PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D39

PROVIDER–
Grace Community Home Health, Inc.

Provider No.: 05-9656

vs.

MEDICARE CONTRACTOR –
National Government Services

HEARING DATE –
August 22, 2017

Cost Reporting Period Ended –
December 31, 2017

CASE NO.: 17-0854

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ISSUE STATEMENT:

Whether Grace Community Home Health, Inc., ("Grace Community" or "Provider") should be subject to a two percentage point reduction to its calendar year ("CY") 2017 home health market basket percentage increase[1] for failure to meet the Home Health Quality Reporting Program requirements in accordance with 42 C.F.R. § 484.225(i).[2]

DECISION:

After considering the Medicare law and regulations, the arguments presented and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that the Centers for Medicare & Medicaid Services ("CMS") properly imposed a two percentage point reduction to Grace Community's CY 2017 home health market basket percentage increase.

INTRODUCTION:

Grace Community is a small home health agency located in Mountain View, California. National Government Services (the "Medicare Contractor") notified Grace Community that CMS reduced its 2017 Medicare payment update by two percentage points because it failed to timely submit quality data as required by federal law. Grace Community asked CMS to reconsider its determination, and on December 13, 2016, CMS upheld its determination.

Grace Community timely appealed to the Board and met the jurisdictional requirements for a hearing.[3] The Board held a telephonic hearing on August 22, 2017. Rodica Stoltzfus, Administrator, represented Grace Community. Joe Bauers, Esq., of Federal Specialized Services, represented the Medicare Contractor.

STATEMENT OF FACTS:

In the Balanced Budget Act of 1997, Congress mandated that the Secretary of Health and Human Services ("Secretary") establish a prospective payment system for home health services covered by Medicare.[4] Congress also directed the Secretary to increase the prospective payments made to Home Health Agencies ("HHAs") each calendar year by a percentage, known as the "home

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[1] Grace Community did not provide a formal issue statement in its Request for Hearing or Final Position Paper. The Medicare Contractor's Final Position Paper describes the following issue that was subsequently read at the hearing: "Whether the Provider should be subject to a two percent (2%) reduction in the Home Health Prospective Payment System (HHPPS) payments for Calendar Year 2017 for noncompliance with the procedures to report and submit quality data in accordance with the guidelines and required timeframes." The Board notes that Grace Community is not subject to a two percent reduction in its total home health prospective payment for 2017 but, rather, a two percentage point reduction in its home health market basket percentage increase for 2017. 42 U.S.C. § 1395fff(b)(3)(B)(v)(I) (2012); 42 C.F.R. § 484.225(i) (2014). The Board has corrected the Medicare Contractor's issue statement to reflect the proper payment reduction.

[2] Effective January 1, 2016, 42 C.F.R. § 484.225 was revised and the language under subsection (i) was moved to subsection (c). 80 Fed. Reg. 68624, 68717 (Nov.5, 2015).

[3] *See* Grace Community's Request for Hearing, Tab 3 at unnumbered pages 1-2.

[4] Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997).

health market basket percentage increase"[5] or the Annual Payment Update ("APU").[6] Subsequently, in the Deficit Reduction Act of 2005 ("DRA"), Congress added a data reporting requirement whereby HHAs must submit data that the Secretary determines are appropriate for the measurement of health care quality.[7] Further, if an HHA fails to submit data in the form and manner, and at a time, determined by the Secretary, it is subject to a two percentage point reduction in its APU for a particular year.[8]

CMS' Home Health Conditions of Participation ("CoP") require Medicare-participating HHAs to provide CMS with a comprehensive assessment for each patient that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress. This comprehensive assessment uses Outcome and Assessment Information Set ("OASIS") items. CMS has required HHAs to submit OASIS data as a condition of payment of their Medicare claims since 2010.[9]

Subsequently, CMS established that one part of the HHA quality reporting requirements would be met by the submission of the OASIS assessments for episodes occurring in the twelve month period between July 1, two years prior to the APU effective date, and June 30, one year prior to the APU effective date. CMS required this data to be submitted within 30 days of the assessment date.[10] For the CY 2017 APU, HHAs were required to submit OASIS data for patient episodes beginning on or after July 1, 2015, and before June 30, 2016.[11]

The dispute in this appeal is whether Grace Community fulfilled the OASIS portion of the quality reporting requirements in order to receive the full APU for CY 2017.

