CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1647	**Date: December 12, 2008**
	Change Request 6286

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

I. SUMMARY OF CHANGES: This transmittal revises the home health agency billing chapter to include the pay-for-reporting requirements created by the Deficit Reduction Act of 2005.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: March 16, 2009

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	10/10.1.6/Split Percentage Payment of Episodes and Development of Episode Rates
R	10/10.1.7/Basis of Medicare Prospective Payment Systems and Case-Mix
N	10/120/Payments to Home Health Agencies That Do Not Submit Required Quality Data

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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: 1647	Date: December 12, 2008	Change Request: 6286

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

Effective Date: January 1, 2007
[Note: Unless otherwise specified, the effective date is the date of service.]

Implementation Date: March 16, 2009

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 this process, this transmittal adds the steps outlined in the earlier RUNs and JSM/TDLs to the Medicare Claims Processing 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

Use "Shall" to denote a mandatory requirement

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	
6286.1	Upon receipt of the annual list of providers who have not submitted OASIS data, 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.	X				X					
6286.2	If any claims are found in requirement 6286.1, Medicare contractors shall notify the provider in writing of their 2% payment reduction for the upcoming year, using the model language provided in the Medicare Claims Processing Manual, chapter 10, section 120.	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	
6286.3	Medicare contractors shall report to the CMS contacts on each year's JSM/TDL the agencies which received written notice of a 2% reduction.	X				X					
6286.4	Immediately after the submission period closes, Medicare contractors shall transmit to CMS all timely documentation submitted by HHAs that dispute their 2% reduction.	X				X					
6286.5	Medicare contractors shall notify HHAs of the result of CMS research of disputes using the model language provided in the Medicare Claims Processing Manual, chapter 10, section 120.	X				X					
6286.6	Medicare contractors shall update HHA provider files to reflect whether the HHA has submitted the required quality data.	X				X					
6286.6.1	If an HHA is identified as having submitted claims but not submitted quality data, Medicare contractors shall set an indicator of "2" in the "Federal PPS Blend Indicator" field of the provider file.	X				X					
6286.6.2	If an HHA is identified as having submitted claims but not submitted quality data and also is not eligible to receive RAP payments, Medicare contractors shall set an indicator of "3" in the "Federal PPS Blend Indicator" field of the provider file. **NOTE:** These HHAs will have an indicator of "1" in this field for the preceding year.	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:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6286.1 through 6286.6.2	Currently, this process is only performed by RHHIs, but by the 2010 rate update cycle certain RHHI workloads may have transitioned to MACs. MACs should be aware of these requirements, though no action is required for payments in calendar year 2009.

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 (SOW). 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.

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 1647, 12-12-08)

10.1.6 - Split Percentage Payment of Episodes and Development of Episode Rates

(Rev.1647, Issued: 12-12-08, Effective: 01-01-07, Implementation: 03-16-09)

A split percentage payment *is* made for most *HH PPS* episode periods. There *are* two payments (initial and final). The first paid in response to a Request for Anticipated Payment (RAP), and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible payment for the episode. There are two exceptions to split payment, the No-RAP LUPA, discussed in §§10.1.18 and 40.3 in this chapter, and the RAPs paying zero percent as discussed in §10.1.12 in this chapter.

There *is* a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments *is* 60 percent in response to the RAP, and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments *is* 50 percent of the estimated casemix adjusted episode payment.

There is no set length required for a gap in services between episodes for a following episode to be considered initial rather than subsequent. If any gap occurs, the next episode *is* considered initial for payment purposes.

Payment rates for HH PPS episodes were developed from audited cost reports of previous years' data, from claims for each of the six home health visit disciplines and other services delivered by HHAs. These amounts were updated for inflation, and also include:

- Nonroutine medical supplies, even those that could have been unbundled to Medicare Part B;
- Therapy services that could have been unbundled to Part B; and
- Adjustments for OASIS reporting costs, both one time and ongoing.

After these adjustments, the resulting rates were further standardized so that case-mix and wage indexing could be appropriately applied, adjusted for budget neutrality, and then reduced to allow for a pool for outlier payments.

