PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D04

PROVIDER –
Hospice of Washington County

HEARING DATE –
November 8, 2022

Provider No. –
16-1544

Fiscal Year –
2021

vs.

MEDICARE CONTRACTOR –
CGS Administrators

Case No. –
21-0661

INDEX

ISSUE STATEMENT

Whether the Centers for Medicare and Medicaid Services ("CMS") properly imposed a two percentage point reduction to the fiscal year ("FY") 2021 Medicare annual payment update ("APU") for Hospice of Washington County (the "Provider").[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that the Provider did not submit its hospice quality data in the form and manner, and at the time specified by the Secretary of Health and Human Services ("Secretary") and, thus, the two (2) percentage point reduction in its FY 2021 APU was proper.

INTRODUCTION

The Provider is a Medicare-certified freestanding hospice provider located in Washington, Iowa.[2] The Provider's assigned Medicare contractor[3] is CGS Administrators ("Medicare Contractor").

By letter dated July 10, 2020, the Medicare Contractor notified the Provider that it was subject to a reduction of its APU by two (2) percentage points for FY 2021 "for not meeting the Affordable Care Act ("ACA") requirement for hospices to submit quality data."[4] Specifically, the Notice stated that the Provider was noncompliant with the quality data reporting requirements for the timely submission of Hospice Item Set ("HIS") data.[5]

The Provider requested reconsideration of CMS's decision. By letter, dated September 28, 2020, the Medicare Contractor notified the Provider that CMS upheld the decision to reduce the APU for Medicare payments for FY 2021 by two (2) percentage points, explaining that the Provider did not furnish evidence "that it submitted the required quality measure data during the required timeframes."[6] On February 1, 2021, the Provider timely appealed the reconsideration determination to the Board and met the jurisdictional requirements for a hearing.[7]

The Board held a video hearing on November 8, 2022. The Provider was represented by the following Provider employees: Rose Fisher, Medical Social Worker; and Katrina Altenhofen, Director. The Medicare Contractor was represented Joseph Bauers, Esq. of Federal Specialized Services ("FSS").

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[1] The parties stipulated to the issue statement at the hearing. *See* Transcript ("Tr.") at 6.
[2] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3.
[3] CMS's 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.
[4] Exhibit C-1 at C0003.
[5] *Id.* at C0002. Of note, by letter dated July 29, 2020, the Medicare Contractor corrected the header of the July 10, 2020 letter, which erroneously stated the incorrect fiscal year of the APU.
[6] Exhibit C-2.
[7] Provider's Appeal Request (Feb. 1, 2021).

STATEMENT OF FACTS

In § 122 of the Tax Equity and Fiscal Responsibility Act of 1982, Congress amended 42 U.S.C. § 1395f(i) to provide a Medicare Hospice Benefit for Medicare beneficiaries. The Medicare hospice benefit provides a per diem payment in one of four prospectively determined rate categories of hospice care.[8] 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.[9]

Under § 3004(c) the Patient Protection and Affordable Care Act of 2010 ("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.[10] These provisions further mandated that a hospice's APU be reduced by two (2) percentage points if that hospice failed to properly report the required quality data measures for a particular fiscal year.[11] 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.[12] 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.[13] The CAHPS survey "seeks information from the informal caregivers of patients who died while enrolled in hospices."[14] The data from the CAHPS surveys must be submitted on behalf of the hospice by a CMS-approved third party vendor, though it remains the hospice's responsibility to ensure its vendor is submitting the data in a timely manner.[15]

With regard to the HIS data submission, CMS finalized the hospice reporting requirements in the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule issued on August 6, 2015 ("FY 2016 Hospice Final Rule").[16] To avoid the APU reduction for FY 2021, hospices were to complete HIS data collection for Calendar Year ("CY") 2019 (*i.e.*, the reporting period) in accordance with the reporting requirements specified in the FY 2016 Hospice Final Rule, which required regular and ongoing electronic submission of the HIS data.[17]

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[8] 82 Fed. Reg. 36638, 36641 (Aug. 4, 2017).
[9] 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).
[10] ACA, Pub. L. No. 111-148, § 3004(c), 124 Stat. 119, 368 (2010).
[11] 42 U.S.C. § 1395f(i)(5)(A).
[12] CMS initially implemented the HIS submission requirements 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).
[13] All hospices were required to participate in the CAHPS survey for one month in the first quarter of 2015, with the requirement of ongoing monthly participation beginning April, 2015. 78 Fed. Reg. 48233, 48263 (Aug. 7, 2013).
[14] 79 Fed. Reg. at 50491.
[15] 80 Fed. Reg. 47141, 47196 (Aug. 6, 2015).
[16] *Id.* at 47189-92.
[17] *Id.* at 47192.