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Grace Community states that it "has been submitting OASIS data weekly since [it] received [its] CMS Certification Number[,]" and that the "OASIS File Submission" confirmation print-outs included within its documentation are "evidence of OASIS transmissions during the reporting period."[12] Grace Community admits that after receiving its quality reporting reconsideration decision, it "conducted a second investigation and found that there was a systematic error in [its] submission."[13] Grace Community states that it had entered an incorrect "<HHA_AGENCY_ID>" along with its OASIS data.[14] Dr. Albert Lam, Grace Community's Medical Director, testified that Grace Community had mistakenly been submitting its OASIS data to CMS using the word "California" as its Agency ID.[15]

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[5] 42 U.S.C. §§ 1395fff(b)(3)(B)(i)-(iii) (2014).
[6] Home Health Quality Reporting Requirements, 79 Fed. Reg. 66032, 66074 (Nov. 6, 2014).
[7] Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5201(c)(2), 120 Stat. 4, 46-47 (2006).
[8] 42 U.S.C. § 1395fff(b)(3)(B)(v) (2014).
[9] 79 Fed. Reg. at 66076.
[10] 77 Fed. Reg. 67068, 67093 (Nov. 8, 2012). *See also* Medicare Contractor's Final Position Paper at Exhibit I-13, page 1.
[11] 79 Fed. Reg. at 66075.
[12] Grace Community's Request for Hearing, Tab 3 at unnumbered pages 1-2.
[13] *Id.* at unnumbered page 2.
[14] Grace Community's Final Position Paper at 2.
[15] Transcript ("Tr.") at 26-28.

Grace Community does not believe its error would have prevented Medicare from identifying its agency through the use of other identifiers. Additionally Grace Community points out that the CMS State Operations Manual states that "[t]here is no current time limit to correcting errors in previously submitted records." Based on this, Grace Community believes it was "compliant with both the letter and spirit of CMS regulations."[16]

The Board finds that Grace Community did not submit its OASIS data with the correct identifying numbers by the due date. The Board points out that the OASIS File Submission notifications that Grace Community received when it submitted its OASIS files contains the following statement:

> 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 [Certification And Survey Provider Enhanced Reports] CASPER Reporting application. It is recommended that you print and retain the Final Validation Reports.[17]

If Grace Community had run the recommended Final Validation Report,[18] they would have realized their Agency ID was input incorrectly and their information had not been transmitted into CASPER to be viewed by CMS. Since the OASIS data did not transmit to CMS correctly, the Board finds that Grace Community did not submit their data in the form and manner, and at a time, specified by the Secretary.[19]

The Board is cognizant of Grace Community's size and recognizes the staffing and administrative challenges that face small, independent providers. However the statute, regulations[20] and relevant final rules mandate application of the two percentage point reduction in the APU if a provider fails to timely submit home health quality data in the form and manner, and at the time specified, by the Secretary. The Board does not have the authority to consider factors outside those specifically recognized under the statute and regulations.

DECISION AND ORDER:

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board finds that CMS properly imposed a two percentage point reduction to Grace Community's CY 2017 home health market basket percentage increase.

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[16] Grace Community's Final Position Paper at 2.
[17] Grace Community's Request for Hearing, Tab 3 at unnumbered pages 3-4, 6-9, 11-15, 17 and 19. Validation reports are run in the CASPER system. The CASPER manual is located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQICASPER.pdf.
[18] Tr. at 50.
[19] 42 U.S.C. § 1395fff(b)(3)(B)(v) (2014).
[20] 42 U.S.C. § 1395fff and 42 C.F.R. § 484.225(i).

BOARD MEMBERS PARTICIPATING:

Charlotte F. Benson, C.P.A.
Gregory H. Ziegler, C.P.A., CPC-A
Robert A. Evarts, Esq.

FOR THE BOARD:

/s/
Charlotte F. Benson C.P.A.
Board Member

DATE: June 4, 2018