Medicare Quality Reporting Incentive Programs Manual

Chapter 3 – Contractor Incentive Program Payment Operational Instructions

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(Rev. 12293; Issued: 10-12-23)

Transmittals for Chapter 3

10 - Foreword
(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

Generally, this chapter describes the yearly payment instructions used by the Medicare contractors when making incentive payments described in this manual (the Medicare Quality Reporting Incentives Manual, Internet Only Manual Publication 100-22).

20 - Contractor Payment Instructions for the Physician Quality Reporting System (PQRS)
(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

The Medicare contractors will receive recurring update notification change requests for PQRS incentive payments. For additional information on this program, see Chapter 1 of this manual.

Contractors shall make the PQRS incentive payments to a group practice, or individual for a private practice, associated with the Tax Identification Number (TIN) identified on the PQRS Incentive Payment file. There will be an annual payment file, developed by a CMS specialty contractor, containing the following information:

- Eligible Professional (EP) Contractor Number
- EP Tax ID Number
- EP Incentive Amount
- Incentive Report Start Date
- Incentive Report End Date

The CMS specialty contractor shall include a header record on the payment file to identify the type of incentive file and reporting period. PQ denotes PQRS. The file transfer process is as follows: (1) The specialty contractor shall transmit the Incentive Payment file to the CDS and HP EDC in Extended Binary Coded Decimal Interchange Code (EBCDIC); (2) MCS shall segregate the Incentive Payment file MAC/carrier workload number and load into the appropriate instance of MCS; (3) Contractors shall retrieve the file upon direction from CMS after the file is available at the datacenter.

The time frame that Medicare contractors have for completing the PQRS Incentive payments is approximately thirty calendar days. The exact payment beginning and end dates will be in the recurring update notification. There are 4 possible payment months each year: May, August, September, and October. CMS shall add, at its discretion, up to (1) one extra payment cycle per payment year. The Carrier/MACs will be notified via a recurring update notification change request which month the respective incentive payments shall be made. Also, there is the potential for a supplemental payment file that could be provided at a later date, if CMS determines a need for making a supplemental payment. If needed, a supplemental payment would be made in one of these 4 payment months.

20.1 - PQRS Remittance Instructions
(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)
The paper remit for PQRS payments are to have the following explanatory message: "This is a PQRS incentive payment." The Medicare contractors have the ability to revise and/or update this message when CMS deems necessary.

The PLB 03-1 segment of the outgoing electronic remittance will be annotated with "LE". The incentive type year indicator from the header record of the PQRS payment file will be used to populate the PLB 03-2 segment of the outgoing remittance notice. For example: The incentive type year indicator from the header record of the 2010 PQRS payment file was PQ10. Therefore, PQ10 was used to populate the PLB 03-2 segment of the outgoing remittance notice. (See CR 6559 for more information.)

20.2 - Contractor Verification and Reporting Instructions for PQRS

(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

Contractors shall verify that the PQRS Incentive payments have made it through every aspect of processing to payment, including documented confirmation that all payments have been made. Contractors shall receive Excel spreadsheets for each reporting period from CMS via an e-mail notification that lists the grand total of each contractor's incentive payments and the total number of checks each contractor shall issue. **Prior to issuing the incentive payments,** each contractor shall confirm that the grand total incentive payment amount and the total number of checks to be paid from their **FINAL** file for the incentive payment reporting period match the totals from the Excel spreadsheet. **Prior to issuing the incentive payments,** contractors shall send their findings from comparing the payment files for the reporting period to the Excel spreadsheet via email to their Contractor Manager or Project Officer as appropriate, with an informational copy to PQRS_eRx_Payment_Issues@cms.hhs.gov. Contractors shall notify CMS via email of the **date when all of the payments have been completed** for the reporting period to their Contractor Manager or Project Officer as appropriate, with a copy to PQRS_eRx_Payment_Issues@cms.hhs.gov.

Each contractor will report separate results of the incentive payments to CMS as soon as possible but no later than 30 calendar days after payments have been completed using the Incentive Payment Results Report form displayed in Exhibit 1. **NOTE:** The Incentive Payment Results Report displayed in Exhibit 1 is the only acceptable format for capturing this information. CMS will not accept any other formats. Also, contractors are to insert the change request (CR) number for the recurring update notification associated with the payment in the title of the Incentive Payment Results Report.