Hospices have thirty (30) days from patient admission or discharge to submit the appropriate HIS record for that patient through the Quality Improvement and Evaluation System ("QIES") Assessment Submission and Processing ("ASAP") system.[18] "Beginning January 1, 2018 to December 31, 2018 [and thereafter], hospices must score at least ninety percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a two percentage point reduction to their market basket update for FY 2020."[19] The ultimate goal was "to require all hospices to achieve a timeliness requirement compliance rate of ninety percent, or more,"[20] and after implementing this goal over a three (3)-year period, starting with HIS records submitted for CY 2018, and all subsequent years, hospices must score at least ninety percent to avoid the two percentage point reduction to their APU for the FY that falls two years later.

A. Submission of HIS Records and Files

In the FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule ("FY 2018 Hospice Final Rule"), CMS recommended that providers complete and attempt to submit HIS records early, prior to the previously finalized submission deadline of 30 days, beginning in FY 2018, in order to be sure to meet the timeliness requirement. The FY 2018 Hospice Final Rule states:

> In the FY 2016 Hospice [Final Rule] (80 FR 47191), we also clarified the difference between the completion deadlines and the submission deadlines. Current sub-regulatory guidance produced by CMS (for example, HIS Manual, HIS trainings) states that the completion deadlines for HIS records are 14 days after the Event Date for HIS Admission records and 7 days after the Event Date for HIS Discharge records. Completion deadlines continue to reflect CMS guidance only; these guidelines are not statutorily specified and are not designated through regulation. These guidelines are intended to offer clear direction to hospice agencies in regard to the timely completion of HIS Admission and HIS Discharge records. The completion deadlines define only the latest possible date on which a hospice should complete each HIS record. This guidance is meant to better align HIS completion processes with clinical workflow processes; however, hospices may develop alternative internal policies to complete HIS records. Although it is at the discretion of the hospice to develop internal policies for completing HIS records, *we will continue to recommend that providers complete and attempt to submit HIS records early, prior to the previously finalized submission deadline of 30 days, beginning in FY 2018*. ***Completing and attempting to submit records early allow providers ample time to address any technical issues encountered in the QIES ASAP submission process, such as correcting fatal error messages***. Completing and attempting to submit records early will ensure that providers are able to comply with the 30-

[18] *Id.*
[19] *Id.*
[20] *Id.*

> day submission deadline. *HQRP guidance documents, including the CMS HQRP Web site, HIS Manual, HIS Trainings, Frequently Asked Questions, and Fact Sheets,* continue to offer the most up-to-date CMS guidance to *assist providers in the successful completion and submission of HIS records*.[21]

The HIS Manual, *Guidance Manual for Completion of the Hospice Item Set (HIS)*, effective November 15, 2018 (V2.01) ("HIS Manual"), provided, in section 3.3, Validation of Records and Files, further details on the HIS data submission process, as follows:

> The QIES ASAP system validation edits are designed to monitor the timeliness and ensure that the submitted records conform to the HIS Data Submission Specifications. *If submitted HIS records do not meet the edit requirements, the system will provide fatal error and/or warning messages on the Final Validation Report*. The following describes the validation, storage, and reporting of records in a submission file.
>
> **1. Initial Submission Confirmation.** For each file submitted, the submitter will receive an online confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the file submission number, as well as the date and time the file was received for processing. Providers should print and maintain a copy of this confirmation.
>
> **2. Validation and Editing.** Each time a user submits a HIS file to the QIES ASAP system, three types of validation are performed:
>
> - **Fatal File Errors.** The file structure is validated to ensure it follows the requirements outlined in the HIS Data Submission Specifications provided by CMS. The file is rejected by the QIES ASAP system if the file structure does not meet these requirements. *Examples of fatal file errors include the following*:
>   – *The file is not a ZIP file*.
>   – The records in the ZIP file cannot be extracted.
>   – The file cannot be read.
> - *The Submitter Final Validation Report will list any fatal file error(s). Files that are rejected must be corrected and resubmitted*.
> - **Fatal Record Errors.** If the file structure is acceptable, then each HIS record in the file is validated individually for fatal record errors.
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> ****
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> - **Warnings (Non-fatal Errors).** The record is also validated for warnings (non-fatal errors). Warnings include, but are not

[21] 82 Fed. Reg. 36638, 36664 (Aug. 4, 2017) (emphasis added).

> limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. . . . All warnings (non-fatal errors) are reported to the provider in the Final Validation Report. The provider must evaluate each warning to identify necessary corrective actions.
>
> **3. Storage to the QIES ASAP System.** If there are any fatal record errors, the record will be rejected and not stored in the QIES ASAP system. If there are no fatal record errors, the record is stored in the QIES ASAP system, even if the record has warnings (non-fatal errors).
>
> Detailed information on the validation error and warning messages is available in the **Hospice Item Set (HIS) Submission User's Guide**, which is available on the hospice welcome page and on the QTSO website at https://qtso.cms.gov/providers/hospiceproviders/reference-manuals.[22]

The QIES Technical Support Office ("QTSO") for the HIS publishes the HIS Submission User's Guide mentioned above.[23] The subsection of Chapter 3, titled "Submitting HIS Data," provides detailed instructions on how to submit HIS data as well as screenshots of what the provider will see on the screen at each step through the end of the submission when the user receives the "Submission Received Confirmation Message."[24]

At Step 6 of the "Submitting HIS Data" instructions, this Guide explains that the Hospice File Submission File Upload webpage displays a message confirming that the file the provider submitted was successfully received by the National Submission Database.[25] That message states that the Provider will receive a message showing not only that the submission has been received, the Submission ID, Submission Date and File Name, but also the following message: "Your submission file will be processed for errors within 24 hours. The Final Validation Report, which contains detailed information about your submission, may be accessed in the CASPER Reporting application. It is recommended that you print and retain the Final Validation Report."[26] The "NOTE" at the end of Step 6 of the Guide's instructions advises that "[e]rrors that exist in the submitted file are identified only after the Hospice system subsequently validates the file."[27]

Step 8 of the "Submitting HIS Data" instructions, provides similar instructions as those provided in the screenshot message, described above, as follows:

> After your submitted HIS data file is successfully received at the National Submissions Database, the QIES ASAP Hospice system validates the file structure and data content based upon the HIS data

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[22] (Italics and underline emphasis added.)
[23] HIS Submission User's Guide, *available at* https://qtso.cms.gov/providers/hospice-providers/reference-manuals (last accessed Nov. 28, 2022); *see also* Exhibit C-8.
[24] HIS Submission User's Guide, Ch. 3, pp. 3-11 to 3-14 (v1.01 Feb. 2018).
[25] *Id.* at 3-14.
[26] *Id.* at Figure 3-14.
[27] *Id.* at 3-15.

> specifications. Within 24 hours of a successful submission, you may access a Final Validation Report in the CASPER Reporting application that provides a detailed account of any errors found during the validation of the records in the submitted HIS file.[28]

Chapter 5 of the HIS Submission User's Manual is entitled "Error Messages" provides a list of example errors, including "[i]nvalid Zip file format," and "[e]mpty Zip file."[29] Chapter 5 further states that "[a]ll fatal errors in a file or record must be corrected and the file or record resubmitted."[30] The error, "Invalid Zip File" is categorized as a ***fatal*** error, and indicates CMS is unable to process the submitted file.[31] The HIS Submission User's Guide provides a list of potential causes, tips to correct the error, as well as suggested actions for the user to take to correct the error.[32]

B. Extensions and Exemptions to HIS Data Submission Requirements

The regulation at 42 C.F.R. § 418.312(i) provides certain extensions and exemptions to data submission requirements under the HQRP. While subsection (i) was not added to the text of § 418.312 until the August 31, 2020, CMS had adopted its extensions and exemptions policy as part of the FY 2016 Hospice Final Rule as explained in the preamble to the August 31, 2020 final rule:

