PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D47

PROVIDER-
Post Acute Medical Specialty Hospital of Texarkana North

Provider No.: 45-2061

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –
November 16, 2017

Cost Reporting Period Ended –
09/30/2017

CASE NO. – 17-1018

INDEX

Page No.

Issue Statement…………………………………………………………………… 2

Decision……………………………………………………………………………... 2

Introduction…………………………………………………………………….... 2

Statement of the Facts………………………………………………………………… 3

Discussion, Findings of Facts, and Conclusions of Law………………………….. 4

Decision……………………………..……………………………………………….. 6

ISSUE STATEMENT:

Whether the payment penalty that CMS imposed under the Long-Term Care Hospital Quality Reporting Program to reduce the Provider's payment update for the federal fiscal year of 2017 by two percent was proper.[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Centers for Medicare & Medicaid Services ("CMS") properly imposed a two percent reduction of the annual update to the standard Federal rate used to calculate the Fiscal Year ("FY") 2017 Medicare payments for Post Acute Medical Specialty Hospital of Texarkana North ("Provider" or "Texarkana") under the inpatient prospective payment system for long-term care hospitals ("LTCH-PPS").

INTRODUCTION:

The Provider is a Medicare-certified LTCH located in Texarkana, Texas. The Provider's Medicare Contractor is Novitas Solutions, Inc. ("Medicare Contractor").

On July 14, 2016, CMS determined that the Provider failed to meet the requirements of the Long-Term Care Hospital Quality Reporting Program ("LTCH QRP") for FY 2017.[2] Specifically, the determination letter stated that the Provider was subject to a two percent reduction in the FY 2017 annual payment update because:

- The Provider failed to submit the required data to the Centers for Disease Control and Prevention ("CDC") National Healthcare Safety Network ("NHSN"); and/or
- The Provider failed to submit the required quality measures that are to be submitted to the CMS Quality Improvement Evaluation System ("QIES") system.[3]

Following the Provider's request for reconsideration,[4] CMS upheld its decision to reduce the annual increase factor.[5]

The Provider timely appealed the CMS reconsideration determination to the Board[6] and met the jurisdictional requirements for a hearing before the Board. The Board conducted a live hearing on November 16, 2017. Jason M. Healy, Esq., of The Law Offices of Jason M. Healy, PLLC represented the Provider. Jerrod Olszewski, Esq., of Federal Specialized Services, represented the Medicare Contractor.

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[1] Transcript ("Tr") at 5-6.
[2] Provider's Final Position Paper, Exhibit P-2.
[3] *Id.*
[4] *Id.* at Exhibit P-3.
[5] *Id.* at Exhibit P-4.
[6] *Id.* at Exhibit P-1.

STATEMENT OF THE FACTS:

The Patient Protection and Affordable Care Act of 2010 requires LTCHs to report on the quality of their services in the form and manner, and at a time, specified by the Secretary.[7] A LTCH that fails to submit the LTCH QRP data to the Secretary is assessed a one-time two percent reduction to its annual update to the standard Federal LTCH prospective payment.[8]

As set forth in the final rule published on August 18, 2011 ("August 2011 Final Rule"), CMS required that LTCHs submit certain quality data to the CDC's NHSN system starting with calendar year ("CY") 2012.[9] CMS updated the quality data to be submitted for CY 2015 requiring Texarkana to submit data on the following quality measures to NHSN for all four quarters of CY 2015:

1. Catheter-Associated Urinary Tract Infection Outcome Measure ("CAUTI");
2. Central Line-Associated Bloodstream Infection Outcome Measure ("CLABSI");
3. Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus Bacteremia Outcome Measure ("MRSA")
4. Facility-Wide Inpatient Hospital-onset Clostridium difficile Infection Outcome Measure ("CDI");
5. Influenza Vaccination Coverage among Healthcare Personnel; and[10]
6. Percent of Residents with Pressure Ulcers that Are New or have Worsened ("Pressure Ulcer measure").[11]

CMS set the following deadlines for the submission of the LTCH QRP CY 2015 quality measures data for FY 2017 payment determination:

Q1 (January-March 2015) – February 15, 2016
Q2 (April-June 2015) – February 15, 2016
Q3 (July-September 2015) – February 15, 2016
Q4 (October-December 2015) – May 15, 2016[12]

The Medicare Contractor reduced Texarkana's annual payment update for FY 2017 by two percent because Texarkana failed to properly submit all of the required quality data for CY 2015 to CMS.[13] Specifically, the Medicare Contractor states, and the Provider concedes, that

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[7] 42 U.S.C. § 1395ww(m)(5)(C). *See also,* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3004(a), 124 Stat. 119, 368-69 (Mar. 23, 2010).
[8] 42 U.S.C. § 1395ww(m)(5)(A); 42 C.F.R. § 412.523(c)(4).
[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) (to be codified at 42 C.F.R. pts. 412, 413, & 476).
[10] Healthcare influenza vaccine coverage data only required for October 1, 2015 through March 31, 2016.
[11] *See* Exhibit P-9 at 2.
[12] *Id.*
[13] *See* Exhibit P-2.

