PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2017-D18

PROVIDER –
Vibra Hospital of Fort Wayne

Provider No.: 15-2027

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

DATE OF HEARING –
August 21, 2015

Cost Reporting Period Ended –
September 30, 2015

CASE NO.: 15-1879

INDEX

ISSUE STATEMENT

Whether the payment penalty that the Centers for Medicare and Medicaid Services ("CMS") imposed under the Long-Term Care Hospital Quality Reporting Program ("LTCH QRP") to reduce the Provider's payment update for Fiscal Year ("FY") 2015 by 2 percent was proper.[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that CMS properly imposed a 2 percent reduction to the annual update to the standard Federal rate used to calculate the FY 2015 Medicare payments for Vibra Hospital of Fort Wayne under the inpatient prospective payment system for long-term care hospitals ("LTCH").

INTRODUCTION

Vibra Hospital of Fort Wayne ("Fort Wayne" or "Provider") is a Medicare-certified LTCH located in Fort Wayne, Indiana. Fort Wayne's designated Medicare administrative contractor is Wisconsin Physicians Service ("Medicare Contractor").

On June 27, 2014, CMS determined that Fort Wayne failed to meet the requirements of the LTCH QRP for FY 2015. Specifically, the determination stated that Fort Wayne was subject to a 2 percent reduction in the FY 2015 annual payment update because it did not submit twelve months of data for two of the three required quality measures.[2]

On July 22, 2014, Fort Wayne requested that CMS reconsider the decision regarding the reduction to its FY 2015 Medicare payments.[3] On September 22, 2014, CMS upheld its reduction decision.[4] On March 19, 2015, Fort Wayne timely appealed this reduction to the Board.[5]

Fort Wayne met the jurisdictional requirements for a hearing before the Board, and the Board held a hearing on the record. Jason M. Healy, Esq., of The Law Offices of Jason M. Healy, PLLC represented Fort Wayne. Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association represented the Medicare Contractor.

STATEMENT OF THE FACTS

The Medicare Contractor reduced Fort Wayne's payment update for FY 2015 by 2 percent because Fort Wayne failed to submit twelve months of quality data for calendar year ("CY")

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[1] *See* Provider's Final Position Paper at 2.
[2] *See* Provider Exhibit P-2 at 1.
[3] *See* Provider Exhibit P-3 at 2.
[4] *See* Provider Exhibit P-4.
[5] *See* Provider Exhibit P-1.

2013.[6] As delineated in the final rule published on August 18, 2011 ("August 2011 Final Rule"), CMS required that Fort Wayne submit certain quality data to the Centers for Disease Control and Prevention's ("CDC's") National Health Safety Network ("NHSN") system for all four quarters of CY 2013.[78] Specifically, Fort Wayne had to submit data on the following three quality measures to NHSN for CY 2013:

1. Urinary Catheter - Associated Urinary Tract Infections ("CAUTI");
2. Central Line Catheter- Associated Bloodstream Infection ("CLABSI"); and
3. Percent of Residents with Pressure Ulcers that Are New or have Worsened ("Pressure Ulcer measure").[9]

Fort Wayne disputes that it failed to timely report all CAUTI and CLABSI occurrences for CY 2013 to NHSN. Fort Wayne contends that in June 2014, numerous issues[10] were discovered with the NHSN system that prevented Fort Wayne's data submissions for CY 2013 from being timely transmitted to CMS[11] and that it made a good-faith effort to comply with the LTCH QRP reporting requirements as CMS now possesses all required data.[12] In addition, Fort Wayne argues that the CMS redetermination was invalid because it was not the product of reasoned decision making[13] and failed to render a specific determination with respect to whether Fort Wayne met the CMS criteria for a "justifiable excuse" sufficient to reverse the 2 percent penalty.[14] Fort Wayne requests that the Board use its equitable discretion to reverse the application of the penalty.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Federal statute, 42 U.S.C. § 1395ww(m)(5), requires LTCHs to report on the quality of their services in the form, manner and time as specified by the Secretary.[15] An LTCH that fails to submit the LTCH QRP data to the Secretary is assessed a one-time 2 percent reduction to its annual update to the standard Federal LTCH prospective payment.[16]

