CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-22 Medicare Quality Reporting Incentive Programs	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 52	**Date: December 18, 2015**
	Change Request 9460

SUBJECT: Fiscal Year 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR9091.

I. SUMMARY OF CHANGES: This Change Request revises Pub. 100-22, Medicare Quality Reporting Incentive Programs, Chapter 3, Section 40, to reflect changes to the payment reduction reconsideration process. It also includes general clarifications to the section.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 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
R	3/40/Fiscal Year 2017 and After 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:

Recurring Update Notification
Manual Instruction

Attachment - Recurring Update Notification

Pub. 100-22	Transmittal: 52	Date: December 18, 2015	Change Request: 9460

SUBJECT: Fiscal Year 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR9091.

EFFECTIVE DATE: January 1, 2016
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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. For payments in fiscal years 2014 through 2016, this requirement was limited to the reporting of Hospice Item Set (HIS) data. Effective for payments in fiscal year 2017 and after, the requirement also includes submission of Hospice Consumer Assessment of Health Providers and Systems (CAHPS®) Survey data.

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.

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	
9460.1	Medicare contractors shall send hospices initial notification letters that indicate whether the hospice was non-compliant with regard to HIS reporting, hospice CAHPS survey reporting, or both no later than 10 business days from the receipt of the Technical Direction Letter that provides the list of hospices potentially subject to reductions.			X						CCSQ

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9460.2	Medicare contractors shall use the model language to indicate whether the hospice was noncompliant with regard to Hospice Quality Reporting.			X						CCSQ
9460.3	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
9460.4	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
9460.5	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
9460.6	Contractors shall send this second letter only to hospices that requested a reconsideration.			X						CCSQ
9460.7	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
9460.8	Following the reconsideration process, CMS will provide the Medicare contractors with a final list of hospices that failed to comply with the data reporting 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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9460.9	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.52, Issued: 12-18-15)

Transmittals for Chapter 3

40 – Fiscal Year 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data

(Rev. 52, Issued: 12-18-15, Effective: 01-01-2016, Implementation: 04-01-16)

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Agencies. In 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. CMS considers the following data as meeting the reporting requirement:

- HIS data submitted by hospices for all patient admissions beginning on or after January 1 through December 31, and
- Hospice CAHPS® Survey monthly data collection and submission from January 1 through December 31.

NOTE: Reporting requirements consider data reporting by hospices beginning January 1, 2015 through December 31, 2015 for fiscal year 2017 and after.

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 2percentage point 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) which provides a list of hospice agencies that have not submitted the required HIS and/or hospice CAHPS survey data during the established timeframes. 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 and Hospice CAHPS® survey data submitted by 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 being in compliance with the HIS data requirement, the Hospice CAHPS survey data requirement or both. 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.

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 hospice 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.

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-percentage point 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-percentage point 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.

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

If the CMS determination reverses the 2-percentage point reduction, the contractor shall not update their provider file for the hospice and shall notify the hospice that they will receive their full Hospice PPS payment update for the upcoming year.

Model language for initial notification letters:

*"This letter is to officially notify you that (**Facility Name**, CMS Certification Number **000000)** is subject to a reduction in payment for not meeting the Affordable Care Act (ACA) of 2010 requirement for hospices to submit quality data. Therefore, Medicare payments to your agency will be reduced by 2 percentage points 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 Hospice Item Set (HIS) data and timely submission of Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey data. CMS review of HIS and Hospice CAHPS® Survey submissions for this period found that your agency is noncompliant for the reporting requirements for [insert whether the hospice was non-compliant with HIS, Hospice CAHPS®, or both].*

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 an email requesting reconsideration and provide documentation demonstrating your compliance. 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.

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,*
- *Evidence of HIS transmissions during the reporting period (e.g. an HIS Final Validation Report from the CASPER system showing a timely submission date);*
- *For HIS reporting, proof of previous exemption/extension approval for the prescribed reporting period.*
- *For hospices that have served fewer than 50 survey-eligible decedents/caregivers during the reporting period, evidence that the hospice filed the Participation Exemption Request Form by the deadline date and received approval from CMS.*
- *Notification of the CCN activation letter to prove that the CCN was not activated by November 1st.*
- *Evidence that the hospice continuously collected data and submitted data to the CAHPS® Hospice Survey Data Warehouse during the required timeframe.*

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.*

Your letter and documentation must be submitted via email to CMS for reconsideration, using the following email address: HospiceQRPReconsiderations@cms.hhs.gov.

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 HIS documentation in response to a Hospice CAHPS® 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 hospice (do not combine requests or attach a list of hospice provider numbers to a request);*
- *If requesting a Hospice CAHPS® reconsideration regarding a participation exemption, provider specific information detailing why your hospice had no eligible patients.*

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."

A hospice 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)."

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-percentage point 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 percentage point 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 percentage point reduction, and requested a reconsideration, but on reconsideration CMS upheld the decision to apply the 2 percentage point reduction, then the Medicare contractor shall set a quality reporting indicator in the provider file that

triggers Medicare systems to calculate the 2 percentage point 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 percentage point reduction, and requested a reconsideration, and on reconsideration CMS determined that the hospice should not be subject to the 2 percentage point 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 percentage point reduction, then the Medicare contractor shall take no action regarding the quality reporting indicator in the hospice's provider file.

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 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 quality data 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."