Centers for Medicare & Medicaid Services
Home Health, Hospice and DME Open Door Forum
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*Webinar Recording:*
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**Jill Darling:** Hi, everyone. Sorry about that. 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 (ODF). Again, thank you for your patience as we were getting more folks in the room. For those who need closed captioning, I provided a link in the chat, and I can provide it again for you. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage. I will provide that link as well, and it was on the agenda that was sent out. 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, I will be displaying the agenda slide for you, and one of our presenters does have a slide deck for you as well.

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. We ask that any live questions relate to the topics presented during today's call. If you do have any 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 that I will provide, and we will 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 on you when it's time for Q&A. Please introduce yourself with your organization or business you're calling from. And when the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question. And we will do our best to get to all your questions today. And now I'll turn the call over to Brian Slater.

**Brian Slater:** Thanks, Jill. Just wanted to give everyone an update. We're going to obviously go through the agenda momentarily, but wanted to flag for everyone that I will be unable to attend the Q&A portion today. So, anything that comes up payment policy related for either home health or hospice, we won't be able to answer on today's call, unfortunately. However, I would have those people, if any payment questions come up, email either policy mailbox, the home health is "home health policy," all one word, "at cms dot hhs dot gov," and hospice is "hospice policy," all one word, "at cms dot hhs dot gov." And without further ado, I'll pass things off to Marcie O'Reilly for Home Health Value-Based Purchasing.

**Marcie O'Reilly:** Thanks, Brian. Good day, everyone, I'm Marcie O'Reilly, the Coordinator for the expanded Home Health Value-Based Purchasing Model, otherwise referred to as HHVBP or the expanded model. I have a brief but important update. The first annual performance report, or APR, was posted in August. This preview report includes each HHA's (home health agency) annual total performance score for the calendar year 2023 performance year 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, and the information that will be publicly reported starting in January. The recalculation request period for the preview report ended on September 7. Preliminary APRs will be posted on or around September 27 once all recalculation requests are processed. And then the next phase of the appeals process is reconsideration, and reconsideration is only available to those HHAs that submitted a recalculation request. Additionally, earlier this week—yesterday, because it's early in the week, I'm used to the ODFs being on Wednesday—we added a web-based training to the model's webpage entitled "The Expanded HHVBP Model Web-Based Training Changes to the Applicable Measure Set Beginning in the Calendar Year 2025," and it was also sent out through the expanded model listserv today, and I will add the link to the chat.

And finally, if you're not receiving those email announcements from CMS about the model, please go to our webpage and join our listserv. The link is near the bottom of the model's webpage. And I will add the webpage URL and the help desk email address to the chat so that you can copy them. So, thank you, and have a great rest of your day. I'll now hand it over to Jermama Keys for Home Health and Hospice QRP (Quality Reporting Program) updates.

**Jermama Keys:** Thank you, Marcie. Good afternoon, everyone. I am going to be giving several announcements today about the Home Health Quality Reporting Program or HHQRP. First, we do have a rulemaking update. The comment period for the calendar year 2025 Home Health Prospective Payment system notice of proposed rulemaking actually ended on August 26. CMS is currently in the process of reviewing these public comments, but if you would like to see additional public comments, you can find them at regulations.gov. The Quality Reporting Program also has some upcoming public reporting updates. The October 2024 Care Compare preview reports will actually have three measures. You'll be able to see the Transfer of Health Patient, Transfer of Health Provider, and Discharge Function Score. These will all be reported for the first time on Care Compare in January of 2025. If you would like further information on these measures, please review the resource on the Home Health Quality Measures page.

In October 2024, as well, we will be releasing the annual Post-Acute Care Health Equity Confidential Feedback Reports and the new quarterly Post-Acute Care Screen Positive for the HRSN (health-related social needs) Indicator Confidential Feedback Reports, and then those two reports again will be released in October. Finally, we do have a couple of resources available on the Home Health QRP training webpage. These are basically updates of our previous web-based trainings. The first is about Section GG, which is a web-based training series. It was posted in August, and that training provided an overview of the assessment and guidance to promote accurate coding of Section GG. Section 1 is from data elements to quality measures, which was actually posted on September 4, and that training provides a high-level overview of how data

elements within the CMS patient and resident assessment instruments are used to construct quality measures across all post-acute care settings. The course also discusses the relationship between those data elements and the quality reporting program, actual measures, and measure calculations, and it also talks about how the access to reports and to use quality measure data for quality improvement. And that is the end of the home health quality reporting updates.

