E-Alliance Extra

***Missouri Alliance for* Home Care**

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In This Edition: *(from NAHC Reports)*

CMS Restructures BFCC-QIO Regions - New BFCC-QIO for Missouri

Effective June 8, 2019, the Centers for Medicare & Medicaid Services (CMS) restructured the BFCC-QIO coverage and created 10 Regions across the United States. Beginning June 8, 2019, KEPRO will be responsible for Regions 1,4,6,8, and 10. Livanta will be responsible for Regions 2,3,5,7, and 9.

If your agency is located in a state where the BFCC-QIO will be changing, please take action to update your Notice of Medicare Non-coverage (NOMNC) with the correct BFCC-QIO phone number for your Region.

Effective June 8, 2019, KEPRO will be the BFCC-QIO in Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, and Wyoming.
Region 1 (CT, MA, ME, NH, RI, VT)1-888-319-8452
Region 4 (AL, FL, GA, KY, MS, NC, SC, TN) 1-888-317-0751
Region 6 (AR, LA, NM, OK, TX) 1-888-315-0636
Region 8 (CO, MT, ND, SD, UT, WY)1-888-317-0891
Region 10 (AK, ID, OR, WA) 1-888-305-6759

Effective June 8, 2019, Livanta will be the BFCC-QIO in New York, New Jersey, Puerto Rico Virgin Islands, Pennsylvania, Maryland, Delaware, District of Columbia, Virginia, West Virginia, Ohio, Indiana, Illinois, Michigan, Minnesota, Wisconsin, Iowa, **Missouri**, Kansas, Nebraska, California, Arizona, Nevada, Hawaii, and Pacific Territories
Region 2 (NY, NJ, PR, VI): 1-866-815-5440,
Region 3 (PA, MD, DE, DC, VA, WV): 1-888-396-4646
Region 5 (OH, IN, IL, MI, MN, WI): -888-524-9900

Region 7 (IA, MO, KS, NE): 1-888-755-5580
Region 9 (CA, AZ, NV, HI, GU, CN, AS):

NEW HHCCN Form for Home Health Agencies

The Office of Management and Budget (OMB) has approved the renewal of the Home Health Change of Care (HHCCN) Form, CMS-10280.

Effective July 1, 2019, all Home Health Agencies (HHA) will be required to use the renewed form with the expiration date of 4/30/2022 on the bottom. Please note that HHAs may continue to use the old form up until July 1, 2019 but we encourage HHAs to begin transitioning to the renewed form. There have been no changes made to the layout or content of the form other than the expiration date. HHAs may find the form and the form instructions in the download section of the CMS FFS HHCCN webpage.

CMS Releases Additional Instructions for Claims under PDGM

The Centers for Medicare & Medicaid Services (CMS) has released a second set of revisions to Chapter 10 of the Medicare Claims Processing Manual providing instructions to home health agencies for claims submission under PDGM. CMS Transmittal 4294/Change Request (CR) 11272, Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions, provides some clarity over the first set of revisions via CR 11081.

NAHC reached out to CMS with questions that remained after the release of CR 11081. These questions, along with additional revisions to the Claims Processing Manual, have been addressed with the changes outlined in CR 11272.

Specifically, the following is clarified:

- The percentage payment for the RAP under PDGM is based on the HIPPS code as submitted. It was previously unclear how the Medicare systems would be able to identify the correct HIPPS code at the time the RAP is submitted since the OASIS does not need to be submitted prior to the RAP. This will remain the case under PDGM. Upon receipt of the corresponding claim, grouping to determine the HIPPS code used for final payment will occur in Medicare systems. This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.
- For claim "From" dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases. Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment – RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

- For claim "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.
- In CR 11081 there was a section titled "SCIC" without any additional information. This has been removed from the Claims Processing Manual, but NAHC fully expects that CMS will insert this section in future CRs.

Additional revisions include technical instructions describing systems handling of the claims as well as one that holds HHAs responsible for submitting claims with required visit charge information. All services must be billed on one claim for the entire episode/period. The A/B MAC (HHH) will return to the provider TOB 0329 when submitted without any visit charges.

CMS has indicated it will continue to release instructions for billing under PDGM.

