PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D29

PROVIDER –
Spectrum Home Care, Inc.
Detroit, MI

Provider No.: 23-7251

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING -
October 2, 2012

Reporting Period Ended -
Calendar Year 2012

CASE NO.: 12-0251

INDEX

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 and 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, regulations, and interpretive 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

[1] Transcript, ("Tr.") at 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).

> prospective 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 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

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

for certain subsequent periods, the November 2006 Final Rule required the provider to comply with the additional OASIS data submission for CY 2007.

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 points 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 that 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 be to 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.

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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'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 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 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).

> 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 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

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

> 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 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 2 percentage point reduction 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 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]

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

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 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 "[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 the APU, reconsiderations, and appeal procedures:

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[23] *Id.* at 58100.
[24] *Id.*
[25] 75 Fed. Reg. 70372 (Nov. 17, 2010). .
[26] *Id.* at 70405.
[27] *Id.*

> 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 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:

Spectrum Home Health Care, Inc. ("SHHC" or "Provider") is a home health agency providing services in the Detroit, MI area. SHHC provided home health services to Medicare recipients during CY 2012.

The Provider's designated intermediary was Palmetto Government Benefits Administration, LLC ("Intermediary"). The Intermediary determined that, for CY 2012, the Provider's Medicare payment was subject to a 2 percent reduction because the Provider failed to timely submit the requisite HHCAHPS data: (1) for the dry run for the third quarter of 2010; and (2) for the fourth quarter of 2010 and the first quarter of 2011.

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[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 Provider does not assert that any exclusion from participation applies in this case. *See generally:* Provider's Final Position Paper

[29] 75 Fed. Reg. at 70405-70406 (footnote added).

[30] *Id.* at 70406.

As a result, CMS directed the 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 Medicare payments for CY 2012 would be reduced by 2 percentage points because the Provider "was non-compliant with HHCAHPS dry run."[31] 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.[32] The Provider timely requested reconsideration[33] but the Intermediary upheld its original determination.[34]

On February 7, 2012, the Provider timely appealed the Intermediary's imposition of the 2 percentage points penalty to the Board. The Provider was represented by James E. Plonsey of Medicare Training & Consulting, Inc. The Intermediary was represented by Bernard M. Talbert, Esq., of the BlueCross BlueShield Association.

PROVIDER'S CONTENTIONS:

The Provided states it contracted with Fields Research, a CMS-approved HHCAHPS Survey vendor, to collect and submit its HHCAHPS quality data.[35] The Provider alleges that its vendor, Fields Research, submitted the data in a timely manner. However, because the Provider admittedly "failed to designate Fields Research as its vendor with CMS,"[36] the data that was submitted could not be properly transmitted, accepted, and tabulated.[37] The Provider contends that it should not be subject to a 2 percentage points reduction in APU for CY 2012 because CMS issued confusing instructions to providers and vendors. In support of this contention, the Provider points to two extensions of the deadline for submitting the requisite HHCAHPS data – one due to inclement weather and the other resulting from many HHAs failing to use an online form to inform CMS of the chosen vendor.[38]

INTERMEDIARY'S CONTENTIONS

The Intermediary asserts that the Provider failed to properly identify its designated HHCAHPS Survey vendor and, as a result, the compliance information it submitted was not (and could not be) accepted by the Medicare program. The Intermediary explains that the failure to identify a vendor meant that the vendor was not authorized to submit on behalf of the Provider and resulted in HHCAHPS data from the Provider's dry run and HHCAHPS data from the Provider's first five months of the compliance period not being accepted. The Intermediary argues that the

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[31] Provider Exhibit P-3.
[32] *Id.*
[33] Provider Exhibit P-5.
[34] Provider Exhibit P-4.
[35] *See* Provider's Final Position Paper *See also* Provider Exhibit P-8.
[36] Provider's Final Position Paper.
[37] *Id.*
[38] *See id.* at 6-7; Provider Exhibits P-9 and P-10.

Provider was simply non-compliant with CMS rules regarding designation of an authorized vendor and the submission of HHCAHPS data.[39]

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 the deadline to submit both the dry run data and the data for the fourth quarter of 2010 and the first quarter of 2011.[40] Although the Provider contracted with an approved vendor for the HHCAHPS data submission, the Provider admittedly "failed to designate Fields Research as its vendor with CMS."[41] As the proper authorization was not on file with the Medicare program, the HHCAHPS data submitted by the vendor on behalf of the Provider was not (and could not be) accepted and tabulated.[42] The Provider is asking the Board to permit an exception to the filing requirement.