> On page 47207 of the FY 2016 final rule, we made technical errors in the regulations text of § 418.312. In this section, we inadvertently omitted language on our extension and exemption requirements policy. Accordingly, we are adding § 418.312(i) to accurately reflect our policy on extension and exemption requirements for the [HQRP].[33]

Accordingly, the Secretary made "[t]his [August 31, 2020] *correcting* amendment . . . applicable beginning October 1, 2015."[34] As a result of this ***retroactive*** codification, subsection (i) applies to the period at issue in this case and reads as follows:

> *(i) Exemptions and extensions requirements.* (1) A hospice may request and CMS may grant exemptions 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 hospice.
>
> (2) A hospice requesting an exemption or extension must do so within 90 days of the date that the extraordinary circumstances occurred by sending an email to CMS Hospice QRP Reconsiderations at *HospiceQRPReconsiderations@cms.hhs.gov* that contains all of the following information:

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[28] *Id.*
[29] *Id.* at 5-3.
[30] *Id.* at 5-4.
[31] *Id.* at 5-5.
[32] *Id.*
[33] 85 Fed. Reg. 53679, 53680 (Aug. 31, 2020).
[34] *Id.* at 53679.

(i) Hospice CMS Certification Number (CCN).

(ii) Hospice Business Name.

(iii) Hospice Business Address.

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

(v) Hospice's reason for requesting the exemption or extension.

(vi) Evidence of the impact of extraordinary circumstances beyond the hospice's control, including, but not limited to photographs, newspaper, other media articles, or independent sources attesting to the incident that can be reasonably corroborated. Include dates of occurrence and other documentation that may support the rationale for seeking extension or exemption.

(vii) Date when the hospice believes it will be able to again submit data under paragraph (b) of this section and a justification for the proposed date.

(3) CMS may grant exemptions or extensions to hospices without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance, such as an act of nature including a pandemic, affects an entire region or locale.

(ii) A systemic problem with one of CMS' data collection systems directly affect the ability of a hospice to submit data under paragraph (b) of this section.

CMS further stated that, "[i]f a hospice is granted an exemption, we will not require that the hospice submit any quality data for a given period of time."[35] The exemption/extension process was in guidance materials and posted on the CMS website.[36]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

In its Final Position Paper, the Provider explains that this appeal "is based on the fact that the HIS reports were completed and sent to CMS for review; however *due to system error*, they were not formatted correctly, and CMS was not able to open and review them."[37] After the alleged "system error" was discovered, the Provider completed and re-uploaded all HIS records for the 2019 calendar year to the QIES ASAP system.[38]

[35] 80 Fed. Reg. 47142, 47193 (Aug. 6, 2015).
[36] *See* Exhibit C-4 at C0045 (providing link to CMS website); Exhibit C-6 (HIS checklist).
[37] Provider's Final Position Paper ("Provider's FPP") at 1.
[38] *Id.* (emphasis added).

According to the Provider, the alleged "system error" was the result of a change in a new electronic medical record ("EMR") system, and a change in staffing that included passing on the responsibility of submitting the required HIS records/reports to a different employee.[39] Specifically, the Provider contends that instructions (such as manuals or guidance for completing the HIS records) were not provided, and that the "lack of clear and concise education on the EMR and HIS process resulted in [the Provider's] staff continuing to perform the task as they were previously;"[40] namely submitting HIS records in an invalid file format.[41] As a result, the HIS records were not showing up as being submitted to CMS.[42] The Provider explains that *this file **formatting** error* was a result of "how the files were saved and uploaded to the QIES system [by the Provider]."[43]

While the Provider acknowledges that the HIS reports were not received by CMS in the format requested, the Provider asserts that the later resubmission of the corrected files shows that the Provider "understands the importance of the HIS reports and their submission, and put forward a good faith effort to correct [its] mistakes and maintain compliance with CMS rules."[44]

At the hearing, the Provider's social worker testified that it was not until April 2020, during those changes in the EMR system and staffing, described above, that "it was discovered that the reports were not submitted to the QIES teams system correctly, and no [HIS] records were present for the time frame [that included the HIS data submitted for the FY 2021 APU, *i.e.*, for admissions and discharges during the 2019 calendar year.]"[45] Thereafter, "[w]ithin a matter of days, several months' worth of admission and discharge records were processed."[46] While the records "were not submitted in the correct format within the correct time frame, the data files were in fact submitted to the system, and the system shows them as uploaded."[47]