Once issues are identified that have prevented payment of the PQRS incentive, where possible contractors shall notify any impacted providers of the issue and the expected resolution date.

The Medicare contractors send their findings for the Incentive Payment Results Report via e-mail to their Contract Manager or Project Officer as appropriate, with an informational copy to PQRS_eRx_Payment_Issues@cms.hhs.gov. If payment issues are reported in the Incentive Payment Results Report, the Medicare contractor is required to provide updates to CMS once each week until the payment issues have been resolved.

30 - Contractor Payment Instructions for the Electronic Prescribing (eRx) Incentive Program

(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

The Medicare contractors will receive recurring update notification change requests for eRx incentive payments. For additional information on this program, see Chapter 2 of this manual.

Contractors shall make the eRx incentive payments to a group practice, or individual for a private practice, associated with the Tax Identification Number (TIN) identified on the eRx Incentive Payment file. There will be an annual payment file, developed by a CMS specialty contractor, containing the following information:

- EP Contractor Number
- EP Tax ID Number
- EP Incentive Amount
- Incentive Report Start Date
- Incentive Report End Date

The CMS specialty contractor shall include a header record on the payment file to identify the type of incentive file and reporting period. RX denotes eRx. The file transfer process is as follows: (1) The specialty contractor shall transmit the Incentive Payment file to the CDS and HP EDC in Extended Binary Coded Decimal Interchange Code (EBCDIC); (2) MCS shall segregate the Incentive Payment file MAC/carrier workload number and load into the appropriate instance of MCS; (3) Contractors shall retrieve the file upon direction from CMS after the file is available at the datacenter.

The time frame that Medicare contractors have for completing the eRx Incentive payments is approximately thirty calendar days. The exact payment beginning and end dates will be in the recurring update notification. There are 4 possible payment months each year: May, August, September, and October. CMS shall add, at its discretion, up to (1) one extra payment cycle per payment year. The Carrier/MACs will be notified via a recurring update notification change request which month the respective incentive payments shall be made. Also, there is the potential for a supplemental payment file that could be provided at a later date, if CMS determines a need for making a supplemental payment. If needed, a supplemental payment would be made in one of these 4 payment months.

30.1 - eRx Remittance Instructions

(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

The paper remit for eRx payments are to have the following explanatory message: "This is an eRx incentive payment." The Medicare contractors have the ability to revise and/or update this message when CMS deems necessary.

The PLB 03-1 segment of the outgoing electronic remittance will be annotated with "LE". The incentive type year indicator from the header record of the eRx payment file will be used to populate the PLB 03-2 segment of the outgoing remittance notice. For example: The incentive type year indicator from the header record of the 2010 eRx payment file was RX10. Therefore, RX10 was used to populate the PLB 03-2 segment of the outgoing remittance notice. (See CR 6559 for more information.)

30.2 - Contractor Verification and Reporting Instructions for eRx

(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

Contractors shall verify that the eRx Incentive payments have made it through every aspect of processing to payment, including documented confirmation that all payments have been made. Contractors shall receive Excel spreadsheets for each reporting period from CMS via an e-mail notification that lists the grand total of each contractor's incentive payments and the total number of checks each contractor shall issue. **Prior to issuing the incentive payments,** each contractor shall confirm that the grand total incentive payment amount and the total number of checks to be paid from their **FINAL** file for the incentive payment reporting period match the totals from the Excel spreadsheet. **Prior to issuing the incentive payments,** contractors shall send their findings from comparing the payment files for the reporting period to the Excel spreadsheet via email to their Contractor Manager or Project Officer as appropriate, with an informational copy to PQRS_eRx_Payment_Issues@cms.hhs.gov. Contractors shall notify CMS via email of the **date when all of the payments have been completed** for the reporting period to their Contractor Manager or Project Officer as appropriate, with a copy to PQRS_eRx_Payment_Issues@cms.hhs.gov.

