PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D37

PROVIDER –
Hospice Care in Westchester and Putnam, Inc.

Provider No.: 33-1542

vs.

MEDICARE CONTRACTOR –
National Government Services

HEARING DATE –
September 27, 2016

Cost Reporting Period Ended –
September 30, 2016

CASE NO.: 16-0828

INDEX

ISSUE STATEMENT:

Hospice Care in Westchester and Putnam, Inc. ("Hospice Care" or the "Provider") challenges the Centers for Medicare & Medicaid Services' ("CMS'") reduction to the Provider's Annual Payment Update ("APU") for Fiscal Year ("FY") 2016.[1]

DECISION:

After considering the Medicare law and regulations, arguments presented, and evidence submitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that Hospice Care did not submit its hospice quality data in the form and manner, and at the time specified by the Secretary of Health and Human Services ("Secretary"), and therefore is subject to a 2% reduction in its FY 2016 APU.

INTRODUCTION:

Hospice Care is a Medicare-certified hospice provider located in New York. CMS reduced Hospice Care's FY 2016 APU by 2% because Hospice Care failed to timely submit quality data to CMS as required by federal law.[2] Hospice Care requested that CMS reconsider its decision, and on September 4, 2015 CMS upheld it determination. Hospice Care timely appealed the reconsideration decision to the Board and met the jurisdictional requirements for a hearing.

The Board held a telephonic hearing on September 27, 2016. Robert P. Charrow, Esq. of Greenberg Traurig, LLP represented Hospice Care. Joe Bauers, Esq. and Ed Lau, Esq. of Federal Specialized Services represented the Medicare Contractor.

STATEMENT OF FACTS:

In section 122 of the Tax Equity and Fiscal Responsibility Act of 1982, Congress amended the Social Security Act ("Act") in order to provide a Medicare Hospice Benefit for Medicare beneficiaries. The Medicare Hospice Benefit provides a per diem payment in one of four prospectively-determined rate categories of hospice care.[3] Subsequently, Congress further amended the Act to include an annual increase in the daily payment rate for hospice services based upon the inpatient market basket percentage increase, also known as the APU.[4] Under the Affordable Care Act ("ACA"), Congress tied a hospice provider's eligibility for its full APU increase to submission of certain quality data based upon measures specified by the Secretary.[5] The ACA further mandated that a hospice's APU be reduced by 2% if that hospice failed to report the required quality data measures for a particular fiscal year.[6] Section 1814(i)(5)(C) of

---

[1] The Parties did not stipulate to the issue statement prior to the hearing. Both the Provider's and the Medicare Contractor's proposed issue statements were read into the Record by the Acting Chairperson. *See* Transcript ("Tr.") at 6-9.
[2] Medicare Contractor's Final Position Paper, Exhibit I-13.
[3] FY 2015 Hospice Wage Index and Payment Rate Update, 79 Fed. Reg. 50452, 50455-57 (Aug. 22, 2014).
[4] Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 (1989); Section 4441(a) of the Balanced Budget Act of 1997, Pub. L. No. 105-33 (1997).
[5] Section 3004(c) of the Affordable Care Act, Pub. L. No. 111-148 (2010).
[6] 42 U.S.C. § 1395f(i)(5)(A).

the Act states that hospices must submit their quality data measures in a form and manner, and at a time, specified by the Secretary.[7] CMS finalized the hospice reporting requirements for the 2016 payment determination in the August 7, 2013 Final Rule.[8]

In order to meet the quality reporting requirements for FY 2016 payment determinations, CMS required hospices to use CMS' standardized data collection instrument called the Hospice Item Set ("HIS") to electronically submit the hospice's quality data measures for each patient admitted to the hospice on or after July 1, 2014.[9] The quality data collection period for the FY 2016 payment determination ran from July 1, 2014 through December 31, 2014.[10]

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Hospice Care states that it complied on a timely basis, with regular and ongoing electronic submissions of HIS data for each patient admission on or after July 1, 2014.[11] Hospice Care's Data Base Administrator would extract the patient information and quality measures from the patient tracking system and upload these files to HIS twice monthly.[12] Hospice Care's Data Base Administrator claims that upon completion of each of these transmissions, the computer program indicated that they were in a "completed" status, which meant the submissions were both received and processed.[13]

Hospice Care argues that it is entitled to the full APU increase for FY 2016 because the Facility Identification Number is not a "quality measure" within the meaning of the statute and that, as long as the actual quality data was timely submitted, the Provider has fulfilled its quality obligations under the Social Security Act.[14] Although the Provider admits that it omitted its Facility Identification Number, Hospice Care argues that the Facility Identification Number is not listed as a "quality measure" and a failure to include the number cannot constitute the omission of quality measures.[15] Hospice Care also argues that CMS could determine the source of the quality data without the Facility Identification Number and; therefore, the Facility Identification Number is redundant and unnecessary.[16]

Hospice Care states that the Office of Management and Budget ("OMB")-approved form requires hospices to include its CMS Certification Number ("CCN") and its National Provider Identification ("NPI"); however, it does not require the Facility Identification Number. Hospice Care states that CMS lacks the authority to require a Facility Identification Number because the

