CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-22 Medicare Quality Reporting Incentive Programs	Centers for Medicare & Medicaid Services (CMS)
Transmittal 45	**Date: June 24, 2015**
	Change Request 9091

Transmittal 39, dated March 6, 2015, is being rescinded and replaced by Transmittal 45 to revise incorrect email address in the IOM. All other information remains the same.

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

I. SUMMARY OF CHANGES: Penalties for Failure to Report

For fiscal year 2014, and each subsequent year, if a hospice agency does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that fiscal year. Application of the 2% reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

Every year, CMS will provide Medicare contractors with a Technical Direction Letter (TDL) identifying hospice agencies who did not meet 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. For calendar year 2014, CMS considers Hospice Item Set data submitted by the Hospices to CMS for reporting periods beginning on or after July 1, 2014 through December 31, 2014 as meeting the reporting requirements. For calendar year 2015 and subsequent years, CMS considers Hospice Item Set data submitted by the Hospices to CMS for reporting periods beginning on or after January 1, through December 31 as meeting the reporting requirements for that year.

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79, FR 50487), CMS finalized that hospices that receive notification of certification on or after November 1 of the preceding year involved are excluded from any payment penalty for quality reporting purposes for the following FY. This requirement was codified at §418.312.

EFFECTIVE DATE: June 8, 2015 - Non systems change
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 8, 2015 - Non systems change

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	40/Payments to Hospice 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: 45	Date: June 24, 2015	Change Request: 9091

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

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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. 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 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 would not be cumulative or be taken into account in computing the payment amount for subsequent FYs.

B. Policy: Section 3004(c) of the Affordable Care Act amended section 1814(i)(5) of the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with fiscal year (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 FY. 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 would not be cumulative or 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. The data must be submitted in a form, manner, and at a time specified by the Secretary.

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	
9091.1	Medicare contractors shall send hospices **initial notification letters** using the model language to indicate whether the hospice was non-compliant with regard to Hospice Quality Reporting no later than 10			X						CCSQ

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	business days from the receipt of the Technical Direction Letter that provides the list of hospices potentially subject to reductions.									
9091.2	Once all noncompliant hospices have been notified the MACs shall send a report to the CMS COR for the Hospice Quality Reporting Program.			X						CCSQ
9091.3	Medicare Administrative Contractor (MAC) shall include within the report, the provider name, provider CCN, provider address, provider contact name, and date of notification.			X						CCSQ
9091.4	Medicare contractors shall send hospices **dispute notification letters** using the model language to indicate the CMS decision in regards to the reconsideration process no later than 10 business days from the receipt of the Technical Direction Letter that provides the list of hospices subject to reductions.			X						CCSQ
9091.4.1	Contractors shall send this second letter only to hospices that request a reconsideration.			X						CCSQ
9091.5	Medicare contractors shall insert the correct (upheld or reversed) CMS provided model language statement with regard to the reconsideration determination in the dispute determination letters.			X						CCSQ
9091.6	Following the reconsideration process, CMS will provide the Medicare contractors with a **final** list of hospices that failed to comply with the data submission requirements. Medicare contractors shall update the hospice provider file based on the final APU determination decision as provided on the final list.			X						CCSQ

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
9091.7	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, 410-786-1648 or Michelle.Brazil@cms.hhs.gov

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.45, Issued: 06-24-15)

Transmittals for Chapter 3

40 – Payments to Hospice Agencies That Do Not Submit Required Quality Data

(Rev.45, Issued: 06-24-15, Effective: 06-08-15, Implementation: 06-08-15)

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

Penalties for Failure to Report

For fiscal year 2014, and each subsequent year, if a hospice agency does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that fiscal year. Application of the 2% reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

Every year, CMS will provide Medicare contractors with a Technical Direction Letter (TDL) identifying hospice agencies who did 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. For calendar year 2014, CMS considers Hospice Item Set data submitted by the Hospices to CMS for reporting periods beginning on or after July 1, 2014 through December 31, 2014 as meeting the reporting requirements. For calendar year 2015 and subsequent years, CMS considers Hospice Item Set data submitted by the Hospices to CMS for reporting periods beginning on or after January 1, through December 31 as meeting the reporting requirements for that year.