Each contractor will report separate results of the incentive payments to CMS as soon as possible but no later than 30 calendar days after payments have been completed using the Incentive Payment Results Report form displayed in Exhibit 1. **NOTE:** The Incentive Payment Results Report displayed in Exhibit 1 is the only acceptable format for capturing this information. CMS will not accept any other formats. Also, contractors are to insert the change request (CR) number for the recurring update notification associated with the payment in the title of the Incentive Payment Results Report.

Once issues are identified that have prevented payment of the eRx incentive, where possible contractors shall notify any impacted providers of the issue and the expected resolution date.

The Medicare contractors send their findings for the Incentive Payment Results Report via e-mail to their Contract Manager or Project Officer as appropriate, with an informational copy to PQRS_eRx_Payment_Issues@cms.hhs.gov. If payment issues are reported in the Incentive Payment Results Report, the Medicare contractor is required to provide updates to CMS once each week until the payment issues have been resolved.

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."

50 – Fiscal Year 2017 and After Payments to Inpatient Rehabilitation Facilities (IRFs) That Do Not Submit Required Quality Data

(Rev. 54, 02-19-16, Effective: 01-01-16, Implementation: 04-01-16)

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for IRFs. Beginning with fiscal year 2014, and each subsequent year, if an IRF 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 IRF 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, in late spring/summer, CMS will provide Medicare contractors with a Technical Direction Letter (TDL) identifying IRFs not meeting the quality data reporting requirements. The contractor shall notify the IRFs 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 IRFs. The notification letter shall inform the IRF whether they were identified as not complying with the IRF quality reporting requirements. The notification letter shall also inform the IRF 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 facilities 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 IRF documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the IRF. 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 IRFs that failed to comply with the data submission requirements. The Medicare contractors will then be responsible for notifying each IRF that failed to comply with the quality data submission requirements that it will receive a two (2) percentage point reduction in the annual increase factor. The Medicare contractors will also update the IRF 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 letters to the IRFs. Contractors shall send this second letter only to IRFs that requested reconsideration. Additionally, the Medicare contractors shall include information regarding the IRFs 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 IRF does not dispute their reduction, the Medicare contractor shall update their provider file for the IRF. 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 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 IRF and shall notify the IRF that they will receive their full IRF 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 IRFs to submit quality data. Therefore, Medicare payments to your facility 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 IRF Quality Reporting Program (QRP) annually through rulemaking.

CMS has determined that this IRF is subject to a 2% reduction in the FY (insert upcoming year) annual increase factor for failure to meet quality reporting requirements pursuant to the Affordable Care Act Section 3004 because of the following reason(s):

- The IRF failed to submit the required data to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN); and/or

- The IRF 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 IRF CMS Certification Number (CCN);
- The IRF business name;
- The IRF 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 IRF 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 IRF staff, even if the involved staff member are no longer employed by the IRF 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 IRF to perform reporting functions; and,
- Evidence of delays establishing electronic data interchange connectivity between the IRF and the Medicare claims processing contractor for the purpose of billing, since IRF 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: IRFQRPReconsiderations@cms.hhs.gov.

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

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

Upheld

- If the IRF was notified that it was potentially subject to the 2% 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% reduction on all of the IRF's claims for the upcoming fiscal year.

- If the IRF 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 IRF's claims for the upcoming fiscal year.

Reversed

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

- If the IRF submitted the necessary IRF 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 dispute notification letters (IRF 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 IRF's annual update for failure to meet the requirements of the IRF Quality Reporting Program (QRP).

CMS reviewed the reconsideration request of this IRF and is **upholding** the decision to reduce the annual increase factor for Medicare payments for Fiscal Year (FY) (insert upcoming year). Our records indicate that this IRF did not provide evidence that it submitted required quality data during the required timeframes. Therefore, for services provided by this IRF between **October 1, (insert upcoming year) and September 30, (insert upcoming year)**, the annual increase factor 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 IRF QRP. For additional concerns related to the reconsideration process, questions may be submitted to the following CMS email address: IRFQRPReconsiderations@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 IRF's annual increase factor for failure to meet the requirements of the IRF Quality Reporting Program (QRP).

CMS reviewed the reconsideration request and determined that this IRF **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 increase factor for failure to comply with quality reporting requirements will not be applied.

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

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, Implementation: 04-01-16)

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."

