CENTERS FOR MEDICARE AND MEDICAID SERVICES

Hearing Officer Decision

In the Matter of

Citrus Health Care	*	
	*	Docket No. 2010 C/D App 2
Denial of Service Area Expansion	*	
(Contract # H5407)	*	

Jurisdiction

This appeal is provided pursuant to 42 C.F.R. §422.660. The Centers for Medicare and Medicaid Services (CMS) Hearing Officer designated by the CMS Administrator to hear this case is the undersigned, Benjamin Cohen.

Issue

Whether CMS' denial of the Applicant's MA-PD Service Area Expansion (SAE) application for calendar year 2011 was consistent with the requirements of 42 C.F.R. §§422.501 and 422.502.[1]

Statutory and Regulatory Background

The Social Security Act (SSA or the Act) authorizes CMS to enter into contracts with entities seeking to offer Medicare Advantage (MA) benefits (Part C) and Medicare outpatient prescription benefits (Part D) to Medicare beneficiaries.[2] Pursuant to 42 C.F.R. §§422.500 and 423.500 et seq.,[3] CMS has established the general provisions for

[1] The relevant deficiencies cited by CMS relate to the Part C portion of the application. *See* CMS Brief In Support of its Denial of Physician Health Choice's Service Area Expansion Application H5407-2010 C/D App. 2-H5407 Physician Health Choice (Citrus HC) ("CMS Brief") at 10 (July 1, 2010).

[2] *See* SSA §§1857 and 1860D-12.

[3] CMS has recently revised and/or clarified some, but not all of the regulations governing the Part C and Part D programs. *See* Proposed Rule, 74 Fed. Reg. 54634 (October 22, 2009) and Final Rule, 75 Fed. Reg. 19678 (April 15, 2010). The Summary of the Final Rule states "This final rule makes revisions to the regulations governing the Medicare Advantage (MA) program (Part C) and prescription drug benefit program (Part D) based on our continued experience in the administration of the Part C and D programs. The revisions strengthen various program participation and exit requirements; strengthen beneficiary protections; ensure that plan offerings to beneficiaries include meaningful differences; improve plan payment rules and processes; improve data collection for oversight and quality assessment, implement new policies and clarify existing program policy." The Final Rule is effective June 7, 2010 and applies from contract year 2011 (the year at issue) forward.

entities seeking to qualify as Medicare Advantage-Prescription Drug (MA-PD) plans. MA organizations offering coordinated care plans (CCPs) must offer Part D benefits in the same service areas.[4]

Organizations seeking to qualify as an MA-PD plan have their applications reviewed by CMS to determine whether they meet the application requirements to enter into such a contract. *See* 42 C.F.R. §§422.501 and 423.502.

The current regulation concerning the Part C application requirements at 42 C.F.R. §422.501 states, in relevant part:

> (c) Completion of an Application.
>
> > (1) In order to obtain a determination on whether it meets the requirements to become an MA organization and is qualified to provide a particular type of MA plan, an entity, or an individual authorized to act for the entity (the applicant) must fully complete all parts of a certified application, in the form and manner required by CMS...
> >
> > (2) The authorized individual must thoroughly describe how the entity and MA plan meet, or will meet, all the requirements described in this part.

CMS has established an online application process for both Part C and Part D plans called the Health Plan Management System (HPMS). All new applicants and requests to expand service areas had to submit their applications through the HPMS by deadlines established by CMS. CMS provided training and technical assistance to plans in completing their applications and plan applications were evaluated solely on the materials they submitted into the HPMS by the deadlines established by CMS.

After an applicant files its initial application, CMS reviews the application, notifies the applicant of any deficiencies and gives the applicant an opportunity to correct those deficiencies.

The regulation at 42 C.F.R. §422.502 specifies the evaluation and determination criteria qualifying a plan applicant to act as a Part C sponsor. It states, in relevant part:

> (a) Basis of Evaluation and Determination. (1) With the exception of evaluations conducted under paragraph (b) of this section, CMS evaluates an application for an MA contract solely on the basis of information contained in the application itself and any additional information that CMS obtains through other means such as on-site visits.

[4] *See* 42 C.F.R. §422.4(c)(1).

(2) After evaluating all relevant information, CMS determines whether the applicant's application meets **all the requirements** described in this part.

