PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D26

PROVIDER –
CMK Home Health Agency, Inc.
Westmont, Illinois

Provider No.: 14-7970

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Palmetto GBA

DATE OF HEARING –
February 22, 2013

Reporting Period Ended –
Calendar Year 2012

CASE NO.: 12-0407

INDEX

ISSUE:

Whether the imposition of a 2 percentage point reduction in the annual market basket percentage update for CMK Home Health Agency, Inc.'s Medicare payments for calendar year ("CY") 2012 was proper?[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the U.S. Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

The Balanced Budget Act of 1997 ("BBA")[4] provided for the development of a prospective payment system for all Medicare-covered home health services ("HH PPS"). Specifically, BBA §4603 added 42 U.S.C. § 1395fff requiring the Secretary to establish an HH PPS for all covered home health care services effective October 1, 2000.

The Deficit Reduction Act of 2005 ("DRA")[5] required home health agencies ("HHAs") to submit health care quality data as determined by the Secretary and imposed a penalty upon the home health care agency for failure to do so. Specifically, DRA § 5201(c)(2) added the following language, in pertinent part, at 42 U.S.C. § 1395fff(b)(3)(B):

> (v) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.
>
> (I) ADJUSTMENT. For purposes of clause (ii)(V), for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the prospective

[1] Transcript, ("Tr.") at 5-6
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See:* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] Pub. L. No. 105-33, 111 Stat. 251 (1997). *See also*: 65 Fed. Reg. 41128, 41129 (July 3, 2000).
[5] Pub. L. No. 109-171, 120 Stat. 4 (2006). *See also*:72 Fed. Reg. 49762, 49763 (Aug. 29, 2007).

> payment amount under this section for a subsequent year, and the Medicare Payment Advisory Commission shall carry out the requirements under section 5201(d) of the Deficit Reduction Act of 2005.
>
> (II) SUBMISSION OF QUALITY DATA. For 2007 and each subsequent year, each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause....

The Secretary exercised the authority delegated by Congress in subclause (II) above to define required data through notices published as rulemakings in the Federal Register.

The first notice was published as a final rule issued on November 9, 2006 ("November 2006 Final Rule"). [6] CMS codified the DRA pay-for-reporting requirement at 42 C.F.R. §§ 484.225(h) and (i):

> (h) For 2007 and subsequent calendar years, in the case of a home health agency that submits home health quality data, as specified by the Secretary, the unadjusted national prospective 60-day episode rate is equal to the rate for the previous calendar year increased by the applicable home health market basket index amount.
>
> (i) For 2007 and subsequent calendar years, in the case of a home health agency that does not submit home health quality data, as specified by the Secretary, the unadjusted national prospective 60-day episode rate is equal to the rate for the previous calendar year increased by the applicable home health market basket index amount minus 2 percentage points. Any reduction of the percentage change will apply only to the calendar year involved and will not be taken into account in computing the prospective payment amount for a subsequent calendar year. [7]

For CY 2007, the November, 2006 Final Rule advised providers that avoiding the 2 percentage point reduction in the annual market basket percentage update ("APU") was tied to submission of additional data for the Outcome and Assessment Information Set ("OASIS"), a pre-existing home health agency reporting tool, for episodes beginning on or after July 1, 2005 and before July 1, 2006. [8] Further, in order to avoid the 2 percentage point reduction to the APU for certain subsequent periods, the November, 2006 Final Rule required the provider to comply with the additional OASIS data submission for CY 2007.

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[6] 71 Fed. Reg. 65884 (Nov. 9, 2006).
[7] *Id.* at 65935.
[8] *Id.* at 65889, 65891.

The notices for CYs 2008, 2009, and 2010 were published as final rules on August 29, 2007 ("August 2007 Final Rule"),[9] November 3, 2008 ("November 2008 Final Rule"),[10] and November 10, 2009 ("November 2009 Final Rule")[11] respectively. Similar to the November, 2006 Final Rule and consistent with 42 C.F.R. §§ 484.225(h) and (i), these rulemakings advised providers that avoiding the 2 percentage point penalty to the APU was tied to the submission of additional data for the OASIS.[12] In particular, avoiding the 2 percentage point penalty for the APU for CYs 2008, 2009 and 2010 was tied to submission of additional OASIS data for a 12-month cycle beginning July 1 of the year that is two years prior to the rate year (*e.g.*, for CY 2008, OASIS data for the 12-month cycle beginning July 1, 2006).[13] CMS also confirmed that the APU for subsequent rate years would be tied in a similar fashion to the 12-month cycle beginning July 1 of the year that is two years prior to the rate year.[14]