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

(Rev. 12293; Issued:10-12-23; Effective: 01-01-23; Implementation: 11-13-23)

In calendar year 2007 and each subsequent year, if a home health agency does not submit required quality data, their annual payment updates (APU) for the year are reduced by 2 percentage points. Original Medicare considers the following data as meeting the reporting requirement:

- OASIS data submitted by HHAs for all episodes beginning on or after July 1 of the previous year, and before July 1, of the current year, and

- Home Health Care Consumer Assessment of Health Providers and Systems (HHCAHPS)

monthly data collection and submission from April 1 of the prior year through March 31 of the current year.

NOTE: If agencies have *served 59 or fewer* HHCAHPS-*s*urvey *eligible* patients in the year immediately prior to the data collection year, and these agencies complete an HHCAHPS Participation Exemption Request form for the APU year associated with the data collection year, then they are exempt from HHCAHPS for the APU year. Annually, HHAs must count their patients in the year prior to the data collection year to determine if they need to do HHCAHPS data collection. The exemption form is on the HHCAHPS website, https://homehealthcahps.org. The HHCAHPS Survey eligibility criteria are listed on the HHCAHPS website: https://homehealthcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid1.

Illustration of HHCAHPS periods:

(A) Annual Payment Update Calendar Year	**(B) Did the HHA serve 60 or more HHCAHPS eligible patients in the previous year?**	**(C) If the HHA served 60 or more survey eligible patients in the previous year, then the HHA must collect HHCAHPS for the year below.**	**(D) If the HHA served 59 or less survey eligible patients in the previous year, then the HHA must complete the Participation Exemption Request form on the HHCAHPS website in the "For HHAs Only secure portal Column C". To receive an exemption, the HHA must submit a Participation Exemption Request Form by the date noted below.**
2020	April 1, 2017 - March 31, 2018	April 1, 2018 - March 31, 2019	March 31, 2019
2021	April 1, 2018 - March 31, 2019	April 1, 2019 - March 31, 2020	March 31, 2020

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 the required OASIS and/or HHCAHPS data during the established timeframes and which have submitted covered claims to Medicare during these timeframes. The list(s) provided will have the facility name, CCN, mailing information, reason for failure (OASIS or CAHPS or both) and will also provide the MAC that should be sending out the letter.

The contractor shall notify the HHAs on the list that they have been identified as not being in compliance with the requirement of submitting quality data and are scheduled to have Medicare reduce their annual payment update (APU) by two percentage points.

Medicare contractors shall include the model language at the end of this section in their notification letter to the HHA. The notification letter shall inform the HHA whether they were identified as not being in compliance with the OASIS data requirement, the HHCAHPS data requirement, or both. Contractors shall send notification letters no later than 5 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 home health 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 electronically requesting reconsideration and documentation to support a finding of compliance.

Using the model language at the end of this section contractors shall inform HHAs about documentation to support a finding of compliance.

For payments in calendar year 2011 and after, documentation of OASIS compliance may include any of the following:

- evidence of OASIS transmissions during the reporting period (e.g., an OASIS Final Validation Report from the *CMS designated data submission* system showing a timely submission date);

- for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that the HHA did not receive their CMS Certification Number (CCN) from Medicare until after the close of the reporting year (e.g., a notification letter from the survey and certification staff at the CMS RO dated after June 30);

- for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that they received their CCN too late in the reporting year for the provider to receive their permanent OASIS transmitter ID from their State OASIS Automation Coordinator and submit data (e.g., during the last week of June); or

- for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that the HHA received their CCN in the last weeks of the reporting year (e.g., in June), took prompt action to request their permanent OASIS transmitter ID from their State OASIS Automation Coordinator and were delayed by CMS or its agents.

For payments in calendar year 2012 and after, HHAs requesting reversal of the HHCAHPS decision need to include the following:

- Evidence that the HHA continuously collected data for the 12 months, and submitted data to the Home Health CAHPS Data Center during the required timeframe. The required 12 months are for April 1st through March 31st, or

- For HHAs *that have served 59 or fewer* HHCAHPS-*survey* eligible patients show evidence of their census. If the HHAs have evidence of their completion of the exemption form, then they should send a copy of their form.