(Emphasis added).[5]

If the applicant fails to correct all of the deficiencies, CMS issues the applicant a "Notice of Intent to Deny" under the regulation at 42 C.F.R. §422.502(c)(2). It states, in relevant part:

(c) *Notice of Determination.* * * *

(1) *Approval of Application.* * * *

(2*) Intent to Deny*.

(i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization and/or has not provided enough information to evaluate the application, CMS gives the contract applicant notice of intent to deny the application for an MA contract and a summary of the basis for this preliminary finding.

(ii) Within 10 days from the date of the intent to deny notice, the contract applicant must respond in writing to the issues or other matters that were the basis for CMS' preliminary finding and must revise its application to remedy any defects CMS identified.

(iii) If CMS does not receive a revised application within 10 days from the date of the notice, or if after a timely submission of a revised application, CMS still finds the applicant does not appear qualified to contract as an MA organization or has not provided enough information to allow CMS to evaluate the application, CMS will deny the application.

If CMS denies an MA-PD application, the applicant has a right to a hearing before a CMS Hearing Officer under 42 C.F.R. §§422.660. The current Part C regulation at §422.660(b)(1) states that at hearing, the applicant has the burden of proving by a preponderance of the evidence that CMS' determination was inconsistent with the requirements of §§422.501 and 422.502.[6]

[5] The preamble to the Final Rule at 75 Fed. Reg. 19678, 19683 (April 15, 2010) states: "we specifically proposed to make explicit that we will approve only those applications that demonstrate that they meet all (not substantially all) Part C and Part D requirements." CMS also states that expecting applicants to meet "all" standards is practical and explains that "applicants receive enough information to successfully apply and are given two opportunities with instructions to cure deficiencies."

[6] CMS' denial was issued on June 7, 2010, the effective date of CMS revised regulations (*supra*, note 3). Accordingly, pursuant to the unambiguous directive in the Final Rule, the Hearing Officer will apply this new burden of proof. Prior to June 7, 2010 (for hearings involving determination regarding contract year 2010), the burden of proof regulations at 42 C.F.R. §§422.660 and 423.650 required the sponsor "to demonstrate that it was in substantial compliance with the requirements" of the Part C and Part D programs.

Specific Regulations and Other Rules Related to the Alleged Deficiencies

A, Regulatory Background

CMS is authorized to evaluate the plan sponsors' past performance using information from a current or prior contract in accordance with 42 C.F.R. §422.502(b). The current regulation states in relevant part:

> (b) Use of Information from a current or prior contract. If an MA organization fails during the 14 months preceding the deadline established by CMS for the submission of contract qualification applications to comply with the requirements of the Part C program under any current or prior contract with CMS under title XVIII of the Act or fails to complete a corrective action plan during the 14 months preceding the deadline established by CMS for the submission of contract qualification applications, CMS may deny an application based on the applicant's **failure to comply with the requirements** of the Part C program under any current or prior contract with CMS even if the applicant currently meets all of the requirements of this part.[7]

(Emphasis added)

Additionally, the Final Rule added a new provision (effective on June 7, 2010) specifying that CMS may determine sponsor non-compliance with the Part C requirements in accordance with 42 C.F.R. §§422.504(m)(1) and (2). The regulation at §422.504(m) states in relevant part:

> (1) CMS may determine that an MA organization is out of compliance with a Part C requirement when the organization **fails to meet performance standards articulated in the Part C statutes, regulations, or guidance**.
>
> (2) **If CMS has not already articulated a measure** for determining noncompliance, CMS may determine that a MA organization is out of compliance **when its performance** in fulfilling part C requirements **represents an outlier** relative to the performance of other MA organizations.

(Emphasis added).

B. CMS' Point System for Rating Part C Sponsors' Negative Performance

CMS designed a point based system to rate Medicare Part C sponsors' negative contract performance. Within this point system, CMS determined that earning four or more points

[7] The Hearing Officer notes that this current version of the regulation (effective as of June 7, 2010) is substantially similar to the previous version. The main change in the cited current version is the addition of a look-back period of 14 months which limits the time period from which prior contract information can be drawn to evaluate a contract application.

would deem any sponsor's Service Area Expansion (SAE) application automatically denied. Further, CMS established that any sponsor who is placed under intermediate sanctions receives three points, and any sponsor who receives a below average (less than a "3") Stars Rating automatically receives one additional point.[8]