Now, I will be providing you guys with some updates for the Hospice Quality Reporting Program. First, we have a public reporting announcement. There is a refresh of hospice data on Care Compare that is scheduled to occur in November of 2024. So, provider preview reports for the upcoming November refresh were actually released to providers in August. In addition to rulemaking updates, the fiscal year 2025 Hospice final rule was actually published on July 31, 2024, and the effective date of that role will be October 1 of 2024. We also have some additional updates and resources that are available on the Hospice Quality Reporting website. We recently posted the Hospice Quality Reporting Quarterly Q&As for quarter two. That is available on the Hospice QRP website, and it covers help desk questions received during the second quarter of 2024, which would be from April 1 to about June 30. There is a recording and materials from a recent August HQRP forum now available on the provider and stakeholder engagement webpage. Providers can access that information, and it would be a recording, there is a transcript, and then there's also a PowerPoint to view. We also just recently posted the final HOPE (Hospice Outcomes and Patient Evaluation) Guidance Manual and other materials related to HOPE, such as the change table, the final item sets, and the HOPE Manual. The HQRP HOPE webpage is where that information can be viewed. The HOPE time points video explainer was also published in August 2024, and there is a new web-based training that is titled "Introducing the Hospice Outcomes and Patient Evaluation or HOPE Tool," which we will be publishing in the next coming weeks. Please visit the HQRP Training and Education webpage for additional information on those trainings and future trainings.

Finally, CMS will be providing the HOPE data specs sometime in October of 2024. And additional information related to the hospice items set to HOPE transition information about the heart submission, sunsetting, and any transitions from the QUIES to the iQUIES (Internet Quality Improvement and Evaluation System) system will be provided within the next coming months. As always, please stay tuned. Sorry for that. As always, please stay tuned to the announcements and spotlight page on the HQRP website for any additional information. And for those that have additional questions, please forward them to our Hospice Quality Reporting email for questions you may have related to the upcoming information. And I can pass it over to, I think it's Jordan.

**Deanna Keesecker:** Hello, can you hear me?

**Jermama Keys:** Yes, we can hear you, Jordan.

**Deanna Keesecker:** OK, this is Deanna Keesecker, and I'll wait for Jordan to start the presentation.

**Jermama Keys:** Apologies, Deanna.

**Deanna Keesecker:** Oh, that's OK. OK, wonderful. Good afternoon, everyone. I am Deanna Keesecker, and also with me today is Jordan Tabor, the COR (Contracting Officer's Representative) of the FHIR (Fast Healthcare Interoperability Resources) Project, and Vishnu Yarmaneni of Mettle Solutions, our contractor for the FHIR project. Today, we are going to talk to you about the FHIR and ECTA (Electronic Clinical Templates API) Pilot Program. The FHIR and ECTA pilot program goal is to increase FHIR documentation exchanges, develop electronic clinical template that include FHIR formatted questionnaires and a digital coverage rule library. These functionalities will enable the submission of required data elements and accurate information to improve the claim review process. Next slide.

The PCG (Provider Compliance Group) FHIR and ECTA pilot program is directly related to the CMS Interoperability and Prior Authorization (PA) final rule, which was released on January 17, 2024. This rule promotes electronic health information exchange to allow real-time access to health records for patients, health care providers, and payers. This rule mandates that impacted payers implement standardized APIs (application programming interface) to facilitate data sharing. Relevant to this project, it will enhance prior authorization processes through new FHIR capabilities to reduce delays in care and administrative burdens. In addition to keeping patients at the center of their own care, this rule focuses on efforts to reduce provider burden and improve prior authorization processes through real-time data exchange. Next slide.