The contractor shall inform HHAs that documentation of the following does not support a finding of compliance:

- evidence or admission of error on the part of HHA staff, even if the involved staff members are no longer employed by the HHA 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 HHA to perform reporting functions (the HHA is responsible for the actions of its contractors, vendors or other agents on the HHA's behalf);

- evidence of delays establishing electronic data interchange connectivity between the HHA and the Medicare claims processing contractor for the purpose of billing, since OASIS transmission is not dependent on billing and the HHA should request their OASIS transmitter ID from the State at the same time they request billing system access from the Medicare claims processing contractor; and

- in cases where the ownership of the HHA changed during the reporting year but the CCN of the HHA did not change, evidence that failure to comply was the fault of a previous owner.

Contractors should direct electronic submission of reconsideration requests and documentation to a dedicated CMS e-mail address. If a provider's documentation contains protected health information (PHI) in error, documents containing PHI should not be forwarded. CMS will review the documentation and provide a determination to the Medicare contractor as soon as possible, but typically within a period of 6-7 weeks.

The following example illustrates the timeframes for the complete process using hypothetical dates:

1) CMS issues the TDL providing the list of HHAs on Friday, September 17;

2) Contractors must issue notification letters to HHAs by the fifth business day after receipt of the TDL, on September 24;

3) The timely reconsideration period ends 30 calendar days later, no later than October 24;

4) CMS provides determinations to contractors during the second week of December.

In its review of the HHA's documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the HHA. The determination will be made based solely on the documentation provided. CMS will not contact the HHA to request additional information or to clarify incomplete or inconclusive information. 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.

If the CMS determination upholds the 2% reduction, CMS shall provide the Medicare contractor with a statement of the findings that support the decision. 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. Contractors shall insert the CMS-provided statement of findings in the blank provided in the model language. Contractors shall send this second letter only to HHAs that requested a reconsideration.

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 upholds the 2% reduction, the contractor shall update their provider file in this fashion also.

If the CMS determination reverses the 2% reduction, the contractor shall not update their provider file for the HHA and shall notify the HHA that they will receive their full HH PPS annual payment update (APU) for the upcoming year.

Model language for initial notification letters:

"This letter is to officially inform you that CMS has determined your home health agency (HHA) is subject to a reduction in the annual payment update for not meeting the Deficit Reduction Act (DRA) of 2005 requirement for HHAs to submit quality data. Therefore, Medicare payments to your agency will be reduced 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 Outcomes and Assessment Information Set (OASIS) data as required by your conditions of participation (CoPs), and timely submission of Home Health Care Consumer Assessment of Health Providers and Systems (HHCAHPS) data.

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.

[For letters in calendar year 2012 only:]
In order to meet the HHCAHPS requirement, HHAs needed to participate in an HHCAHPS dry run in third quarter 2010, and continue monthly data collection and submission of data to the Home Health CAHPS Data Center beginning in October 2010, through March 2011. If agencies had less than 60 patients between April, 1, 2009, and March 31, 2010, then they were exempt from HHCAHPS participation for CY 2012. These HHAs were to complete an HHCAHPS Participation Exemption Request form for CY 2012 on the HHCAHPS Website, https://homehealthcahps.org.

[For letters in calendar years 2013 and after:]

In order to meet the HHCAHPS requirement, HHAs must collect monthly HHCAHPS data and submit data to the Home Health CAHPS Data Center from April 1, [insert the prior year] through March 31,[insert the current year]. If agencies had *59 or fewer HHCAHPS-survey eligible* patients between April 1, [insert the year 2 years prior] and March 31, [insert the prior year], then they are exempt from HHCAHPS participation for [insert current year]. These HHAs were to complete an HHCAHPS Participation Exemption Request form on the HHCAHPS Website, https://homehealthcahps.org.

CMS review of OASIS and HHCAHPS submissions for this period found that your agency is not excluded or exempt from the reporting requirements and [insert whether the HHA was non-compliant with OASIS, HHCAHPS or both]. CMS's review of paid claims 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], annual payment updates 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 quality data reporting requirement and have been identified for this payment reduction in error, you must submit a letter requesting reconsideration and provide documentation demonstrating your compliance.

