CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-22 Medicare Quality Reporting Incentive Programs	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 57	**Date: May 27, 2016**
	Change Request 9651

SUBJECT: Payments to Home Health Agencies That Do Not Submit Required Quality Data

I. SUMMARY OF CHANGES: This Change Request updates instructions for the home health 2% payment reduction process. It also moves those instructions from Pub. 100-04 to Pub. 100-22.

EFFECTIVE DATE: August 30, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 30, 2016

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
N	3/70/Payments to Home Health Agencies That Do Not Submit Required Quality Data

III. FUNDING:
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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-22	Transmittal: 57	Date: May 27, 2016	Change Request: 9651

SUBJECT: Payments to Home Health Agencies That Do Not Submit Required Quality Data

EFFECTIVE DATE: August 30, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 30, 2016

I. GENERAL INFORMATION

A. Background: The Deficit Reduction Act (DRA) of 2005 added a pay-for-reporting requirement to payments for Medicare home health services, effective January 1, 2007. For payments in calendar years 2007 through 2011, this requirement was limited to the reporting of Outcomes and Assessment Information Set (OASIS) data. Effective for payments in calendar year 2012 and after, the requirement also includes submission of Home Health Consumer Assessment of Health Providers and Systems (HHCAHPS) data.

This Change Request moves instructions regarding this process from Pub. 100-04, Medicare Claims Processing Manual, chapter 10 to Pub. 100-22, Medicare Quality Reporting Incentive Programs Manual, chapter 3. It also includes some revisions to the instructions to reflect the current notification and reconsideration processes.

B. Policy: This Change Requests contains no new policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9651 - 22.1	The contractors shall use the model language provided in Pub. 100-22, chapter 3, section 70 when issuing notification letters.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9651 - 22.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 5 business days after receipt of the notification from CMS announcing the availability of the 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.			X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov (For Pub. 100-04) , Michelle Brazil, michelle.brazil@cms.hhs.gov (For Pub. 100-22)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

Medicare Quality Reporting Incentive Programs Manual

Chapter 3 – Contractor Incentive Program Payment Operational Instructions

Table of Contents
(Rev. 57, Issued: 05-27-16)

70- Payments to Home Health Agencies That Do Not Submit Required Quality Data

(Rev.57, Issued: 05-27-16, Effective: 08-30-16, Implementation: 08-30-16)

In calendar year 2007 and each subsequent year, if a home health agency does not submit required quality data, their payment rates for the year are reduced by 2 percentage points. Original Medicare considers the following data as meeting the reporting requirement:

- *OASIS data submitted by HHAs for all episodes beginning on or after July 1 of the previous year, and before July 1, of the current year, and*

- *Home Health Care Consumer Assessment of Health Providers and Systems (HHCAHPS) monthly data collection and submission from April 1 of the prior year through March 31 of the current year.*

NOTE: *If agencies had less than 60 patients between April 1 and March 31 and complete a Participation Exemption Request form, then they are exempt from HHCAHPS participation for the following year. Each year the exemption applies, these HHAs are to complete an HHCAHPS Participation Exemption Request form on the HHCAHPS Website, https://homehealthcahps.org. Patient survey-eligible criteria are included in Chapter IV of the HHCAHPS Protocols and Guidelines Manual, which is available at https://homehealthcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid1.*

Illustration of HHCAHPS periods:

(A) ***Annual Payment Update Calendar Year***	***(B)*** ***Did the HHA serve 60 or more survey-eligible patients during the 12-month period specified below?***	***(C)*** ***If the HHA served 60 or more survey-eligible patients during the 12-month period specified in Column B, to receive the annual payment update for a specific calendar year, the HHAs must administer the survey and submit an HHCAHPS data file for each month as noted below.***	***(D)*** ***If the HHA served 59 or fewer survey-eligible patients during the 12-month period specified in Column B, the HHA is eligible for an exemption from participating in the HHCAHPS Survey for the 12-month period specified in Column C. To receive an exemption, the HHA must submit a Participation Exemption Request Form by the date noted below.***
2013	*April 1, 2010 - March 31, 2011*	*April 2011–March 2012*	*January 21, 2012*
2014	*April 1, 2011 - March 31, 2012*	*April 2012–March 2013*	*Date is announced in a HH PPS payment update rule*

Each fall, Medicare contractors with home health workloads will receive a technical direction letter (TDL) which provides a list of HHAs that have not submitted the required OASIS and/or HHCAHPS data during the established timeframes and which have submitted covered claims to Medicare during these timeframes.

