CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-22 Medicare Quality Reporting Incentive Programs	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12182	**Date: August 3, 2023**
	Change Request 13242

SUBJECT: Fiscal Year 2018 and After Payments to Skilled Nursing Facilities (SNFs) That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR 9944.

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update language for the skilled nursing facility 2% payment reduction process. Revisions include aligning language across pack settings for the CMS designated data submission system and correcting language related to the Annual Payment Update (APU).

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 4, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/80 - Payment to Skilled Nursing Facilities that Do not Submit Required Quality Data

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The Improving Medicare Post-Acute Care (PAC) 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). Section 1888(e)(6)(B)(i)(II) of the Act requires that each SNF submit, for fiscal years beginning on or after the specified application date (as defined in section 1899B(a)(2)(E) of the Act), data on quality measures specified under section 1899B(c)(1) of the Act and data on resource use and other measures specified under section 1899B(d)(1) of the Act in a manner and within the time frames specified by the Secretary. Revisions include aligning language across pack settings for the CMS designated data submission system and correcting language related to the Annual Payment Update (APU).

B. Policy: This Change Request contains no new policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13242.1	The contractors shall refer to Pub.100-22, chapter 3, section 80 for instructions regarding the SNF 2% Payment reduction process, including model language when issuing notification letters.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Quality Reporting Incentive Programs Manual

Chapter 3 – Contractor Incentive Program Payment Operational Instructions

Table of Contents
(Rev. 12182, Issued:08-03-23)

Transmittals for Chapter 3

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

(Rev. 12182, Issued:08-03-23, Effective:01-01-23, Implementation: 09-04-23)

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 *Annual Payment Update (APU)* 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 Payment Update (APU)*. 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 Payment Update (APU)* 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 data to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN); and/or*
- The SNF failed to submit the required quality *data* that are to be submitted to the CMS *designated data submission* 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 *CMS designated data submission system;*
- *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 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 Payment Update (APU)* 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 Payment Update (APU)* 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 Payment Update (APU)* 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 Payment Update (APU)* 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."