CMS Adds Correction to PDGM Billing Instructions

NAHC reported previously that The Centers for Medicare & Medicaid Services (CMS) released a second set of revisions to Chapter 10 of the Medicare Claims Processing Manual providing instructions to home health agencies for claims submission under PDGM — CMS Transmittal 4294/Change Request (CR) 11272, Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions. During a recent CMS Home Health, Hospice, & DME Open Door Forum (ODF), CMS indicated it would be correcting the CR to reflect the new diagnosis instructions that were added to section 40.2 (HH claims) of the Claims Processing Manual, Chapter 10 – Home Health Agency Billing, would be added to section 40.1 (RAPs) as they are applicable to both sections.

Specifically, under PDGM ICD-10 codes used for payment groupings will be taken from claim instead of the OASIS. As a result, the claims and OASIS diagnosis codes will not be expected to match in all cases. Second 30-day claims in any 60 day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no requirement for HHAs to complete an OASIS Other Follow-up Assessment (RFA05) just to ensure that the diagnosis codes match the assessment. However, the HHA is required to complete the RFA05 when there is a change due to major decline or improvement in the health status of the patient.

To reiterate, this change was not reflected in the RAP section of the Manual and is now corrected.

New HHS Fact Sheet on Direct Liability of Business Associates under HIPAA

The Health and Human Services (HHS) Office for Civil Rights (OCR) has issued a new fact sheet that provides a clear compilation of all provisions through which a business associate can be held directly liable for compliance with certain requirements of the HIPAA Privacy, Security, Breach Notification, and Enforcement Rules ("HIPAA Rules"), in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. In 2013, OCR issued a final rule that, among other things, identified provisions of the HIPAA Rules that apply directly to business associates and for which business associates are directly liable.

OCR has authority to take enforcement action against business associates only for those requirements and prohibitions of the HIPAA Rules that appear on the following list.

- Failure to provide the Secretary with records and compliance reports; cooperate with complaint investigations and compliance reviews; and permit access by the Secretary to information, including protected health information (PHI), pertinent to determining compliance.
- Taking any retaliatory action against any individual or other person for filing a HIPAA complaint, participating in an investigation or other enforcement process, or opposing an act or practice that is unlawful under the HIPAA Rules.
- Failure to comply with the requirements of the Security Rule.
- Failure to provide breach notification to a covered entity or another business associate.
- Impermissible uses and disclosures of PHI.
- Failure to disclose a copy of electronic PHI to either the covered entity, the individual, or the individual's designee (whichever is specified in the business associate agreement) to satisfy a covered entity's obligations regarding the form and format, and the time and manner of access under 45 C.F.R. §§ 164.524(c)(2)(ii) and 3(ii), respectively.
- Failure to make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.
- Failure, in certain circumstances, to provide an accounting of disclosures.
- Failure to enter into business associate agreements with subcontractors that create or receive PHI on their behalf, and failure to comply with the implementation specifications for such agreements.
- Failure to take reasonable steps to address a material breach or violation of the subcontractor's business associate agreement.

"As part of the Department's effort to fully protect patients' health information and their rights under HIPAA, OCR has issued this important new fact sheet clearly explaining a business associate's liability," said OCR Director Roger Severino. "We want to make it as easy as possible for regulated entities to understand, and comply with, their obligations under the law."

Home health and hospice providers should consider adding an audit of business associate contracts and activities to their compliance plan if they don't already have one, and sharing the information in this Fact Sheet with their business associates.

The new fact sheet and OCR's guidance on business associates may be found **HERE**.

Policy Change for Assessment Submission Timeframe Impacts Hospice and Home Health Providers

The Centers for Medicare & Medicaid Services (CMS) announced an upcoming change in policy regarding the timeframe for submission of "assessments" that are part of the quality reporting program. Specifically, current CMS policy for submission of patient assessment records allows providers to submit records for up to 36 months from the assessment target date. Effective October 1, 2019, the CMS policy for patient assessment submission will be changed to 24 months from the assessment target date. The policy change applies to new, modified, and inactivated records.

This policy change applies to the OASIS for home health providers and the HIS for hospice providers. Even though CMS stresses that the HIS is not an assessment tool it is a data extraction tool, it is still part of the quality record submissions to which this policy applies.

