PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2021-D13

PROVIDER –
ProHealth Home Care, Inc.

Provider No.: 92-1588

vs.

MEDICARE CONTRACTOR -
National Government Services, Inc. (J-6)

HEARING DATE –
February 4, 2020

Fiscal Year Ending –
September 30, 2019

CASE NO.: 19-0070

INDEX

ISSUE

Whether the two-percentage point reduction to the Annual Percentage Update ("APU") of ProHealth Home Care, Inc. ("ProHealth" or "Provider") for Fiscal Year ("FY") 2019 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 Medicare Contractor properly imposed a 2 percent reduction to ProHealth's APU for FY 2019.

INTRODUCTION

ProHealth is a hospice located in Sacramento, California and the Medicare contractor[2] assigned to it is National Government Services ("NGS").

On July 10, 2018, the Medicare Contractor notified ProHealth that it was subject to a reduction in its FY 2019 payments for not meeting quality reporting requirements in place for hospice providers.[3] ProHealth sought reconsideration of that determination, but on September 18, 2018, CMS informed ProHealth that the decision was affirmed because ProHealth did not provide evidence that it submitted the required quality measure data during the required timeframes.[4] ProHealth had hospices in four different locations where each location was assigned a separate and unique CMS Certification Number ("CCN"); however, ProHealth submitted its quality reporting data for all four locations under a single CCN.[5]

ProHealth timely appealed the decision to reduce its FY 2019 APU by 2 percent and met the jurisdictional requirements for a hearing before the Board. A telephonic hearing was held on February 4, 2020. ProHealth was represented by Mohamed Marleen, the President of ProHealth. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services, LLC.

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[1] Note that the Medicare Contractor's Final Position Paper ("MAC Final Position Paper") and the transcript both identify the issue as, "Whether the 2 percentage point reduction to the Provider's Hospice payments for Fiscal Year 2019 was proper." Medicare Contractor's Final Position Paper at p. 3. Transcript ("Tr.") at 6. However, the 2 percent reduction was not imposed on Provider's FY 2019 hospice payments. Rather, the Provider's FY 2019 *Annual Payment Update* was reduced by 2 percent for an alleged failure to timely submit required quality measurement data. *See, e.g.*, Fiscal Year 2019 Annual Payment Update for the Hospice Quality Reporting Program Determination (Sept. 18, 2018), copy with Provider's Request for PRRB Hearing, Model Form A.

[2] The term "Medicare contractor" refers to fiscal intermediary or Medicare administrative contractor as relevant.

[3] Exhibit C-4 at 1-3.

[4] *Id.* at 4.

[5] *See* Tr. at 16-17, 34-37. *See also* MAC Final Position Paper at 10; Exhibit C-7.

STATEMENT OF FACTS

In § 122 of the Tax Equity and Fiscal Responsibility Act of 1982, Congress amended 42 U.S.C. § 1395f(i) in order to provide a Medicare Hospice Benefit for Medicare beneficiaries.[6] The Medicare hospice benefit provides a per diem payment in one of four prospectively-determined rate categories of hospice care.[7] Subsequently, Congress further amended the Medicare hospice benefit to include an annual increase in the daily payment rate for hospice services based upon the inpatient market basket percentage increase, also known as the annual payment update, or APU.[8]

Under the Affordable Care Act ("ACA"), Congress added 42 U.S.C. § 1395f(i)(5) to tie a hospice provider's eligibility for its full APU increase to submission of certain quality data based upon measures specified by the Secretary.[9] These provisions further mandated a 2 percent reduction to a hospice's APU for a hospice that failed to properly report the required quality data measures for a particular fiscal year.[10] In particular, 42 U.S.C. § 1395f(i)(5)(C) states that hospices must submit their quality data measures in a form and manner, and at a time, specified by the Secretary.