The CMS Interoperability and Prior Authorization final rule requires impacted payers to implement and maintain a prior authorization API to automate the process for providers to determine three capabilities. One, whether a prior authorization is required for an item or service, also known as coverage requirements discovery, CRD. Two, to identify prior authorization information and documentation requirements, also known as documentation template rules, DTR. As well as three, facilitate the exchange of prior authorization requests and decisions from their EHRs, also known as prior authorization support, or PAS. CMS has already implemented these capabilities through the PCG FHIR server, and it is ready to be tested. On the next slide, Jordan will be walking through how the three capabilities just discussed—the coverage requirements, discovery documentation, template and rules, and prior authorization support—would present in your current workflow.

**Jordan Tabor:** So, we are going to go through the FHIR ECTA process flow. So first, on your left-hand side, you will see the various kinds of providers who are providing various services for Medicare fee-for-service beneficiaries. They have some kind of EHR or similar system on their end that they're working with. On the right side, we have the payer, which in this case is Medicare fee-for-service, and they have their medical reviewers, medical review decision rules, guidelines, documentation requirements, and payer coverage requirements. All of these cover the guidelines the reviewers use to make the decisions. This is a depiction of the existing ecosystem. So currently, if a provider needs to place an order for a service or item, which requires prior authorization, someone on the provider side must manually look up or understand each payer's prior authorization requirements and documentation requirements to be able to check if a PA is

required and what coverage rules exist. To alleviate manual interventions and make it all a system-to-system communication, this is where PCG FHIR comes in. In the middle picture, we have the PCG FHIR system that acts as the PCG FHIR server for CMS. We have taken the information on the right-hand side that sits in the guide repositories, such as the NCDs (National coverage determinations), LCDs (local coverage determinations), etc. and created digitized rules in the form of electronic templates that can be presented to provider systems.

Now, we're going to walk through the FHIR solution. The first step at the point of care, the physician wants to place an order for a servicer item, which they put into their EHR. What happens next is there is a check from the provider's EHR to the active directory to figure out where that payer's endpoint exists, as in where is the system location, where they can find out the information about the payer's coverage rules. Once the information is available, the EHR would come to our specific FHIR server that says, is there a PA requirement for this particular order that the physician is placing? And at this time, it would then also ask what documentation requirements exist? The system we created doesn't only have the capability to confirm if there is a prior authorization requirement, but it also tells us what the documentation requirements are, and the SMART on FHIR app pulls the applicable documentation template and requirements for this item or service. At step five, the SMART on FHIR app uses existing data in the patient's medical record located in the provider's EHR system to pre-fill the template. Most of the information will be pre-filled into the order, and for any gaps in the information, the provider can manually enter what is required. The provider then submits the order, sending it to the FHIR server. This does not only work for PAs but also for additional documentation requests or claim documentation submissions. Step seven, the template is then turned into a FHIR structured format document that is sent to the payer and review contractor and loaded into the review contractor system. By the information coming in a structured format, what happens on the reviewer's end is they're able to do some intelligent processing on this information, as we no longer need a reviewer that can manually review a scanned PDF document. They have rules that do computer assistant processing that assist the RCs (Review Contractors) to make adjudications on the claim.

Once the review decision is made, it is then sent back to the FHIR endpoint, and then, ultimately, the review decision is sent back to the providers through the same channel again. Here we are going to examine some benefits for providers adopting the FHIR solution. As you can see on the left, during the ordering process, provider systems can interact with the payer systems to automatically discover the PA requirements and coverage requirements. At this point, the provider systems can know precise data elements, whether there requires a prior authorization or for an ADR (additional documentation request). These data elements are pre-populated from information available in the EHR. Required data elements are updated immediately when there are changes to documentation requirements. And this is a big one, no need to send traditional medical records through fax or mail, such as face-to-face encounter or discharge summary. Finally, as part of the solution, an all-payer provider application will be made available to providers, which can pull data requirements from all payers. Deanna, I'll turn it back to you.

**Deanna Keesecker:** OK. If you are interested in joining the pilot program, which we would be very happy, the onboarding criteria for providers is to have a certified EHR system with an ability to launch a SMART on FHIR application. You would conduct a discovery call with our CMS team and your provider's IT team to assess your current workflow and capabilities. And there is a time obligation to complete both the authentication and security as well as the integration processes, and that can vary until those are complete. Next slide.

