

Centers for Medicare and Medicaid Services  
Questions and Answers:  
Home Health, Hospice and DME Open Door Forum  
Wednesday, April 3, 2024

1. Question: Will CMS provide an opportunity for hospices and interested parties to ask questions about the HOPE tool to better understand what's in it? I've been reading through it, and I've noticed a few inconsistencies between the rule itself and the HOPE Tool Manual. Will there be a public forum where we can ask those questions in the future?
  - a. Answer: Yes, we do plan on doing several HQRP forums. We also have some additional general training scheduled that will be addressing the different time points, the different updates. For now, what is available is the all-item document, the manual documents, and the information related specifically to the two HOPE QMs (quality measures) that are being proposed. Does that help?
    - i. Question: Yes. Will those forums happen before the comments for the proposed rule are due?
      1. Answer: The plan forums are actually happening after the finalization of the rule. Any comments, though, that you have in reference to what is being proposed, we ask that you provide those comments via rulemaking.
2. Question: How did the hospices verify that a physician that has opted out is still authorized to refer and certify? We've had one hospice that their physician showed on the opt-out list, but it said that they were not eligible for certification. How did they get that fixed?
  - a. Answer: Hospices can verify a physician's enrollment or opt-out status using the CMS ordering and referring data file, ORDF, and it lists all Medicare-enrolled and opted out physicians. But are you saying that you did check that file and I should mention that the file was updated yesterday with a hospice column, but are you saying that that file isn't accurate with respect to one of your physicians?
    - i. Comment from participant: When we were looking in PECOS (Provider Enrollment, Chain, and Ownership System) originally, they showed as not active, and when we looked on the opt-out list, and this was a month ago, it showed she was on the opt-out list, but was not on the ordering list, the ability to order.
3. Question: Medicare provider certification lookup tool. So, we are wondering what the differentiator between the HHA column, and the hospice column actually is because

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it appears that some physicians who are listed as certified for the HHA area are not listed as such for hospice. And so, we're just kind of wondering what is the difference between those two columns so that if we need to create our own mechanisms, we can match what you guys are using.

- a. Answer: If an individual is listed on the ordering/referring file (ORDF), it means that he/she meets the requirement to enroll or opt-out as a prerequisite for ordering or certifying the services/items outlined in 42 CFR 424.507. These services/items are hospice services, home health services, DMEPOS items, clinical laboratory services, and imaging services. Meeting the requirement to enroll/opt-out under 42 CFR § 424.507 is different, however, than the individual qualifying as a provider type under Medicare regulations that can order or certify the service/item. For example, suppose an individual provider -- Provider Smith -- is enrolled in Medicare to order/certify. Assume further that he/she meets the regulatory requirements to order/certify HH services for patients but not to certify hospice services per § 418.22(c). Whether an enrolled/opted-out individual listed in the ORDF is of a provider type that can order/certify for the services/items in § 424.507 will be denoted by a "Y" or "N" in the ORDF column for that service. Using our above example, the ORDF HH column next to Smith's name will indicate "Y" while the Hospice column will indicate "N."
4. Question: I'm still confused about this enrolling physician thing, and I can't find that article. I've been Googling and I've been on the MLN site, so if somebody can drop it in the chat, I would very much appreciate it. But my question is, I understand that NPs (nurse practitioners) and PAs (physician assistants) cannot certify, and I think what I'm reading is that this really only applies to physicians, so MDs (medical doctors) or DOs (doctors of osteopathic medicine) that are attendings or certifying physicians. So, if an NP or PA is the attending and they are not in PECOS, it's okay?
  - a. Answer: This enrollment and opt-out requirement is not changing who can certify for hospice purposes. It's not making any changes to the applicable regulation, which I believe is 418.22. So, nothing in that vein is changing. All this requirement does is require that the person be enrolled or opted out. The web link for the article, it may be on the Helpful Resources page. Yes, it's on the Helpful Resources screenshot here. If you look at the middle column, it should be on the very bottom of the page.
    - i. Question: So, does this apply to PAs and NPs?
      1. Answer: PAs and NPs can't make the hospice certification referenced in § 418.22(c). We stated this in CMS-1787-F, which is the regulation that finalized our new provision. So,

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they need not be enrolled for purposes of meeting the enrollment/opt-out requirements of § 424.507(b) regarding hospice certifications under § 418.22(c).

