PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2020-D21

PROVIDER –
Encompass Home Health of the West, LLC

PROVIDER NO. – 03-7450

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

TELEPHONIC HEARING DATE –
February 14, 2019

Cost Reporting Period Ended –
December 31, 2018

CASE NO. – 18-1331

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor's reduction to the Provider's home health prospective payment system ("HHA PPS") payments for calendar year ("CY") 2018 by two percent was proper.[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Centers for Medicare & Medicaid Services ("CMS") properly imposed a two percent reduction to the CY 2018 HHA PPS payments from the Medicare Program to Encompass Home Health of the West, LLC ("Encompass" or "Provider").

INTRODUCTION:

Encompass is a home health agency ("HHA") located in Arizona and the Medicare contractor[2] assigned to Encompass is National Government Services, Inc. ("Medicare Contractor"). On October 2, 2017, the Medicare Contractor notified Encompass in writing that CMS had determined it failed to meet certain quality data reporting requirements, specifically the submission of "Home Health Care Consumer Assessment of Healthcare Providers and Systems" ("HHCAHPS") data for the 12-month reporting period of April 1, 2016 through March 31, 2017, and, as a result, it would be subject to a two percent payment reduction for its CY 2018 Medicare HHA PPS payments.[3] Encompass filed a request for reconsideration. On December 6, 2017, CMS confirmed its decision, finding that Encompass failed to submit the requisite four quarters of HHCAHPS data (*i.e.*, data from April 1, 2016 to March 31, 2017).[4]

Encompass timely appealed the denial of its reconsideration request to the Board and has met the jurisdictional requirements for a hearing before the Board. A telephonic hearing was held on February 14, 2019. Encompass was represented by Jung Lee, Esq., their Associate General Counsel. The Medicare Contractor was represented by Joseph J. Bauers, Esq., of Federal Specialized Services, LLC.

STATEMENT OF FACTS:

In the Balanced Budget Act of 1997[5], Congress mandated that the Secretary of Health and Human Services ("Secretary") establish a prospective payment system for home health services covered by Medicare.[6] Along with the establishment of this prospective payment system, Congress also directed the Secretary to increase the prospective payments made to HHAs each calendar year by a percentage, estimated by the Secretary, otherwise known as the "home health

[1] Transcript of Proceedings ("Tr."), 5.
[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[3] Exhibit C-12.
[4] Exhibit P-2 at 13.
[5] Pub. L. 105-33, 111 Stat. 251 (1997).
[6] *Id.* at § 4603, 111 Stat. at 467-472.

market basket percentage increase" or Annual Payment Update ("APU").[7] Subsequently, in § 5201(c) of the Deficit Reduction Act of 2005[8] ("DRA"), Congress added a data reporting requirement. In order to qualify for the full APU, the DRA requires HHAs to submit data that the Secretary determines are appropriate for the measurement of health care quality.[9] Further, if an HHA fails to submit data "in a form and manner, and at a time, specified by the Secretary," it is subject to a two percentage point reduction in its APU for a particular payment year.[10]

In an effort to measure, and publicly report patient experiences with home health care, the Secretary requires the submission HHCAHPS survey results for an HHA's patient population during four, pre-determined calendar quarters as part of an HHA's quality reporting requirements.[11] CMS instructs each Medicare-participating HHAs to contract with an approved HHCAHPS vendor who will survey the HHA's patients and submit HHCAHPS data on behalf of the HHA to CMS.[12] The HHCAHPS data collection and reporting period tied to the CY 2018 APU ran from April 1, 2016 through March 31, 2017.[13] For the CY 2018 APU, CMS required the HHCAHPS data files to be submitted to the HHCAHPS Data Center on a rolling basis for the four quarters as follows:

- Data for April through June 2016 by 11:59 p.m., EST on October 20, 2016;
- Data for July through September 2016 by 11:59 pm, EST on January 19, 2017;
- Data for October 2016 through December 2016 by 11:59 pm, EST on April 20, 2017; and
- Data for January 2017 through March 2017 by 11:59 pm, EST on July 20, 2017.[14]

In addition to setting forth very specific deadlines and requirements, the 2013 Home Health PPS final rule directed HHAs to utilize additional resources to assist them in complying with the requirements of the HHCAHPS survey. One such resource is the HHCAHPS website. The website, which is regularly updated, has a vast amount of information about the HHCAHPS survey, including the "Home Health Care CAHPS Survey Protocols and Guidelines Manual (the "HHCAHPS Manual").[15] The HHCAHPS Manual explains the requirements and obligations of the HHAs and their vendors with respect to data submission. The HHCAHPS survey vendors retained by the HHAs are responsible for submitting the data to the HHCAHPS Data Center following the guidelines specified in the HHCAHPS Manual[16] and in the *Home Health Care CAHPS Web Site User and Data Submission Manual*. Each HHA ultimately remains responsible for ensuring that its selected vendor submits the HHA's data files both on time and in accordance with the guidelines in the HHCAHPS Manual.[17]

