CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2043	**Date: September 3, 2010**
	Change Request 7114

SUBJECT: Calendar Year 2011 Payments to Home Health Agencies That Do Not Submit Required Quality Data

I. SUMMARY OF CHANGES: This Change Request revises instructions regarding the home health agency pay-for-reporting program.

EFFECTIVE DATE: October 5, 2010
IMPLEMENTATION DATE: October 5, 2010

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/120/Payments to Home Health 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; contractor activities are to be carried out within 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 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

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2043	Date: September 3, 2010	Change Request: 7114

SUBJECT: Calendar Year 2011 Payments to Home Health Agencies That Do Not Submit Required Quality Data

Effective Date: October 5, 2010

Implementation Date: October 5, 2010

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 and 2008, this requirement was implemented based on instructions in the annual HH PPS payment Recurring Update Notification (RUN) and an accompanying Joint Signature Memorandum/Technical Direction Letter (JSM/TDL). To provide permanent documentation of the process, Change Request 6286, Transmittal 1647, added the steps outlined in the earlier instructions to Pub. 100-04, Medicare Claims Processing Manual.

Based on additional years of experience administering the pay-for-reporting program, CMS is revising the manual instructions. This transmittal seeks to clarify the timelines of the process. It also provides additional information about the process for an HHA to request a reconsideration of the payment reduction. The requirements below outline the significant changes for contractors from the revisions to the manual.

B. Policy: Section 1895(b)(3)(ii)(V) of the Social Security Act requires that each home health agency submit data for the measurement of health care quality. In calendar year 2007 and each subsequent year, if a home health agency does not submit the required data, their payment rates for the year are reduced by 2 percentage points.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7114.1	Medicare contractors shall exclude claims with condition code 21 when reviewing their claims history for claims within the reporting period.	X				X					
7114.2	Medicare contractors shall send HHAs notification letters no later than 10 business days from the receipt of the JSM/TDL that provides the list of HHAs potentially subject to reductions.	X				X					
7114.3	Medicare contractors shall use the revised model language provided in Pub. 100-04, Medicare Claims Processing	X				X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Manual, chapter 10, section 120 when issuing notification letters.										
7114.4	Medicare contractors shall forward reconsideration requests to CMS in electronic format no later than 2 business days from receipt of the request from the HHA.	X				X					
7114.5	Medicare contractors shall use the revised model language provided in Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 120 when issuing dispute determination letters.	X				X					
7114.5.1	Medicare contractors shall insert a CMS-provided statement of findings in the blank provided in the model language of dispute determination letters.	X				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
6286.1 through 6286.5.1	Currently, this process is only performed by RHHIs and the Jurisdiction 14 MAC. However, by future payment cycles, additional RHHI workloads may have transitioned to other MACs.

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts specified 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.

120 – Payments to Home Health Agencies That Do Not Submit Required Quality Data

(Rev.2043, Issued: 09-03-10, Effective: 10-05-10, Implementation: 10-05-10)

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. Since calendar year 2007, CMS has considered OASIS data submitted by HHAs to CMS for episodes beginning on or after July 1 of the previous year, and before July 1, of the current year as meeting the reporting requirement. CMS will continue to use that timeframe for future years.

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 OASIS data *during the established timeframe*. These Medicare contractors shall review their paid claims history for claims which have:

- a provider number on the list,
- dates of service from July 1 of the previous year through June 30 of the current year AND
- a beneficiary who is over 18 years of age.

Contractors shall exclude any billings for denial (claims with condition code 21).

If the contractor finds any such claims, the *contractor* shall notify the HHAs 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. *Contractors shall send notification letters no later than 10 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 allow home health agencies who wish to dispute their payment reduction a 30 *calendar* 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 that documentation to support a finding of compliance may include any of the following:

- *evidence of OASIS transmissions during the reporting period (e.g., an OASIS Final Validation Report from the State 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 Regional Office 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.*

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;*

- *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; 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.*

If the contractor receives *a 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.* CMS will *review the documentation* and provide a determination to the Medicare contractor *within 75 calendar days of the receipt of the JSM/TDL.*

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 10th business day after receipt of the TDL, on October 1;*

3) *The timely reconsideration period ends 30 calendar days later, no later than October 31;*

4) *CMS provides determinations to contractors within 75 days of September 17, no later than December 1.*

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). 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.

CMS review of OASIS submissions for this period found that your agency is not a new agency and has not made any timely OASIS submissions as defined above. [Insert Medicare contractor name]'s review of our paid claims history 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 may include any of the following:

- *evidence of OASIS transmissions during the reporting period (e.g., an OASIS Final Validation Report from the State 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 Regional Office 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.

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.*

The documentation you provide will be directed to CMS for *reconsideration*. *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).* Send your written requests *and supporting documentation* to [insert contact address] postmarked no later than 30 days from the date of this notification."

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 having not complied with the DRA requirement of submitting quality data (OASIS). As published in the recent HH PPS payment update final regulation for 2009, in order to receive full home health prospective payment system (HH PPS) payments in CY [insert upcoming year], HHAs were to have submitted OASIS data for episodes beginning on or after July 1, [insert previous year] and *on or* before June 30, [insert current year].

CMS has reviewed the *documentation you provided* and have 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 (OASIS) during the period described above. *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."