5. Question: When can we expect a draft of the updated CAHPS, hospice, P&G, or protocols and guidelines, including changes from the FY 2025 hospice proposal rule?
  - a. Answer: The proposals that I discussed are just that. They're just proposals. So, we will collect comments and then we will finalize a rule later this year. So, any changes that are adopted and finalized, you can expect those before 2025 in time for our survey vendor trainings, which we typically do in the fall.
    - i. Question: Okay. Also, it's a different question regarding Discharge Function Score. We're aware that CMS is updating the technical specifications guide to accommodate a change in the vision, coefficient, and recalibration accordingly. Is there a scheduled release date for that?
      1. Answer: I do not have the specific release date for that yet. Once those final specs are verified, we'll be able to provide a little bit more detail.
6. Question: We were instructed on another webinar with our EMR (electronic medical record) to look up the enrollments of our physicians that they're uploaded with the files twice a week and to try to keep up with when we review the PECOS files to see if the physician is enrolled. Is there anything that—in looking it up and I've pulled a file to look at it, but it doesn't state when that physician's expiration for enrollment is—is there any way to see when their PECOS enrollment expires, or it has to be revalidated?
  - a. Answer: The PECOS file will only include those actively enrolled providers actively approved or opted out. When they become no longer active, then they would be removed from the file. So, you can assume that anyone listed on the file is actively enrolled or opted out of Medicare and would qualify to certify for hospice.
    - i. Question: How frequently is it suggested that we're looking at these files to make sure that they are still active?
      1. Answer: The file is updated twice a week. So, it would be updated as of those days and as of the day you're looking at it, you can assume that that provider is actually enrolled or after that.
        - a. Question: Okay. So, it's expected that we're supposed to be looking at it twice a week to see if our providers are still active.

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- i. Answer: I think it really lies within your discretion as to how frequently you want to check it.
- 7. Question: To effectively monitor our VBP outcomes to kind of mirror CMS, we just had a question if we should be running our SHP (Strategic Healthcare Program) reports for a rolling calendar year, or we should be doing a year today? So, for example, if I was looking for today, would I go February of 23 through February of 24, or should it be year to date, where it's January 24 to February of 24? What is the most accurate way to run those reports to mirror CMS' outcomes on VBP?
  - a. Answer: I don't want to tell you how to do it off the cuff and tell you something wrong on this call. So, we'll send you that information shortly.  
*(Participant submitted question to the help desk)*
- 8. Question: The Discharge Function Score for Home Health. I wasn't aware of a recalibration coming. Is there information on that? The latest spec I have is February 24.
  - a. Answer: Any of the current updates that are in the data specs will remain current unless there are any changes after the final vendor call this month. The updates to the actual data specifications weren't available on the, within the last refresh, but they should be available now. But if you refer to those specs that are current, then that information will more than likely be true to what you'll see moving forward.
    - i. Question: Okay. So, the February 2024 update is the latest that we know.
      - 1. Answer: Yes.
- 9. Question: So, then the next question I had was in the CMS or EVT (endovascular mechanical thrombectomy) finding, with all that were the average expected function scores less than the observed?
  - a. Answer: The final cross-setting DC Function for a given HHA is the proportion of that HHA's quality episodes where a patient's observed discharge function score meets or exceeds their expected discharge function score. HHAs with low scores indicate that they are not achieving the functional gains at discharge that are expected based upon patient characteristics and patient status at start of care (SOC) or resumption of care (ROC) for a larger share of their patients.

As stated in the [Discharge Function Score for Home Health Technical Report Updated February 2024](#) the exclusions for the Discharge Function Score measure are as follows:

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- The quality episode is defined as an incomplete stay by meeting one of the following criteria:
  - Quality episodes that end in a transfer (M0100 reason for assessment = 6 or 7) during the reporting period
  - Quality episodes that end with Death at Home (M0100 reason for assessment = 8); and
  - Quality episodes lasting less than 3 days.
- The quality episode is for a patient considered to be non-responsive, in which the primary diagnosis (M1021) or other diagnoses (M1023) indicates that the patient has a diagnosis of coma, persistent vegetative state, complete tetraplegia, locked-in state, severe anoxic brain damage, cerebral edema, or compression of brain and in which the patient's cognitive functioning (M1700) is totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
- The patient is discharged to hospice (home or institutional).

In response to the question “**Are patients under 18 still excluded?**” patients under the age of 18 are excluded from the OASIS requirement.

Publicly available documentation will be updated shortly.

*Information contained in this response may be superseded by guidance or specifications published by CMS at a later date.*

**Home Health Quality Help Desk:** [homehealthqualityquestions@cms.hhs.gov](mailto:homehealthqualityquestions@cms.hhs.gov)

*Questions related to: Guidance on OASIS coding and documentation of the OASIS responses; Home Health Quality Measures including, but not limited to: quality manuals, quality measures, measure calculation, Quality of Patient Care Stars, Home Health Compare, risk adjustment, public reporting, and Quality Assessment Only (QAO)/Pay for Reporting (P4R).*

**Home Health Value-Based Purchasing Help Desk:** [HHVBPquestions@cms.hhs.gov](mailto:HHVBPquestions@cms.hhs.gov)

*Questions related to: Expanded Model details including Model calculations, Model reports, and available Model resources*

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10. Question: Wondering if there was a timeline on whether or not RCD (Review Choice Demonstration) was going to be expanded past the end of May deadline.

