CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-22 Medicare Quality Reporting Incentive Programs	Centers for Medicare & Medicaid Services (CMS)
Transmittal 55	**Date: March 4, 2016**
	Change Request 9544

SUBJECT: Fiscal Year 2017 and After Payments to Long Term Care Hospitals That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR 9105.

I. SUMMARY OF CHANGES: This Change Request revises Pub. 100-22, Medicare Quality Reporting Incentive Programs, Chapter 3, Section 60, 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	3/60/Fiscal Year 2017 and After Payments to Long Term Care Hospitals (LTCHs) 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

Attachment - Recurring Update Notification

Pub. 100-22	Transmittal: 55	Date: March 4, 2016	Change Request: 9544

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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 long term care hospitals (LTCHs). Section 1886 (m)(5)(A)(i) of the Act requires application of a 2% reduction of the applicable market basket increase factor for LTCHs that fail to comply with the quality data submission requirements. FY 2014 was the first year that the mandated reduction was applied for LTCHs that failed to comply with the data submission requirements during the data collection period October 1, 2012 through December 31, 2012.

B. Policy: Beginning with fiscal year 2014, and each subsequent year, if an LTCH 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.

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	
9544.1	Medicare contractors shall send LTCHs initial notification letters that indicate whether the LTCH was non-compliant with regard to LTCH Quality Reporting no later than 10 business days from the receipt of the Technical Direction Letter that provides the list of LTCHs potentially subject to reductions.	X								
9544.2	Medicare contractors shall use the model language found in Pub. 100-22, chapter 3, section 60 when issuing notification letters.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9544.3	Once all noncompliant LTCHs have been notified, the MACs shall send a report to the CMS COR for the LTCH Quality Reporting Program.	X								
9544.4	The Medicare Administrative Contractor (MAC) shall include, within the report, the provider name, provider CCN, provider address, provider contact name, and date of notification.	X								
9544.5	Medicare contractors shall send LTCHs 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 LTCHs subject to reductions.	X								
9544.6	Contractors shall send this second letter only to LTCHs that requested a reconsideration.	X								
9544.7	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								
9544.8	Following the reconsideration process, CMS will provide the Medicare contractors with a **final** list of LTCHs that failed to comply with the data submission requirements. Medicare contractors shall update the LTCH provider file based on the final APU determination decision as provided on the final list.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9544.9	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): Christine Grose, 410-786-1362 or christine.grose@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.55, Issued: 03-04-16)

Transmittals for Chapter 3

60 – Fiscal Year 2017and After Payments to Long Term Care Hospitals (LTCHs) That Do Not Submit Required Quality Data

60 – *Fiscal Year 2017 and After* Payments to *Long Term Care Hospitals* (LTCHs) That Do Not Submit Required Quality Data

(Rev.55, Issued: 03-04-16, Effective: 01-01-16),

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs. *Beginning with fiscal year 2014, and each subsequent year, if an LTCH does not submit required quality data, their payment rates for the year are reduced by two (2) percentage points for that fiscal year.*

Penalties for Failure to Report

For fiscal year 2014, and each subsequent year, if an LTCH does not submit required quality data, their payment rates for the year are reduced by two (2) percentage points for that fiscal year. Application of the 2 percentage 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, *in late spring/summer*, CMS will provide Medicare contractors with a Technical Direction Letter (TDL) identifying LTCHs not meeting the quality data reporting requirements. The contractor shall notify the LTCHs that they have been identified as not complying with the requirements of submitting quality data and are scheduled to have Medicare payments to their facility 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 LTCHs. The notification letter shall inform the LTCH whether they were identified as not complying with the LTCH quality reporting requirements. The notification letter shall also inform the LTCH regarding the process to request a reconsideration of 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. 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 LTCH documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the LTCH. 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 second TDL that includes the **final** list of LTCHs that failed to comply with the data submission requirements. The Medicare contractors *will then be responsible for notifying each LTCH that failed to comply with the quality data submission requirements that it will receive a 2 percentage point reduction in the annual payment update. The Medicare contractors will also update the LTCH 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 LTCHs. Contractors shall send this second letter only to LTCHs that requested reconsideration. Additionally, the Medicare contractors shall include information regarding the LTCH's right to further appeal the 2 percentage point reduction via the Provider Reimbursement Review board (PRRB) appeals process. Contractors shall send these second notification letters no later than 10 business days from the receipt of the TDL.*