New Information on Hospice Compare

The May 2019 quarterly Hospice Compare refresh of quality data is now available. It is based on Hospice Item Set (HIS) quality measure results from data collected Q3 2017-Q2 2018 and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® results reported Q3 2016 – Q2 2018. This refresh includes additional information on hospice characteristics. Specifically, CMS has added:

- A General Information tab that describes the four levels of hospice care and shows whether a hospice provided routine home care only or routine home care and at least one other level of care during calendar years 2014-2016.
- A Conditions tab that shows the percent of patients served by a hospice with the following conditions in calendar year 2016
    - Cancer
    - Dementia/stroke
    - Circulatory/heart disease
    - Respiratory disease
    - All other conditions
    - A Location of Care tab that shows where a hospice provided care to patients in 2016
    - Home
    - Assisted Living Facility
    - Nursing Facility
    - Skilled Nursing Facility
    - Inpatient Hospital Facility
    - Inpatient Hospice Facility
    - Other

The hospice's Average Daily Census and Date Certified is directly below the hospice name in each of the above tabs. CMS also updated the zip code database to help ensure accurate search results.
CMS indicated that adding the above information, which comes from the Hospice PUF (Payment Public Use File), will empower Hospice Compare users to engage in meaningful conversations with their providers and make informed decisions about selecting a hospice.

Hospices had been made aware of the additional information to be added to Hospice Compare prior to the refresh. The data is somewhat dated with the most current information being calendar year 2016 as this is the most current information available from CMS. The PUF utilizes hospice claims data which is somewhat limited. For instance, the data on whether a hospice provided routine home care only is just that and does not indicate if the hospice has the ability to provide other levels of care.

The next Hospice Compare refresh is scheduled for August. CMS has indicated it will be adding the results of Measure 1 of the Hospice Visits When Death is Imminent Measure Pair. Measure 1 captures the percentage of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life. As previously reported, CMS is pursuing further testing and analysis of Measure 2.

For more information please see the "Hospice Compare May 2019 Refresh Fact Sheet" and the "Hospice Compare May 2019 Refresh Question & Answer" document in the Downloads section of the Public Reporting: Background and Announcements webpage and the Hospice Compare site.

CMS Open Door Forum is a Status Update on Developing a Hospice Assessment Tool

The Center for Clinical Standards and Quality(CCSQ), part of the Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum (ODF) to allow hospices and other interested parties to ask questions on the development of a Hospice Assessment Tool. This SODF is part of a series of regular SODF's CMS plans to host on this tool and other key topics related to the Hospice Quality Reporting Program.

The SODF will take place on Wednesday, June 12, 2019 from 2:00 PM to 3:00 PM Eastern Time. It will be conference call only.

The purpose of a hospice assessment tool is to develop a tool that enables CMS and hospices to understand the care needs of people through the dying process and to ensure the safety and comfort of individuals enrolled in hospice institutions nationwide. The SODF will provide a status update and welcomes your questions.

You can learn about the hospice assessment tool HERE.

Special Open Door Participation Instructions:
Participant Dial-In Number: 1-800-837-1935
Conference ID #: 9490006

Summary of Key Points in the CMS Open Door Forum on Home Health, Hospice

The Centers for Medicare & Medicaid Services (CMS) held a Home Health, Hospice & DME Open Door Forum (ODF) on May 15, 2019. Below is a summary of the ODF topics pertaining to home health and hospice.

Hospice

CMS reviewed the FY2020 Hospice Proposed Rule key points. It was clear from the questions at the end of the ODF that hospice providers may not fully understand the impact of the proposed payment changes, and CMS replied that it is not able to respond because of the fact that we are in the comment period for the Proposed Rule. CMS encouraged providers to submit their comments.

CMS also provided an update on the Hospice Quality Reporting Program (HQRP) including the CAHPS Hospice Survey. CMS continues to engage stakeholders as it develops the hospice assessment tool. The next open door forum specific to this topic is scheduled for June 12, 2019. More information will be shared as it becomes available.

The Hospice Compare May refresh will include data from the Hospice PUF (Provider Utilization and Payment Data File) and an update to the zip code file. The zip code file update is to improve the search function in Hospice Compare. The PUF data is based on claims that have been adjudicated and the following data from PUF will be added to Compare later this month:

- # of patients cared for by hospice on average each day which is the average daily census (ADC),
- levels of hospice care provided,
- medical conditions treated, and
- location of care provided.

CMS indicated this data is intended to help patients make more informed choices. CMS has also proposed that additional data such as that from the Census Bureau, National Institute of Health, or other government websites also be added in the future to round out the information available to consumers.

