measures from public reporting:
        - Acute Care Hospitalization During the First 60 days of Home Health (ACH)
        - Emergency Department (ED) Use without Hospitalization During the First 60 Days of Home Health
4. Comment: 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 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.
5. Question: 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.
    a. Answer: 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.
6. Question: 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?
    a. Comment: 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, not necessarily something that would be used 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.

7. Question: Did you say that 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. 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.
    a. Answer: 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.
8. Question: I had a question about the CAHPS Survey fact sheet. Where can that be found?
    a. Answer: 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.
9. Question: I was going to follow up on the changes to the acute care hospitalization and the 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.
    a. Question back to participant from CMS: This is in reference to the specs themselves?
        i. Answer: 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 are effective October 1 are actually included in the grouper.
            1. Answer from CMS: 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. Are you asking about the decision process?
                a. Answer from participant: Yes, 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?

i. Answer from CMS: Decisional more so than actually technical.
    1. Comment from participant: I'm going to comment Z51 needs to be added to the grouper. 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 and said, "what about these?"
        a. Answer from CMS: 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.