In order to meet the quality reporting requirements, CMS implemented two data collection obligations. First, CMS requires hospices to use CMS' standardized data collection instrument called the Hospice Item Set ("HIS") and to electronically submit certain quality data measures for each patient admitted to the hospice on or after July 1, 2014.[11] Second, as of January 1, 2015, CMS also requires the collection of data using the Consumer Assessment of Healthcare Providers and Systems ("CAHPS") Hospice Survey.[12]

CMS finalized the hospice reporting requirements for the FY 2019 payment determination in the final rule issued on August 6, 2018.[13] To avoid the APU reduction for FY 2019, hospices were obligated to complete HIS data collection for Calendar Year ("CY") 2017 (January 1, 2017 through December 31, 2017) in accordance with the reporting requirements specified in the FY 2015 Hospice final rule, which requires regular and ongoing electronic submission of the HIS data.[14] Hospices have thirty days from patient admission or discharge to submit the appropriate

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[6] Pub. L. No. 97-248, § 122, 96 Stat. 324, 356 (1982). Initially, Congress made the hospice benefit temporary benefit with a sunset in October 1986 but, in April 1986, Congress made it permanent. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9123(a), 100 Stat. 82, 168 (1986) ("COBRA '85").
[7] 82 Fed. Reg. 36638, 36641 (Aug. 4, 2017).
[8] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6005(a), 103 Stat. 2106, 2160 (1989); Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4441(a), 111 Stat. 251, 422 (1997).
[9] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3004(c), 124 Stat. 119, 368 (2010).
[10] 42 U.S.C. § 1395f(i)(5)(A).
[11] CMS initially implemented the HIS through instructions and in preamble statements, then subsequently codified the HIS submission requirements at 42 C.F.R. § 418.312 in CMS' August 22, 2014 final rule. *See* 79 Fed. Reg. 50451, 50486-88 (Aug. 22, 2014).
[12] The CAHPS survey seeks information from the informal caregivers of patients who died while enrolled in hospices. *Id.* at 50491. Submission of the CAHPS survey data is not at issue in this appeal.
[13] 83 Fed. Reg. 38622 (Aug. 6, 2018).
[14] *Id.* at 38638 (citing 79 Fed. Reg. at 50486).

HIS record for that patient through the Quality Improvement and Evaluation System ("QIES") Assessment Submission and Processing ("ASAP") system.[15]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

ProHealth was notified that it was subject to a 2 percent reduction to its FY 2019 APU for its Sacramento location because it failed to submit HIS data in the form and manner, and at the time, specified by the Secretary. After receiving the reduction notice, ProHealth contacted the QIES Technical Support Office for clarification and learned that:

1. ProHealth should have submitted the data for its Sacramento location under its unique CMS Certification Number ("CCN") (92-1588);
2. Each ProHealth location has its own CCN; and
3. Each ProHealth location was required to submit its data under the CCN assigned to that location.[16]

ProHealth claims that it timely submitted HIS data for all four of its locations.[17] However, ProHealth submitted the HIS data for all four locations under the CCN assigned to the Provider's San Jose location (55-1561).[18] The Provider explains that it subsequently corrected this error by un-posting the Sacramento HIS data from the San Jose location's CCN and reposting it under the correct CCN.[19]

CMS has published a number of subregulatory resources and hosted trainings to assist hospice providers with their data submission requirements.[20] One such resource is the HIS Manual, which offers guidance to hospices on the collection and submission of HIS data to CMS.[21] The HIS manual makes multiple references to the requirement to submit HIS data under each facility's unique CCN. First, it explains that a new hospice must begin submitting HIS data based on the date it received *its CCN* (*i.e.*, whether the hospice would be exempt if its CCN was

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[15] 80 Fed. Reg. 47141, 47191 (Aug. 6, 2015). *See also* Hospice Quality Reporting Program: Requirements for the Fiscal Year 2019 Reporting Year at 1-2 (Sept. 29, 2017) (*available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Sept-2017_FY-19-HQRP-Requirements.pdf) (copy at Exhibit C-2) ("HQRP Requirements for FY 2019"). In addition to the HIS data collection requirements, ongoing monthly participation with the CAHPS survey was required for the reporting period of CY 2017, and the CAHPS quality data was to be submitted quarterly by deadlines set forth in the August 6, 2015 Final Rule. 80 Fed. Reg. at 47196. *See also* at 83 Fed. Reg. at 38640; HQRP Reporting Requirements for FY 2019 at 2. As previously noted, submission of the CAHPS survey data is not at issue in this appeal.

[16] Provider's Initial Appeal Request Cover Letter (Sept. 27, 2018). *See also* Tr. at 17.