Texarkana failed to enter the proper location code when uploading portions of its CY 2015 CDI data to NHSN.[14]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The Provider disputes that it failed to timely report all CDI data for CY 2015 because all of the data was entered into NHSN before the submission deadlines.[15] Texarkana operates under only one Provider Number and, as a result, asserts that the location code does not impact the availability of data in NHSN.[16] Furthermore, Texarkana contends CMS failed to follow its own published procedures[17] for reconsideration of determinations of non-compliance with the LTCH QRP.[18] Specifically, the Provider argues that the CMS redetermination was invalid because CMS ignored the submitted evidence of compliance [19] and the redetermination was not the product of reasoned decision making.[20] Finally, Texarkana argues that the Board may use its equitable discretion to reverse CMS' Reconsideration and restore the full annual payment update for FY 2017.[21]

The Board's review of the record shows that the Provider failed to comply with the LTCH QRP requirement to submit data in the form and manner, and at a time, specified by the Secretary.[22] Although the CDI data was submitted to NHSN by the applicable deadlines, the Provider admits that when it submitted some of the CDI data for Quarter 2 and Quarter 3 of FY 2015, the wrong location identifier was used.[23] The Provider changed the location identifier on the monthly reporting plans on July 15, 2016,[24] after the deadline for submission of this data. The Provider argues that CMS should not penalize the Provider because the location change did not alter any of the quality data that it previously reported to NHSN.[25] However, the Board finds that the required LTCH QRP data was not submitted in the form and manner, and at the time specified by the Secretary.

The Board notes that the Provider stated during the hearing that it received training on how to report the quality data.[26] Post hearing, the Board received documentation from the Medicare Contractor that the Provider was given direction to use the correct (facility wide) location codes when submitting its FY 2015 quality data.[27]

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[14] Medicare Contractor's Final Position Paper at 8. Transcript ("Tr.") at 13-14.
[15] Provider's Final Position Paper at 1.
[16] Tr. at 14.
[17] *See* Exhibit P-10.
[18] Provider's Final Position Paper at 1.
[19] *Id.* at 11
[20] *Id.* at 21.
[21] *Id.*
[22] Pub. L. No. 111-148, § 3004(a) added LTCH QRP statutory provisions at 42 U S.C. § 1395ww(m)(5).
[23] Provider's Final Position Paper at 9-10.
[24] Provider's Final Position Paper at 10. *See* Exhibit P-7 at 2.
[25] Provider's Final Position Paper at 10.
[26] Tr. 41 -42.
[27] Exhibit I-5.

The Provider requested that the Board provide equitable relief because it made a good faith effort to comply with the LTCH QRP data submission requirements.[28] However, the Board cannot consider the Provider'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.[29] Neither the statute nor relevant regulations allow for a partial penalty to reduce the full impact of the two percent reduction. Rather, the statute and relevant regulations mandate a two percentage point penalty whenever an LTCH fails to submit LTCH QRP data in the form and manner and at a time as specified by the Secretary.[30]

The Provider further contends that CMS' reconsideration process was arbitrary and capricious because it failed to address its arguments in support of a waiver of the penalty based on a valid or justifiable excuse for not reporting CY 2015 quality data and/or failed to 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.[31] 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-compliance to the Board.[32] 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.[33]

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[28] Provider's Final Position Paper at 21-27.

[29] In particular, the Board recognizes that Texarkana argues that the reconsideration decision issued by CMS was deficient because it failed to provide adequate notice of 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 Texarkana is subject to a two percent reduction if it fails to submit LTCH QRP data in the form and manner and at a time specified by the Secretary. Further, 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 the Provider has not documented any specific substantial, technical or operational problem that may have constituted a justifiable excuse.

[30] 42 U.S.C. § 1395ww(m)(5)(A)(i); *see also* 42 C.F.R. § 412.523(c)(4).

[31] Provider's Final Position Paper at 14-21.

[32] 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.] (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 . . . .").

[33] *Id.* at 50886.

The record shows that CMS sent a letter on September 21, 2016 to the Provider stating that "CMS reviewed the reconsideration request … and is upholding the decision" and "records indicate that this LTCH did not provide evidence that it submitted required quality data during the required timeframes."[34] 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 the Provider's reconsideration request including a re-review of the data submitted by the LTCH and determined that the Provider did not comply with the LTCH QRP requirements. As provided for in the final rule,[35] the Provider exercised its right and timely appealed CMS' reconsideration determination to the Board.

The Board finds that unless all required data is submitted in the form and manner and at the time specified by the Secretary, the Board cannot reverse the penalty required by 42 C.F.R. § 412.523(c)(4).

DECISION:

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that CMS properly imposed a two percent reduction to the annual update to the standard Federal rate used to calculate the FY 2017 Medicare payments for the Provider under LTCH PPS.

BOARD MEMBERS PARTICIPATING:

Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD:

/s/
Charlotte F. Benson, CPA
Board Member

DATE: September 6, 2018

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[34] Provider's Final Position Paper, Exhibit P-4.
[35] *See* 78 Fed. Reg. at 50887.