CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2696	**Date: May 3, 2013**
	Change Request 8241

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 8, 2013. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet..

SUBJECT: Implementation of the Hospice Quality Reporting Required by the Affordable Care Act (ACA) Section 3004

I. SUMMARY OF CHANGES: This instruction implements the payment reduction required for hospice agencies failure to report quality data as specified in Section 3004 of the ACA. The Hospice PRICER input record is being modified to allow for the quality indicator. Medicare is taking this opportunity to expand the input record to also allow for the Health Care Procedure Coding System (HCPCS), though this field is not being used for pricing of services.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/50.1/Outpatient Provider Specific File
R	11/ Table of Contents
N	11/30.2.1/Payments to Hospice Agencies That Do Not Submit Required Quality Data

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2696	Date: May 3, 2013	Change Request: 8241

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SUBJECT: Implementation of the Hospice Quality Reporting Required by the Affordable Care Act (ACA) Section 3004

EFFECTIVE DATE: October 1, 2013
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I. GENERAL INFORMATION

A. Background: Section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices. As added by section 3004 (c), new section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that fiscal year. Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points could result in the annual market basket update being less than 0.0 percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the particular FY involved. Any such reduction will not be cumulative and will not be taken into account in computing the payment amount for subsequent FYs.

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary.

The specific quality data submission requirements for each annual payment determination are proposed and finalized in rulemaking.

This instruction implements the payment reduction required for hospice agencies failing to report quality data as required by Section 3004 of the Affordable Care Act (ACA). The Hospice PRICER input record is being modified to allow for the quality indicator. In addition, Medicare is taking this opportunity to expand the input record to also allow for the Health Care Procedure Coding System (HCPCS), though this field is not being used for pricing of services.

B. Policy: For fiscal year 2014, and each subsequent year, failure of hospices to submit required quality data shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.

In the Hospice Wage Index for Fiscal Year 2012 Final Rule (76 FR 47302, 47320 (August 4, 2011)), to meet the quality reporting requirements for hospices for the FY 2014 payment determination as set forth in section 1814(i)(5) of the Act, CMS finalized the requirement that hospices report two measures:

● An NQF-endorsed measure that is related to pain management, NQF #0209. The data collection period for this measure was October 1, 2012 through December 31, 2012, and the data submission deadline is April 1, 2013. The data for this measure are collected at the patient level, but are reported in the aggregate for all patients cared for within the reporting period, regardless of payer.

● A structural measure that is not endorsed by NQF: Participation in a Quality Assessment and Performance Improvement (QAPI) program that includes at least three quality indicators related to patient care. The data collection period for this measure was October 1, 2012 through December 31, 2012, and the data submission deadline was January 31, 2013. Hospices are not asked to report their level of performance on these patient care related indicators.

Hospices failing to report quality data prior to the specified deadline in 2013 will have their market basket update reduced by 2 percentage points in FY 2014. Hospice programs will be evaluated for purposes of the quality reporting program based on whether or not they submit data, not based on their performance level on required measures.

In the Home Health Prospective Payment System Rate Update for Calendar Year 2013 Final Rule (77 FR 67068, 67133 (November 8, 2012), to meet the quality reporting requirements for hospices for the FY 2015 payment determination and each subsequent year, as set forth in section 1814(i)(5) of the Act, we finalized the requirement that hospices report two measures:

● The NQF-endorsed measure that is related to pain management, NQF #0209

● The structural measure: Participation in a Quality Assessment and Performance Improvement (QAPI) Program that Includes at Least Three Quality Indicators Related to Patient Care. We did not extend the requirement that hospices provide a list of their patient care indicators.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8241.1	Medicare contractors shall establish an outpatient provider specific file (OPSF) for new hospices and any hospices on file that do not have an OPSF in the system.	X					X					
8241.2	Medicare Contractors shall create a new OPSF record each year for hospice agencies and default the OPSF field 74 for hospice agencies to blank each year when the new OPSF is created.							X				
8241.3	Upon receipt of an annual Technical Direction Letter from CMS identifying Hospice agencies subject to the quality reporting payment reduction, Medicare contractors shall update the outpatient provider specific file (OPSF) as indicated for the payment year specified. OPSF field 74: Revised to include Hospice: Valid values for Hospice agencies: Blank = no reduction	X					X					

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	1 = 2 percent payment reduction to the market basket											
8241.4	Medicare contractors shall send the OPSF field 74 indicators for the Hospice quality reduction to the Hospice PRICER. (See Attachment: REVISED HOSPICE BILL RECORD FOR FISCAL YEAR 2014).							X				
8241.5	Medicare contractors shall send the HCPCS reported on revenue code line items 0651, 0652, 0655 and 0656 to the Hospice PRICER. (See Attachment: REVISED HOSPICE BILL RECORD FOR FISCAL YEAR 2014).							X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8241.6	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information: N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wendy Tucker, Wendy.Tucker@cms.hhs.gov (Claims Processing) , Robin Dowell, Robin.Dowell@cms.hhs.gov (Quality Reporting Policy)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENT

ATTACHMENT

FIELD LEVEL/NAME	PICTURE	FIELD NUMBER	START	END	LE
HOLD-BILL-DATA			1	215	
10 BILL-NPI	X(10)	1	1	10	
10 BILL-PROV-NO	X(6)	2	11	16	
10 BILL-FROM-DATE-ALL	GROUP	3	17	24	
15 BILL-FROM-CC	99	4	17	18	
15 BILL-FROM-DATE	GROUP	5	19	24	
20 BILL-FROM-YY	99	6	19	20	
20 BILL-FROM-MM	99	7	21	22	
20 BILL-FROM-DD	99	8	23	24	
10 FILLER	X(8)	9	25	32	
10 BILL-PROV-MSA-LUGAR	GROUP	10	33	37	
15 BILL-PROV-MSA	X(4)	11	33	36	
15 BILL-PROV-LUGAR	X	12	37	37	
10 BILL-PROV-CBSA REDEFINES BILL-PROV-MSA-LUGAR					
10 BILL-PROV-CBSA	X(5)	13	33	37	
10 BILL-BENE-MSA-LUGAR	GROUP	14	38	42	
15 BILL-BENE -MSA	X(4)	15	38	36	
15 BILL-BENE -LUGAR	X	16	42	42	
10 BILL-BENE-CBSA REDEFINES BILL-BENE-MSA-LUGAR					
10 BILL-BENE-CBSA	X(5)	17	38	42	
10 FILLER	X(10)	18	43	52	
10 BILL-PROV-WAGE-IND	99V9(4)	19	53	58	
10 BILL-BENE-WAGE-IND	99V9(4)	20	59	64	
10 FILLER	X(20)	21	65	84	
10 BILL-QIP-REDUCTION-IND	X	22	85	85	
10 BILL-GROUP1	GROUP	23	86	109	
15 BILL-REV1	X(4)	24	86	89	
15 BILL-HCPC1	X(5)	25	90	94	
15 BILL-UNITS1	9(7)	26	95	101	
15 BILL--THEIR-PAY-CHG1	9(6)V99	27	102	109	
10 BILL-GROUP2	GROUP	28	110	133	
15 BILL-REV2	X(4)	29	110	113	
15 BILL-HCPC2	X(5)	30	114	118	
15 BILL-UNITS2	9(7)	31	119	125	
15 BILL--THEIR-PAY-CHG2	9(6)V99	32	126	133	
10 BILL-GROUP3	GROUP	33	134	157	
15 BILL-REV3	X(4)	34	134	137	
15 BILL-HCPC3	X(5)	35	138	142	
15 BILL-UNITS3	9(7)	36	143	149	
15 BILL--THEIR-PAY-CHG3	9(6)V99	37	150	157	
10 BILL-GROUP4	GROUP	38	158	181	
15 BILL-REV4	X(4)	39	158	161	
15 BILL-HCPC4	X(5)	40	162	166	
15 BILL-UNITS4	9(7)	41	167	173	
15 BILL--THEIR-PAY-CHG4	9(6)V99	42	174	181	

10 BILL-RETURNED-DATA	GROUP	43	182	191	
15 BILL-PAY-AMT	9(6)V99	44	182	189	
15 BILL-RTC	XX	45	190	191	
10 FILLER	X(24)	46	192	215	

50.1 - Outpatient Provider Specific File

(Rev.2696, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

NOTE: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The created/run date of the PROV report for submittal to CO.

41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeros or contain a termination date. (once the official "tie-out" notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting intermediary ceased servicing the provider in question).
49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS. N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.
50-54	9(5)	Intermediary Number	Enter the Intermediary #.
55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, contractors will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center

			(during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services

			49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. For End Stage Renal Disease (ESRD) facilities value "Y" equals low volume adjustment applicable.
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank)(blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.
71-72	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. Contractors shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs

74	X(1)	Quality Indicator Field	Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. Blank = Hospital does not meet criteria. Independent and Hospital-based End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction * Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator. *Hospice Agencies:* *Blank = no reduction* *1 = 2 percent payment reduction*
75	X(1)	Filler	Blank.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 3 6 for Ohio, where the facility is physically located.

85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.
101	X(1)	Quality Indicator ESRD Children's Hospitals	Children's Hospitals for End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction

The contractor enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to systems capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced coinsurance amount elected by the provider

The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).

Future updates will be issued in a Recurring Update Notification.

Medicare Claims Processing Manual
Chapter 11 - Processing Hospice Claims

Table of Contents
(Rev.2696, Issued: 05-03-13)

30.2.1 – Payments to Hospice Agencies That Do Not Submit Required Quality Data
Rev.2696, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.

Penalties for Failure to Report

For fiscal year 2014, and each subsequent year, failure to submit required quality data shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.

Medicare will provide contractors with a Technical Direction Letter (TDL) prior to each fiscal year, identifying hospice agencies not meeting the quality data reporting requirements. Contractors must update the quality indicator in the Provider Outpatient Specific File for each identified, hospice agency subject to the payment reduction.