---

[7] 42 U.S.C. § 1395f(i)(5)(C).
[8] 78 Fed. Reg. 48234, 48257-62 (Aug. 7, 2013).
[9] CMS initially implemented the HIS through instructions and in preamble statements, then subsequently codified the HIS submission requirements at 42 C.F.R. § 418.312 in CMS' August 22, 2014 Final Rule. *See* 79 Fed. Reg. at 50486-88.
[10] 78 Fed. Reg. at 48261-62.
[11] Provider's Final Position Paper at 2.
[12] *Id.* at 2-3.
[13] *Id.* (citing *CMS File Submission Status section of the Certification and Survey Provider Enhanced Report CASPER Reporting Hospice Providers Users Guide ("CMS Users Guide"))* and Exhibit P-2.
[14] Provider's Final Position Paper at 1.
[15] *Id.* at 6.
[16] *Id.*

requirement was not issued as part of notice and comment rulemaking. Therefore, Hospice Care concludes it submitted all of its quality data according to the Final Rule requirements.[17]

The Medicare Contractor argues that hospices must submit data "*in a form and manner, and at a time*, specified by the Secretary" and that the failure to submit the required quality data will result in a 2 percentage point reduction to the market basket percentage increase for that hospice.[18] The Medicare Contractor points out that the Provider's data submissions were rejected by CMS because the data submissions lacked a Facility Identification Number as noted on the Final Validation Reports.[19]

The Board finds that the statute requires hospice providers to not just submit their patients' quality data, but to submit the data in the *form and manner, and at the time* specified by the Secretary.[20] The Board finds that CMS issued various manuals and instructions that implemented the form, manner, and time specifications for submitting quality data.[21] The Board agrees that a provider's Facility Identification Number, in the context of the quality reporting statute and regulation, is not a "data" point (quality measure), but finds that it falls under the "manner" requirements that, pursuant to the Act, is within the discretion of the Secretary.

Furthermore, the Board finds that, contrary to Hospice Care's allegations, CMS provided the necessary instructions for hospice data submission, including information related to the Facility Identification Number and Final Validation Reports.[22] CMS provided information and details regarding HIS through its website and provider trainings.[23] Specifically, the HIS Manual explains that once a file is received, the system performs a series of validation checks to evaluate whether the data submitted meets the required data specifications. The provider is notified of the validation results by error and warning messages on a Final Validation Report.[24] If submitted HIS records do not meet the edit requirements, the system will provide fatal error and/or warning messages on the Final Validation Report; any fatal errors must be corrected and resubmitted.[25]

The Board notes that Hospice Care failed to access its Final Validation Reports until *after* the data submission deadline.[26] As a result, Hospice Care was unaware of the fatal error messages

---

[17] Provider's Post-Hearing Brief at 3. Hospice Care cites to 79 Fed. Reg. at 50487, which contains a link to the HIS Form submitted to the OMB as part of the review process under the Paperwork Reduction Act.
[18] Medicare Contractor's Final Position Paper at 4-6. 42 U.S.C. §§ 1395f(i)(5)(C) and 1395f(i)(5)(A) (emphasis added).
[19] Medicare Contractor's Final Position Paper at 8. *See also* Provider's Final Position Paper, Exhibit P-3.
[20] 42 U.S.C. § 1395f(i)(5)(C) and 42 C.F.R. § 418.312(a) (emphasis added).
[21] In addition to the exhibits submitted by the Provider and the Medicare Contractor, the Board introduced Exhibit B-1, "[CMS] Hospice Quality Reporting Program, HIS Manual: Guidance Manual for Completion of the Hospice Item Set (HIS), V1.00.0 Effective July 1, 2014."
[22] *See* Medicare Contractor's Post-Hearing Brief, Exhibit I-14, HIS Submission User's Guide v1.00 (effective July 1, 2014) at REPORTS 4-3 ("The Final Validation Report provides a detailed account of the errors found during the validation of the records in the submitted HIS file.") and at GLOSSARY 6-3 ("The Facility ID is a unique number assigned to the provider for submission processing.").
[23] 79 Fed. Reg. 50487.
[24] Medicare Contractor's Post-Hearing Brief, Exhibit I-18, Guidance Manual for Completion of the HIS V1.00.0 (effective July 1, 2014) at 3-2.
[25] *Id.* at 3-2, 3-3.
[26] Tr. at 68:6-12.

on its Final Validation Reports.[27] If Hospice Care had accessed its Final Validation Reports timely, it would have known about the missing Facility Identification Number and could have corrected the problem within the data submission deadline. The Board recognizes that accessing the Final Validation Reports is not a requirement, but rather a recommendation for hospices.[28] However, the Board asserts that it is in the Provider's best interest to run the Final Validation Reports in order to confirm that its quality data was input correctly.

The Board finds that Hospice Care did not perform the recommended steps prior to the submission deadline to assure that its quality data was error free. The Board concludes that Hospice Care did not submit its data in the form and manner, and at a time specified by the Secretary, and therefore, in accordance with 42 U.S.C. § 1395f(i)(5)(A), CMS was correct in reducing Hospice Care's 2016 APU by 2 percentage points.

DECISION AND ORDER:

After considering the Medicare law and regulations, arguments presented, and evidence submitted, the Board finds that Hospice Care did not submit its hospice quality data in the form and manner, and at the time specified by the Secretary, and therefore is subject to a 2% reduction in its FY 2016 APU.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

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

DATE: May 22, 2018

[27] Provider's Final Position Paper at 3. The Data Base Administrator reviewed the Final Validation Report for the first time in April 2015 and re-submitted the data on April 28, 2015. Tr. at 59:14-21.
[28] Medicare Contractor's Post-Hearing Brief, Exhibit I-14 at FUNCTIONALITY 3-15.