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[6] *See* Provider Exhibit P-2.
[7] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates; Hospitals' FTE Resident Caps for Graduate Medical Education Payment, 76 Fed. Reg. 51476, 51753 (Aug. 18, 2011) (to be codified at 42 C.F.R. pts. 412, 413, & 476).
[8] Note that the relevant excerpt from the Federal Register can be found in Exhibit I-2 of the Medicare Contractor's Final Position Paper.
[9] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates; Hospitals' FTE Resident Caps for Graduate Medical Education Payment, 76 Fed. Reg. at 51745–50; *see also* 42 U.S.C. § 1395ww(m)(5)(D)(iii) (requiring the Secretary to select and publish LTCH QRP quality measures by October 1, 2012).
[10] Note that the submission of data for the Pressure Ulcer measure is not at issue in this case.
[11] *See* Provider Exhibit P-3 at 2.
[12] Provider's Final Position Paper at 21.
[13] Provider's Final Position Paper at 6.
[14] *Id.* at 12–13.
[15] The Patient Protection and Affordable Care Act added LTCH QRP statutory provisions at 42 U.S.C. § 1395ww(m)(5). Patient Protection and Affordable Care Act, Pub. L. 111–48, § 3004(a), 124 Stat. 119, 368–69 (2010).
[16] 42 U.S.C. § 1395ww(m)(5); 42 C.F.R.§ 412.523(c)(4).

The preamble to the August 2011 Final Rule established FY 2012 as the first reporting year for the LTCH QRP and required submission of quality data on CAUTI, CLABSI and pressure ulcers. This submission would be used to determine FY 2014 LTCH payments.[17] CMS directed LTCHs to the CDC website at http://www.cdc.gov/nhsn for additional details regarding data submission[18] and stated that additional reporting requirements would be posted on the CMS web site at http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/ by no later than January 31, 2012.[19] CMS restated this information as well as the due dates for data submission in the preamble to the final rule published on August 31, 2012 ("August 2012 Final Rule").[20][21]

The Board's review of the record shows that Fort Wayne failed to timely report the CAUTI and CLABSI data for CY 2013. Fort Wayne asserts that the delay in submitting its data was solely due to systemic errors of the NHSN system itself.[22] However, the Board finds that Fort Wayne failed to submit evidence into the record to support its assertion. Further, the Board notes that Fort Wayne had the ability to generate reports from the NHSN system to monitor what data had been submitted and, thereby, ensure its compliance with the data submission requirements.[23] Accordingly, the Board finds that the Fort Wayne failed to comply with the LTCH QRP requirement to submit data in the form, manner and time specified by the Secretary.

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[17] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates; Hospitals' FTE Resident Caps for Graduate Medical Education Payment, 76 Fed. Reg. at 51743–48.

[18] *Id*. at 51752.

[19] *Id*. at 51754.

[20] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers, 77 Fed. Reg. 53258, 53619 (Aug. 31, 2012) (to be codified at 42 C.F.R. pts. 412, 413, 424, & 476) (specifying collection and submission deadlines as well as the following CMS website address for additional instruction and guidance: http://www.cms.go78v/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnical Information.html).

[21] In the preamble to the August 2012 Final Rule, CMS noted that it was in the process of finalizing the LTCH QRP Manual and "invited the public to submit questions and comments related to the LTCHQR Program and the [then] draft LTCHQR Program Manual" to a specified email address. *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers, 77 Fed. Reg. at 53620–23. Excerpts from the LTCH RP Manual, Version 1.1 (Aug. 2012) that were issued contemporaneously with the August 2012 Final Rule are located at Medicare Contractor Exhibit I-3.

[22] *See* Provider's Final Position Paper at 21.

[23] *See* Medicare Contactor Exhibit I-3 at 4-2 (discussing the ability to create a "Final Validation Report" in § 4.3); *see also September 2012 Newsletter*, NHSN E-NEWS (Ctrs. for Disease Control & Prev., Nat'l Healthcare Safety Network, Atlanta, Ga.), Sept. 2012, at 3, https://www.cdc.gov/nhsn/pdfs/newsletters/September-2012-Newsletter.pdf (discussing NHSN data analysis tools and reports and providing links for guidance on how to generate reports); *see also October 2013 Newsletter*, NHSN E-NEWS (Ctrs. for Disease Control & Prev., Nat'l Healthcare Safety Network, Atlanta, Ga.), Oct. 2013, at 6, https://www.cdc.gov/nhsn/pdfs/newsletters/Oct-2013.pdf (providing a refresher on NHSN alerts).

Fort Wayne requests that the Board provide equitable relief because it made a good faith effort to comply with the LTCH QRP data submission requirements.[24] However, the Board cannot consider Fort Wayne's request for equitable relief because the Board's authority is limited to the statutory and regulatory requirements and to the facts and circumstances of the issues presented.[25] Specifically, in connection with the penalty, the Board neither has the authority to consider factors outside of those specifically recognized under the statute and regulations, nor the authority to consider whether the penalty is overly punitive.[26] Likewise, neither the statute nor relevant regulations provide for any partial penalty that would reduce the full impact of the 2 percent reduction. Rather, the statute, regulations and relevant final rules mandate application of the 2 percentage point penalty whenever an LTCH fails to submit LTCH quality data in the form, manner and time as specified by the Secretary.[27]

Fort Wayne further asserts that CMS' reconsideration process was arbitrary and capricious because it did not discuss Fort Wayne's arguments in support of a valid or justifiable excuse for not reporting CY 2013 quality data timely. The Board points to the final rule that established the LTCH QRP appeal process where CMS made it clear that an LTCH could choose whether to use the voluntary reconsideration process prior to appealing an initial determination of non-compliance to the Board.[28] In this final rule, CMS set forth the standard for review in the event that a provider elected to use the reconsideration process. Specifically, the final rule stated:

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[24] Provider's Final Position Paper at 17–18.