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79, FR 50487), CMS finalized that hospices that receive notification of certification on or after November 1 of the preceding year involved are excluded from any payment penalty for quality reporting purposes for the following FY. This requirement was codified at §418.312.

Each spring, Medicare contractors with hospice workloads will receive a technical direction letter (TDL), which provides a list of hospices that have not submitted the required hospice quality reporting data during the established timeframes. The contractor shall notify the hospice that they have been identified as not complying with the requirements of submitting quality data and are scheduled to have Medicare payments to their agency reduced by 2 percentage points. Medicare contractors shall include the model language at the end of this section in their initial notification letter to the hospices. The notification letter shall inform the hospice whether they were identified as not complying with the hospice quality reporting requirements. The notification letter shall also inform the hospice regarding the process to dispute their payment reduction if they disagree with the determination. The reconsideration process shall be outlined within the initial notification letter. Contractors shall send the notification letters no later than 10 business days from the receipt of the TDL.

CMS will then review all reconsideration requests received and provide a determination to the Medicare contractor typically within a period of 2 to 3 months. In its review of the hospice documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the hospice. The determination will be made based solely on the documentation provided. 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.

After the reconsideration process has occurred and prior to October 1 of each FY, CMS will provide the

*Medicare contractors with a **final** list of hospices that failed to comply with the data submission requirements. The Medicare contractors will then be responsible for notifying each hospice that failed to comply with the quality data submission requirements that it will receive a 2 percentage point reduction in payment. The Medicare contractors will also update the hospice provider file based on the appropriate scenarios listed below. Medicare contractors shall include the model language at the end of this section in the dispute notification letter to the hospices. Contractors shall send this second letter only to hospices that requested a reconsideration. Additionally, the Medicare contractors shall include information regarding the hospices right to further appeal the 2% reduction via the Provider Reimbursement Review board (PRRB) appeals process. Contractors shall send the notification letters no later than 10 business days from the receipt of the TDL.*

The Medicare contractor shall update (or not update) the hospice provider file based on the appropriate scenario listed below:

Upheld

• If the hospice was notified that it was potentially subject to the 2% reduction, and did not request a reconsideration, then the Medicare contractor shall set a quality reporting indicator in the provider file that triggers Medicare systems to calculate the 2% reduction on all of the hospice's claims for the upcoming fiscal year.

• If the hospice was notified that it was potentially subject to the 2% reduction, and requested a reconsideration, but on reconsideration CMS upheld the decision to apply the 2% reduction, then the Medicare contractor shall set a quality reporting indicator in the provider file that triggers Medicare systems to calculate the 2% reduction on all of the hospice's claims for the upcoming fiscal year.

Reversed

• If the hospice was notified that it was potentially subject to the 2% reduction, and requested a reconsideration, and on reconsideration CMS determined that the hospice should not be subject to the 2% reduction (i.e., reversed its decision), then the Medicare contractor shall not update the quality reporting indicator in the hospice's provider file and shall notify the hospice that they will receive their full hospice PPS payment update for the upcoming fiscal year.

• If the hospice submitted the necessary Hospice Quality Reporting data and was never notified that it might potentially be subject to the 2% reduction, then the Medicare contractor shall take no action regarding the quality reporting indicator in the hospice's provider file.

Model language for initial notification letters:

*"This letter is to officially notify you that (**Facility Name**, CMS Certification Number **000000)** did not meet the Hospice Quality Reporting (QRP) requirements for Fiscal Year (FY) (insert upcoming year).*

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79, FR 50486, 50487), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the submission of six NQF endorsed measures and one modified measure for hospice. Submission of admission and discharge data collected via the Hospice Item Set (HIS) from July 1, (insert past year) through December 31, (insert past year) and reported by April 1, (insert current year) was required in order to meet the quality reporting requirements for hospices for the FY (insert upcoming year) payment determination.