- a. Answer: There is no update yet on any extension of the RCD. Updates will be provided on the RCD website: <https://www.cms.gov/data->

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[research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/review-choice-demonstration-home-health-services](#). Additionally, any questions about the Review Choice Demonstration can be sent to the following mailbox: [homehealthRCD@cms.hhs.gov](mailto:homehealthRCD@cms.hhs.gov).

11. Question: My first is a comment to another caller's question regarding the ORDF file and the different columns that exist for Home Health, Hospice, DME, and so on. Just wanted to help out with that one. The different columns are there because physicians who are enrolled in PECOS might be of different practitioner types, and the different Medicare programs only allow certain practitioner types to order and certify. They can be different. For example, on hospice, you can't have an NP or PA certify the hospice terminal illness, so they would have an "N," but in home health, they might be able to order. So that same physician might have a "Y." So, I just wanted to help out with that question, and I did receive that information from CMS, so I think that's pretty solid. You did inform that the MLN exists with updated important concepts for hospices to be aware of as it relates to the PECOS enrollment requirement. My question is, that really doesn't go into the actual claim edits that are being implemented with the current change requests and what will be addressed in the October 1, I guess transmittal, when those gaps are fixed. Is there a point in time when the gaps that exist in the existing implementation transmittal, where only one field is being looked at with the initial implementation, will be updated, and do we know when that will be released?

a. Answer: This MLN Matters article, as it exists now, is not necessarily going to be the final product, never subject to change. There could be additional issues that come up, and we will, of course, update the article to address them. The claims people are not on the line. They would be in the best position to address that. But what I can assure you of is that we do understand the urgency behind this, and we will get revised guidance, including dealing with the issues that you talked about as soon as we can. That's pretty much all I'm in a position to say.

i. Question: There were quite a few questions today regarding expiration of PECOS enrollment, and we do know that the existing ORDF file, which is a tool for enrollment, will show a "Y" for those that are good to certify, a "no" for those that are not good to certify, if they're not in a file at all, that is actually a red flag as well, they're not good to certify. But I think what providers might be asking for, and if such a thing is available, it would be good to know is if there are physicians who are eligible to certify today but they were to become deactivated

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tomorrow or they're due for the one who has an I type enrollment where they're billing Medicare and they're due to revalidate their enrollment every five years—is there a tool that will allow them to see when they're set to expire on their expiration date? So, I think that's what providers are looking for. Another tool that focuses on those physicians that might be due for revalidation that, if so, might expire or those that are in midst of their enrollment process, but the enrollment process isn't done yet. Is there a separate list? I believe the MACs (Medicare Administrative Contractors) have published something on their sites that there's some type of opt-out affidavit list that could be looked at for those that are opt-out application type and so on. And I don't mean to belabor this, but I think that over the years that I've been in this industry, this is a recurring question from not just hospice providers but home health providers of having a tool that would provide them with information about when an enrollment is set to expire for those enrollment types that do need to be revalidated as well as some way of knowing that a physician's enrollment is in process but not completed yet and therefore it wouldn't be on that ORDF.

1. Answer: So, we do have a revalidation lookup tool, and I can provide the link in the chat that will give the revalidation due date. Providers are required to revalidate every five years and three years for DME, but unrelated in this situation. But that lookup tool does provide the revalidation due date for all of the enrolled providers. It will just provide a due date. It won't tell you if that revalidation is in process or anything like that. But if that would be helpful to providers to know when their individual physicians are coming up for revalidation, then that tool of resource is available to you.
12. Question: Along the lines of the new HH CAHPS Survey fact sheet, is there something similar for hospice that could be provided to caregivers in an appropriate way at an appropriate time?
  - a. Answer: I'll check on that and see if we have a fact sheet.
13. Question: Was something mentioned about some OASIS training, maybe in April?
  - a. The OASIS vendor call is scheduled for April the 30<sup>th</sup>, and there's a link to the registration in the chat.
14. Question: The question is related to the new HH CAHPS information sheet. So, we have one that we've been using so far because there wasn't a sheet previously.

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Assuming that that is consistent with CMS rules for what we can communicate with patients ahead of the HH CAHPS, can we continue to use that or are we required to use the new form?

- a. Answer: It is absolutely fine if this HHA still uses their own information sheet.

15. Question: You mentioned on this order and referring search, if they're not listed at all, even though they're on an opt-out list, what does that mean? Why would they not show up?

- a. Answer: We would have to look into the specific example, but it could be like one of the callers said, that they don't meet the specialty, where they don't have the correct specialty to order a service.

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