PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D32

PROVIDER –
Carinosa Healthcare, Inc.
McAllen, Texas

Provider Nos.: 45-3108

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Palmetto GBA

DATE OF HEARING –
February 21, 2013

Reporting Period Ended –
Calendar Year 2012

CASE NO.: 12-0408

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ISSUE:

Whether the imposition of a 2 percent reduction in Carinosa Healthcare, Inc.'s Medicare payments for calendar year ("CY") 2012 was proper? [1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

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

> (v) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.
>
> (I) ADJUSTMENT. For purposes of clause (ii)(V), for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such 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.") at 5-6.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See:* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] Pub. L. No. 105-33, 111 Stat. 251 (1997). *See also*: 65 Fed. Reg. 41128, 41129 (July 3, 2000).
[5] Pub. L. No. 109-171, 120 Stat. 4 (2006). *See also*:72 Fed. Reg. 49762, 49763 (Aug. 29, 2007).

> 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.[7] 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. [8]

For CY 2007, the November 2006 Final Rule advised providers that avoiding the 2 percentage point 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.[9] Further, in order to avoid the 2 percentage point reduction to the APU for certain subsequent periods, the November 2006 Final Rule required the provider to comply with the additional OASIS data submission for CY 2007.

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[6] 71 Fed. Reg. 65884 (Nov. 9, 2006).
[7] Hereinafter referred to as the "2 percentage point penalty."
[8] *Id.* at 65935 (footnote added).
[9] *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"), [10] November 3, 2008 ("November 2008 Final Rule"), [11] and November 10, 2009 ("November 2009 Final Rule") [12] respectively. Similar to the November 2006 Final Rule and consistent with 42 C.F.R. §§ 484.225(h) and (i), these rulemakings advised providers that avoiding the 2 percentage point penalty to the APU was tied to the submission of additional data for the OASIS.[13] 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).[14] 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.[15]

Further, in the November 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").[16] 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.[17] 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

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

> the 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.[18]

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.[19]

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

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

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[18] 73 Fed. Reg. at 65351, 65357 (footnote added).
[19] 74 Fed. Reg. at 58104.

> *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....[20]

The preamble to the November 2009 final rule also states: "...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."[21]

CMS reiterated that the failure to participate in the dry run or failure to continuously collect and submit survey data as stated in the November 2009 Final Rule would cause a reduction of 2 percentage points to the APU for CY 2012.[22]

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

> To collect and submit HHCAHPS data to CMS, Medicare-certified agencies will need to contract with an approved HHCAHPS survey vendor. Beginning in summer 2009, interested vendors applied to become approved HHCAHPS vendors. The application process was (and still is) delineated online at https://www.homehealthcahps.org. Vendors are required to attend training conducted by CMS and the HHCAHPS Survey Coordination team, and to pass a post-training certification test.[23]

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:

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

> 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.[24]

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.[25]

In the final rule published on November 17, 2010 ("November 2010 Final Rule"),[26] CMS reaffirmed the timeline for expanding the HHA quality measures reporting requirements to include HHCAHPS. Specifically, CMS reiterated that "the mandatory period of data collection for the CY 2012 APU includes the [HHCAHPS] dry run data in the third quarter 2010, [HHCAHPS] data from the fourth quarter 2010 (October, November and December 2010), and [HHCAHPS] data from the first quarter of 2011 (January, February and March 2011)."[27] CMS clarified that while the relevant dry run data time period had passed (July, August and September of 2010) and the period to report data had just started (October 2010 through March 2011), the deadlines for data submission 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.)"[28]

CMS again provided notification of the 2 percentage point reduction to the APU, as well as notification of the reconsiderations and appeal procedures:

> For CY 2012, we maintain our policy that all HHAs, unless covered by specific exclusions,[29] meet the quality reporting requirements or be subject to a 2 percentage point reduction in the HH market basket percentage increase in accordance with section 1895(b)(3)(B)(v)(I) of the Act.

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[24] *Id.* at 58100.
[25] *Id.*
[26] 75 Fed. Reg. 70372 (Nov. 17, 2010).
[27] 75 Fed. Reg. at 70405.
[28] *Id.*
[29] 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 FY 2012. *See* 74 Fed. Reg. at 58100. The Provider does not assert that any exclusion or exemption from participation applies in this case. *See generally* Provider's Final Brief; Provider's Post Hearing Brief.

