CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3533	**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
D	10/120/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. 100-04	Transmittal: 3533	Date: May 27, 2016	Change Request: 9651

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EFFECTIVE DATE: August 30, 2016

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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 Request 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	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9651 - 04.1	The contractor shall refer to Pub. 100-22, chapter 3, section 70 for instructions regarding the HH 2% payment reduction process. Note: The instructions in Pub. 100-04, chapter 10, section 120 are removed.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9651 - 04.2	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): Michelle Brazil, michelle.brazil@cms.hhs.gov (For Pub. 100-22) , Wil Gehne, wilfried.gehne@cms.hhs.gov (For Pub. 100-04)

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