[17] *Id.*

[18] *Id.*

[19] Provider's Initial Appeal Request; Provider's Final Position Paper. *See also* Exhibits P-2 & P-3.

[20] *See, e.g.*, MLN Connects, *Updates to the Hospice Item Set Manual V1.02* (June 17, 2015), *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Module-2-Updates-to-Chapter-1-of-V102-of-the-HIS-Manual.pdf (copy submitted as a post-hearing exhibit by the Medicare Contractor) ("HIS Manual Training Slides").

[21] HIS Manual, *Guidance Manual for Completion of the Hospice Item Set*, V2.00, § 1.2 (Effective April 1, 2017) ("HIS Manual"). A copy of this document is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Archives (located in the zip file accessed by the link "Hospice Item Set (HIS)").

issued late in a calendar year).[22] It further explains that "HIS reporting is at the CCN level" and that, for example, the transfer of a patient between two hospice facilities that have different CCNs creates *independent*, HIS data reporting requirements for *each* hospice.[23]

ProHealth essentially contends that any error on its part in submitting the data under one CCN is inconsequential because all of ProHealth's locations are part of the same corporation and share a common tax ID number.[24] Moreover, ProHealth's witness alleged during the hearing that it received instruction from the Medicare Contractor that submitting under one user ID for all four locations was sufficient to comply with the quality reporting requirements.[25] The Provider also maintains that it has consistently submitted all four locations' HIS data under the same CCN and that, when new locations were opened, it was instructed to continue this practice.[26] The Board notes that it is the Provider's burden to substantiate these claims.[27] However, ProHealth failed to produce any written or documentary evidence to support them.

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[22] *Id.* at § 1.4. *See also* 42 C.F.R. § 418.312(c) (stating "A hospice that receives notice of its CMS certification number before November 1 of the calendar year before the fiscal year for which a payment determination will be made must submit data for the calendar year."); 80 Fed. Reg. 47142, 47190 (Aug. 6, 2015) ("After consideration of the comments, we are finalizing our proposal that new providers be required to begin reporting quality data under the HQR beginning on the date they receive their CCN Notification Letter from CMS."); HQRP Activities Checklist (Last Updated 9/29/2017) (submitted by the Medicare Contractor as a post hearing exhibit).

[23] "Patient transfers from a provider with one CCN to a provider with a different CCN: ***HIS reporting is at the CCN level***. If a hospice patient's care transfers or changes from one hospice to another, and the two hospices have different CCNs, each hospice should complete a HIS-Admission and HIS-Discharge record for the care provided to the patient by their organization." HIS Manual at § 1.6 (emphasis added). *See also* HIS Manual Training Slides at 10:

> Sometimes, due to patient preference or patient re-location, a patient will change hospice providers. These situations can involve two related hospices under common ownership who have the same CMS Certification (or CCN) Number, or these situations can involve two unrelated hospices, each with their own CCN.
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> ***In general, HIS reporting occurs at the CCN level.*** Thus, when a patient transfers from a provider with one CCN, to a provider with different CCN, ***each provider is independently responsible for compliance with HIS reporting.*** In the situation where a patient transfers from one hospice to another, and the two hospices have different CCNs, each hospice should complete an HIS-Admission and an HIS-Discharge record for the care provided to the patient by their organization. . . .
>
> When a patient transfers between two providers with one common CCN, there is no need for the transferring hospice to complete an HIS-Discharge, or for the receiving hospice to complete an HIS-Admission. In this situation, the transferring hospice would complete the HIS-Admission and the receiving hospice would complete the HIS-Discharge, both under the [s]ame CCN.

(Emphasis added). Similarly, ***the HIS form*** in the HIS Manual at 2A-2 makes clear that the ***form*** collects patient-by-patient data based on the hospice's facility provider numbers, namely the CCN and national provider identifier ("NPI"). Similarly, the HIS Submission User's Guide at Exhibit C-6, 3-15 confirms that HIS data files are sorted and processed by Facility ID. Finally, the Hospice Final Validation Reports submitted by the Provider post-hearing confirm that the Provider's CCN is part of report and, thereby, confirms that the data is being collected by CCN.

[24] Tr. at 16-17.

[25] *Id.* at 26-28.

[26] *Id.* at 37-39.

[27] 42 C.F.R. § 405.1871(a)(3).