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. This reduction process is described in section 120 of this chapter.

New payment rates *for each calendar year* are issued annually in a Recurring Update Notification instruction. *This Notification includes both the national standard rates and the rates for agencies that did not submit required quality data.*

10.1.7 - Basis of Medicare Prospective Payment Systems and Case-Mix

(Rev.1647, Issued: 12-12-08, Effective: 01-01-07, Implementation: 03-16-09)

There are multiple prospective payment systems (PPS) for Medicare for different provider types. Before 1997, prospective payment was a term specifically applied to inpatient hospital services. In 1997, with passage of the Balanced Budget Act, prospective payment systems were mandated for other provider groups/bill types:

- Skilled nursing facilities;
- Outpatient hospital services;
- Home health agencies;
- Rehabilitation hospitals; and
- Others.

While there are commonalities among these systems, there are also variations in how each system operates and in the payment units for these systems. HH PPS is the only system with the 60-day episode as the payment unit.

The term prospective payment for Medicare does not imply a system where payment is made before services are delivered, or where payment levels are determined prior to the providing of care. With HH PPS, at least one service must be delivered before billing can occur. For HH PPS, a significant portion for the 60-day episode unit of payment *is* made at the beginning of the episode with as little as one visit delivered. HH PPS also means a shift of the basis of payment from payment tied to a claim or distinct revenue or procedural code, to an episode.

Case-mix is an underlying concept in prospective payment. With the creation of inpatient hospital PPS, the first Medicare PPS, there was a recognition that the differing characteristics of hospitals, such as teaching status or number of beds, contributed to substantial cost differences, but that even more cost impact was linked to the characteristics of the patient populations of the hospitals. Other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care, use this concept of case-mix complexity, meaning that patient characteristics affect the complexity, and therefore, cost of care. HH PPS considers a patient's clinical and functional condition, as well as service demands, in determining case-mix for home health care.

For individual Medicare inpatient acute care hospital bills, DRGs are produced by an electronic stream of claim information, which includes data elements such as procedure and diagnoses, through Grouper software that reads these pertinent elements on the claim and groups services into appropriate DRGs. DRGs are then priced by a separate Pricer software module at the Medicare claims processing contractor. Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs. In HH PPS, 60-day episode payments are case-mix adjusted using elements of the patient assessment.

Since 1999, HHAs have been required by Medicare to assess potential patients, and reassess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case-mix adjusted episode payment is based on elements of the OASIS data set including the therapy visits provided over the course of the episode. The number of therapy visits projected at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted on the claim for the episode. Though therapy visits are adjusted only with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mix adjusted based on Grouper software run by the HHAs, often incorporated in the HAVEN software supporting OASIS. Pricer software run by the Medicare contractor processing home health claims performs pricing including wage index adjustment on both episode split percentage payments.

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

(Rev.1647, Issued: 12-12-08, Effective: 01-01-07, Implementation: 03-16-09)

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. 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.*

If the contractor finds any such claims, they 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.

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 day period to submit documentation to support a finding of compliance. If

the contractor receives documentation within the allowed timeframe, the documentation should be forwarded to the CMS contacts noted in the TDL immediately following the close of the submission period. CMS will re-examine OASIS submission data and provide a determination to the Medicare contractor within 30 days.

If the CMS determination upholds the 2% reduction, 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.

If the CMS determination upholds the 2% reduction, or 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 finds that the HHA has been identified for the 2% reduction in error, the contractor shall not update their provider file for the HHA and shall notify the HHA of the determination.

Model language for initial notification letters:

"This letter is to officially inform you that your home health agency (HHA) has been identified as being subject to a reduction in payment for not meeting the Deficit Reduction Act (DRA) of 2005 provision requiring HHAs to submit quality data. Therefore, your agency is scheduled to have Medicare payments reduced by 2% for [insert upcoming year].

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 CoPs and have been identified for this payment reduction in error, you must submit documentation in writing demonstrating your submission of OASIS data and your rationale for being in compliance. This documentation will be directed to CMS for review. Send your written requests for this review 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 dispute 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 before June 30, [insert current year].

We have reviewed the facts at issue 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, and published in the final rule. 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."