If you're interested in learning more, you can visit the CMS PCG FHIR page, which a link will be in the slides here. And there's also a link in the agenda that you should have received. And you can send an email to our pcg_fhir@mettles.com. And then additionally, we have our contact information for Jordan and I and then our contractor information. And we want to thank you so much for your time and listening today. Thank you.

**Jordan Tabor:** Thank you, everyone, and I will give it back to you, Jill.

**Jill Darling:** Great. Thank you, Jordan, Deanna, Jermama, and Marcie. I greatly appreciate you guys joining us today. So now we will go into our Q&A. So, if you have a question or comment, please use the raise hand feature at the bottom of your screen, and we will wait for any hands. In the meantime, the emails that I'd sent in the chat—home health policy and the hospice policy emails—please utilize those for any payment questions.

**Victoria Barkin:** Hi. What kind of prior authorization would a home health agency, I guess, need to get? I am trying to figure out if this is something we should sign up for.

**Jordan Tabor:** You mean, like, what service or item?

**Victoria Barkin:** Yeah.

**Jordan Tabor:** An example that we actually have an ECTA electronic template for is oxygen. So, like home health oxygen. That's an example that we actually have a vetted template for. And by vetted the MACs (Medicare Administrative Contractors) have given their approval. Other home health, Deanna, or we actually have our FHIR SME (Subject Matter Expert) on as well, Tamika Bevels, if they have anything else. But home oxygen is a big one.

**Deanna Keesecker:** And Victoria, this is Deanna Keesecker. We encourage you just to reach out to our email that we provided, and we'd be happy to set up an initial meeting with you and your team to discuss further.

**Victoria Barkin:** OK, thank you.

**Jordan Tabor:** Thanks, Victoria.

**Jackie:** All right. We have Nanette. You're able to unmute.

**Nanette Smith:** Hi, good afternoon. My question is, I'm actually on representing providers with the Managed Care plans, Medicare Advantage plans. Will this be a system that will eventually work with the Medicare Advantage plans in the same capacity for those authorizations? You said all payers, so clarification.

**Jordan Tabor:** That is a great question, Nanette, that I am not 100% sure we can answer. I can certainly take your question back to our contractor and get you a more accurate answer.

**Nanette Smith:** Because this is, I'm sorry, this is part of the interoperability rule, right? That the advantage plans are going to have to get on board with as well.

**Jordan Tabor:** By 2027.

**Nanette Smith:** Correct.

**Jordan Tabor:** Yes.

**Nanette Smith:** Right. So, it would be easy if everybody used the same thing, but we know that's not going to happen.

**Jordan Tabor:** I would assume the answer should be like you said, everyone should use the same thing. But I will definitely get you a more accurate answer, and if you want to reach out to our email or if you want to provide your email address to us.

**Nanette Smith:** I'll put my email address in the link.

**Jordan Tabor:** OK, perfect. I will get back to you with your answer.

**Nanette Smith:** Thank you.

**Jackie:** Beth, you're able to unmute.

**Beth Noyce:** OK. I am wondering if the FHIR system, it did mention ADRs as well and state that there would no longer be a need for a medical reviewer. Does that mean that this system with its templates are going to be the deciders for whether claims get paid when they're called for ADRs? Is that changing the whole way the medical review system is working?

**Deanna Keesecker:** Hi, Beth. This is Deanna Keesecker. It would not be preventing an ADR. So, the resources would be stored in the FHIR server to make it easier for the RC to review their claim. But at this time, the medical reviewer still needs to do the adjudication of the claims. The technology is not there to be automatically approving or denying claims. This is just to reduce that administrative burden of multiple medical records.

**Beth Noyce:** So, just for my follow-up question, then explain how it does affect ADRs, because those were mentioned in the description.

**Deanna Keesecker:** We'd have to get back to you on the specifics about that.

**Beth Noyce:** Prior authorization really is not an element for home health or hospice, and the oxygen, home oxygen, that you mentioned is a DME product, not something for home health or hospice, except when hospice works through DME. So, prior authorization really isn't an element for home health and hospice. So, I'm just trying to see how this truly would affect those lines of businesses.