The contractor shall notify the HHAs on the list that they have been identified as not being in compliance with the requirement of submitting quality data and are scheduled to have Medicare payments to their agency reduced by 2%. Medicare contractors shall include the model language at the end of this section in their notification letter to the HHA. The notification letter shall inform the HHA whether they were identified as not being in compliance with the OASIS data requirement, the HHCAHPS data requirement, or both. Contractors shall send notification letters no later than 5 business days from the receipt of the TDL.

Immediately after the notification letters are issued, Medicare contractors shall submit to the CMS contacts noted in the TDL a list of agencies who received a letter. Medicare contractors shall notify home health agencies who wish to dispute their payment reduction of the procedure to request a reconsideration. There is a 30 day period from the date of the notification letter to submit a letter requesting reconsideration and documentation to support a finding of compliance.

Using the model language at the end of this section, contractors shall inform HHAs about documentation to support a finding of compliance.

For payments in calendar year 2011 and after, documentation of OASIS compliance may include any of the following:

- *evidence of OASIS transmissions during the reporting period (e.g., an OASIS Final Validation Report from the national system showing a timely submission date);*

- *for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that the HHA did not receive their CMS Certification Number (CCN) from Medicare until after the close of the reporting year (e.g., a notification letter from the survey and certification staff at the CMS RO dated after June 30);*

- *for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that they received their CCN too late in the reporting year for the provider to receive their permanent OASIS transmitter ID from their State OASIS Automation Coordinator and submit data (e.g., during the last week of June); or*

- *for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that the HHA received their CCN in the last weeks of the reporting year (e.g., in June), took prompt action to request their permanent OASIS transmitter ID from their State OASIS Automation Coordinator and were delayed by CMS or its agents.*

For payments in calendar year 2012 and after, documentation of HHCAHPS compliance may include any of the following:

- *Evidence that the HHA continuously collected data and submitted data to the Home Health CAHPS Data Center during the required timeframe. The required period of data collection includes all months from April 1 of the prior year through March 31 of the current year; or*

- *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 is on www.homehealthcahps.org, by the deadline date specified in that year's Home Health Prospective Payment System Final Rule in the* ***Federal Register****.*

The contractor shall inform HHAs that documentation of the following does not support a finding of compliance:

- *evidence or admission of error on the part of HHA staff, even if the involved staff members are no longer employed by the HHA and/or a corrective action plan has been or will be put in place after the end of the reporting year;*

- *evidence or assertion that failure to comply was the fault of a vendor or contractor that was hired by the HHA to perform reporting functions (the HHA is responsible for the actions of its contractors, vendors or other agents on the HHA's behalf);*

- *evidence of delays establishing electronic data interchange connectivity between the HHA and the Medicare claims processing contractor for the purpose of billing, since OASIS transmission is not dependent on billing and the HHA should request their OASIS transmitter ID from the State at the same time they request billing system access from the Medicare claims processing contractor; and*

- *in cases where the ownership of the HHA changed during the reporting year but the CCN of the HHA did not change, evidence that failure to comply was the fault of a previous owner.*

Contractors should direct electronic submission of reconsideration requests and documentation to a dedicated CMS e-mail address. HHAs may, if they are unable to submit electronically, request a mailing address for the submission of paper requests and documentation. If the contractor receives a paper reconsideration request and documentation from the HHA within the allowed timeframe, the documentation should be forwarded to the CMS contacts noted in the TDL as soon as possible and no later than 2 business days from receipt. The documentation shall be forwarded in an electronic format (e.g., scanned copies of the documents) via e-mail. If a provider's documentation contains protected health information (PHI) in error, documents containing PHI should not be forwarded. CMS will review the documentation and provide a determination to the Medicare contractor as soon as possible, but typically within a period of 6-7 weeks.

