CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-22 Medicare Quality Reporting Incentive Programs	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 42	**Date: May 1, 2015**
	Change Request 9105

SUBJECT: Payments to Long Term Care Hospitals that Do Not Submit Required Quality Data

I. SUMMARY OF CHANGES: For fiscal year 2014, and each subsequent year, if an LTCH 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 LTCHs not meeting the quality data reporting requirements. Contractors must update the quality indicator in the Provider Outpatient Specific File for each identified, LTCH agency subject to the payment reduction.

EFFECTIVE DATE: September 2, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 2, 2015

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/Table of Contents
N	3/60 /Payments to Long Term Care Hospitals 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: 42	Date: May 1, 2015	Change Request: 9105

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EFFECTIVE DATE: September 2, 2015
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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 LTCHs. Section 1886(m)(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 LTCH 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 1886(m)(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: Beginning with FY 2016 and subsequent years, MACs 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 agency reduced by 2 percentage points.

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	
9105.1	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								
9105.2	Medicare contractors shall use the model language found in Pub. 100-22, chapter 3, section 60 when issuing notification letters.	X								
9105.3	Once all noncompliant LTCHs have been notified, the MACs shall send a report to the CMS COR for the LTCH Quality Reporting Program.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9105.4	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								
9105.5	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 specific file based on the final list.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9105.6	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): Roxanne Dupert-Frank, 410-786-9667 or Roxanne.Dupert-Frank@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.42, Issued: 05-01-15)

60 – Payments to LTCHs That Do Not Submit Required Quality Data

(Rev. 42, Issued: 05-01-15, Effective: 09-02-15, Implementation: 09-02-15)

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

Penalties for Failure to Report

For fiscal year 2014, and each subsequent year, if an LTCH 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 LTCHs not meeting the quality data reporting requirements. Contractors must update the quality indicator in the Provider Specific File for each identified, LTCH agency subject to the payment reduction.

Medicare contractors will receive a technical direction letter (TDL), which provides a list of LTCHs that have not submitted the required LTCH quality reporting data during the established timeframes. The contractor shall notify the LTCH 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 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.

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% 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 LTCHs that failed to comply with the data submission requirements. The Medicare contractors shall update the LTCH provider file based on the appropriate scenarios listed below.*

Upheld

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

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

Reversed

• If the LTCH was notified that it was potentially subject to the 2% reduction, and requested a reconsideration, and on reconsideration CMS determined that the LTCH 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 LTCH's provider specific 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% reduction, then the Medicare contractor shall ensure that the indicator value does not apply the reduction.

Model language for initial notification letters:

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

In the FY2013 Hospital IPPS/LTCH PPS Final Rule, 77 FR 53614-53637, published August 31, 2012, CMS finalized the LTCH QRP quality reporting requirements for the FY 2015 payment. Each subsequent year, CMS has updated the requirements and the quality reporting measures required for the LTCH QR Program. 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; and/or*
- *The LTCH failed to submit the required quality measures that are to be submitted to the CMS QIES system.*

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. LTCHs that wish to request reconsideration are required to submit a request via email to the following address: LTCHQRPReconsiderations@cms.hhs.gov.

The request must include the following information:

- *The LTCH CMS Certification Number (CCN);*
- *The LTCH Business Name;*
- *The LTCH Business Address;*
- *The CEO contact information including name, e-mail address, telephone number and physical mailing address; or*
- *The LTCH may provide CEO-designated representative contact information including name, title, e-mail address, telephone number and physical mailing address; and*
- *CMS identified reason(s) for non-compliance from the non-compliance notification*
- *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:

- *Proof of Submission;*
- *E-mail communications;*
- *Data submission reports from the Quality Improvement Evaluation System (QIES);*
- *Data submission reports from the 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; or*
- *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 member 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;*

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: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Reconsideration-and-Disaster-Waiver-Requests.html