PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D21

PROVIDER–
Vibra Hospital of Amarillo
Vibra Hospital of Richmond

Provider Nos.: 45-2060
49-2009

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

DATE OF HEARING –
September 24, 2015

Cost Reporting Period Ended –
September 30, 2015

CASE NOs.: 15-1873; 15-1880

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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 Amarillo ("Amarillo") and Vibra Hospital of Richmond ("Richmond") under the inpatient prospective payment system for long-term care hospitals ("LTCH-PPS").

INTRODUCTION

Amarillo and Richmond are Medicare-certified long-term care hospitals ("LTCHs") located in Amarillo, Texas and Richmond, Virginia, respectively. Vibra Healthcare ("Vibra") purchased Amarillo and Richmond from Kindred Healthcare ("Kindred"), an unrelated company, on September 1, 2013. Amarillo and Richmond's designated Medicare administrative contractor[2] is Wisconsin Physicians Service ("Medicare Contractor").

On June 27, 2014, CMS determined that both Amarillo and Richmond failed to meet the requirements of the LTCH QRP for FY 2015.[3] Specifically, each determination stated that the LTCH was subject to a 2 percent reduction in the FY 2015 annual payment update because it "[d]id not submit twelve months of data for 2 of the 3 quality measures."[4]

Both Amarillo and Richmond requested that CMS reconsider the decision regarding the reduction to their FY 2015 Medicare payments.[5] On September 22, 2014, CMS upheld its reduction decision for both Amarillo and Richmond.[6]

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[1] Transcript of Proceedings, *Vibra Hospital of Amarillo and Vibra Hospital of Richmond v. Wisconsin Physicians Service*, Provider Reimbursement Review Board at 6 (Sept. 24, 2015) (Case No. 15-1873) [hereinafter Tr.].

[2] Medicare's payment and audit functions were historically contracted to organizations known as fiscal intermediaries ("FIs"). These functions are now contracted with organizations known as Medicare Administrative Contractors ("MACs"). The term, "Medicare Contractor," refers to both FIs and MACs as relevant.

[3] Amarillo's Post-Hearing brief at 2; Amarillo's Final Position Paper at Exhibit P-2; Richmond's Post-Hearing Brief at 2; Richmond's Final Position Paper at Exhibit P-2.

[4] *Id.*

[5] Amarillo's Final Position Paper at Exhibit P-3; Richmond's Final Position Paper at Exhibit P-3.

[6] Amarillo Final Position Paper at Exhibit P-4; Richmond's Final Position Paper at Exhibit P-4.

On March 19, 2015 Amarillo and Richmond timely appealed the CMS reconsideration determinations to the Board[7] and met the jurisdictional requirements for a hearing. The Board held a live hearing on September 24, 2015. Jason M. Healy, Esq., of The Law Offices of Jason M. Healy, PLLC represented Amarillo and Richmond. Robin Sanders, Esq., of the Blue Cross and Blue Shield Association, represented the Medicare Contractor.[8]

STATEMENT OF THE FACTS

CMS required LTCHs to submit certain quality data to the Centers for Disease Control and Prevention's ("CDC") National Health Safety Network ("NHSN") system for all four quarters of CY 2013.[9] Specifically, Amarillo and Richmond were required to submit data to the NHSN regarding:

1. Urinary Catheter -Associated Urinary Tract Infections ("CAUTI"), and
2. Central Line Catheter-Associated Bloodstream Infection ("CLABSI").[10]

Amarillo states that it did timely submit all of its quality data, except August 2013 quality data—which was submitted to the NHSN under two different digital certificates because of a September 1, 2013 change of ownership.[11] Specifically, prior to the change of ownership, Amarillo submitted under the digital certificate assigned to its then-owner, Kindred and, following the change of ownership, submitted information under the digital certificate assigned to its new owner, Vibra.[12]

Richmond claims that it timely reported all quality data for 2013.[13] Richmond asserts, unlike Amarillo, that it did not have an issue with the two certifications.[14] Richmond concludes that CMS improperly imposed the penalty because CMS did not look at the quality reporting under both digital certifications.[15]

The Medicare Contractor asserts that the problem was not the submission under two different digital certificates but that both Amarillo and Richmond simply failed to submit

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[7] Amarillo's Final Position Paper at Exhibit P-1; Richmond's Final Position Paper at Exhibit P-1.
[8] Note that Federal Specialized Services now represents the Medicare Contractor.
[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. 51476, 51753 (Aug. 18, 2011) (codified at 42 C.F.R. pts. 412, 413, & 476) (included at Medicare Contractor's Post-Hearing Brief at Exhibit I-2) [hereinafter Medicare Program, 76 Fed. Reg.].
[10] *See id*. 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).
[11] Tr. at 14-15, 95-96.
[12] *See* Tr. At 14-15, 53.
[13] Richmond's Final Position Paper at 7.
[14] *See id.* at 7-8.
[15] *Id.*

all twelve months of data as was required.[16] The date on Richmond's summary report[17] is not legible, and the report does not show any data for the CLASBI measure for November 2013. The Medicare Contractor points out that the submission rule is clear and missing even one month of data results in a finding of noncompliance.[18] As the new owner, Vibra was responsible for verifying that all data was submitted properly.[19]

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.[20] A 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.[21]

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. To ensure comprehensive quality data, CMS required all LTCHs to timely report required data. Failure to do so would result in a reduction in the FY 2014 LTCH payment update.[22] CMS directed LTCHs to the CDC website at http://www.cdc.gov/nhsn for additional details regarding data submission[23] 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.[24] 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").[25]