C. Star Rating System Background[9]

The Star Rating System uses data available from various sources to calculate a rating for each plan sponsor's contract performance. According to CMS, an entity's overall summary rating is based on adjusted averages, with consistent good performance recognized with a higher rating. Individual measures that make up the summary score rating do not include half star points, but the summary rating, which is composed of individual ratings, does allow for half star points to provide more differentiation between plans. A score of three stars in any individual measure is considered an indicator of adequate performance, while a summary score falling below three stars indicates a poor or negative "outlier" performance.[10]

In March 2008, CMS first publicly announced that it would use the Star Rating System as a basis for monitoring and compliance actions against Part D plans in the 2009 Call Letter[11]. The Call Letter did not mention the use of the Star Rating System in any manner with respect to Part C. The relevant parts of the Call Letter stated the following:

> "CMS maintains that only sponsors receiving 'good' ratings (*i.e.* two stars in 2006, three stars in 2007) or better can provide the quality of services needed to ensure beneficiary satisfaction with their Part D benefits.
>
> "It is expected that all sponsors, regardless of their CMS ratings, are continually working to improve their Part D operations. However, sponsors with less than 'good' ratings in any performance category should expect to be the subject of CMS monitoring and compliance actions. These sponsors will be afforded a reasonable opportunity to bring their performance up to a three-star rating or better. In instances where sponsors do not take advantage of that opportunity, and CMS determines that a sponsor's continued rating of three or less stars is

[8] *See* CMS Brief at 8-9. The Hearing Officer notes that the CMS Brief at 10 states that 1 point is allotted to a below average Star Rating, while the CMS Brief, Exhibit 9 at 2, states that 2 points shall be allotted. However, this discrepancy is immaterial to the issue at hand, because the additional point Citrus received due to its below average Star Rating placed Citrus over the four negative performance points threshold which resulted in the SAE denial.

[9] The three deficiency points issued to Citrus HC because of intermediate sanctions by CMS for compliance matters were not contested by Citrus. The only deficiency point which was contested by Citrus was the one point attributed to the below average rating from the Star Rating System.

[10] *See* CMS Brief at 6. The Hearing Officer notes, that at testimony, CMS generally described a 2.5 Star rating as "below average" or "inadequate". *See* Transcript (Tr.) of Proceedings, at 84-85. In contrast, the Applicant's Brief, Exhibit 3 contained copies of Citrus' Star Ratings on Medicare.gov, which contains a key which states that a Star Rating of two stars is "fair" and a rating of three 3 stars is "good".

[11] *See* CMS Brief, Exhibit 24, "2009 Call Letter" at 74.

> indicative of its failure to substantially carry out the terms of its Medicare contract, CMS may impose intermediate sanctions (*e.g.* suspension of marketing and enrollment activities) or pursue contract termination."[12]

CMS did not repeat the above information about the use of the Star Rating System with respect to Part D, and did not add it with respect to Part C, in Call Letters for subsequent years. At the hearing, CMS explained that policies contained in prior year Call Letters continue to apply to contract applications for future years unless a Call Letter for a year specifically changes a policy stated in a previous Call Letter.[13] At the hearing, CMS also noted the application of the Star Rating System was also mentioned in the October 2009 proposed regulation and the April 2010 final regulation, as well as at various presentations.[14]

Factual and Procedural Background

Citrus Health Care (CHC) holds a contract with CMS to offer Medicare Advantage-Prescription Drug (MA-PD) Health Maintenance Organization (HMO) plans in 20 counties in the State of Florida. On December 16, 2008, CMS placed CHC on intermediate sanctions for contract number H5407, resulting in suspension of enrollment of, and marketing to new beneficiaries effective January 1, 2009.[15] On March 31, 2009, CHC via letter requested relief from CMS' intermediate sanctions.[16] Numerous rounds of negotiations and remediation efforts by Citrus ensued.[17] On November 20, 2009 via letter, CMS released the imposed intermediate sanctions from CHC.[18]

On February 25, 2010, CHC filed an application for calendar year 2011 with CMS to expand its contract service area to Martin County, Florida. On May 5, 2010, CMS notified CHC via email of its intent to deny CHC's MA-PD application.[19] On June 7, 2010[20] via email, CMS notified CHC that its 2011 MA-PD application was denied for the following reasons:

> 1. Citrus has received an intermediate sanction in the form of a marketing and enrollment suspension. These sanctions were imposed as a result of numerous significant Citrus compliance issues. While the sanction has since been lifted, these issues were serious, and occurred during the period that CMS considered in its analysis.