Further, in the November 3, 2008 Final Rule, CMS notified providers that, in the near future, the HHA quality measures reporting requirements would be expanded to include a new survey tool referred to as the Consumer Assessment of Health Care Providers and Systems ("CAHPS") Home Health Care Survey ("HHCAHPS Survey").[15] The HHCAHPS Survey would measure and publicly report patient experiences with home health care. The rule advised the public of the then-current status of this initiative and where additional information could be obtained:

> CMS is working with a contractor to develop protocols and guidelines for implementation of CAHPS Home Health Care survey.[16] Administration of the survey will be conducted by multiple, independent survey vendors working under contract with home health agencies to facilitate data collection and reporting. During 2008, vendor training materials are being developed, and implementation procedures for data submission and processing will be finalized. Recruitment and training of vendors who wish to be approved to collect survey data will begin in 2009. The CAHPS Home Health Care Survey will be implemented similar to the CAHPS Hospital survey where vendors are approved to conduct

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[9] 72 Fed. Reg. 49762 (Aug. 29, 2007).
[10] 73 Fed. Reg. 65351 (Nov. 3, 2008).
[11] 74 Fed. Reg. 58078 (Nov. 10, 2009).
[12] *See* 72 Fed. Reg. at 49861, 48964; 73 Fed. Reg. at 65356; 74 Fed. Reg. at 58096.
[13] *See* 72 Fed. Reg. at 49765; 73 Fed. Reg. at 65353, 65356; 74 Fed. Reg. at 58096.
[14] *See* 74 Fed. Reg. at 58096. *See also* Medicare Claims Processing Manual, CMS Pub 100-04 ("MCPM 100-04"), Transmittal 1647 (Dec. 12, 2008) (adding § 120 to MCPM 100-04, Ch. 10)
[15] 73 Fed. Reg. at 65351, 65356.
[16] Research Triangle Institute ("RTI") is CMS' current contractor and has been since the implementation of HHCAHPS. RTI has multiple responsibilities and roles. RTI serves as the data warehouse for the submission of HHCAHPS data and its output. It also helped write the procedure manual critical to HHCAHPS. RTI also functions as an information source for HHAs and their vendors regarding HHCAHPS and is a major source of the postings on the HHCAHPS web site located at http://www.homehealthCAHPS.org. The manual referred to, specifically the HHCAHPS Protocols and Guidelines Manual, is an extensive document covering all aspects of HHCAHPS. There are references in the Federal Register rule making process and frequent postings on the web site. The most recent version is always available in the HHCAHPS website. *See generally* HHCAHPS website: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ActiveProjectReports/Active-Projects-Reports-Items/CMS1187490.html (providing description of RTI contract).

> the survey and trained prior to agency participation in the survey. Home health agencies interested in learning about the survey are encouraged to view the CAHPS Home Health Care Survey Web site: http://www.homehealthCAHPS.org. They can also call toll-free: 1-866-354-0985 or send an email to the project team at HHCAHPS@rti.org for more information. [17]

In the November, 2009 Final Rule, CMS provided additional substantive guidance on expanding the HHA quality measures reporting requirements to include the HHCAHPS Survey. In this regard, the preamble to the final rule provides the following summary of CMS' planned implementation of the HHCAHPS Survey:

> For this final rule, we are adopting three changes to the previously proposed provisions for HHCAHPS. The first change is the delay in the HHCAHPS linkage to the annual payment update, from CY 2011 to CY 2012. This delay means that home health agencies will need to conduct a dry run for at least one month in the third quarter 2010, and continuously collect survey data beginning in the fourth quarter 2010 and moving forward. HHAs are urged to note the revised dates in this Final Rule and to routinely check the Web site http://www.homehealthcahps.org for the key dates. The second change concerns the patients eligible for the survey: only Medicare and/or Medicaid patients will be eligible to take the HHCAHPS survey. The third change is that V codes may be submitted if ICD – 9 codes are unavailable. Home Health Compare will be updated to reflect the addition of HHCAHPS to the quality reporting requirements. [18]