The following example illustrates the timeframes for the complete process using hypothetical dates:

1) *CMS issues the TDL providing the list of HHAs on Friday, September 17;*

2) *Contractors must issue notification letters to HHAs by the fifth business day after receipt of the TDL, on September 24;*

3) *The timely reconsideration period ends 30 calendar days later, no later than October 24;*

4) *CMS provides determinations to contractors during the second week of December.*

In its review of the HHA's documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the HHA. The determination will be made based solely on the documentation provided. CMS will not contact the HHA to request additional information or to clarify incomplete or inconclusive information. If clear evidence to support a finding of compliance is not present, the 2% reduction will be upheld. If clear evidence of compliance is present, the reduction will be reversed.

If the CMS determination upholds the 2% reduction, CMS shall provide the Medicare contractor with a statement of the findings that support the decision. The contractor shall notify the HHA in writing and inform them of their right to further appeal the 2% reduction via the Provider Reimbursement Review Board (PRRB) appeals process. Medicare contractors shall include the model language at the end of this section in their dispute determination letter to the HHA. Contractors shall insert the CMS-provided statement of findings in the blank provided in the model language. Contractors shall send this second letter only to HHAs that requested a reconsideration.

If the HHA does not dispute their reduction, the Medicare contractor shall update their provider file for the HHA. The contractor shall set an indicator in the provider file that triggers Medicare systems to calculate the 2% reduction on all claims for the upcoming calendar year. If the CMS determination upholds the 2% reduction, the contractor shall update their provider file in this fashion also.

If the CMS determination reverses the 2% reduction, the contractor shall not update their provider file for the HHA and shall notify the HHA that they will receive their full HH PPS payment update for the upcoming year.

Model language for initial notification letters:

"This letter is to officially inform you that CMS has determined your home health agency (HHA) is subject to a reduction in payment for not meeting the Deficit Reduction Act (DRA) of 2005 requirement for HHAs to submit quality data. Therefore, Medicare payments to your agency will be reduced by 2% for [insert upcoming year], unless you can provide evidence that this determination is in error. Currently, the quality data reporting requirement consists of timely submission of Outcomes and Assessment Information Set (OASIS) data as required by your conditions of participation (CoPs), and timely submission of Home Health Care Consumer Assessment of Health Providers and Systems (HHCAHPS) data.

In order to meet the CoPs, OASIS data is required to be transmitted within 30 days of the assessment date. OASIS data submitted within 30 days of the assessment date is considered to have met the requirement of submitting the required quality data. The reporting year for [insert upcoming year] was the period between July 1, [insert previous year] and June 30, [insert current year]. Under the CoPs, assessments in June [insert current year] would meet the requirement if submitted by July 31, [insert current year]. New HHAs, defined as agencies with participation dates in the Medicare program on or after May 1, [insert current year], are excluded from this requirement.

[For letters in calendar year 2012 only:]

In order to meet the HHCAHPS requirement, HHAs needed to participate in an HHCAHPS dry run in third quarter 2010, and continue monthly data collection and submission of data to the Home Health CAHPS Data Center beginning in October 2010, through March 2011. If agencies had less than 60 patients between April, 1, 2009, and March 31, 2010, then they were exempt from HHCAHPS participation for CY 2012. These HHAs were to complete an HHCAHPS Participation Exemption Request form for CY 2012 on the HHCAHPS Website, https://homehealthcahps.org.

[For letters in calendar years 2013 and after:]

In order to meet the HHCAHPS requirement, HHAs must collect monthly HHCAHPS data and submit data to the Home Health CAHPS Data Center from April 1, [insert the prior year] through March 31,[insert the current year]. If agencies had less than 60 patients between April 1, [insert the year 2 years prior] and March 31, [insert the prior year], then they are exempt from HHCAHPS participation for [insert current year]. These HHAs were to complete an HHCAHPS Participation Exemption Request form on the HHCAHPS Website, https://homehealthcahps.org.

CMS review of OASIS and HHCAHPS submissions for this period found that your agency is not excluded or exempt from the reporting requirements and [insert whether the HHA was non-compliant with OASIS, HHCAHPS or both]. CMS's review of paid claims has shown that you have received Medicare payment for claims with dates of service within the reporting year. Consequently, for episodes that end on or after January 1, [insert upcoming year] and prior to January 1, [insert following year], payments to your agency will be reduced by 2%. The national 60-day episode payment amount and the national standardized per-visit amounts used to calculate low utilization payment adjustments (LUPAs) and outlier payments for providers that did not submit quality data, are listed in separately labeled tables in the recent HH PPS payment update final regulation for [insert upcoming year].