CMS required regular and ongoing electronic submission of HIS data for each patient admission to

hospice on or after July 1, 2014, regardless of payer or patient age (78 FR 48234, 48258). CMS has determined that this hospice is subject to a 2% reduction in the FY (insert upcoming year) Annual Payment Update (APU) for failure to meet quality reporting requirements pursuant to the Affordable Care Act Section 3004 because of the following reason(s):

- *Hospice failing to report quality data via the HIS in (insert past year)*

You have the right to request a reconsideration of this decision. If you choose to request a reconsideration of this decision, you must submit the request no later than 30 days following the receipt of this letter. Hospices that wish to request reconsideration are required to submit a request via email to the following address: HospiceQRPReconsiderations@cms.hhs.gov. Reconsideration requests submitted through any other method will not be accepted.

The request must include the following information:

- *The Hospice CMS Certification Number (CCN),*
- *The Hospice business name,*
- *The Hospice business address,*
- *The Administrator contact information, including name, email address, telephone number, and physical mailing address; or,*
- *The hospice may provide contact information for an Administrator-designated representative, to include name, email address, telephone number, and physical mailing address; and,*
- *The reason(s) for requesting reconsideration.*

The request for reconsideration must be accompanied by supporting documentation demonstrating compliance. CMS will be unable to review any request that fails to provide the necessary documentation along with the request for reconsideration. Supporting documentation may include any or all of the following:

- *Email communications,*
- *Data submission reports from the Quality Improvement Evaluation System (QIES),*
- *Proof of previous waiver approval,*
- *Notification of the CCN activation letter to prove that the CCN was not activated by November 1*

Documentation that does not support a finding of compliance is as follows:

- *Evidence or admission of error on the part of hospice staff, even if the involved staff member are no longer employed by the hospice 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 hospice to perform reporting functions;*
- *Evidence of delays establishing electronic data interchange connectivity between the hospice and the Medicare claims processing contractor for the purpose of billing, since hospice quality reporting data is not dependent on billing, and;*
- *In cases where the ownership of the hospice changed during the reporting year, but the CCN of the hospice did not change evidence that failure to comply was the fault of the previous owner.*

In its review of the hospice documentation, CMS will determine whether evidence to support a finding of

noncompliance has been provided by the hospice. The determination will be made based solely on the documentation provided. CMS will not contact the hospice to request additional information or to clarify incomplete or inconclusive information. For further questions related to the reconsideration process, please refer to the following CMS hospice website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html."

Model language for dispute notification letters:

Upheld:

"Thank you for requesting a reconsideration of the determination made by the Centers for Medicare & Medicaid Services (CMS) regarding reduction to this hospice's annual update for failure to meet the requirements of the Hospice Quality Reporting Program (HQRP).

CMS reviewed the reconsideration request of this hospice and is ***upholding*** *the decision to reduce the annual payment update for Medicare payments for Fiscal Year (FY) (insert upcoming year). Our records indicate that this hospice did not provide evidence that it submitted required quality measure data during the required timeframes. Therefore, for services provided by this hospice between* ***October 1, (insert upcoming year) and September 30, (insert upcoming year)****, the annual payment update for Medicare payments for FY (insert upcoming year) will be reduced by two (2) percentage points.*

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. CMS appreciates the opportunity to respond to the reconsideration request for the HQRP. For additional concerns related to the reconsideration process, questions may be submitted to the following CMS email address: HospiceQRPReconsiderations@cms.hhs.gov."

Reversed:

"Thank you for requesting a reconsideration of the determination made by the Centers for Medicare & Medicaid Services (CMS) regarding reduction to this hospice's annual update for failure to meet the requirements of the Hospice Quality Reporting Program (HQRP).

CMS reviewed the reconsideration request and determined that this hospice ***satisfactorily met*** *the above listed requirements for the FY (insert upcoming year) payment determination. Therefore, the two (2) percentage point reduction to the FY (insert upcoming year) market basket update for failure to comply with quality reporting requirements will not be applied.*

CMS appreciates the opportunity to respond to this reconsideration request for the HQRP. For additional concerns related to the reconsideration process, questions may be submitted to the following CMS email address: HospiceQRPReconsiderations@cms.hhs.gov."