

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



News Flash –

REVISED product(s) from the Medicare Learning Network® (MLN)

- "[Hospital Reclassifications](#)", Fact Sheet, ICN 907243, Downloadable

MLN Matters® Number: MM7459 Revised

Related Change Request (CR) #: CR 7459

Related CR Release Date: July 1, 2011

Effective Date: October 3, 2011

Related CR Transmittal #: 2249CP

Implementation October 3, 2011

## Calendar Year 2012 and After Payments to Home Health Agencies That Do Not Submit Required Quality Data

Note: This article was updated September 4, 2012, to reflect current Web addresses. It was previously revised on June 4, 2012, to add a reference to MM7833 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7833.pdf>) which describes revisions to the "Claims Processing Manual", that includes improvements to the payment reduction reconsideration process and other clarifications. All other information is unchanged.

### Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare contractors, (Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for home health services provided to Medicare beneficiaries.

### Provider Action Needed



#### STOP – Impact to You

This article is based on Change Request (CR) 7459 which revises the instructions, regarding required

#### Disclaimer

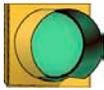
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HHA quality data, to include the reporting of Home Health Consumer Assessment of Health Provider and Systems (HHCAHPS) data.



### CAUTION – What You Need to Know

The addition of HHCAHPS data to the reporting requirement adds consumer satisfaction information to Centers for Medicare & Medicaid Services (CMS) databases and will improve the information available to the public via the HH Compare website. This reporting comes under the pay-for-reporting authority created by the Deficit Reduction Act in 2005, and the policy was finalized in the 2010 HH PPS final regulation.



### GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

## Background

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The Social Security Act (Section 1895(b)(3)(ii)(V); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1895.htm](http://www.ssa.gov/OP_Home/ssact/title18/1895.htm) on the Internet) requires that each HHA submit data for the measurement of health care quality. In Calendar Year (CY) 2007 and each subsequent year, if a HHA does not submit the required data, their payment rates for the year are reduced by two percentage points.

The Deficit Reduction Act (DRA) of 2005 (see <http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/index.html> on the CMS website) added a pay-for-reporting requirement to payments for Medicare HH services, effective January 1, 2007. For payments in CYs 2007 through 2011, this requirement was limited to the reporting of Outcomes and Assessment Information Set (OASIS) data. Effective for payments in CY 2012 and after, the requirement also includes submission of HHCAHPS data. For payments in CY 2012 and after, documentation of HHCAHPS compliance may include any of the following:

- For CY 2012 only, evidence that the HHA participated in a HHCAHPS dry run for at least one month in third quarter 2010 (July, August, September 2010) and submitted the HHCAHPS dry run data to the HHCAHPS Data Center by 11:59 pm EST on January 21, 2011.
- Evidence that the HHA continuously collected data and submitted data to the HH CAHPS Data Center during the required timeframe. For CY 2012, the required period of data collection includes the dry run data in the third quarter 2010, the fourth quarter 2010 (all the months of October, November and December 2010), and the first quarter 2011 (all the months of January, February, and March 2011). For CY 2013 and after, the required period of data collection includes all months from April 1 of the prior year through March 31 of the current year.

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- For HHAs with less than 60 HHCAHPS eligible patients in the year prior to the current reporting year, evidence that the HHA filed the Participation Exemption Request Form, on the form that can be found at <http://www.homehealth.org> by the deadline date specified in that year's HH Prospective Payment System Final Rule.

CR7459 revises the "Medicare Claims Processing Manual" (Chapter 10, Section 120 (Payments to Home Health Agencies That Do Not Submit Required Quality Data)) to reflect the addition of HHCAHPS reporting, and the revised Section 120 is included as an attachment to CR7459. The following requirements outline the significant changes for contractors from the revisions to the manual.

CR7459 instructs your Medicare contractors to:

- Send notification letters to HHAs that indicate whether the HHA was non-compliant with regard to OASIS reporting, HHCAHPS reporting, or both no later than 10 business days from the receipt of a Technical Direction Letter (TDL) from CMS that provides the list of HHAs potentially subject to reductions;
- Use the model language provided in the revised "Medicare Claims Processing Manual," Chapter 10, Section 120 when issuing notification letters and dispute determination letters; and
- Insert a CMS-provided statement of findings with regard to OASIS compliance, HHCAHPS compliance, or both in the model language of dispute determination letters.

## Additional Information

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The official instruction, CR7459, issued to your FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2249CP.pdf> on the CMS website.

If you have any questions, please contact your FIs, A/B MACs, or RHHs at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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