PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D27

PROVIDER –
Inteli Home Healthcare, Inc.
Houston, Texas

Provider No.: 45-9410

vs.

INTERMEDIARY
BlueCross BlueShield Association/
Palmetto GBA

DATE OF HEARING -
September 27, 2012

Reporting Period Ended -
Calendar Year 2012

CASE NO.: 12-0180

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ISSUE:

Whether the imposition of a 2 percent reduction in the Medicare payments to the home health agency 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 payment amount under this section for a subsequent

[1] Transcript,("Tr.") p.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 and 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).

> 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 notice 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 points penalty for CY 2007 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 points reduction to the APU for 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 points penalty to the APU was tied to 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

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[9] 72 Fed. Reg. 49762 (Aug. 29, 2007).
[10] 72 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's 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 anual 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 on the HHCAHPS web site. *See generally* HCCAHPS 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).

> conduct 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 rollout 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.
> *Response:* CMS has carefully considered the comments it received, and is delaying the linkage of HHCAHPS data to the quality reporting requirements for the annual payment update by 6

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

> 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 be cause for 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's 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 athttps://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 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

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

> 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 timing for expanding the HHA quality measures reporting requirements to include HHCAHPS. Specifically, CMS reiterated that "[t]he 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 real 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 were coming up on January 21, 2011 for the dry run data and April 21, 2011 for the 3-month data from the last quarter of 2010. 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 points payment reduction to APU, reconsiderations, and appeal procedures:

> 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.
> A reconsiderations and appeals 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

[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 CY2012. *See* 74 Fed. Reg. at 58100. The Provider does not assert that any exclusion from participation applies in this case. Tr. at 26-28.

> 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 would 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:

Inteli Home Healthcare ("Provider") is an HHA located in Houston, Texas and was acquired by Reachout Home Care ("ROHC") in May, 2010. When ROHC acquired the Provider, it believed that the previous owner had arranged with an approved contractor to handle the HHCAHPS Survey data collection and submission requirements. The Provider was required to submit its dry run data for the HHCAHPS initiative no later than October 21, 2010. However, the Provider relocated and adopted new reporting software immediately after the change in ownership and through a series of errors, missed its submission date.[31]

CMS detected the delinquent filing and directed Palmetto GBA ("Intermediary") to impose a 2 percentage points reduction in the Provider's APU for CY 2012. On September 16, 2011, the Intermediary advised the Provider that the APU for payments for CY 2012 would be reduced by 2 percentage points because the Provider "was non-compliant with HHCAHPS."[32] The letter went on to advise the Provider of the opportunity to obtain a reconsideration and listed on its second page the reasons which would support a reversal upon reconsideration as well as those that would not. [33] The Provider timely requested reconsideration[34] but the Intermediary upheld its original determination.[35]

On February 3, 2012, the Provider timely appealed the Intermediary's imposition of the 2 percentage points penalty to the Board. The Provider was represented by Peter Lynch, Administrator, Inteli Home Healthcare. The Intermediary was represented by Bernard M. Talbert, Esq., of the BlueCross BlueShield Association.

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[29] 75 Fed. Reg. at 70405-70406 (footnote added).
[30] *Id.* at 70406.
[31] Tr. at 10-11; Provider's Final Position Paper at 1.
[32] Intermediary Exhibit I-7.
[33] *Id.*
[34] Intermediary Exhibit I-8.
[35] Intermediary Exhibit I-9.

There is no dispute that the Provider missed its submission date or that the regulations impose a 2 percentage points penalty for late filing.[36] Rather the dispute centers on the severity of the penalty in relation to the effect of the late filing on the Medicare program.

PROVIDER'S CONTENTIONS:

The Provider acknowledges that its submission of the dry run data was late. However, the Provider asks the Board to consider a series of events that lead to its late filing.

The Provider argues that Inteli Home Healthcare was acquired by ROHC in May 2010. When ROHC acquired the facility, it believed that the previous owner had arranged with an approved contractor to handle the HHCAHPS Survey data collection and submission requirements and, consequently, assumed that the filing would be timely handled.[37] The Provider further contends that, although it notified the Intermediary of a change in address in August 2010, the Intermediary did not act on the initial submission but rather issued a notice in September to the Provider that it had to file an address change (Form CMS-855) with the Intermediary to establish the new address.[38] The Provider filed the Form CMS-855 in January 2011.[39] The Provider argues that, due to the late update of its address, it received no additional correspondence with specifics about the timing of the HHCAHPS Survey requirements at its new address and that the absence was a contributing factor to its late filing.

The Provider also contends that the Provider is a 12 year old company that has a near flawless record over its history and ranks in the top 10 percent of all HHAs nationwide.[40] Further, ROHC was deficiency free in its last state survey and ranks in the top 25 percent of agencies in the U.S.[41] All of the requisite live data have been pulled and submitted on time since October 2010.[42] The Provider argues that its sustained quality performance and ongoing compliance with data requirements should operate to reduce the severity of the 2 percentage points penalty.