The Provider is requesting the Board "consider all the facts presented that we took all necessary steps to fix the issue and since then have been in compliance with on time submissions."[28] While the Board is sympathetic to the fact that the Provider made a good faith effort to submit its quality reporting data, the Board is bound by applicable statutes and regulations[29] and has no authority to provide equitable relief. The regulation at 42 C.F.R. § 418.312 governs the hospital quality reporting program and states, in pertinent part:

> (a) *General rule*. **Except as provided in paragraph (g) of this section**, Medicare-certified hospices **must submit** to CMS data on measures selected under section 1814(i)(5)(C) of the Act **in a form and manner, and at a time, specified by the Secretary**. . . .
>
> (g) No organization, firm, or business that owns, operates, or provides staffing for a hospice is permitted to administer its own Hospice CAHPS® survey or administer the survey on behalf of any other hospice in the capacity as a Hospice CAHPS® survey vendor. Such organizations will not be approved by CMS as CAHPS® Hospice Survey vendors.
>
> (h) *Reconsiderations and appeals of Hospice Quality Reporting Program decisions*. (1) A hospice may request reconsideration of a decision by CMS that the hospice has not met the requirements of the Hospice Quality Reporting Program for a particular reporting period. A hospice must submit a reconsideration request to CMS no later than 30 days from the date identified on the annual payment update notification provided to the hospice.
>
> (2) Reconsideration request submission requirements are available on the CMS Hospice Quality Reporting Web site on CMS.gov.
>
> (3) A hospice that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.[30]

The regulation is quite clear that hospices "must submit" hospice quality reporting data "in a form and manner, and at a time, specified by the Secretary." One of these "form and manner" requirements is that HIS data be submitted by CCN number as discussed above.[31]

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[28] Provider's Final Position Paper.
[29] 42 C.F.R. § 405.1867.
[30] (Italics emphasis in original and bold underline emphasis added.) *See also* FY 2015 Hospice Final Rule, 79 Fed. Reg. 50452 (Aug. 22, 2014) (adopting the version of § 418.312 in effect during the time at issue in this case).
[31] *See supra* notes 21-23 and accompanying text.

ProHealth contends that the entire basis for its APU reduction was the untimely submission of the required HIS data.[32] ProHealth also insists that this allegation is incorrect and that it was compliant with the data reporting requirements because it did, in fact, submit HIS data for each location prior to the established deadlines.[33] The Board disagrees. The applicable statute requires hospices to submit their quality data measures at a time, *and in a form and manner*, specified by the Secretary.[34] As discussed above, the Secretary requires each hospice to submit its unique HIS data under its own CCN by the relevant data submission deadline. The Provider does not dispute that the HIS data for the Sacramento location was not posted under its own CCN *until after the relevant deadline*.[35] Therefore, the Board finds that ProHealth failed to comply with the HIS data reporting requirements necessary to avoid the statutory 2 percent reduction in its FY 2019 APU, *i.e.*, failed to submit the requisite data "in a form and manner, and at a time, specified by the Secretary" as required by 42 C.F.R. § 418.312(a). The Board notes that its decision in this case is consistent with the following decisions involving CCNs: (a) a 2020 decision where a home health agency was assigned a new CCN but failed to use that new CCN when its quality data was submitted;[36] and (b) a 2015 decision where an HHA was assigned a new CCN but failed use that new CCN when its quality data was submitted (rather it submitted the data in error under the CCN for the parent HHA site).[37]

DECISION AND ORDER

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly imposed a 2 percent reduction to the Provider's APU for FY 2019.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

3/19/2021

X Clayton J. Nix

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

[32] Tr. at 17-18.
[33] *Id.* at 10-11, 56. *But see id.* at 21 (Provider acknowledging that its re-submission was untimely).
[34] 42 U.S.C. § 1395f(i)(5)(C).
[35] *See, e.g.*, Tr. at 10-11, 21.
[36] *Encompass Home Health of the West, LLC v. National Gov. Servs., Inc.*, PRRB Dec. No. 2020-D21 (Sept. 4, 2020).
[37] *Liberty Healthcare Grp., LLC v. Palmetto GBA*, PRRB Dec. No. 2015-D10 (May 27, 2015), *declined review*, CMS Adm'r (June 23, 2015).