Documentation to support a finding of compliance with OASIS reporting may include any of the following:

- evidence of OASIS transmissions during the reporting period (e.g., an OASIS Final Validation Report from the national system showing a timely submission date);

- if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA did not receive your CMS Certification Number (CCN) from Medicare until after the close of the reporting year (e.g., a notification letter from the survey and certification staff at the CMS RO dated after June 30);

- if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA received your CCN too late in the reporting year to request and receive your permanent OASIS transmitter ID and submit data (e.g., during the last week of June); or

- if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA received your CCN in the last weeks of the reporting year (e.g., in June), took prompt action to request your permanent OASIS transmitter ID and were delayed by CMS or its agents.

Documentation to support a finding of compliance with HHCAHPS reporting may include any of the following:

- Evidence that the HHA continuously collected data and submitted data to the Home Health CAHPS Data Center during the required timeframe. [For letters in calendar year 2012 only:] The required period of data collection includes the dry run data in the third quarter 2010, the fourth quarter 2010 (all the months of October, November and December 2010), and the first quarter 2011 (all the months of January, February, and March 2011). [For letters in calendar year 2013 and after:] The required period of data collection includes all months from April 1, [insert the prior year] through March 31, [insert the current year]; or

- For HHAs *that have served 59 or fewer* HHCAHPS-*survey* eligible patients in the year from April 1, [insert the year 2 years prior] and March 31, [insert the prior year], evidence that the HHA filed the Participation Exemption Request Form, on the form that is on www.homehealthcahps.org, by the deadline date specified in the HH PPS payment update final regulation for [insert current year].

Note that documentation of the following does NOT support a finding of compliance:

- evidence or admission of error on the part of your staff, even if the involved staff members are no longer employed by your HHA 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 your HHA to perform reporting functions;

- evidence of delays establishing electronic data interchange connectivity between your HHA and [insert Medicare contractor name] for the purpose of billing, since OASIS transmission is not dependent on billing and the HHA should request their OASIS transmitter ID from the State at the same time they request billing system access from [insert Medicare contractor name]; or

- in cases where the ownership of the HHA changed during the reporting year but the CCN of the HHA did not change, evidence that failure to comply was the fault of a previous owner.

Your letter and documentation should be submitted via e-mail to CMS for reconsideration, using the following e-mail address: HHAPUreconsiderations@cms.hhs.gov .

Requests and supporting documentation must be received electronically no later than 30 days from the date of this notification.

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 OASIS documentation in response to a HHCAHPS 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 HHA (do not combine requests or attach a list of HHA provider numbers to a request)

- If requesting a HHCAHPS reconsideration regarding a participation exception, provider specific information detailing why your HHA had no eligible patients.

An HHA 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)."

Model language for dispute determination letters:

"This letter is in response to your request for reconsideration of the scheduled 2% Annual Payment Update reduction in payments to your agency, due to your agency being identified as [insert whether the HHA was non-compliant with OASIS, HHCAHPS or both].

CMS has reviewed the documentation you provided and determined that your agency is subject to the 2% reduction in the Annual Payment Update for CY [insert upcoming year], due to your

agency's noncompliance with submitting quality data during the required timeframes. Specifically, CMS officials found [insert CMS-provided statement of findings]. 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.

Exhibit 1 – Incentive Payment Results Report

(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

Contractors are to insert the change request (CR) number for the recurring update notification associated with the PQRS or eRx payment in the title of the Incentive Payment Results Report displayed in Exhibit 1.

Exhibit 1 – Incentive Payment Results Report

(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

Contractors shall report the following to CMS for each workload:

Glossary of terms:

Workload – each contractor number for which the MAC is responsible (Example: 01503, 01504, 01505)

Payment/Paid – check has been invoiced and mailed or check has been sent via EFT

1. Have you verified that the incentive payments have made it through every aspect of processing to payment?

   Yes _____ No_____
2. Do you have documentation available confirming that all payments have been paid to eligible professionals?

   Yes_____ No_____
3. Annotate how many incentive checks you were scheduled to pay per the payment file received from the CMS mainframe.

   # of checks scheduled to be paid = _____

Note: Use one line to report for each workload. The totals in this chart should equal the number of checks annotated above that the contractor was scheduled to pay.

