PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D27

PROVIDER-
Universal Health Care / Fletcher, Inc.

Provider No.: 34-5522

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc. (J-M)

RECORD HEARING DATE –

November 6, 2020

Cost Reporting Period–
FFY 2019

CASE NO. – 19-1472

INDEX

ISSUE STATEMENT

Whether the payment penalty imposed by the Centers for Medicare and Medicaid Services ("CMS") to reduce Universal Health Care's ("Provider" or "Universal") Fiscal Year ("FY") 2019 Medicare payment by two percent was proper.[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that CMS properly imposed a two percent reduction to Universal's Annual Percentage Update ("APU") for FY 2019.

INTRODUCTION

Universal is a Skilled Nursing Facility ("SNF") located in Fletcher, North Carolina. The Medicare contractor[2] assigned to Universal for this appeal is Palmetto GBA ("Medicare Contractor"). On July 9, 2018, CMS notified Universal that it had not met one or more of the Quality Reporting Program ("QRP") requirements for FY 2019.[3] As a result, Universal's FY 2019 APU would be reduced by two percent.[4] Universal submitted a request for reconsideration, but CMS upheld its initial findings in a notice dated October 1, 2018.[5] Universal timely appealed CMS' final determination and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on November 6, 2020. Universal was represented by David Senter of Young Moore & Henderson, P.A. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

In October 2014, Congress passed the Improving Medicare Post-Acute Care Transformation ("IMPACT") Act of 2014.[6] The IMPACT Act mandated that the Secretary require SNFs to report data on certain quality measures (the SNF Quality Reporting Program, or "QRP").[7] Beginning with FY 2018, a SNF which fails to report or submit its quality data for a particular year is subject to a reduction in its annually updated payment rates by two percentage points for that year.[8]

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[1] Provider's Final Position Paper ("FPP") at 1; Medicare Contractor's FPP at 3.
[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 and relevant.
[3] Exhibit P-1.
[4] *Id.*
[5] Exhibit P-2.
[6] Pub. L. No. 113-185, 128 Stat. 1952 (2014).
[7] *Id.* at § 2.
[8] *Id.* at 1965. *See also* 42 C.F.R. § 413.360(a), (b)(1).

In 2015, CMS proposed to adopt, beginning with FY 2018 for the SNF QRP, NQF #2631 as a quality measure to be reported.[9] Under the SNF QRP, and pursuant to 42 C.F.R. § 413.360, Universal was required to report quality data to CMS. Based on the quality data reported, Universal was required to meet an 80 percent completion threshold for NQF #2631. 42 C.F.R. § 413.360(b)(2). The NQF #2631 quality measure provides the percent of all SNF Medicare Part A residents with an admission and discharge functional assessment and a care plan that addresses function.[10]

QRP data is collected using the minimum data set ("MDS") 3.0 assessment form and that data is then submitted through the Quality Improvement and Evaluation System Assessment Submission and Processing ("QIES ASAP") system.[11] The data collection requirements were to be rolled out in 2016, and that year's data would be used to determine any FY 2018 APU penalties.[12] In the initial year of quality reporting, only a single quarter of data would be collected (2016 Q4: October 1, 2016 through December 31, 2016). SNFs would also be given until May 15, 2017 "to correct and/or submit their quality data."[13] For FY 2019, three quarters of data would be collected (2017 Q1, Q2, & Q3: January 1, 2017 through September 30, 2017), and FY 2020 would collect a full calendar year, but submission deadlines for FYs 2019 and 2020 were not finalized at this time.[14]

CMS initially proposed to adopt policies and procedures for validation of the QRP data submitted at a later date. Some commenters raised concerns that the self-reported MDS data may not be accurate, and CMS acknowledged that policies and careful monitoring would be implemented to ensure data accuracy to "align with other QRPs and propose through future rulemaking data validation policies."[15]

In 2016, CMS reiterated that for payment determinations related to FY 2019 and subsequent years, SNFs would submit data quarterly, but also announced the intent to change to a calendar year reporting schedule. This shift would allow submission of a full year's data for FY 2019 (January 1, 2017 through December 31, 2017) rather than using an interim year with only nine months of data. Each particular quarter's data would be due approximately 4.5 months after the quarter ended, which would "give SNFs enough time to submit corrections to the assessment data[.]"[16] For the FY 2019 APU determination, NQF #2361 would have the following reporting periods and deadlines:[17]

[9] *See* 80 Fed. Reg. 46427, 46444 (Aug. 4, 2015).
[10] *Id.*
[11] *Id.* at 46446.
[12] *Id.* at 46457.
[13] *Id.*
[14] *Id.*
[15] *Id.* at 46458.
[16] 81 Fed. Reg. 51970, 52042 (Aug. 5, 2016).
[17] *Id.* at 52043.