> A reconsiderations and appeal process is being developed for HHAs that fail to meet the HHCAHPS data collection requirements. We proposed that these procedures will be detailed in the CY 2012 HH payment rule, the period for which HHCAHPS data collection would be required for the HH market basket percentage increase. During September through October 2011, we will compile a list of HHAs that are not compliant with OASIS-C and/or HHCAHPS for the 2012 APU requirements. These HHAs 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.[30]

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.[31]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Carinosa Healthcare, Inc. ("Provider") is a for-profit home health agency located in McAllen, Texas. The Provider's designated Intermediary is Palmetto GBA ("Intermediary").

On September 16, 2011, the Intermediary issued a notice to the Provider notifying it that CMS had determined that it was subject to a 2 percentage point reduction in the APU for its CY 2012 Medicare payments for not meeting the Deficit Reduction Act's requirement for HHAs to submit quality data. Specifically, the HHAs should have participated in a HHCAHPS dry run in the third quarter of 2010 and continued monthly collection and submission of data to the HHCAHPS Data Center beginning in October, 2010 through March, 2011.[32]

The Provider submitted a request for reconsideration to the Intermediary on September 23, 2011.[33] On December 27, 2011, the Intermediary issued a notice to the Provider denying its request for reconsideration and notifying the Provider that it was subject to a 2 percent reduction in the APU for its HH PPS payments for CY 2012 due to noncompliance with submission of quality data during the required timeframes. Specifically, CMS noted that the Provider did not conduct a HHCAHPS dry run in the third quarter of 2010 as required for meeting HHCAHPS

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[30] 75 Fed. Reg. at 70405-70406 (footnote added).
[31] *Id.* at 70406.
[32] Provider's Final Position Paper, Exhibit B.
[33] Provider,s Final Position Paper, Exhibit C.

requirements for the CY 2012 annual payment update.[34] On June 20, 2012, the Provider timely appealed CMS' reconsideration denial to the Board.[35]

The Provider was represented by Jonathan W. Wu, Esq., of Rivas Goldstein, LLP. The Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

PARTIES CONTENTIONS:

The Provider does not dispute that it did not conduct a dry run in the third quarter of 2010, one of the requirements that it needed to satisfy in order to receive its full market basket update for CY 2012.[36] Rather, the Provider argues that CMS failed to provide adequate and meaningful notice of this requirement as evidenced through the numerous, changing and conflicting publications regarding HHCAHPS requirements and the rules establishing that the violation of those requirements would be justification for implementing the 2 percentage point reduction.[37] The Provider claims that, at the time and during the months immediately prior to the third quarter of 2010, the regulations themselves and CMS' implementation of these regulations were not set in stone.[38] The Provider maintains that, if CMS had made it clear that compliance with the HHCAHPS dry run was not "voluntary" and that the Provider was already noncompliant at the time it contracted with its vendor in December 2010, the Provider would not have expended financial resources until the following year and would have been able to more effectively plan for the inevitability of the 2 percentage point reduction.[39]

The Intermediary contends that the Provider received adequate notice of the HHCAHPS survey requirements via the HH PPS final rules for CYs 2009, 2010, and 2011 that were published in the Federal Register. The Intermediary argues that each of these final rules was replete with information and guidance regarding the HHCAHPS survey process and the timelines for data submission that HHAs needed to follow in order to avoid a 2 percentage point reduction to their CY 2012 annual payment update.[40]

In addition to the information contained in the Federal Register, the Intermediary notes that a wealth of information is available to HHAs on the HHCAHPS website. The Intermediary points out that the website also houses the HHCAHPS Protocols and Guidelines Manual. This extensive document covers all aspects of the HHCAHPS survey process. The most recent version is always available on the website.[41]

Finally, with respect to communication of the HHCAHPS survey requirements and the associated submission deadlines, the Intermediary stated that it published an article on its website

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[34] Provider,s Final Position Paper, Exhibit D.
[35] Provider,s Final Position Paper, Exhibit E.
[36] Provider,s Post-hearing Brief at 2.
[37] *Id.* at 10.
[38] *Id.* at 7.
[39] *Id.*, at 9.
[40] MAC's Final Position Paper at 3-6.
[41] MAC's Final Position Paper at 8-9.

on August 26, 2010 that spelled out all of the steps that HHAs needed to take in order to fulfill the HHCAHPS requirements for the CY 2012 HH PPS annual payment update.[42]

Finally, the Intermediary noted that the Provider's third quarter 2010 (September 2010) dry run patient data itself was not submitted to its HHCAHPS survey vendor to conduct the dry run survey until February 16, 2011 which was after the submission deadline for the dry run results. Additionally, the Intermediary points out that the official CMS record of submissions to the HHCAHPS website by the Provider's vendor documents that there were no successful submissions of either the dry run data for the third quarter of 2010 or any data for the fourth quarter of 2010 on behalf of the Provider.[43] Therefore, the Provider did not fulfill the requirements necessary to avoid a 2 percentage point reduction in its CY 2012 annual payment update. It did not submit dry run data from the third quarter of 2010 to the HHCAHPS Data Center by January 21, 2011 nor did it submit the fourth quarter 2010 data by April 21, 2011.