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[7] *Id.*
[8] Pub. L. 109-171, § 5201(c), 120 Stat. 4, 46 (2006) (codified at 42 U.S.C. § 1395fff).
[9] 42 U.S.C. § 1395fff(b)(v)(II). *See also* Exhibit C-1 at 3.
[10] 42 U.S.C. § 1395fff(b)(v)(I). *See also* Exhibit C-1 at 3; C-6 at 5.
[11] 42 C.F.R. § 484.250(a)(2) (2018).
[12] 42 C.F.R. § 484.250(c). *See also* Exhibit C-5 at 3.
[13] 80 Fed. Reg. 68624, 68708 (Nov. 5, 2015) (excerpt at Exhibit C-9).
[14] *Id.*
[15] Exhibit C-8.
[16] *Id.* at 11.
[17] 80 Fed. Reg. at 68708. *See also* Exhibit C-9 at 3.

On August 2, 2015, Encompass purchased a home health agency which was, at that time, a subunit of a hospital owned by HealthSouth Valley of the Sun Rehabilitation Hospital, LLC ("HealthSouth Valley of the Sun").[18] The CMS Certification Number ("CCN") then associated with the subunit being purchased was 037323.[19] On April 26, 2016, Encompass received a letter from CMS acknowledging the change in ownership effective August 2, 2015, noting the automatic assignment of HealthSouth's Valley of the Sun's Medicare Provider Agreement to Encompass, and assigning a new CCN of 037450 to the HHA.[20] On June 14, 2016, Encompass received another letter from the Medicare Contractor, notifying it that its enrollment application was approved listing Encompass' identifying information including Provider Name, practice location, Provider Transaction Access Number ("PTAN"), National Provider Identifier ("NPI"), etc. The letter identified Encompass' PTAN as 037450 *with an effective date August 2, 2015* (this PTAN and CCN are the same number with the same effective date).[21] The June 14, 2016 letter further instructed Encompass that it "must use its NPI number on all Medicare claim submissions."[22]

On October 19, 2016 (one day prior to the October 20, 2016 filing deadline), Encompass' HHCAHPS survey vendor submitted Encompass' HHCAHPS survey data for April, May, and June of 2016 ("Q1"); however, it submitted this data using the *old,* inactivated CCN (037323).[23] Beginning with the data for July 2016, the next three quarters of data (Q2 – Q4), were correctly submitted under the *new* CCN (037450) on January 18, and April 4, and July 6, 2017, respectively.[24] CMS imposed the two percent reduction in Encompass' CY 2018 HHA PPS APU because it determined that Encompass did not properly submit its data for all four quarters of the reporting period.[25]

Encompass contends that, even though all four of the quarters at issue were not filed under the same CCN, that data was timely reported in accordance with 42 C.F.R. § 484.225 and, therefore, it was incorrectly penalized by a two percent reduction in their CY 2018 Medicare payments.[26]

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Encompass acknowledges that it failed to notify their HHCAHPS survey vendor of its new CCN timely because of an oversight/error and, therefore, its Q1 data was submitted under the old, inactivated CCN.[27] Encompass argues that it is unusual that a change in ownership of an HHA would result in a new CCN being issued.[28] Encompass further claims that this alleged unusual occurrence was the source of significant internal chaos for Encompass with regard to cancelling

[18] Provider's Final Position Paper at 2; Tr. at 24.
[19] *Id.*
[20] Exhibit P-3.
[21] Exhibit P-4.
[22] *Id.*
[23] Exhibit P-2 at 23.
[24] Exhibit P-5 at 2-4; Tr. at 41-42.
[25] Exhibit P-1. *See also* Exhibit C-12.
[26] Provider's Final Position Paper at 5.
[27] Tr. at 33 ("And this particular operational issue was missed during that chaos. I'm not trying to say that it was done correctly. I am just saying in the chaos that this piece of information was missed.").
[28] Provider's Final Position Paper at 5; Tr. at 16, 19, 31-33.

and rebilling claims that it had filed with the Medicare Program using the incorrect provider numbers, as well as trying to associate and/or update its systems with the new provider numbers.[29] Encompass alleges that it received little guidance from CMS or the Medicare Contractor with regard to what systems or operations needed to be manually updated with their new CCN, and that it ultimately relied upon rejection or error notices to identify what that data or other information was being improperly submitted and needed correction.[30]