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[12] *See* Id.
[13] *See* Tr. at 77-80 and 104-108.
[14] *See* Tr. at 79-81. *See also* CMS Brief at 10; *See also* CMS Brief Exhibit 14 (a copy of materials from an actual presentation).
[15] *See* CMS Brief Exhibit 1 "CMS Notice of Intent to Impose Intermediate Sanctions" at 1.
[16] *See* CMS Brief Exhibit 2 "Request for Release from Intermediate Sanctions" at 1.
[17] *See* CMS Brief at 3.
[18] *See* CMS Brief Exhibit 3 "CMS Release of Intermediate Sanctions" at 1.
[19] *See* CMS Brief Exhibit 10 "H5407 –MA Application—Notice of Intent to Deny" at 1.
[20] June 7, 2010 is also the effective date of the new CMS regulations related to past performance compliance.

2. Additionally, Citrus has received a below average star rating (2.5 stars or lower out of 5 stars) in the area of health plan quality.[21]

Citrus filed a timely request for a hearing concerning CMS' determination. On July 1, 2010, CMS submitted a brief in support of its denial of the Applicant's initial application based on the deficiencies noted in the denial notice.[22] On July 1, 2010, the Applicant submitted a memorandum requesting relief from the application denial.[23] A hearing was held on July 8, 2010.

Applicant's Contentions

Citrus contends that CMS did not possess legal authority to use the Star Rating System in assessing compliance of health plans with Part C and applying compliance information with respect to contract applications for the year at issue. Citrus also contends that in the Call Letter process where the agency articulates policy on an annual basis, all discussion about the use of the Star Rating System (for alleged purposes beyond informing consumers) pertained only to Part D, and CMS has not offered any evidence that extends that policy to Part C.[24]

Citrus contends that the Star Rating System, in and of itself, was designed and intended to be a mechanism for beneficiaries to use in selecting or assessing health plans that they might want to choose from, and was not intended as a measure of a plan for the kinds of compliance analyses that CMS used it for.[25] Moreover, Citrus contends that the data used by CMS in determining whether to approve or deny a contract application is limited to a 14 month period pursuant to the current version of 42 C.F.R. §422.502(b), and that standard needs to be applied to the Star Rating System. Citrus contends that even though the stars were awarded during the 14 month period relevant to the 2011 contract year, the data from which the ratings were derived originated prior to the 14 month period.[26]

Further, Citrus contends that the Star Rating System is supposed to provide information to CMS to trigger an inquiry into whether the plan represents an "outlier", and the rating that was issued to Citrus by CMS of 2.5 is not indicative of an "outlier" status, because it is between "Fair" and "Good".[27] Citrus also contends that the determination of a rating of 2.5 as an outlier is inaccurate, because so many new and low enrollment plans do not receive quality ratings due to lack of data.[28] Further, Citrus contends that even if the 2.5 rating as an outlier is accurate, it doesn't allow CMS to deny the application based on that star rating score alone, but instead can only be used as a trigger to investigate whether a

[21] *See* CMS Brief Exhibit 11 "Application Denial" at 1.
[22] *See* CMS Brief at 1.
[23] *See* Petitioner's Memorandum In Support of Appeal of CMS Denial of Application #H5407 ("Citrus Brief") at 2.
[24] *See* Id. at 160-161.
[25] *See* Id. at 8.
[26] *See* Id. at 9, 27-31, and 36-37. *See also* Citrus Brief at 4.
[27] *See* Tr. at 10.
[28] *See* Citrus Brief at 4.

failure to comply exists or to impose a corrective action plan.[29] Citrus contends that the new regulation which determines that a plan is out of compliance when CMS finds that they are an "outlier" (relative to the performance of other organizations), did not take effect until June 7, 2010, or in other words after the SAE application was submitted.