If you believe you have been in compliance with the quality data reporting requirement and have been identified for this payment reduction in error, you must submit a letter requesting reconsideration and provide documentation demonstrating your compliance.

Documentation to support a finding of compliance with OASIS reporting may include any of the following:

- *evidence of OASIS transmissions during the reporting period (e.g., an OASIS Final Validation Report from the national system showing a timely submission date);*

- *if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA did not receive your CMS Certification Number (CCN) from Medicare until after the close of the reporting year (e.g., a notification letter from the survey and certification staff at the CMS RO dated after June 30);*

- *if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA received your CCN too late in the reporting year to request and receive your permanent OASIS transmitter ID and submit data (e.g., during the last week of June); or*

- *if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA received your CCN in the last weeks of the reporting year (e.g., in June), took prompt action to request your permanent OASIS transmitter ID and were delayed by CMS or its agents.*

Documentation to support a finding of compliance with HHCAHPS reporting may include any of the following:

- *[For letters in calendar year 2012 only:] Evidence that the HHA participated in a HHCAHPS dry run for at least 1 month in third quarter 2010 (July, August, September 2010) and submitted the HHCAHPS dry run data to the Home Health CAHPS Data Center by 11:59 pm EST on January 21, 2011;*

- *Evidence that the HHA continuously collected data and submitted data to the Home Health CAHPS Data Center during the required timeframe. [For letters in calendar year 2012 only:] 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 letters in calendar year 2013 and after:] The required period of data collection includes all months from April 1, [insert the prior year] through March 31, [insert the current year]; or*

- *For HHAs with less than 60 HHCAHPS eligible patients in the year from April 1, [insert the year 2 years prior] and March 31, [insert the prior year], evidence that the HHA filed the Participation Exemption Request Form, on the form that is on www.homehealthcahps.org, by the deadline date specified in the HH PPS payment update final regulation for [insert current year].*

Note that documentation of the following does NOT support a finding of compliance:

- *evidence or admission of error on the part of your staff, even if the involved staff members are no longer employed by your HHA and/or a corrective action plan has been or will be put in place after the end of the reporting year;*

- *evidence or assertion that failure to comply was the fault of a vendor or contractor that was hired by your HHA to perform reporting functions;*

- *evidence of delays establishing electronic data interchange connectivity between your HHA and [insert Medicare contractor name] for the purpose of billing, since OASIS transmission is not dependent on billing and the HHA should request their OASIS transmitter ID from the State at the same time they request billing system access from [insert Medicare contractor name]; or*

- *in cases where the ownership of the HHA changed during the reporting year but the CCN of the HHA did not change, evidence that failure to comply was the fault of a previous owner.*

Your letter and documentation should be submitted via e-mail to CMS for reconsideration, using the following e-mail address: HHAPUreconsiderations@cms.hhs.gov .

If you are unable to submit via e-mail, please call [insert contact number] to request the mailing address for paper submissions. Requests and supporting documentation must be received electronically or postmarked no later than 30 days from the date of this notification.

When preparing your request, be careful to ensure the following:

- *Documents provided are relevant to the reason for your payment reduction (i.e. do not send OASIS documentation in response to a HHCAHPS related reduction)*

- *No protected health information (PHI) is included in the documents*

- *All documents pertain to the same, current reporting year*

- *Each request provides documents regarding a single HHA (do not combine requests or attach a list of HHA provider numbers to a request)*

- *If requesting a HHCAHPS reconsideration regarding a participation exception, provider specific information detailing why your HHA had no eligible patients.*

An HHA must submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB).”

Model language for dispute determination letters:

“This letter is in response to your request for reconsideration of the scheduled 2% reduction in payments to your agency, due to your agency being identified as [insert whether the HHA was non-compliant with OASIS, HHCAHPS or both].

CMS has reviewed the documentation you provided and determined that your agency is subject to the 2% reduction in HH PPS payments for CY[insert upcoming year], due to your agency’s noncompliance with submitting quality data during the required timeframes. Specifically, CMS officials found [insert CMS-provided statement of findings]. If your agency wishes to further appeal this determination, the appeals process set forth in 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board (PRRB) appeal) applies.”