MAC/Carrier	Contractor Number	States	Number of Checks Paid	Total Dollar Amount for Checks Paid	Number of Checks Not Paid Provide details in chart 4	Total Dollar Amount for Checks NOT paid Provide details in chart 4
Example:	00000	AK	225	$17,234.50	10	$2,359.00
Totals						

4. Annotate the details for incentive checks "Not Successfully" paid due to the appropriate reason below.

# of checks "**Not Successfully**" paid = _____:

Note: This chart should only show details for payment issues that remain unresolved as of the date of this report. If you encountered a payment issue and it has been resolved, do not report it in this chart.

MAC/Carrier	Contractor Number	States	# of HIGLAS Rejections	Total Dollar Amount for HIGLAS rejections	# of Invalid TIN(s) Provide details in Chart 5	Total Dollar Amount for Invalid TINs	# of Do Not Forwards (DNFs) *No follow up is required for DNFs.	Total Dollar Amount for DNFs	# of Other Provide details in chart 6	Total Dollar Amount for Checks not paid for "Other" reasons	Grand Total of ALL checks "Not Successfully" paid
Example:											
Totals											

5. Provide details of unresolved payment issues for payments associated with invalid TINs:

MAC/Carrier	Contractor Number	State	Invalid TIN number(s)	Payment Amount

6. Provide details on unresolved payment issues for payments in "Other" column

MAC/Carrier	Contractor Number	Details for Payment issue(s) annotated in table 4

Add additional rows to report as necessary.

Exhibit 2 – PQRS and eRx Incentive Payment File Record Layout
(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

The PQRS and eRx incentive payments are not combined into one file. Each incentive has its own separate file.

Exhibit 2
(Rev. 11, Issued: 03-26-13, Effective: 06-25-12, Implementation: 06-25-12)

PQRS and eRx INCENTIVE PAYMENT FILE RECORD LAYOUT

FIELD NAME	START/END POSITION	PIC	COMMENT
HEADER RECORD			
Header Indicator	1-4	X(4)	Value "HEAD"
Header Record Number	5-5	X(1)	Value 1 to 9
Filler	6-6	X(1)	Value spaces
Incentive Type Year Indicator	7-10	X(4)	
--Incentive Type	7-8	X(2)	Value PQ denotes PQRS Incentive; Value RX denotes eRx Incentive. NOTE: Each incentive will have its own separate file; they are not combined into one file.
--Incentive Reporting Year	9-10	X(2)	Value denotes reporting year for Incentive
Filler	11-125	X(115)	Value spaces
DATA RECORD			
Carrier/MAC Number	1-5	X(5)	Left justified.
FILLER	6-24	X(19)	Value spaces (in the future, this field may contain the NPI).
Incentive Recipient Tax ID	25-34	X(10)	Left justified, one blank field.
FILLER	35-39	X(5)	Value spaces
Incentive Amount	40-49	9(8)v99	
FILLER	50	X(1)	Value spaces
Report Start Date	51-58	X(8)	CCYYMMDD (beginning time period for reporting of claims for PQRS or eRx; i.e. January 1, 2009).

FILLER	59	X(1)	Value spaces
Report End Date	60-67	X(8)	CCYYMMDD (ending time period for reporting of claims for PQRS or eRx; i.e. December 31, 2009).
FILLER	68-125	X(58)	Value spaces

80– Fiscal Year 2018 and After Payments to Skilled Nursing Facilities (SNFs) That Do Not Submit Required Quality Data

(Rev. 67, Issued: 07-14- 17, Effective: 08-14 - 17, Implementation: 08- 14- 17)

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) added section 1899B to the Act that imposed new data reporting requirements for certain PAC providers, including SNFs, and required that the Secretary implement a SNF quality reporting program (SNF QRP). Beginning with fiscal year 2018, and each subsequent year, if a SNF 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 2018, and each subsequent year, if a SNF 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, in late spring/summer, CMS will provide Medicare contractors with a Technical Direction Letter (TDL) identifying SNFs not meeting the quality data reporting requirements. The contractor shall notify the SNFs 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 SNFs. The notification letter shall inform the SNF whether they were identified as not complying with the SNF quality reporting requirements. The notification letter shall also inform the SNF 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 facilities 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 SNF documentation, CMS will determine whether evidence to support a finding of compliance has been