The social worker testified that the Provider's previous employee completed the first phase (*i.e.*, uploading the reports to the QIES ASAP system) and had that previous employee continued on and performed the next step (which was getting the Final Validation Report and of which she had not been aware) she would have received the ZIP file error.[48] The social worker testified that she was not aware of the HIS Manual or the Submission User's Guide at that time.[49] When they were implementing a new EMR system, and making sure they were doing everything correctly, that is when they discovered the errors in the HIS record submissions, which began with the former employee's submissions.[50]

In response, the Medicare Contractor notes that, "[a]ccording to the Provider, the reason that nothing was showing up as being submitted [in the QIES ASAP system] was *since the ZIP files*

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[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.* at 2.
[45] *See* Tr. at 17.
[46] *Id.*
[47] *Id.* at 18.
[48] *Id.* at 17-24.
[49] *Id.* at 25.
[50] *Id.* at 26, 32-33.

were not valid. Based on the [information in the] HIM [*sic* HIS] Manual, any fatal file errors would have been listed on the Submitter Final Validation Report. Then the Provider can correct and resubmit the files."[51] The Provider indicated that, when it was determined that a Final Validation Report had not been obtained, the Provider "contacted [the] CMS Help Desk and was informed that zero HIS records had been accepted by the system for the dates of April 1, 2019 through April 13, 2020, as they were submitted in an invalid [file] format."[52] By then the Provider had passed the HIS data submission timeline for the 2019 calendar year, which requires submission of "at least 90% of all HIS records within 30 days of the event date (patient's admission date or discharge date) for patient admissions/discharges occurring [during the 2019 calendar year]."[53]

The Medicare Contractor argues that CMS cannot be expected to bear the burden of the Provider's inability to be in compliance with the format and timeliness requirements.[54] The Contractor notes that "[i]t is the Provider's responsibility to develop sufficient internal processes to ensure that its submitted data is accepted in a timely manner as specified by the Secretary"[55] and, in support of its position, cites to 42 U.S.C. § 1395(i)) and the FY 2018 Hospice final rule's recommendations for internal processes, which are quoted above.[56]

At the hearing, the Medicare Contractor argued that the HIS Submission User's Guide provides detailed instructions and guidance on submitting files as demonstrated by excerpts from that Guide at Exhibit C-8. The Medicare Contractor specifically identified portions of the HIS Submission User's Guide that explain that submitted files are not the same as accepted files. Successful submission is a two-step process in which the files are: (1) submitted or uploaded, and then (2) validated and resubmitted with corrections as relevant. As part of the second step, those files are reviewed or scanned for errors over an approximately 24-hour period and, after that scanning, the QIES ASAP system produces a Final Validation Report detailing any errors. The Guide states that the Final Validation Report is available to providers in the CASPER reporting application; and that all fatal errors ***must*** be corrected, and the corrected file or record ***must*** be resubmitted.[57]

The Medicare Contractor argues that, while the Provider resubmitted the corrected files or records, they were not resubmitted until April 2020, well beyond the 30-day submission window for any 2019 calendar year admissions or discharges. Further, CMS makes the information available, and the fact that the Provider did not know (or chose not) to look at the CASPER reports does not somehow shift its burden to CMS given that numerous notices and instructions/guidance are sent out to providers and trainings are available. Finally, the Medicare Contractor notes that the HQRP requirements are in binding regulations that neither CMS nor the Medicare Contractor have to ability to ignore, and thus they must implement the two percent penalty when the HQRP requirements are not met.[58]

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[51] Medicare Contractor's Final Position Paper at 11 (emphasis added).
[52] *Id.* at 12.
[53] *Id.*
[54] *Id.* at 13.
[55] *Id.* at 14.
[56] *Id.* at 13-14 (citing 82 Fed. Reg. at 36664).
[57] Tr. at 43-44 (citing to Exhibit C-8 at C0104-05).
[58] *Id*. at 43-46.

