

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



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Implementation Date: April 1, 2016

Fiscal Year 2017 and After Payments to Long-Term Care Hospitals That Do Not Submit Required Quality Data – This Change Request (CR) Rescinds and Fully Replaces CR9105

Provider Types Affected

This MLN Matters® Article is intended for Long-Term Care Hospitals (LTCHs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9544 revises Chapter 3, Section 60 of the “Medicare Quality Reporting Incentive Programs Manual” to reflect changes to the payment reduction reconsideration process. It also includes general clarifications to the section. Make sure your billing staffs are aware of these revisions and clarifications.

Background

Section 3004 of the Affordable Care Act amended the Social Security Act (the Act) to authorize a quality reporting program for LTCHs. Section 1886(m)(5)(A)(i) of the Act requires application of a 2 percent reduction of the applicable market basket increase factor for LTCHs that fail to comply with the quality data submission requirements. Fiscal Year (FY) 2014 was the first year that the mandated reduction was applied for LTCHs that failed to comply with the data submission requirements during the data collection period of October 1, 2012, through December 31, 2012.

Disclaimer

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Beginning with FY 2014, and each subsequent year, if an LTCH does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that fiscal year. Application of the 2-percent 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 fiscal year involved.

Every year, in late Spring/Summer, the Centers for Medicare & Medicaid Services (CMS) will provide MACs with a list of those LTCHs not meeting the quality data reporting requirements. The MAC will then 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. The notification letter will inform the LTCH that they were identified as not complying with the LTCH quality reporting requirements. The notification letter will also inform the LTCH regarding the process to request a reconsideration of their payment reduction if they disagree with the determination. The reconsideration process will be outlined within that initial notification letter.

There is a 30-day period from the date of the notification letter for the LTCH 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 MAC 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 MACs with a **final** list of LTCHs that failed to comply with the data submission requirements. The MACs 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 MACs will send this second letter only to LTCHs that requested reconsideration. Additionally, the MACs will include information regarding the LTCHs right to further appeal the 2 percentage point reduction via the Provider Reimbursement Review board (PRRB) appeals process.

Additional Information

The official instruction, CR9544 issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R55QRI.pdf> on the CMS website.

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If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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