CMS provided more detailed information regarding the planned implementation of HHCAHPS in response to a comment:

> *Comment*: While commenters were generally supportive of the survey and of quality improvement measures in home health, many requested a delay in the implementation of the survey. Commenters were concerned about implementing this new requirement at the same time as the roll-out for OASIS-C. They wanted home health agencies to have additional time to select a vendor to conduct the survey for them. Commenters were concerned about not accounting for this expense in their 2010 budgets, and wanted additional time to evaluate and pilot the survey on their own.
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> *Response*: CMS has carefully considered the comments it received, and is delaying the linkage of HHCAHPS data to the quality

[17] 73 Fed. Reg. at 65351, 65357.
[18] 74 Fed. Reg. at 58104.

> reporting requirements for the annual payment update by 6 months. This will allow home health agencies to first fully implement OASIS-C before being required to implement the HHCAHPS survey for payment considerations. As such, agencies will be required to do a dry run for at least one month in third quarter CY 2010, and to begin data collection on an ongoing basis in October 2010. With this change, HHAs will be required to submit dry run data from the third quarter of CY 2010 to the Home Health CAHPS Data Center by 11:59 p.m. EST on January 21, 2011. Similarly, HHAs will be required to submit data for the fourth quarter of CY 2010 to the Home Health CAHPS Data Center by 11:59 p.m. on April 21, 2011. With this delay, HHCAHPS will be a requirement for agencies to receive their full 2012 annual payment update.... [19]

The preamble to the November, 2009 final rule also states that "...HHAs will have the opportunity to voluntarily implement HHCAHPS for a year (October 2009 through September 2010) for 'practicing' the implementation procedures before data collection 'counts' toward an annual payment update." [20]

CMS reiterated that the failure to participate in the dry run or failure to continuously collect and submit survey data as stated in the November, 2009 Final Rule would cause a reduction of 2 percentage points to the APU for CY 2012. [21]

The preamble to the November 2009 Final Rule also advised providers relative to CMS' data collection requirements:

> To collect and submit HHCAHPS data to CMS, Medicare-certified agencies will need to contract with an approved HHCAHPS survey vendor. Beginning in summer 2009, interested vendors applied to become approved HHCAHPS vendors. The application process was (and still is) delineated online at https://www.homehealthcahps.org. Vendors are required to attend training conducted by CMS and the HHCAHPS Survey Coordination team, and to pass a post-training certification test. [22]

Finally, the preamble to the November, 2009 Final Rule gave advice to providers on what to review and monitor. First, CMS gave the following advice regarding HHCAHPS data submission reports:

> In the proposed rule, we strongly recommended that home health agencies participating in the HHCAHPS survey promptly review

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[19] *Id.* at 58103.
[20] *Id.* at 58126.
[21] *Id.* at 58101.
[22] *Id.* at 58099.

> the required Data Submission Summary Reports that are described in the Protocols and Guidelines Manual posted on https://www.homehealthcahps.org. These reports will enable the home health agency to ensure that its survey vendor has submitted their data on time, and that the data have been accepted/received by the Home Health CAHPS Data Center. We received no comments on this proposal, and are finalizing it as proposed. [23]

CMS continued by advising providers to monitor the HHCAHPS website for updates:

> It is strongly recommended that all home health care agencies participating in the HHCAHPS survey regularly check the Web site https://www.homehealthcahps.org for program updates and information. [24]

In the final rule published on November 17, 2010 ("November 2010 Final Rule"),[25] CMS reaffirmed the timeline for expanding the HHA quality measures reporting requirements to include HHCAHPS. Specifically, CMS reiterated that "the mandatory period of data collection for the CY 2012 APU includes the [HHCAHPS] dry run data in the third quarter 2010, [HHCAHPS] data from the fourth quarter 2010 (October, November and December 2010), and [HHCAHPS] data from the first quarter of 2011 (January, February and March 2011)." [26] CMS clarified that while the relevant dry run data time period had passed (July, August and September of 2010) and the period to report data had just started (October 2010 through March 2011), the deadlines for data submission on January 21, 2011 for the dry run data and April 21, 2011 for the 3-month data from the last quarter of 2010 were approaching. CMS concludes this paragraph with the statement: "These data submission deadlines are firm (that is, no late submissions will be accepted)." [27]

CMS again provided notification of the 2 percentage point reduction to the APU and the reconsiderations and appeal procedures for such penalties:

> For CY 2012, we maintain our policy that all HHAs, unless covered by specific exclusions,[28] meet the quality reporting requirements or be subject to a 2 percentage point reduction in the HH market basket percentage increase in accordance with section 1895(b)(3)(B)(v)(I) of the Act.