Citrus contends that even if CMS had authority to, and did apply the Star Rating System accurately, the Star Ratings should not have been applied to Citrus because the SAE was actually a reduction in service area, and not an expansion. In its 2011 application, Citrus eliminated 8 counties from its service area and proposed to add one new county, for a net reduction in service area of 7 counties and a 30% decline in projected enrollment in 2011 compared to enrollment in 2010.[30] Citrus contends that the regulations contemplate the use of past performance data to evaluate an SAE in order to ensure that plans with performance issues avoid obligations in addition to existing operations. Since its SAE application did not propose additional obligations, but instead reduced obligations, Citrus contends the use of the Star Rating System was precluded from use to evaluate its SAE.[31]

Citrus contends that any past performance compliance issues that CMS cited as the reason for denying the application in fact pertain to a different organization. Citrus contends that it would be inequitable and inappropriate to deny Citrus' application considering that the Physician Health Choice acquisition of Citrus (effective April 1, 2010) yielded a completely overhauled corporate and executive structure leading to a vastly different company.[32] Further, Citrus contends that because of these corporate changes, Citrus (via acquisition by Physician Health Choice) does not qualify as a high risk organization exhibiting a pattern of poor performance, which is the standard set forth in the preamble to the Final Rule with respect to determinations under 42 C.F.R. §§422.502(b), and that in the preamble CMS stated that it intended to make conservative agency determinations in denying applications.[33]

CMS' Contentions

CMS contends that the regulations at 42 C.F.R. §422.502(b) have been in effect since 2005, and such regulations have permitted contract denials based on past performance."[34] CMS contends that Citrus has displayed weaknesses across a range of operational and regulatory categories, several directly related to quality of care and beneficiary protections as reflected in its mediocre performance (star) ratings for the 2010 contract year.[35] Likewise, based upon failures identified in a CMS audit, Citrus was subject to a marketing and enrollment sanction that was in place through much of the 2009 contract year.[36] CMS contends that both of these factors, assessed in comparison to the other

[29] *See* Id.
[30] *See* Id. at 5.
[31] *See* Id.
[32] *See* Id. at 6; *See also* Tr. at 12-13.
[33] *See* Citrus Brief at 7.
[34] *See* Tr. at 111-112.
[35] *See* Id. at 15.
[36] *See* CMS Brief at 12.

Medicare Advantage contractors, showed Citrus to be an operational outlier earning a sufficiently negative past performance rating (4 points), thus justifying CMS' denial of the Citrus SAE.[37]

CMS contends that while Citrus alleges that the use of the Star Rating System was improper and never meant to be used as a Part C performance metric, CMS issued numerous communications that this was the actual intent of the Star Rating System. Further, CMS contends that even though the ratings are indeed posted for use by beneficiaries to provide information for their treatment choices, CMS publicly gave notice that these metrics would be relied upon for compliance and operational status.[38]

CMS contends it is not reasonable to expect that the data used to calculate the Star Ratings be limited only to data generated within the 14 month look-back period specified in 42 C.F.R. §422.502(b) for the use of data from prior contracts.[39] CMS stated that the Star Rating System uses the most recent data available and that data lags are intrinsic in quality measurement. [40]

CMS contends that according to its statistical reviews, a 2.5 star rating places Citrus in the lowest 25% of plans with respect to its summary rating, and despite having had the opportunity to challenge this rating (and the same earned rating in 2009) under CMS procedures, Citrus did not do so.[41] CMS contends that Citrus was ranked on a five star system, and scored below the required three star rating of "adequate" in its summary rating, as well as various Part C domain categories. CMS contends that these ratings presented sufficiently significant concerns that required CMS consideration in its determination that Citrus was unable to take on a new or expanded service area.[42]

CMS contends that Citrus' claim that its application, when judged as a whole, constituted an aggregate contraction of its service area, thus precluding Citrus from the applicability of past performance analysis, is irrelevant. CMS contends that Citrus' explanation ignores the impact on individual beneficiaries (within the areas for which Citrus requested an expansion) that CMS is required and responsible to protect from any harm due to insufficiencies in a plan sponsor's ability to perform under its contract.[43]

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[37] *See* Tr. at 15-16.
[38] *See* Id. at 18. *See also* CMS Brief at 10. At the hearing, CMS explained that it made its intent to utilize the Star Rating System as a performance metric in the preambles to the October 22, 2009 Proposed Rule and the April 15, 2010 Final Rule, as well as in the 2009 Call Letter. CMS also publicized this intent at industry conferences, including the September 2009 America's Health Insurance Plans (AHIP) Annual Medicare Conference; the December 2009 Industry Collaboration (ICE) Conference; and the February 2010 Health Care Compliance Association (HCCA) Managed Care Compliance Conference. *See* CMS Brief, Exhibit 14.
[39] *See* Tr. at 37-38.
[40] *See* Tr. at 128-130.
[41] *See* Tr. at 20.
[42] *See* CMS Brief at 13.
[43] *See* Tr. at 21-22.