INTERMEDIARY'S CONTENTIONS:

The Intermediary admitted that there was an issue with the address change but it was not relevant to the Provider's failure to comply with the data submission requirements because "almost all of the relevant communications on this issue really . . . come through a sophisticated internet system not a paper communication."[43] In this regard, the Intermediary submitted evidence of emails sent to HHAs and vendors about the HHCAHPS Survey.[44] The Intermediary further contends that the Provider had received ample notice of the upcoming data submission requirements through the Federal Register notices and publication of final rules. It explained

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37 Provider's Final Position Paper at 1-2.

38 Provider Exhibit B.

39 Provider Exhibit C.

40 Provider's Final Position Paper at 2.

41 *Id.*

42 *Id.*

43 Tr. at 18.

44 *See* Intermediary Exhibit I-5.

that successful completion of the dry run was an all-or-nothing requirement — it is either completed or it is not.[45] There can be no partial credit or completion.

Further, the Intermediary maintains that the Provider's mistaken belief that the previous owner had contracted with a survey contractor does not support a finding of compliance. The denial letter dated February 16, 2011 specifically states, in pertinent part:

> Note that documentation of the following does NOT support a finding of compliance: . . .
>
> - in cases where the ownership of the HHA changed during the reporting year but the CCN of the HHA did not change, evidence that failure to comply was the fault of a previous owner.[46]

The Intermediary maintains that the Provider admits to the real problem in its position paper statement:

> Inteli Home Healthcare was acquired by HOHC, LLC in May of 2010. When ROCH acquired the agency we were led to believe the previous owner had contracted with an approved contractor to handle the HHCAHPS collection and submission.[47]

The Intermediary argues that the Provider has identified a "private post sale business problem" between buyer and seller[48] which Congress did not allow as a basis for relief from having to comply with the data submission requirements and the imposition of the 2 percentage points penalty. Similarly, the Intermediary does not believe that both Inteli and ROHC's long history of general compliance and high performance represent an acceptable basis for relief. As a result, the Intermediary contends that the 2 percentage points reduction was correctly imposed and that the finding should be sustained.

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

The issue presented for the Board's consideration does not involve an interpretation of the statute or the regulations. Neither is there a difference of opinion on the relevant facts. The Provider does not dispute that it missed its submission date for the dry run, that the regulations impose a 2 percentage points penalty for that late filing, or that none of the exclusions from HHCAHPS

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[45] Tr. at 23.
[46] Intermediary Exhibit I-7 at 2.
[47] Provider's Final Position Paper at 1.
[48] Intermediary's Final Position Paper at 12.

participation applies in this case.[49] Rather, based on changes in its operations and management, as well as its sustained quality performance under the program, the Provider requests that the Board permit an exception to the filing requirement or a reduction in the penalty imposed for its late filing.

In essence, the Provider is requesting equitable relief from the filing requirements. The Board notes that, in the last paragraph of its final position paper, the Provider states: "It is our opinion that this penalty is overly punitive and should therefore be reversed. We would be willing to submit to some sort of probationary period as a compromise or open to discussing any other intermediate steps that might reduce the full impact of the 2% revenue reduction." The Secretary's regulations make no provision for circumstances in which the penalty is overly punitive. Likewise, there is no possibility of an intermediate step that would reduce the full impact of the 2 percentage points revenue reduction.

However, the Board cannot consider the Provider's request for equitable relief. 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. Both the statute, regulations, and relevant final rules mandate application of the 2 percentage points penalty if a provider fails to submit home health quality data as specified by the Secretary unless the provider falls within certain specified exclusions.

The Board finds that, in this case, the Provider failed to file its data submission by its October 21, 2010 deadline and that it is undisputed that the Provider failed to qualify for an exclusion to the HHA quality data submission requirements. Failure to make a timely filing of the required HHA quality data triggers imposition of the 2 percentage points penalty that was described and announced in both the November 2009 and November 2010 Final Rules.[50] Neither the statute, regulations nor relevant final rules allow for any equitable relief or partial credit. Accordingly, the Board finds that the Provider failed to satisfy HHCAHPS program requirements and that the 2 percent points penalty was correctly applied. The Provider may not secure relief from the 2 percentage points penalty imposed by CMS.

DECISION AND ORDER:

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

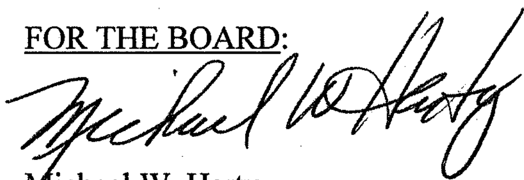
[49] *See* Tr. 26-28.

[50] The Board agrees with the Intermediary that the Provider had received ample notice of the upcoming HHCAHPS data submission requirements through the Federal Register notices and publication of final rules.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: AUG 22 2013