**Jordan Tabor:** Jackie, are you able to take Tamika Bevels off of mute so she can—

**Jackie:** Tamika? Oh yes.

**Jordan Tabor:** OK.

**Jackie:** I can. Here we are. I can move her over actually as a panelist.

**Jordan Tabor:** Perfect, thank you. I see. Beth, she will be able to answer your question.

**Beth Noyce:** Thank you.

**Tamika Bevels:** Hello. Can everyone hear me?

**Jordan Tabor:** Yes, we can hear you, Tamika.

**Tamika Bevels:** Hey, so I thought I heard the question clearly. Please help me if I didn't. The question was around will the ADR process change? Was that the question, Beth?

**Beth Noyce:** Yes. How will this new FHIR system, with its templates and information, which sounded a lot like AI, help with all of this? This is not necessarily bad, but how will it truly affect home health and hospice benefits and processes? It sounds like it would only affect the ADR process because we don't do prior authorization for these benefits, and I want to know in what way it will affect those ADRs.

**Tamika Bevels:** So, a couple of clarifications. This process, this project is really for Medicare fee-for-service prior auth. You had prior auth orders, items, or services. You mentioned oxygen home health oxygen template was mentioned. You're right, that is not prior auth. However, because of industry interest, we decided with the electronic clinical template API project that we would do a template. Even though it's a DME template, it has nothing to do with prior auth. It is just one of the templates that we have completed. In addition to that, what we're doing is we're trying to improve the prior auth process by streamlining how we collect the required documentation for prior auth orders. And in addition to that, we can also do ADRs, but the ADR

process would not change. So additional records, that process will not change. What we're doing is we're just simply improving the process by having the ability to use FHIR functionality and API functionality to be able to pull the information from the provider's EHR system versus what we do now and what the providers are doing now, looking for the coverage rule that may or may not be correct or having the provider interpret the coverage rule and pull the clinical information they believe is correct.

What we're doing, in turn, is providing the most accurate coverage rule, the most updated coverage rule based on what's ordered, and pulling that accurate information from the provider's EHR that's the most accurate and pulling it into a template so when they send it to the MACs, it will be as accurate as possible.

**Beth Noyce:** So, does this affect the review choice demonstrations?

**Tamika Bevels:** It does not. It does not.

**Beth Noyce:** That's the closest we get to prior auth, unless this extends to the Medicare Advantage programs that do cause great problems because of their slowness with prior authorization. That's the only way it could affect our industries. I'm just wondering, I guess this is applicable to the DME providers that are on this call, but right now, it does not affect home health and hospice at all, correct?

**Tamika Bevels:** Yeah, that's correct. Home health and hospice, not right now.

**Beth Noyce:** OK. It's only applicable to the DME providers that are on this call.

**Tamika Bevels:** It's not just DME, it's Medicare fee-for-service items that can be ordered and or one DME item that is only oxygen. It's not all DME items because we know DME does not require prior auth.

**Beth Noyce:** OK. Well, it does not affect our processes or our billing at all, then for home health and hospice benefits, it sounds like.

**Tamika Bevels:** No, ma'am. It does not.

**Beth Noyce:** OK. Thank you.

**Tamika Bevels:** You're welcome. Jordan or Deanna, I was trying to speak to another question. Was there another question? I'm sorry.

**Jordan Tabor:** Nanette had a question about the Medicare Advantage, which I don't think we can speak to, so we will have to follow up.

**Tamika Bevels:** OK. I think, was it to expand to Medicare Advantage? I think that's what I heard.

**Jordan Tabor:** Yes. If by 2027 Medicare Advantage would have to adapt.

**Tamika Bevels:** Yeah, exactly. We wouldn't be able to speak on that at this time, but we are hoping that we can spread as far as we can so that we can streamline the entire process throughout all of the claims process processes rather.

**Jill Darling:** All right, thank you, Tamika. We'll just give it another moment if we see any more raised hands. OK. Well, I'm going to provide the same emails for you again in the chat just so you have them if there was a question you couldn't think of while on the call. So, you may utilize those emails, and we thank you for joining us today. Thank you to all of our speakers, and this concludes today's call. Thanks, everyone.