In essence, the Provider is requesting equitable relief from the filing requirements. However, the Board cannot consider the 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 points penalty if a provider fails to submit home health quality data as required by the Secretary unless the provider falls within certain specified exclusions.

The Provider explains that it failed to follow the data submission rules because CMS' instructions to providers and vendors were confusing. However, the record indicates that instructions regarding the HHCAHPS data submission process were numerous and explicit. The Provider points to delayed due dates in support of its argument that instructions were confusing. However, the movement of the due dates forward would not have prejudiced the Provider. Rather, these extensions gave the Provider more time to meet the data submission requirements. Further, as discussed in the November, 2009 Final Rule and the November Final Rule, CMS "*strongly recommended* that all home health care agencies . . . *regularly check* the Web site

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[39] *See* Intermediary's Final Position Paper at 9-10.
[40] *See* Tr. at 18-19.
[41] Provider's Final Position Paper
[42] The Board notes that a provider's HHCAHPS vendor responsibilities involve HIPAA privacy and compliance issues because the vendor is acting on behalf of the provider to collect and submit patient specific information to the Medicare program. These HIPAA privacy and compliance issues support the Medicare requirement that a provider file the appropriate form with the Medicare program to confirm that a particular vendor is authorized on behalf of the provider to collect and submit the patient specific information. *See* Tr. at 15-16; 32-33.

https://www.homehealthcahps.org for program updates and information"[43] and this website included reminders and updates about upcoming filing deadlines, including information on the filing deadline extensions that CMS issued.[44]

Moreover, evidence submitted by the Provider demonstrates that it, in fact, had notice of its failure to notify CMS of its chosen survey vendor. Provider's Exhibit 9 indicates that the January 21, 2011 deadline for submission of the dry run data was delayed to January 28, 2011. Exhibit 10 indicates that this deadline was postponed once again to February 4, 2011. This email to the chosen vendor stated:

> Some HHHCAHPS vendors could not submit CY 10, Q# HHCAHPS data because their client home health agencies (HHAs) did not complete the online Vendor Authorization Form, which is available on the HHCAHPS Web site at https://homehealthcahps.org. Please urge your client HHAs that have not yet registered for user credentials and/or authorized you to submit HHACAHPS Survey data on their behalf to do so as soon as possible.
> If you have any questions, please contact the HHCAHPS Coordination Team at hhcahps@rti.org.

Provider's Exhibit 11, however, indicates that September data was first submitted on 1/27/2011, again on 1/28/2011, and once more on 2/4/2011. Each data submission "failed" with an indication that the vendor was not authorized (last column on the right indicates "No" under the column heading "Authorized." This chart indicates that the vendor knew that its submission failed because it had not been authorized *before* receiving the January 31st email noting that some HHAs had not authorized their vendors to submit data. There is no indication that the vendor did anything to resolve this problem because Exhibit 11 indicates that the vendor continued to submit data for subsequent months in 2010 and 2011 and each time the submission status failed because the vendor was not authorized.

The letter from National Government Services on September 16, 2011 notifying the Provider of the 2 percentage points 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.[45] In this case, it is clear that both the Provider and vendor failed to comply with the submission requirements—the Provider failed to inform CMS of its authorized vendor; and the vendor failed to notify the Provider that it had not been properly authorized to submit the data even after it was clear that there was a problem with the submission.

The Board finds that, in this case, the Provider failed to file its data submission by the published deadlines. 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

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[43] 74 Fed. Reg. at 58100 (emphasis added).
[44] *See* https://homehealthcahps.org/GeneralInformation/Announcements/tabid/269/catid/4/Data-Submissions.aspx (page on the HHCAHPS website listing prior HHCAHPS announcements).
[45] Provider's Exhibit 3, at 2.

and November, 2010 Final Rules.[46] Neither the statute, regulations nor relevant final rules allow for any equitable relief or partial credit. Indeed, the HHCAHPS Survey Protocols and Guidelines Manual lay out the roles and responsibilities of HHAs participating in the HHCAHPS survey and specifically include the following responsibilities:

> - 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; . . . .[47]

In this case, the Provider failed to submit the requisite data by the submission deadlines because it failed to carry out its responsibilities to file the appropriate vendor designation and authorization form with the Medicare program and failed to monitor/review the vendor's data submissions to ensure that the data was submitted timely and without problems.[48] Accordingly, the Board finds that the Provider failed to satisfy HHCAHPS program requirements and that the 2 percentage 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.

BOARD MEMBERS PARTICIPATING:

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

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[46] 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 as well as postings on the HHCAHPS website.

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

[48] The Board notes that there is no documentation in the record supporting the Provider's assertion that the vendor attempted to submit the requisite dry run data from the third quarter of 2010.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: AUG 27 2013