provided by the SNF. 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 SNFs that failed to comply with the data submission requirements. The Medicare contractors will then be responsible for notifying each SNF that failed to comply with the quality data submission requirements that it will receive a two (2) percentage point reduction in the annual increase factor. The Medicare contractors will also update the SNF 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 letters to the SNFs. Contractors shall send this second letter only to SNFs that requested reconsideration. Additionally, the Medicare contractors shall include information regarding the SNFs 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 SNF does not dispute their reduction, the Medicare contractor shall update their provider file for the SNF. 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 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 SNF and shall notify the SNF that they will receive their full SNF 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 section IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION ACT OF 2014
(IMPACT Act), Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))requirement for SNFs to submit quality data. Therefore, Medicare payments to your facility 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 SNF Quality Reporting Program (QRP) annually through rulemaking.

CMS has determined that this SNF is subject to a 2% reduction in the FY (insert upcoming year) annual increase factor for failure to meet quality reporting requirements pursuant to the Impact Act Section 1888(e) because of the following reason(s):

- The SNF 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 SNF CMS Certification Number (CCN);
- The SNF business name;
- The SNF 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 SNF 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);
- 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 SNF staff, even if the involved staff member are no longer employed by the SNF 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 SNF to perform reporting functions; and,

- Evidence of delays establishing electronic data interchange connectivity between the SNF and the Medicare claims processing contractor for the purpose of billing, since SNF 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: SNFQRPReconsiderations@cms.hhs.gov.

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

A SNF 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 SNF provider file based on the appropriate scenario listed below:

Upheld

- If the SNF was notified that it was potentially subject to the 2% 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% reduction on all of the SNF's claims for the upcoming fiscal year.

- If the SNF 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 SNF's claims for the upcoming fiscal year.

Reversed

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

• If the SNF submitted the necessary SNF 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 dispute notification letters (SNF 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 SNF's annual update for failure to meet the requirements of the SNF Quality Reporting Program (QRP).

CMS reviewed the reconsideration request of this SNF and is **upholding** the decision to reduce the annual increase factor for Medicare payments for Fiscal Year (FY) (insert upcoming year). Our records indicate that this SNF did not provide evidence that it submitted required quality data during the required timeframes. Therefore, for services provided by this SNF between **October 1, (insert upcoming year) and September 30, (insert upcoming year)**, the annual increase factor 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 SNF QRP. For additional concerns related to the reconsideration process, questions may be submitted to the following CMS email address: SNFQRPReconsiderations@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 SNF's annual increase factor for failure to meet the requirements of the SNF Quality Reporting Program (QRP).

CMS reviewed the reconsideration request and determined that this SNF **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 increase factor for failure to comply with quality reporting requirements will not be applied.

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

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12293QRI	10/12/2023	Payments to Home Health Agencies That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR 10874.	11/13/2023	13241
R78QRI	08/10/18	Payments to Home Health Agencies That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR 9651.	09/11/2018	10874
R67QRI	07/14/2017	Fiscal Year 2018 and After Payments to Skilled Nursing Facilities That Do Not Submit Required Quality Data	08/14/2017	9944
R57QRI	05/27/2016	Payments to Home Health Agencies That Do Not Submit Required Quality Data	08/30/2016	9651
R55QRI	03/04/2016	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	04/01/2016	9544
R54QRI	02/19/2016	Fiscal Year 2017 and After Payments to Inpatient Rehabilitation Facilities (IRFs) That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR 9106	04/01/2016	9543
R52QRI	12/18/2015	Fiscal Year 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR9091.	04/01/2016	9460
R44QRI	05/08/2015	Payments to Inpatient Rehabilitation Facilities That Do Not Submit Required Quality Data – Rescinded and replaced by CR 9543, Transmittal 54	08/11/2015	9106
R42QRI	05/01/2015	Payments to Long Term Care Hospitals that Do Not Submit Required Quality Data	09/02/2015	9105
R39QRI	03/06/2015	Payments to Hospice Agencies That Do Not Submit Required Quality Data	06/08/2015	9091
R11QRI	03/26/2013	Medicare Quality Reporting Incentive Programs Manual Update	06/25/2012	7727
R5QRI	03/23/2012	Medicare Quality Reporting Incentive Programs Manual Update-Initial release of chapter 3	06/25/2012	7727