

recoupment as SNF bills are processed or by direct payment by the SNF.

[64 FR 41682, July 30, 1999]

§413.355 Additional payment: QIO reimbursement for cost of sending records electronically or by photocopy and mailing.

An additional payment is made to a skilled nursing facility in accordance with §476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

[85 FR 59025, Sept. 18, 2020]

§413.360 Requirements under the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

(a) *Participation start date.* Beginning with the FY 2018 program year, a SNF must begin reporting data in accordance with paragraph (b) of this section no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, which designates the SNF as operating in the CMS designated data submission system. For purposes of this section, a program year is the fiscal year in which the market basket percentage described in §413.337(d) is reduced by two percentage points if the SNF does not report data in accordance with paragraph (b) of this section.

(b) *Data submission requirement.* (1) Except as provided in paragraph (c) of this section, and for a program year, SNFs must submit to CMS data on measures specified under sections 1899B(c)(1) and 1899B(d)(1) of the Social Security Act and standardized resident assessment data in accordance with section 1899B(b)(1) of the Social Security Act, in the form and manner, and at a time, specified by CMS.

(2) CMS may remove a quality measure from the SNF QRP based on one or more of the following factors:

(i) Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better resident outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired resident outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired resident outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) *Exception and extension requests.* (1) A SNF may request and CMS may grant exceptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the SNF.

(2) A SNF may request an exception or extension within 90 days of the date that the extraordinary circumstances occurred by sending an email to SNFQRPreconsiderations@cms.hhs.gov that contains all of the following information:

(i) SNF CMS Certification Number (CCN).

(ii) SNF Business Name.

(iii) SNF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) SNF's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the SNF believes it will be able to again submit SNF QRP data and a justification for the proposed date.

(3) Except as provided in paragraph (c)(4) of this section, CMS will not consider an exception or extension request

unless the SNF requesting such exception or extension has complied fully with the requirements in this paragraph (c).

(4) CMS may grant exceptions or extensions to SNFs without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance affects an entire region or locale.

(ii) A systemic problem with one of CMS's data collection systems directly affected the ability of a SNF to submit data in accordance with paragraph (b) of this section.

(d) *Reconsideration.*

(1) SNFs that do not meet the requirements in paragraph (b) of this section for a program year will receive a notification of non-compliance sent through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC). A SNF may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance.

(2) Reconsideration requests must be submitted to CMS by sending an email to

SNFQRPreconsiderations@cms.hhs.gov containing all of the following information:

(i) SNF CCN.

(ii) SNF Business Name.

(iii) SNF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) CMS identified reason(s) for non-compliance stated in the non-compliance letter.

(vi) Reason(s) for requesting reconsideration, including all supporting documentation.

(3) CMS will not consider a reconsideration request unless the SNF has complied fully with the requirements in paragraph (d)(2) of this section.

(4) CMS will notify SNFs, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: CMS designated data submission system, the

United States Postal Service, or via email from the CMS Medicare Administrative Contractor (MAC).

(e) *Appeals.* A SNF that is dissatisfied with CMS' decision on a request for reconsideration may file an appeal with the Provider Reimbursement Review Board (PRRB) under 42 CFR part 405, subpart R.

(f) *Data completion threshold.*

(1) SNFs must meet or exceed the following data completeness thresholds with respect to a program year:

(i) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the Minimum Data Set (MDS) on at least 80 percent of the assessments SNFs submit through the CMS designated data submission system for FY 2018 through FY 2025 program years.

(ii) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the MDS on at least 90 percent of the assessments SNFs submit through the CMS designated data submission system for FY 2026 and for all subsequent payment updates.

(iii) The threshold set at 100 percent for measures data collected and submitted through the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) for FY 2023 and for all subsequent payment updates.

(iv) If selected for the data validation process under paragraph (g) of this section, the threshold set at 100 percent submission of medical charts.

(2) These thresholds apply to all measures and standardized patient assessment data requirements adopted into the SNF QRP.

(3) A SNF must meet or exceed each applicable threshold described in paragraph (f)(1) of this section to avoid receiving the applicable penalty for failure to report quality data set forth in § 413.337(d)(4).

(g) *Data validation process.* (1) Beginning with the FY 2027 payment year: for all measures that are calculated using Minimum Data Set (MDS) information, CMS will validate the accuracy of this information. The process by which CMS will request medical

records and by which SNFs must submit the requested medical records is as follows:

(i) On an annual basis, a CMS contractor will select up to 1,500 SNFs for validation. A SNF is eligible for selection for a year if it submitted at least one MDS record to CMS in the fiscal year that is 2 years prior to the applicable program year, and if the SNF has been randomly selected for a periodic audit for the same year under §413.338.

(ii) For each SNF selected under this paragraph (g)(1), the CMS contractor will request up to 10 medical records. Each SNF selected will only be required to submit records once in a fiscal year, for a maximum of 10 records for each SNF selected. Each requested medical record must be the same medical record that has been requested for submission by the SNF for the same year under §413.338. CMS will submit its request in writing to the selected SNF.

(iii) A SNF that receives a request for medical records under this paragraph (g)(1) must submit a digital or paper copy of each of the requested medical records within 45 days of the date of the request.

(2) Beginning with the FY 2027 payment year: the information reported through claims for all claims-based measures are validated for accuracy by Medicare Administrative Contractors (MACs).

[82 FR 36634, Aug. 4, 2017, as amended at 83 FR 39290, Aug. 8, 2018; 84 FR 38832, Aug. 7, 2019; 87 FR 47618, Aug. 3, 2022; 88 FR 53346, Aug. 7, 2023; 89 FR 64162, Aug. 6, 2024]

Subpart K—Payment for Acute Kidney Injury (AKI) Dialysis

SOURCE: 81 FR 77965, Nov. 4, 2016, unless otherwise noted.

§413.370 Scope.

This subpart implements section 1834(r) of the Act by setting forth the principles and authorities under which CMS is authorized to establish a payment amount for renal dialysis services furnished to beneficiaries with an acute kidney injury in or under the supervision of an ESRD facility that meets the conditions of coverage in

part 494 of this chapter and as defined in §413.171.

§413.371 Definition.

For purposes of the subpart, the following definition applies:

Individual with acute kidney injury. The term individual with acute kidney injury means an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under section 1881(b)(14) of the Act.

§413.372 AKI dialysis payment rate.

The amount of payment for AKI dialysis services shall be the base rate for renal dialysis services determined for such year under section 1881(b)(14), that is, the ESRD base rate as set forth in §413.220, updated by the ESRD bundled market basket percentage increase factor minus a productivity adjustment as set forth in §413.196(d)(1), adjusted for wages as set forth in §413.231, and adjusted by any other amounts deemed appropriate by the Secretary under §413.373.

§413.373 Other adjustments to the AKI dialysis payment rate.

The payment rate for AKI dialysis may be adjusted by the Secretary (on a budget neutral basis for payments under section 1834(r)) by any other adjustment factor under subparagraph (D) of section 1881(b)(14) of the Act.

§413.374 Renal dialysis services included in the AKI dialysis payment rate.

(a) The AKI dialysis payment rate applies to renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14) of the Act) furnished under Part B by a renal dialysis facility or provider of services paid under section 1881(b)(14) of the Act.

(b) Other items and services furnished to beneficiaries with AKI that are not considered to be renal dialysis services as defined in §413.171, but that are related to their dialysis treatment as a result of their AKI, would be separately payable, that is, drugs, biologicals, laboratory services, and