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[23] *Id.* at 58100.
[24] *Id.*
[25] 75 Fed. Reg. 70372 (Nov. 17, 2010).
[26] *Id.*. at 70405.
[27] *Id.*
[28] Home health agencies with less than 60 HHCAHPS eligible patients between April 1, 2009 and March 31, 2010, and those that received certification on or after January 1, 2010 were exempt from HHCAHPS participation for CY 2012. *See* 74 Fed. Reg. at 58100. The Providers do not assert that any exemption from participation applies in this case. *See generally* Provider's Final Position Paper.

> A reconsiderations and appeal process is being developed for HHAs that fail to meet the HHCAHPS data collection requirements. We proposed that these procedures will be detailed in the CY 2012 HH payment rule, the period for which HHCAHPS data collection would be required for the HH market basket percentage increase. During September through October 2011, we will compile a list of HHAs that are not compliant with OASIS-C and/or HHCAHPS for the 2012 APU requirements. These HHAs will receive explicit instructions about how to prepare a request for reconsideration of the CMS decision, and these HHAs would have 30 days to file their requests for reconsiderations to CMS. By December 31, 2011, we would provide our final determination for the quality data requirements for CY 2012 payment rates. HHAs have a right to appeal to the Prospective [*sic* Provider] Reimbursement Review Board ("PRRB") if they are not satisfied with the CMS determination.[29]

Finally, in the November, 2010 Final Rule, CMS stated that, for CY 2013, it would begin requiring that four quarters of HHCAHPS data be collected and reported in order to obtain the full APU for CY 2013 rates.[30]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

CMK Home Health Agency, Inc. ("Provider") is a for-profit home health agency located in Westmont, Illinois. The Provider's designated intermediary is Palmetto GBA ("Intermediary").

On September 16, 2011, the Intermediary determined that, for CY 2012, the APU for the Provider's Medicare payment was subject to a 2 percentage point reduction because the Provider failed to timely submit the requisite HHCAHPS data.[31] The Provider requested that the Intermediary reconsider its determination. On December 27, 2011, the Intermediary issued a notice to the Provider denying its request for reconsideration and notifying the Provider that it was subject to a 2 percentage point reduction in the APU for its HH PPS payments for calendar year 2012 due to noncompliance with submitting quality data during the required timeframes.[32] The notice stated that CMS officials had determined that the home health agency did not conduct a HHCAHPS dry run in the third quarter 2010. On June 8, 2012, the Provider timely appealed CMS' reconsideration denial to the Board.[33]

The Provider was represented by Michelle Echevarria, M.D., its Medical Director. The Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

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[29] 75 Fed. Reg. at 70405-70406 (footnote added).
[30] *Id.* at 70406.
[31] Provider Exhibit P-10 at 2-4.
[32] Provider Exhibit P-10 at 1; Intermediary Exhibit I-7.
[33] Provider Exhibit P-11.

PARTIES' CONTENTIONS:

The Provider contends that CMS' final determination is improper as the Provider was compliant with the regulations in choosing, designating and authorizing a CMS-approved HHCAHPS vendor to submit HHCAHPS quality data to CMS on its behalf in accordance with established time frames.[34] Additionally, the Provider argues that it submitted the necessary patient files to its vendor in a timely manner to allow for the vendor to conduct a HHCAHPS dry run in the third quarter of 2010 as well as to begin continuously collecting HHCAHPS survey data in the fourth quarter of 2010. However, the vendor did not meet its obligation to conduct the required surveys and submit the HHCAHPS quality data files to CMS via the HHCAHPS Survey website according to the timelines specified in the regulations.[35]

The Provider argues that it should not be penalized for the failure on the part of its vendor to submit the required HHCAHPS quality data to CMS. In support of its position, the Provider submitted an open letter from its vendor in which the vendor acknowledged that it was solely at fault for the Provider not meeting the quality data submission requirements that were linked to the CY 2012 annual payment update for the HH PPS. The vendor also acknowledged that it missed incorporating the Provider's September, 2010 and October, 2010 patient data files in with the rest of their clients.[36] The Provider concludes that CMS is responsible for the vendor error because CMS failed in its "oversight of [CMS-approved] vendors" as delineated in the preamble to the November 2009 Final Rule.[37]

The Intermediary contends that the Provider failed to satisfy the HHCAHPS program requirements that were necessary to receive a full CY 2012 APU update. The Intermediary argues that the Provider failed to ensure that the HHCAHPS survey data for September, 2010 and October, 2010 were submitted to the HHCAHPS survey website by the required due dates of January 21, 2011 and April 21, 2011 respectively.