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[16] *See* Medicare Contractor's Final Position Paper for Amarillo at 8-12; *see also* Medicare Contractor's Final Position Paper for Richmond at 8-13.
[17] Richmond's Final Position Paper at Exhibit P-3, 3.
[18] *See* Medicare Contractor's Final Position Paper for Amarillo at 8-12; Medicare Contractor's Final Position Paper for Richmond at 8-13.
[19] *See* Medicare Contractor's Final Position Paper for Amarillo at 8-12.
[20] *See also* Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, § 3004(a), 124 Stat. 119, 368-69 (Mar. 23, 2010) (adding LTCH QRP statutory provisions at 42 U.S.C. § 1395ww(m)(5)).
[21] 42 U.S.C. § l395ww(m)(5); 42 C.F.R. § 412.523(c)(4).
[22] *See* Medicare Program, 76 Fed Reg. at 51743-48.
[23] *Id.* at 51752.
[24] *Id*. at 51754.
[25] 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) (codified at 42 C.F.R. pts. 412, 413, 424, & 476) [hereinafter Medicare Program, 77 Fed. Reg.] (specifying collection and submission deadlines as well as the following the CMS web site address for additional instruction and guidance: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html). 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 provide submit questions and comments related to the LTCHQR Program and the [then] draft LTCHQR Program Manual" to a specified email address. *See id.* at 53620, 53621, 53622-23. Excerpts from the LTCH RP Manual, Version 1.1 (Aug. 2012) that was issued contemporaneously with the August 2012 Final Rule are located at Medicare Contractor's Final Position Paper at Exhibit I-3.

The Board's review of the record shows that Amarillo acknowledges that it did not timely submit its third quarter 2013 data.[26] The Board finds no evidence that Amarillo was unable to submit its data by the February 15, 2014 due date because of a problem with the NHSN system.[27] Richmond's summary schedule clearly shows that it failed to timely submit its CLASBI data for November 2013.[28] Accordingly, the Board finds that both Amarillo and Richmond failed to comply with the LTCH QRP requirement to submit data in the form, manner, and time specified by the Secretary.[29]

Amarillo and Richmond requested that the Board provide equitable relief because they both made a good faith effort to comply with the LTCH QRP data submission requirements.[30] However, the Board cannot consider their 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.[31] Nor will the statute nor relevant regulations allow any partial penalty to 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.[32]

Amarillo and Richmond further contend that CMS' reconsideration process was arbitrary and capricious because it failed to address their arguments in support of a waiver of the penalty based on a valid or justifiable excuse for not reporting CY 2013 quality data or properly notify the parties of the basis for the decision in violation of the Administrative Procedure Act, 5 U.S.C. Chapter 5, Subchapter II.[33] The final rule establishing the LTCH QRP appeal process made it clear that it was the LTCH's decision of whether to use the voluntary reconsideration process prior to appealing an initial determination of non-

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[26] Tr. at 95-96.

[27] The Board notes that Richmond was able to submit its data through the NHSN despite the change in ownership.

[28] *See* Richmond's Final Position Paper at Exhibit P-2, 1.

[29] The Patient Protection and Affordable Care Act, Pub. L 111-148, § 3004(a) (2010) added LTCH QRP statutory provisions at 42 U S.C. § l395ww(m)(5).

[30] Amarillo's Final Position Paper at 20-26; Richmond's Final Position Paper at 18-24.

[31]The preamble to the LTCH final rule published on August 19, 2013 stated that, for reconsiderations relevant to FY 2015 LTCH payments, "[w] e may reverse our initial finding of non-compliance if: (1) [t]he 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). It is unclear whether the Board 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 neither Amarillo nor Richmond sufficiently have documented any specific substantial, technical or operational problem that may have constituted a justifiable excuse.

[32] *See* 42 U.S.C. § 1395ww(m)(5)(A)(i); *see also* 42 C.F.R. § 412.523(c)(4).

[33] *See* Amarillo's Final Position Paper at 12-20; *see also* Richmond's Final Position Paper at 11-18.

compliance to the Board.[34] 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:

> 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) [t]he 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.[35]

The record shows that CMS sent a form letter on September 22, 2014 to both Amarillo and Richmond stating that "CMS has re-reviewed the quality data submitted . . ." and "has determined this LTCH did not meet the LTCH QR program requirements for the FY 2015 payment determination."[36] 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 both Amarillo's and Richmond's reconsideration request including a re-review of the data submitted by each LTCH and determined that neither complied with the LTCH QRP requirements. As provided for in the final rule,[37] both Amarillo and Richmond exercised their right to timely appeal CMS' reconsideration determination to the Board.

The Board notes that both Amarillo and Richmond submitted a substantial portion of the required quality data. However the Board finds that unless all required data is submitted timely, the Board cannot reverse the penalty which was imposed for failing 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

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[34] *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 (Aug. 19, 2013) (to be codified at 42 C.F.R. pts. 412, 413, 414, 419, 424, 482, 485, & 489) [hereinafter Medicare Program, 78 Fed. Reg.] (excerpts are located at Medicare Contractor's Final Position Paper to Richmond at 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 . . . .").

[35] *Id.* at 50886.

[36] Amarillo's Final Position Paper at Exhibit P-2; Richmond's Final Position Paper at Exhibit P-2.

[37] *See* Medicare Program, 78 Fed. Reg. at 50887 (excerpts are located at Medicare Contractor's Final Position Paper to Richmond at Exhibit I-12).

the annual update to the standard Federal rate used to calculate the FY 2015 Medicare payments for Amarillo and Richmond under LTCH PPS.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory Ziegler

FOR THE BOARD:

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

DATE: July 13, 2017