On review of the administrative record, the Board finds that the screenshots provided in the HIS Submission User's Guide show that the Provider should have been aware that there was an additional, second step for successful HIS data submission. First, a message that appears on the screen after a user uploads or submits HIS records or files to prompt/remind the user that there is another step. Further, the HIS Submission User's Guide provides instruction at Step 6 of the "Submitting HIS Data" and shows that the Hospice File Submission File Upload webpage displays a message confirming that the file the provider submitted was successfully received at the National Submission Database, as well as the Submission ID, the Submission Date and the File Name, and also the following message:

> Your submission file will be processed for errors within 24 hours. The Final Validation Report, which contains detailed information about your submission may be accessed in the CASPER Reporting application. It is recommended that you print and retain the Final Validation Report.[59]

Thus, while the Provider asserts that it was unaware of the HIS Manual and the Submission User's Guide, the information *that would have appeared as the Provider navigated through the QIES ASAP system's webpages while uploading the invalid ZIP files* included instruction and recommendations on what to do next, in order to ensure a successful submission that was free of errors.

Moreover, Figure 4-1 in the HIS Submission User's Guide is a screenshot of the Welcome to the CMS QIES Systems for Providers webpage, which includes options for selecting links for "Hospice Submissions," as well as "Casper Reporting," next to which states "[s]elect this link to access the Final Validation and Provider reports."[60] Thus, the link to access the Final Validation Report is near the Hospice Submissions link, which the Provider would have had to access in order to have submitted the invalid ZIP files at issue.

The Board notes that the Provider failed to access its Final Validation Reports until *after* the data submission deadline for the 2019 calendar year data and, as a result, was unaware of the *fatal* error messages on its Final Validation Reports. If the Provider had accessed its Final Validation Reports in a timely and prudent fashion, it would have known about the ZIP file errors and could have corrected the *fatal* error within the data submission deadline.

The Board acknowledges that the Provider made efforts to correct the deficiencies in its HIS data submission obligations. Nevertheless, it is undisputed that the Provider did not submit its data in the correct format within the required timeframe. The CASPER Report for the Provider, showing the FY 2021 Hospice Timeliness Compliance Threshold Report, reveals that the Provider submitted 193 HIS records for the 2019 calendar year, and that *none of the records* were submitted and accepted on time.[61]

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[59] HIS Submission User's Guide, Ch. 3, at 3-14, Figure 3-14.
[60] *Id.* at 4-2.
[61] Exhibit P-3 (emphasis added).

The Board finds that the statute requires hospice providers to not just submit their patients' quality data, but to submit the data in the *form and manner, and at the time* specified by the Secretary.[62] The Board finds that CMS issued various manuals and instructions that implemented and explained the form, manner, and time specifications for submitting quality data, as described herein. Moreover, the QIES ASAP system itself provided information during the data submission process notifying the Provider of the second step, which is to access the Final Validation Report and, as relevant, resubmit following correction of any errors identified therein. However, the Provider failed to take that second step to validate its data submission (which, if it had done so, would have resulted in it identifying and correcting the fatal error at issue and resubmitting the data in the correct format).

Further, the Provider did not submit a request for an extension or exemption pursuant to the process memorialized in 42 C.F.R. § 418.312(i)(1)-(2) (as discussed *supra*), nor has it established that it met the requirements for such an extension or exemption. The Board finds that the Provider also did not meet the requirements for an extension or exemption under 42 C.F.R. § 418.312(i)(3), as the Provider has acknowledged that its errors were due to its own internal processes and not an extraordinary circumstance, such as an act of nature including a pandemic, which affects an entire region or locale, or a systemic problem with one of CMS' data collection systems that directly affected the ability of the hospice to submit data.

In sum, the Board concludes that, because the Provider submitted HIS data using ZIP files that were unacceptable to CMS and then failed to correct this fatal error *until after* the deadline to do so, the Provider did not submit its data to CMS in the form and manner, and at a time specified by the Secretary. Accordingly, the Board finds that, in accordance with 42 U.S.C. § 1395f(i)(5)(A), CMS was correct in reducing the Provider's FY 2021 APU by two (2) percentage points.

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that Provider did not submit its hospice quality data in the form and manner, and at the time specified by the Secretary and, thus, the two (2) percentage point reduction in its FY 2021 APU was proper.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

11/29/2023

X Clayton J. Nix

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

[62] 42 U.S.C. § 1395f(i)(5)(C); 42 C.F.R. § 418.312(a) (emphasis added).