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 point penalty imposed by CMS.

The issue presented for the Board's consideration does not involve an interpretation of the statute or the regulations. The Provider does not dispute that it missed its submission date for the third quarter 2010 dry run, and that the regulations impose a 2 percentage point penalty for that missed submission. And finally, the Provider does not dispute that none of the exemptions from HHCAHPS participation apply in this case, or that the regulations impose a 2 percentage point penalty for failing to submit the required data.[44] Notwithstanding, the Provider asserts that it was in "substantial compliance"[45] and that "CMS is not required to reduce a home health agency's annual Medicare APU; CMS has discretion to make such a determination."[46]

In essence, the Provider appears to be requesting equitable relief from the filing requirements. 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. In connection with the 2 percentage point penalty, the Board does not have the authority to consider factors outside those specifically recognized under the statute and regulations. 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 percent revenue reduction. Rather, the statute, regulations, and relevant final rules mandate application of the 2 percentage point penalty if a provider fails to submit home health quality data as specified by the Secretary unless the provider falls within certain specified exclusions or exemptions.

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[42] Tr. at 50-56.
[43] MAC's Final Position Papers, at10.
[44] Stipulations at 1, 7, 8.
[45] Provider's Post-Hearing Brief at 11.
[46] Provider's Final Position Paper at 3.

The Board finds that adequate notice of HHCAHPS program requirements was supplied through notices published as rulemakings in the Federal Register. The November 2006 Final Rule, the August 2007 Final Rule, the November 2008 Final Rule, the November 2009 Final Rule and the November 2010 Final Rule all provided substantive guidance on the requirements, and the steps that providers needed to take in order to avoid a 2 percentage point reduction to the APU for the CY 2012 HH PPS payments. As early as November 2008, CMS had informed providers that it intended to implement a process to measure and publicly report patient experiences with home health care by using the HHCAHPS survey program *in addition* to the previously-mandated OASIS reports.[47] Moreover, in the November 2009 Final Rule, CMS "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."[48] The Board agrees with the Intermediary that the Provider had ample opportunity to understand the program requirements and comply with the survey requirements.

The Board finds that the HHCAHPS program requirements set forth in the Federal Register can be read in harmony with statute and regulations and are also subject to formal notice and comment periods. The Federal Register provides adequate notice for provider compliance with the program requirements.

The Board finds that, in this case, the Provider failed to submit dry run data for the third quarter of 2010 to the HHCAHPS Data Center by January 21, 2011, and also failed to submit the fourth quarter 2010 data to the HHCAHPS data center by April 21, 2011. Failure to timely file the required HHA quality data triggers imposition of the 2 percentage point penalty that was described and announced in both the November 2009 and November 2010 Final Rules. Neither the statute, regulations, nor relevant final rules allow for waiver of the penalty (*e.g.*, partial credit or other equitable relief). Accordingly, the Board finds that the Provider failed to satisfy HHCAHPS program requirements and that the 2 percentage point penalty was correctly applied. The Provider may not secure any relief (equitable or otherwise) from the 2 percentage point penalty imposed by CMS.

The Board notes that the Intermediary letter dated September 16, 2011 which notified the Provider of the 2 percentage point reduction states that evidence of a vendor's failure to comply with the HHCAHPS submission "does not support a finding of compliance" on the part of the Provider.[49] In this case, it is clear that the Provider failed to ensure that its contracted vendor complied with the submission requirements, notwithstanding the Provider's responsibility to do so,[50] and that the Provider is strictly liable for its failure to meet HHCAPHS submission deadlines pursuant to the statute, regulations, and manual provisions governing the HHCAHPS program.

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[47] 73 Fed. Reg. at 65356.
[48] *Id.*
[49] Provider's Final Position Paper, Exhibit B at 2.
[50] *See* HHCAHPS Protocols and Guidelines Manual at 14 (Jan. 2012) (specifying that HHA responsibilities include the responsibility to "[r]eview data submission reports to ensure that the survey vendor has submitted data on time and without data problems"); 74 Fed. Reg. at 58100 ("[W]e strongly recommended that home health agencies participating in the HHCAHPS survey promptly review the required Data Submission Summary Reports . . . . 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.").

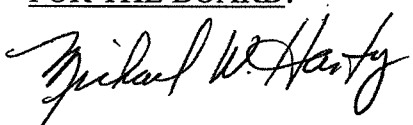
DECISION AND ORDER:

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

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 28 2013