[25] In particular, the Board recognizes that Fort Wayne argues that the reconsideration decision issued by CMS was deficient because it failed to properly notify the basis for the decision in violation of the Administrative Procedure Act, 5 U.S.C. Chapter 5, Subchapter II. Even assuming *arguendo* that there was a notification deficiency, the Board would be unable to offer any relief or to consider substantial compliance as grounds for reversing the penalty because the Board is bound by the relevant statute and regulations which specify that Fort Wayne is subject to a 2 percent reduction if it fails to submit CAUTI and CLABSI data in the form, manner and time specified by the Secretary.

[26] The Board recognizes that, in the preamble to the LTCH final rule published on August 19, 2013, CMS stated that, for reconsiderations relevant to FY 2015 LTCH payments, "[w] e may reverse our initial finding of non-compliance if: (1) The LTCH provides proof of compliance with all requirements during the reporting period; or (2) the LTCH provides adequate proof of a valid or justifiable excuse for non-compliance if the LTCH was not able to comply with requirements during the reporting period." Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. 50495, 50886 (Aug. 19, 2013) (to be codified at 42 C.F.R. pts. 412, 413, 414, 419, 424, 482, 485, & 489). However, it is unclear whether only CMS has the authority to consider a "justifiable excuse" as this discussion was not incorporated into the governing regulation at 42 C.F.R. § 412.523(c)(4). The Board need not resolve this issue, as Fort Wayne did not sufficiently document any specific substantial technical or operational problem that may have established a justifiable excuse.

[27] *See* 42 U.S.C. § 1395ww(m)(5)(A)(i).

[28] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. at 50887 (excerpts are located at Medicare Contractor Exhibit I-12) (stating that "LTCHs dissatisfied with our initial finding of non-compliance, or a decision rendered at the CMS reconsideration level may appeal the decision with the PRRB under 42 CFR Part 405, Subpart R. . . . We would like to clarify that we recommend, rather than require, LTCHs use this order of appeals. We note that the CMS reconsideration process is voluntary . . . .").

> Upon conclusion of our review of each request for reconsideration, we will render a decision. We may reverse our initial finding of non-compliance if (1) The LTCH provides proof of compliance with all requirements during the reporting period; or (2) the LTCH provides adequate proof of a valid or justifiable excuse for non-compliance if the LTCH was not able to comply with requirements during the reporting period. We will uphold our initial finding of non-compliance if the LTCH cannot show any justification for non-compliance.[29]

The record shows that CMS sent a form letter on September 22, 2014 to Fort Wayne stating that "CMS has re-reviewed the quality data submitted . . . " and "has determined this LTCH did not meet the LTCHQR program requirements for the FY 2015 payment determination."[30] The Board finds that the use of uniform language in a form letter does not in and of itself establish that CMS did not meet the minimum requirements of the reconsideration process as established in the final rule. Rather the Board finds that the language in the letter indicates that CMS reviewed Fort Wayne's reconsideration request including a re-review of the data Fort Wayne submitted and determined that Fort Wayne did not comply with the LTCH QRP requirements. As provided for in the final rule, Fort Wayne exercised its right to timely appeal CMS' reconsideration determination to the Board.[31]

The Board notes that Fort Wayne—in a good faith effort to comply with all LTCH reporting requirements—included the missing data with its reconsideration request.[32] However the Board finds that late submitted data does not reverse the penalty which was imposed for the failure to submit the LTCH QRP data in the form, manner and time as specified by the Secretary.

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board finds that CMS properly imposed a 2 percent reduction to the annual update to the standard Federal rate used to calculate the FY 2015 Medicare payments for Fort Wayne under LTCH-PPS.

BOARD MEMBERS PARTICIPATING:

Jack Ahern, M.B.A., CHFP
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Clayton J. Nix, Esq.
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[29] *Id.* at 50886.
[30] Provider Exhibit P-1 at 7–8.
[31] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. at 50887 (excerpts are located at Medicare Contractor Exhibit I-12).
[32] Provider Exhibit P-3.

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.,
Chairperson

DATE: June 6, 2017