Reporting Period	Submission/Correction Deadline
CY 2017 Q3: July 1, 2017 through September 30, 2017	February 15, 2018
CY 2017 Q4: October 1, 2017 through December 31, 2017	May 15, 2018

With regard to data validation, CMS once again stated it did "not propose any further details pertaining to the data validation process for the SNF QRP, but . . . plan[ned] to do so in future rulemaking cycles."[18]

In May 2017, CMS published a manual entitled *Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual*.[19] This manual, however, was not specifically related to data submission or validation, noting that "[t]he purpose of this manual is to present the methods used to calculate quality measures that are included in the Centers for Medicare & Medicaid Services (CMS) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)."[20] The manual does have a chapter on Certification and Survey Provider Enhanced Reports ("CASPER"), and states that they "can help identify data errors that affect performance scores" and "also allow the providers to utilize the data for quality improvement purposes." The main focus of the manual, however, is on what data is displayed, when it can be reviewed, and certain data submission deadlines, all reflecting those discussed in the Final Rules outlined above.[21]

At the same time, CMS held a webcast titled "Review and Correct Reports[22] Provider Training" and ultimately published participant questions and answers ("Q&A").[23] This Q&A indicated that the first reports in CASPER would be available prior to the end of May 2017, and that subsequent reports would be available quarterly.[24] Notably, the following question and reply was published:

> Are the quality measures for the SNF taken from the submitted MDS assessments? How do we verify our data are correct?
>
> ***
>
> SNFs have opportunities to review their information and validate their data for measure calculation using other reports available through CASPER such as data submission reports, which give providers information on fatal errors and warning messages ***related to data submission***. For example, various data submission reports provide details regarding assessment items submitted for a selected

[18] *Id.* at 52045.
[19] V1.0 (current as of May 22, 2017) (copy at Exhibit P-7).
[20] *Id.* at 1.
[21] *Id.* at 15-18.
[22] The CASPER reports include "Review and Correct Reports" and "Quality Measure Reports."
[23] Review and Correct Reports Provider Training, Participant Questions from Webcast on May 2, 2017 (May 19, 2017), *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/May-2-Review-Correct-Webcast-QA-May-2017.pdf.
[24] *Id.* at 2.

> MDS 3.0 assessment and others summarize errors encountered in assessments submitted during a specified period.[25]

In August 2017, which was during the ongoing reporting period for the FY 2019 APU determination, CMS published a final rule that preserved the previous reporting periods and submission/correction deadlines.[26] CMS still did not provide any further information on SNF QRP data validation requirements, but was "continuing to explore data validation methodology that will limit the amount of burden and cost to SNFs, while allowing us to establish estimations of the accuracy of SNF QRP data."[27] The requirements for data reporting and associated penalties were also codified at 42 C.F.R. § 413.360 at this time.[28]

Finally, in November 2017, which was during the reporting period at issue but several months before the final submission/correction deadline, CMS published Help Desk Questions and Answers for the SNF QRP.[29] One question and answer included was:

> How can we determine if our facility is compliant with the SNF QRP?
>
> SNFs have opportunities to review their information and validate their data for compliance with the SNF QRP quality measures using reports available through CASPER such as data submission reports which give providers information on fatal errors and warning messages ***related to data submission***.[30]

Additional Help Desk Questions and Answers were published in October 2018,[31] though this was after the submission/correction deadline had passed for the fiscal year under appeal. In this document, CMS explicitly states it is a SNF's burden to ensure accurate data submission, stating:

> There is not currently a report that will display your facility's current compliance with the annual payment update (APU) minimum submission threshold determination for the SNF QRP. The SNF QRP Review and Correct and Quality Measure Reports do not reflect a SNF's compliance with the QRP for the APU threshold calculation, but rather provide rates of facility performance on each of three assessment-based SNF QRP Quality Measures.[32]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

As a SNF, Universal is required to submit data to satisfy certain quality reporting requirements. Failure to submit the data in the correct form and manner, and at the correct time, will result in a

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[25] *Id.* at 14 (emphasis added).
[26] 82 Fed. Reg. 36530, 36601-36602 (Aug. 4, 2017).
[27] *Id.* at 36605.
[28] *Id.* at 36634-36635.
[29] *See* Exhibit P-8.
[30] *Id.* at 6 (emphasis added).
[31] *See* Exhibit P-9.
[32] *Id.* at 5.