The Intermediary notes that, even though the Provider contracted with a CMS-approved vendor to conduct and submit the HHCAHPS surveys to CMS, it was always the Provider's responsibility to ensure that the HHCAHPS surveys were actually completed and submitted by its contracted vendor agent according to the timelines specified in the regulations. The Intermediary argues that the Provider is seeking relief from the wrong party. Rather than seeking relief from CMS it should be seeking relief from its vendor, who failed to fulfill its contractual obligation, and in turn resulted in the Provider being subject to a 2 percentage point reduction in the APU for its HH PPS payments for CY 2012.[38]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, regulations and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider failed to

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[34] Tr. at 9.
[35] Provider's Final Position Paper at 1.
[36] *See* Provider Exhibit P-7.
[37] *See* Tr. at 15 (discussing 74 Fed. Reg. at 58102).
[38] Tr. at 25-28.

satisfy HHCAHPS program requirements. Consequently, the Provider may not secure any relief from the 2 percentage point penalty imposed by CMS.

The issue presented for the Board's consideration does not involve an interpretation of the statute or the regulations. There is no dispute that the Provider missed the deadline to submit the dry run data and the data for the fourth quarter of 2010. In addition, there is no dispute that the regulations impose a 2 percentage point penalty for the missed submissions. Rather, the Provider requests, in effect, that the Board permit relief from the filing requirements, arguing that the fault lies with its CMS-approved vendor, who failed to submit the required data.

In essence, the Provider is requesting equitable relief from the HHCAHPS filing requirements. However, the Board cannot consider the Provider's request. The Board's authority is limited to the statutory and regulatory requirements and to the facts and circumstances of the issues presented. The Board does not have the authority to consider factors outside those specifically recognized under the statute and regulations. The statute, regulations and relevant final rules mandate application of the 2 percentage point penalty if a provider fails to submit home health quality data as specified by the Secretary.

The Board notes that the letter from the Intermediary dated September 16, 2011 notifying the Provider of the 2 percentage point reduction states that evidence of a vendor's failure to comply with the HHCAHPS submission "does not support a finding of compliance" on the part of the Provider.[39] The HHCAHPS Survey Protocols and Guidelines Manual lays out the roles and responsibilities of HHAs participating in the HHCAHPS survey and specifically includes the provider responsibility of ensuring its vendor complies with the submission requirements:

> - Contract with an approved Home Health Care CAHPS survey vendor to conduct their survey;
> - Authorize the contracted survey vendor to collect and submit Home Health Care CAHPS Survey data to the Home Health Care CAHPS Data Center on the agency's behalf; . . .
> - Review data submission reports to ensure that the survey vendor has submitted data on time and without data problems; . . . .[40]

In this case, it is clear that the Provider (not CMS) contracted[41] with the vendor and that the Provider failed to ensure that its contracted vendor complied with the submission requirements. Also, the Provider did not qualify for an exemption from the obligation to comply with the HHCAHPS requirements. Specifically, the Provider failed to monitor/review the vendor's data submissions to ensure that the data was submitted timely and without problems.[42]

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[39] Provider Exhibit P-10 at 3.

[40] HHCAHPS Protocols and Guidelines Manual at 12 (Aug. 2009).

[41] The Provider contracted with the vendor to perform the HHCAHPS survey and, as part of that contract, agreed to certain terms addressing deliverables, responsibilities, and liabilities. CMS was not a party to that contract. *See* Provider Exhibit P-3.