In support of it position, Encompass points out that the prior year HHCAHPS survey data, August 2, 2015 to March 31, 2016, was accepted without a two percent penalty being imposed even though the incorrect old CCN was used.[31] Encompass is requesting the Board reverse the decision to apply a two percentage point reduction to their CY 2018 HHA PPS APU based on the unusual circumstances related to it receiving a new CCN after a change in ownership.[32] Additionally, Encompass argues that, even though it submitted one of the requisite four quarters of quality reporting data using the incorrect CCNs, it is clear that all four quarters of quality data were, in fact, submitted by the Provider and that this meets the regulatory requirements to receive a their full APU for CY 2018.[33]

The Medicare Contractor points out that the data which was submitted under the wrong CCN was submitted on October 19, 2016, five months after Encompass had been notified of its new CCN. Since only three quarters of data were submitted under the correct CCN, the Medicare Contractor argues that Encompass has not met its reporting requirements for the HHCAHPS survey.[34] As a result, the Medicare Contractor requests that the Board affirm the two percent reduction to Provider's CY 2018 HHA APU.[35]

At the outset, the Board notes that the HHCAHPS Manual is clear when submitting data, the Header Record must include the name of the HHA and its CCN.[36] In this regard, the HHCAHPS Manual directs survey vendors to construct and submit a patient data file containing a header record and a patient administrative record for every sampled case.[37] The "Header Record" section of the chapter on "File Preparation and Data Submissions" states the following:

> The Header Record contains the identifying information for the HHA for which data are included on the file, sampling information, survey administration mode, and the method by which the sample was selected. Information required in this section includes the name of the HHA and its CCN.[38]

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[29] Tr. at 16-19, 31-33; 75.
[30] *Id.* at 18, 34-35.
[31] *Id.* at 51.
[32] Provider's Final Position Paper at 5.
[33] *Id.*
[34] Medicare Contactor's Final Position Paper at 11.
[35] *Id.* at 13.
[36] Exhibit C-8 at 12.
[37] *Id.* at 14 (stating that, in the portion of the XML file containing patient data, "some of the information provided in the Header Record is repeated, including the HHA's CCN and the Sample Year and Sample Month.").
[38] *Id.* at 12.

Similarly, the HHCAHPS Manual makes it clear that the data is organized and identified by CCN.[39] Accordingly, the Board finds that the HHCAHPS Manual and the Web Site User and Data Submission Manual both emphasize that the data files submitted by the HHCAHPS survey vendors must include the CCN of the HHA submitting the data. Without this information, the survey data would not be useful in measuring the quality of the individual HHA (*i.e.*, each Medicare participating HHA) because CMS could not match patient survey results to the specific HHA treating the patient. The whole purpose of the survey data is to allow consumers to compare data for individual HHAs.

The Board's review of the record shows that Encompass received a letter on April 26, 2016 notifying it of its new CCN.[40] Once Encompass received its new CCN it should have immediately notified its HHCAHPS survey vendor. Encompass acknowledges that, under the chaos of having to rebill over a million dollars in claims, it neglected to notify the HHCAHPS survey vendor of its new CCN,[41] and this oversight resulted in the April 2016 to June 2016 HHCAHPS survey data being filed with the incorrect CCN.

The Board finds Encompass erred in not giving the new CCN to its survey vendor. As noted above, the HHCAHPS Manual is clear when submitting data, the Header Record must include the name of the HHA and its CCN.[42] The Board finds that Encompass was given its new CCN on April 26, 2016, well in advance of the October 19, 2016 filing deadline for the Q1 HHCAHPS Survey data, and therefore the new CCN should have been used for the Q1 submission.

Further, the Board recognizes that Encompass claims that it did not expect the CCN to change when it purchased HealthSouth Valley of the Sun[43] based on its belief that it is unusual for the CCN to change when purchasing an HHA.[44] However, it is clear that Encompass' CCN did change and that this change occurred *well in advance* of the October 20, 2016 HHCAHPS filing deadline that is at issue. Specifically, Encompass was clearly notified of the CCN change in CMS' April 26, 2016 letter, which stated in bold "**Please note: CCN status change from HHA subunit (037323) to HHA parent (037450)**."[45] Additionally, shortly thereafter in May 2016, CMS required Encompass to rebill claims using the new CCN retroactive to the August 2, 2015 change in ownership.[46] When asked about this rebilling process, Encompass' witness confirmed it began in May 2016 and confirmed that old CCN had to be reactivated for this process:

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[39] *See, e.g., id.* at 22 (stating "Vendors should note that submitting an XML file for a sample month ***for a CCN*** will overwrite any previously submitted file for that month, . . ." (emphasis added)); *id* .at 24 (stating that '[t[his screen will also provide the vendor with a count of records received by CMS Certification number (CCN)" and the Data Submission Summary Report "will provide sufficient detail, ***by CCN***, of data file errors . . . ." (emphasis added)); *id.* at 25 (stating "the HHCAHPS database only shows CCNs that appear on CMS's current list of active CCNs.").