two percent reduction to a SNF's APU.[33] For FY 2019, SNFs were required to report, at or above an 80 percent completion threshold, on quality measure NQF #2631: *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*. CMS's notice to Universal of its FY 2019 APU reduction advised that Universal did not meet the 80% threshold.[34]

Universal maintains that the two percent reduction to its APU is arbitrary and capricious because it properly relied on CMS' guidance in determining compliance with SNF quality reporting requirements by checking the validation reports.[35] Alternatively, Universal states that it erroneously included data related to thirty-one (31) non-PPS patients in its quality measure submission, and that CMS should not have included those patients in determining whether it met the requisite 80 percent completion threshold.[36]

Universal argues that it ran four different validation reports that showed the data it submitted was compliant and free of errors.[37] Universal maintains that trainings and subregulatory materials published and distributed by CMS encouraged providers to use and rely on these reports to ensure their data submissions were compliant and error free.[38] Universal claims that it did not take advantage of the opportunity to request CMS review or correct any of its quality measure results because these reports showed the submission was compliant.[39]

The Medicare Contractor explains that providers are given an opportunity to review their quality measure results prior to their public display, and that providers can request a review for any errors that are discovered.[40] Providers can submit an e-mail to request a review to correct any errors, and the Medicare Contractor maintains that this is the *only* way to correct any errors in the reported quality measure data.[41] According to the Medicare Contractor, the compliance reports relied upon by Universal are based on data submitted by Universal, which may be inaccurate.[42] The Medicare Contractor argues that Universal could have reviewed its submissions for accuracy or omissions and requested a correction for any underlying errors, such as the thirty one (31) non-Medicare patients which Universal claims were erroneously included in the submission and discovered after being notified of the FY 2019 APU reduction.[43]

Universal says it ran validation reports that showed it was compliant with its SNF QRP requirements for FY 2019. The Board disagrees. The subregulatory guidance released by CMS in 2017 explained that the "data submission reports" would "give providers information on fatal errors and warning messages ***related to data submission***."[44] Critical to the decision in this case,

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[33] 42 C.F.R. § 413.360.
[34] Exhibit C-1.
[35] Provider's FPP. at 6.
[36] *Id.* at 6-8.
[37] Exhibits P-3 – P-6.
[38] Provider's FPP at 2-6.
[39] *Id.* at 3.
[40] Medicare Contractor's FPP at 6, 13.
[41] *Id.* at 9-10, 13-14.
[42] *Id.* at 14-15.
[43] *Id.*
[44] *Supra* n. 25, 30 and accompanying text.

CMS had expressly notified providers that it did "*not* believe that the Review and Correct Reports would be an appropriate mechanism for informing SNFs whether they have complied with our data completion threshold."[45] CMS had repeatedly informed providers that it had not yet implemented comprehensive data validation policies for the SNF QRP,[46] but that providers themselves would have an opportunity to review the data they submitted for accuracy and to make corrections.[47]

Universal urges the Board to consider *PAMC, Ltd. v. Sebelius* as support for its position. In *PAMC*, the court noted that "it would certainly seem arbitrary and capricious for CMS to make an error that essentially prevented the proper submission of data then penalize a hospital for not presenting the data."[48] Universal, however, was never prevented from submitting data to satisfy its SNF QRP obligations.

Moreover, Universal acknowledges that the reason it failed to meet the SNF QRP requirements was due to the fact that Universal, itself, had included in error certain data on non-Medicare patients in its submission.[49] The Board finds no support for Universal's assertion that CMS had assumed or should otherwise have the responsibility for ensuring the accuracy of quality reporting data that providers are responsible for submitting.

Accordingly, the Board finds that Universal failed to comply with the SNF QRP reporting requirements necessary to avoid the two percent reduction of its FY 2019 APU, *i.e.*, failed to submit the requisite data "in the form and manner, and at a time, specified by CMS" as required by 42 C.F.R. § 413.360(b)(1).

DECISION

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

Board Members Participating:

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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
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For the Board:

8/19/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[45] 82 Fed. Reg. 36530, 36605 (Aug. 4, 2017) (emphasis added).
[46] 80 Fed. Reg. 46390, 46458 (Aug. 4, 2015); 81 Fed. Reg. 51970, 52045 (Aug. 5, 2016); 82 Fed. Reg. at 36605.
[47] *See* 80 Fed. Reg. at 46457; 81 Fed. Reg. at 52042; 82 Fed. Reg. at 36607-36608.
[48] 747 F.3d 1214, 1219 (9th Cir. 2014).
[49] Provider's FPP at 6-8.