Finally, CMS contends that Physician Health Choice's acquisition of Citrus (effective April 1, 2010) is not relevant to the SAE denial determination because it takes time for organizations to make the process and cultural changes resulting from an acquisition. CMs cannot delay the contract application review process to evaluate the impact of these changes.[44] In addition, CMS is not obligated to conduct an evaluation of the performance of every sponsor's corporate owners. Therefore, since Citrus has held contract H-5407 since 2004 and remains the legal entity responsible for contract performance currently, information regarding Physician Health Choice's purchase of Citrus would not deem Citrus' past performance irrelevant.[45]

Decision

The Hearing Officer notes that Citrus did not contest CMS' assessment of three negative performance points against its application due to the previous imposition of intermediate sanctions.[46] Therefore, the sole issue for decision is whether CMS correctly assessed the one additional negative performance point resulting from Citrus' below average Star Rating.[47]

CMS relied on 42 C.F.R. §422.502(b) as longstanding authority to consider failure to meet performance standards (e.g. Star Ratings) in making contract determinations.[48] However, the Hearing Officer notes that this section applies to failure to meet Part C *requirements*, not [quality] *performance standards*.

CMS also relied on subparagraphs (1) and (2) of 42 C.F.R. §422.504(m) as authority to apply the Star Rating System to Citrus' application, arguing that these provisions were clarifications of its existing authority (rather than a new regulation).[49] The Hearing Officer notes that the actual Star Rating in controversy was issued on October 9, 2009,[50] two weeks before the initial publication of 42 C.F.R. 422.504(m) within the October 22, 2009 Proposed Rule. The Final Rule was published on April 15, 2010, but did not take effect until June 7, 2010. The effective date of the Final Rule was almost eight months after Citrus' actual Star Rating was issued and over 90 days beyond the February 25, 2010, the date on which MA contract applications were due to CMS for calendar year 2011. Accordingly, 42 C.F.R. §422.504(m) would not be fairly or legally applicable in this case as the actual star rating in controversy was issued not only prior to the effective date of the regulation, but also prior to the issuance of the initial publication of the Proposed Rule itself. The Hearing Officer notes that CMS issued no clear binding

[44] *See* Tr. at 62.
[45] *See* Tr. at 21-23.
[46] *See* Tr. at 47.
[47] This additional negative performance point gave Citrus a total of 4 negative performance points, which ultimately resulted in the denial of its application.
[48] *See* Tr. at 16.
[49] *See* Tr. at 110.
[50] *See* Tr. at 127.

authority that the Star Rating System was a performance standard applicable to Part C contract applications for 2011.[51]

Therefore, based on the above record, the Hearing Officer finds that CMS improperly applied the Star Rating System to Citrus HC's SAE Application in this case.

Conclusion

The Hearing Officer finds that the Applicant has proved by a preponderance of the evidence that CMS' application of the Star Rating System to Citrus HC's SAE was inconsistent with the requirements of 42 C.F.R. §§422.501 and 422.502.

Benjamin Cohen
Hearing Officer

Date: August 13, 2010

[51] The Hearing Officer notes that the only evidence that CMS presented that it provided public notice/guidance to plan sponsors was a 2009 call letter, which addressed Part D plans only. *See* CMS Brief Exhibit 24 "2009 Call Letter" at 74. During closing argument, CMS conceded that CMS had only specified that the Star Rating System applied to Part D. *See* Tr. at 168-169. It should be noted, however, that the Hearing Officer disagrees with the applicant's general premise that the Star Rating System should not be used as a performance metric because the ratings are partially based on data outside the 14 month period referred to in 42 C.F.R §422.502(b). Accordingly, in future similar circumstances, the Hearing Officer notes that CMS could reasonably consider an organization out of compliance under 42 C.F.R.§422.504(m)(1) for failure to meet established performance metrics, even if a portion of the data used to evaluate compliance is technically derived from instances outside the 14 month window.