[42] Testimony provided at the hearing confirms that the Provider did not review data submission reports either for the dry run or for October 2010. *See* Tr. at 118-120. Further, while a provider is prohibited from interfering with the survey itself (*e.g.*, prohibited from certain communications with patients being surveyed) to protect the integrity of

During the hearing, the Provider also argued that CMS failed in its "oversight of [CMS-approved] vendors" as delineated in the preamble to the November, 2009 Final Rule.[43] The Board notes that CMS' oversight did not encompass overseeing specific vendors' real-time compliance on a provider-by-provider basis. Rather it was a high-level retrospective quality assurance program focused on "survey administration" because of the confidentiality, privacy, and security issues inherent in the collection and submission of patient-specific information Specifically, the preamble to the November, 2009 Final Rule describes CMS' oversight activities as follows:

> We proposed that vendors and HHAs be required to participate in HHCAHPS oversight activities to ensure compliance with HHCAHPS protocols, guidelines and survey requirements. The purpose of the oversight activities is to ensure that HHAs and approved survey vendors follow the Protocols and Guidelines Manual. It was proposed that all approved survey vendors develop a Quality Assurance Plan (QAP) for **survey administration** in accordance with the Protocols and Guidelines Manual. The QAP would include the following:
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> - Organizational Chart:
> - Work plan for survey implementation;
> - Description of survey procedures and quality controls:
> - Quality assurance oversight of onsite work and of all subcontractors; and
> - Confidentiality/Privacy and Security procedures in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
>
> As part of the oversight activities the HHCAHPS Survey Coordination Team would conduct on-site visits and/or conference calls. The HHCAHPS Survey Coordination Team would **review the survey vendors' survey systems, and would assess administration protocols** based on the Protocols and Guidelines Manual posted on *https://www.homehealthcahps.org*. We proposed that all materials relevant to **survey administration** would be subject to review. The proposed systems and program review would include but not be limited to: (a) Survey management and data systems; (b) printing and mailing materials and facilities; (c) data receipt, entry and storage facilities; and (d) written documentation of survey processes. Organizations would be given a defined time period in which to correct any problems

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the survey, the Board has found nothing in the HHCAHPS manual that prohibits providers from having communication with its vendor regarding the general status of both their survey and the submission of data from that survey to ensure that the provider is compliant with the data submission deadlines. This general communication would be consistent with the provider's responsibilities delineated in that manual.

[43] *See* Tr. at 15 (discussing 74 Fed. Reg. at 58102).

> and provide follow-up documentation of corrections for review. Survey vendors would be subject to follow-up site visits as needed.
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> We did not receive any comments regarding the proposed oversight activities and therefore, the proposed recommendations are considered to be final for this rule.[44]

Indeed, consistent with the HHCAHPS Manual provision quoted above, the preamble to the November, 2009 Final Rule specifies that it is the provider's responsibility to monitor its chosen vendor to ensure HHCAHPS data is submitted timely without problems:

> In the proposed rule, we strongly recommended that home health agencies participating in the HHCAHPS survey promptly review the required Data Submission Summary Reports that are described in the Protocols and Guidelines Manual posted on *https://www.homehealthcahps.org*. These reports will enable the home health agency to ensure that its survey vendor has submitted their data on time, and that the data have been accepted/received by the Home Health CAHPS® Data Center. We received no comments on this proposal, and are finalizing it as proposed.[45]

In summary, the Board finds, in this case, the Provider failed to file its dry run data for the third quarter 2010 by its January 21, 2011 deadline and its fourth quarter 2010 survey data by its April 21, 2011 deadline. Failure to timely file the required HHA quality data triggers imposition of the 2 percentage point penalty that was described and announced in both the November, 2009 and November, 2010 Final Rules. Neither the statute, regulations nor relevant final rules allow for any waiver of the penalty. Accordingly, the Board finds that the Provider failed to satisfy HHCAHPS program requirements and that the 2 percentage point penalty was correctly applied. The Provider may not secure relief from the 2 percentage point penalty imposed by CMS.

DECISION AND ORDER:

The Provider failed to satisfy HHCAHPS program requirements. CMS' imposition of a 2 percentage point reduction in the Provider's APU for CY 2012 was proper.

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[44] 74 Fed. Reg. at 58100 (bold emphasis added and italics in original). *See also* Tr. at 80-85 (testimony from vendor representative regarding the vendor experience with QAP and CMS oversight activities).
[45] 74 Fed. Reg. at 58100.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

Michael W. Harty
Chairman

DATE: AUG 2 2 2013