The August refresh of Hospice Compare will include the data from Measure 1 of the Visits When Death is Imminent measure pair.

Updates to the CASPER QM reports brought in the Review and Correct reports and the QM reports. CMS will address the Review and Correct reports as part of its upcoming HQRP training webinar on June 11. More information will be available soon about this training.

May 8 was the most recent deadline for submission of CAHPS Hospice Survey data. The next data submission deadline is August 14. As always, CMS encouraged providers to verify that their vendor submitted the data via the Survey Data Warehouse.

The Hospice CAHPS Survey Exemption for Size form for the 2018 reference year is currently available and must be submitted by December 31, 2019. CMS encouraged providers to submit any suggestions they have regarding the Survey to CMS at hospicecahpssurvey@HCQIS.org

In an announcement that may surprise hospice providers, CMS stated that it is starting to do analysis of Hospice CAHPS Survey data to possibly introduce star ratings on the Hospice Compare website. There is no timeline for this. Many thought data from the hospice assessment tool, currently under development, would be available for use in the Star ratings before the rating formula would be finalized and the Star rating added to Compare. This may be the case, but with the CMS announcement on this ODF, it is clear that CMS may not wait.

CMS also commented on Change Request (CR) 10064 which relates to the implementation of electronic submission of the Notice of Election (NOE). Specifically, CMS indicated only 6% of NOEs were submitted electronically since implementation and reminded hospices of this NOE submission option which would reduce and potentially eliminate problems with NOEs that result from errors in the direct entry process, i.e. keying mistakes. For more information on this process, please see the Companion Guide for Electronic Notices of Election.

CMS is working to fix the Medicare software system bug that resulted in underpayment to hospices in situations where a patient has transferred. On July 2, 2018, CMS changed Medicare's claims processing systems to better identify prior hospice days when calculating hospice routine home care payments after a transfer; see MLN Matters Article MM10180. This process is not working correctly, resulting in underpayment for these claims. CMS will fix this issue on October 7:

- Until October 7, do not submit adjustments when there is a transfer within the benefit perio
- Beginning October 7 or after, resume submitting adjustments
- If the dates of service are beyond the timely filling period, submit a reopening request using Type of Bill 8XQ

Home Health

As usual, CMS encouraged home health agencies not currently participating in the HH CAHPS Survey to do so by contacting the vendor, RTI, at HHCAHPS@rti.org

CMS also advised home health agencies to check for their data submission reports by going into the HH CAHPS website and clicking on the icon, For HHAs. On April 1, 2019 the participation period (April 2019 through March 2020)for the CY2021 annual payment update began. Any HHA having 59 or fewer CAHPS eligible patients for the previous period (April 2018 through March 2019) should complete the Participation Exemption Request form.

CMS summarized information from the latest installment in revisions to the Medicare Claims Processing Manual in preparation for PDGM, Change Request (CR) 11272. There were some revisions to diagnosis coding instructions as part of this CR which were not reflected in the RAP section of the CR. Specifically, under PDGM ICD-10 codes used for payment groupings will be taken from claim instead of the OASIS. As a result, the claims and OASIS diagnosis codes will not be expected to match in all cases. Second 30-day claims in any 60 day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no requirement for HHAs to complete an OASIS Other Follow-up Assessment (RFA05) just to ensure that the diagnosis codes match the assessment. However, the HHA is required to complete the RFA05 when there is a change due to major decline or improvement in the health status of the patient. Again, this change is not reflected in the RAP section of the CR and the CR will be corrected to reflect this.

CMS also reminded home health agencies the new OASIS D1 materials are available. More information is available in this CMS Memorandum.

The most recent quarterly OASIS Q&A document is available here.

CMS stressed that the recent announcement it made regarding the change in the timeline for submitting assessments (more information here) does not change the 30-day OASIS submission deadline or the OASIS data correction deadline for public reporting. CMS will be issuing a FACT sheet to clarify this policy change soon.

CMS provided an update on the status of the HH Compare site refresh. Compare is currently undergoing a series of software updates, and the April refresh will take place as soon as the final updates are completed. When available, an announcement will be made on the HHQRP webpage.

There will be an announcement soon regarding the annual performance training for the HHQRP scheduled for June 19, 2019.