If the LTCH does not dispute their reduction, the Medicare contractor shall update their provider file for the LTCH. 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 fiscal 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 LTCH and shall notify the LTCH that they will receive their full LTCH 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 LTCHs to submit quality data. Therefore, Medicare payments to your agency will be reduced by two (2) percentage points for [insert upcoming year], unless you can provide evidence that this determination is in error. CMS updates the requirements and the quality reporting measures required for the LTCH Quality Reporting Program (QRP) annually through rulemaking.*

CMS has determined that this LTCH 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):

- *The LTCH failed to submit the required data to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN); and/or*
- *The LTCH failed to submit the required quality measures that are to be submitted to the CMS Quality Improvement Evaluation System (QIES) system.*

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 LTCH CMS Certification Number (CCN);*
- *The LTCH business name;*
- *The LTCH business address;*
- *The CEO or CEO-designated representative contact information including name, email address, telephone number, and physical mailing address;*
- *The CMS identified reason(s) for non-compliance from the non-compliance notification letter;*
- *Information supporting the LTCH belief that non-compliance is in error, or evidence of the impact of extraordinary circumstances which prevented timely submission of data.*

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 communication;*
- *Data submission reports from the Quality Improvement Evaluation System (QIES);*
- *Data submission reports from the National Healthcare Safety Network (NHSN);*
- *Proof of previous waiver approval;*
- *Notification of the CCN activation letter to prove that the CCN was not activated by the end of the reporting quarter;*
- *Other documentation that may support the rationale for seeking reconsideration.*

Please ensure that NO protected health information (PHI) is included in the documentation being submitted for review.

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

- *Evidence or admission of error on the part of LTCH staff, even if the involved staff members are no longer employed by the LTCH 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 LTCH to perform reporting functions; and,*
- *Evidence of delays establishing electronic data interchange connectivity between the LTCH and the Medicare claims processing contractor for the purpose of billing, since LTCH quality reporting data is not dependent on billing.*

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

In its review of the LTCH documentation, CMS will determine whether evidence to support a finding of noncompliance has been provided by the LTCH. The determination will be made based solely on the documentation provided. CMS will not contact the LTCH 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 LTCH website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Reconsideration-and-Exception-and-Extension.html

An LTCH 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 LTCH provider file based on the appropriate scenario listed below:

Upheld

• If the LTCH was notified that it was potentially subject to the 2 percentage point reduction, and did not request 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 LTCH's claims for the upcoming fiscal year.

• If the LTCH 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 LTCH's claims for the upcoming fiscal year.

Reversed

• If the LTCH was notified that it was potentially subject to the 2 percentage point reduction, and requested a reconsideration, and on reconsideration CMS determined that the LTCH 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 LTCH's provider file and shall notify the LTCH that they will receive their full LTCH PPS payment update for the upcoming fiscal year.

• If the LTCH submitted the necessary LTCH 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 LTCH's provider file.

Model language for dispute notification letters (LTCH provider notification instructions contained in second TDL):

Upheld:

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

CMS reviewed the reconsideration request of this LTCH 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 LTCH did not provide evidence that it submitted required quality data during the required timeframes. Therefore, for services provided by this LTCH 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 facility 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. Details are available on the CMS.gov PRRB Review Instructions website.

CMS appreciates the opportunity to respond to the reconsideration request for the LTCH QRP. For additional concerns related to the reconsideration process, questions may be submitted to the following CMS email address: LTCHQRPReconsiderations@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 LTCH's annual payment update for failure to meet the requirements of the LTCH Quality Reporting Program (QRP).

CMS reviewed the reconsideration request and determined that this LTCH ***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) annual payment 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 LTCH QRP. For additional concerns related to the reconsideration process, questions may be submitted to the following CMS email address: LTCHQRPReconsiderations@cms.hhs.gov."