[40] Exhibit P-3.

[41] Tr. at 16-19, 32-33.

[42] Exhibit C-8 at 12.

[43] Tr. at 68; 75-76.

[44] While Encompass claims it is unusual to get a new CCN when there is a change in ownership, the Provider submitted no evidence to show that the CCN does not change when the purchased HHA subunit becomes an HHA parent after the purchase. Rather, the Medicare Contractor's Post Hearing brief shows that a new CCN was issued to the HHA in Tuscan, Arizona when it went from a subunit to a parent. *See* Medicare Contractor's Post-Hearing Brief at 12.

[45] Exhibit P-3 at 1.

[46] Tr. at 32-33.

> THE WITNESS: So for home health billing, there are two claims that are billed or one is a request for anticipated payment which technically is not a claim. At the beginning of the 60 day period and at the end of the 60 day period, a final claim is billed where we are paid what we should have been paid for the 60 day episode. When a request for anticipated payment is submitted, it is recorded in the CMS common working file so that everyone knows that the patient is on a home health plan of care since there are some consolidated billings that have to occur under that home health plan of care. Requests for anticipated payments through May of 2016 were submitted under the old provider number, the 037323 number, and were recorded as such in the common working file. And *when the 037323 number was inactivated, **it was inactivated with a termination date of August 1, 2015 which practically rendered us incapable of doing anything with that provider number** or under that provider number for any date of service after August of 2015*. However, there were claims that were paid in the system. There is also a process where requests for anticipated payments or RAP's are auto cancelled by CMS if the final claim is not received in a certain period of time. So to be able to cancel that claim, I had to rebill the RAP under the old provider number only to go back and cancel it so that it would clear out everything that had been recorded in the common working file. So to be able -- because I couldn't rebill things with the new provider number because it was rejecting as an overlap with the other provider number. So *NGS activated that number long enough for all of those claims to be rebilled and cancelled to clear out everything . . . .*[47]

As noted above, Encompass' witness conceded that the old inactivated CCN was "practically . . . incapable of doing anything." Accordingly, the Board finds that this rebilling experience should have made clear that Encompass needed use the correct CCN on its billing and any other communication with CMS, including its HHCHAPS survey data. This finding is further reinforced by the fact that the rebilling experience began in May 2016, well in advance of the October 20, 2016 HHCAHPS deadline at issue.

Finally, Encompass did not offer any documentation or oral testimony to suggest that they had conducted any oversight of its HHCAHPS survey vendor to ensure that its HHCAHPS survey data was submitted correctly.[48] Specifically, CMS states:

> HHAs should always monitor their respective HHCAHPS survey vendors to ensure that vendors submit their HCAHPS data on time, by accessing their HHCAHPS Data Submission Reports on *https://homehealthcahps.org*. This helps HHAs

[47] Tr. at 54-56 (emphasis added).
[48] *See* Tr. at 30, 86.

> ensure that their data are submitted in the proper format for data processing to the HHCAHPS Data Center.[49]

Had Encompass monitored its HHCAHPS survey vendor and been accessing the HHCAHPS Data Submission Reports, Encompass would have realized that its Q1 HHCAHPS survey data was submitted with the incorrect CCN.

While the Board sympathizes with the difficulties associated with receiving a new CCN, CMS' regulations require submission of HHCAHPS survey data "in a form and manner, and at a time, specified by the Secretary" as required by DRA § 5201(c).[50] This includes submitting all data under the correct CCN. Accordingly, the Board finds that CMS properly imposed a two percent reduction to Encompass' CY 2018 payments from the Medicare Program because Encompass failed to satisfy the HHCAHPS program requirements that were necessary to receive a full annual payment for CY 2018. The Board notes that its decision in this case is consistent with its 2015 decision in a similar HHCAHPS case where an HHA was assigned a new CCN but failed use that new CCN when its quality data was submitted.[51]

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that CMS properly imposed a two percent reduction to the CY 2018 HHA PPS payments from the Medicare Program to Encompass.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
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FOR THE BOARD:

9/4/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[49] 80 Fed. Reg. 68624, 68708 (Nov. 5, 2015). *See also* Exhibit C-9 at 3.
[50] 42 U.S.C. § 1395fff(b)(v)(II).
[51] *Liberty Healthcare Grp., LLC v. Palmetto GBA*, PRRB Dec. No. 2015-D10 (May 27, 2015), *declined review*, CMS Adm'r (June 23, 2015).